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# Withdrawal/Redaction Sheet

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**RESTRICTION CODES****Presidential Records Act - [44 U.S.C. 2204(a)]**

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Jan. 16, 1997

Urican  
cc Ken  
Nelly G  
Revere.

(Arms)

# AZT denied - and Aids keeps killing

By CHARLENE SMITH

Glory Mapella rocks back and forth, the limp body of 2-year-old Eric in her arms. He has a bandage around his head, and although his eyes are closed, his face is turned up towards his mother, a smile on his lips. She sings softly, "I love my baby, I love my baby", and kisses him. His life expectancy can be counted in days.

In South Africa one in five mothers is infected with HIV/Aids.

Each year, more than 1 million babies are born in South Africa and tens of thousands are infected. Most will not see their second birthday.

But if the government gave babies the drug AZT in their first month of life, and mothers did not breastfeed, the lives of most of these could be saved each year, according to Professor Peter Cooper, head of paediatrics at Johannesburg Hospital.

But Health Minister Dr Nkosazana Zuma is refusing to allow the drug, which costs less than R400 a month per baby, to be given. Within a year of birth, these babies become very ill and require frequent hospitalisation. By the time they die at around 2 or 4 years of age, they will have spent most of their time in hospital - at an average cost of R300 a day.

An Aids baby in a hospice costs around R2 500 a month or R30 000 a year. But, for the cost of R400 and a life saved, hospitals will have to spend a fortune in a losing battle for that child.

There is an argument from the Department of Health, conveyed to health practitioners, that there is no point in saving the lives of babies born to HIV-infected mothers because the mothers will die quite soon anyway and the children will be orphaned. It's a theory which forgets that, constitutionally, children have a right to life.

## Much pain

Eric became infected with Aids from Glory when he was born. She tries to talk but her eyes fill and she cries.

In the next room of Cotlands, an Aids hospice in Johannesburg, Sister Betty Olifant sponges down a baby who seems plump and healthy, but has Aids: "Hai, that baby (Eric) is in too much pain, he will die soon. You never get used to losing them, but at least it gives them relief from the pain."

Some 22.5 million children in sub-Saharan Africa have HIV/Aids, according to the World Health Organisation.

By 1996, of the 4 million babies born each year in the United States (overall population 245 million people), only 600 had Aids transmitted to them from their mothers.

Says Cooper: "Of the deaths in our wards, excluding newborns, at Johannesburg Hospital, 70% will die because of HIV/Aids. Our general paediatric wards accommodate an average of 80 children a day, and 30% to 40% of those have HIV."

"Most HIV patients are under the age of 2, and are infected by their mother (by coming into contact with the mother's blood) during birth or through breastfeeding, but we are now starting to see older children come in with HIV/Aids."

"Half of the children who contract HIV/Aids during birth become ill in their first year. In adults, the average time from contracting the virus to

getting sick is seven to eight years."

Cooper says hospitals began seeing the first HIV/Aids children in the late 1980s. "It has developed from us having to deal with the occasional child to a full-blown epidemic."

Now several children die each week in Johannesburg Hospital alone from HIV/Aids.

Last week British Prime Minister Tony Blair gave South Africa a R100-million package to fight Aids - part of a larger grant Britain is giving to fight Aids on the continent.

According to UN figures, southern and eastern Africa are the world's worst-hit Aids areas.

In 1993, life expectancy in South Africa was 63 years but by last year it had dropped to 55. In the same period, life expectancy in Botswana was 65 and has now plummeted to 40.

A third of all children admitted to South African hospitals are HIV positive or have Aids.

Lindi Sithole approaches newcomers to the paediatric ward that is her second home, smiling sweetly. In her long pink gown with carefully braided hair she looks like a princess.

Dr Ashraf Coovadia turns over her hands: her palms are blue. "Why are you not in bed having your oxygen?" he gently scolds.

Lindi has Aids and should be on oxygen permanently. She is entering



UNBENDING: Dr Zuma has opted to ignore special-price offer from drug company

the final stages of her illness, but paediatric staff at Coronation Hospital, which is wedged between Johannesburg and Soweto, also know the 4-year-old needs to play.

Her mother died in March last year, and no one knows where her father is. Although the hospital regularly sends oxygen to the home she lives in with her aunt, she sometimes becomes so ill she has to be hospitalised.

Professor John Pettifor, head of paediatrics at three hospitals - Coronation, Soweto's Chris Hani Baragwanath, and Johannesburg Hospital - and head of the paediatrics chair at the University of the Witwatersrand, says hopefully, and somewhat wryly, in connection with the British gift: "Could we build a children's hospital with it?"

Blair has said the money will be targeted at educating people about the dangers of Aids and supplying contraceptives. But Pettifor says: "I am pessimistic about changing sexual habits - education is not enough. What we need is a cheap vaccine. Without one we won't make a dent, but such a vaccine is still some time off."

"A survey done in Soweto last year

showed that 20% of all mothers giving birth were HIV positive. Think of it: in the next eight to 10 years, a fifth of all women of child-bearing age will die. Within five years there will be huge numbers of women dying. The disruption to family life and the fabric of society will be enormous."

Dr Glenda Gray, who heads research into Aids at Chris Hani Baragwanath, says three children are born with HIV/Aids every day in Soweto.

Research has shown that if a baby is born negative to an HIV-positive mother, and if she breastfeeds, she will probably transmit Aids to her otherwise healthy infant.

It is becoming increasingly unequivocal that HIV-positive women who have access to clean water for formula feeding endanger the lives of their babies if they breastfeed. A study due out in South Africa on February 1 is expected to reconfirm this.

Pharmaceutical giant Glaxo-Wellcome, the manufacturer of AZT, has made the government an offer, but Zuma has refused.

Glaxo-Wellcome has cut its price by three-quarters for a five-year period and offered the government some free supplies of AZT.

And yet the disease is putting huge strain on health services - Gauteng puts an astounding 45% of its budget into combating the disease, but other provinces tend to have lower figures.

Putting so much of a budget into one disease means that other areas suffer. Hospitals which are already chronically understaffed and poorly resourced, for the most part, are battling with impossible patient loads, and for the past year have had to freeze the posts of doctors and nurses who leave, so all hospitals are suffering critical staff shortages, and those left are working impossible hours.

## Tuberculosis

Jackie Schoeman, assistant director of child care at Cotlands, says many families refuse to look after children with Aids "because of the stigma, so we lie to some family members about why the child is in our care - we say he or she has meningitis or tuberculosis".

Tuberculosis, fuelled by HIV, has become rampant in South Africa. More than 60 people a day succumb to the disease and the figures are climbing steeply.

Cotlands, which receives a small stipend from the government and raises other funds privately, admitted 54 children to its hospice last year. Most were under the age of 4, and 46 died. Cotlands is trying to encourage people to foster Aids babies, but in four years only two children have been fostered.

Doctors are furious that the government is refusing to administer AZT to pregnant mothers, and one province, the Western Cape, is currently ignoring the government's ruling.

Pettifor says: "If we are to decrease the prevalence of children suffering from HIV, we have to look at the use of AZT in pregnancy. But because the government is refusing AZT for pregnant women, all we can do now is give TLC (tender loving care)."

"Doctors are becoming impotent again and it is depressing. Doctors are back in the situation of 40 or 50 years ago when there were no antibiotics - except that now, far more people are dying."

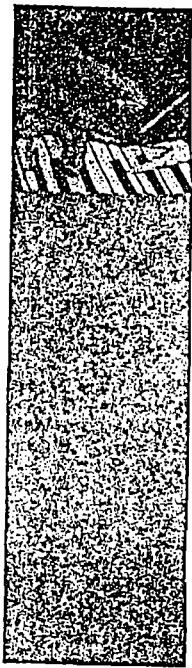
■ Patients' names have been changed to protect their identities.

bank accounts African Nodbank debit card - and spent Christmas b toys, swifery and food.

The fraudsters have estimated R1-million in shopping spree which about 2 000 transactions accounts of more than 100 000 nationwide.

The cards were not duplicated or new for unsuspecting customer.

And despite the bank's halt the fraudulent to which started a week before, thieves were pilfe



STAYER: Quentin Glove he is staying on a little

R2400

THE R



Total concentration



Children discover the





**DESPERATE:** These women claim they were dismissed after being found to be HIV positive. Their employer says infected people shouldn't be in any workplace. Photograph: HERMAN LEEUW

## Two women fired after 'secret' tests

By HERMAN LEEUW

Two middle-aged women were dismissed from their jobs at a Vanderbijlpark textile factory this week for being HIV positive, following what they claim was a secret HIV test ordered by the factory owner.

According to them, their employer, Craig van der Merwe, invited health workers to his Shakespeare Textile Factory in November to test the HIV status of his employees, apparently without consulting them. Both women were later called into Van der Merwe's office and told they had been dismissed because of their HIV status.

One of the dismissed employees, a mother of two, sobbed bitterly when interviewed this week.

"It's better to commit suicide because I have begun to hate every man in this world," she said. "Why did I have to invite this deadly disease into my house? I always feel guilty whenever I see my family, especially my boyfriend. What wrong have I done to deserve dismissal? I am the sole breadwinner."

### Not convinced

"I am still not convinced that I am HIV positive because none of the HIV test procedures were carried out in a professional manner," she claimed. "I intend to consult a lawyer."

But Van der Merwe told the *Saturday Star* that he wouldn't employ HIV/Aids sufferers. "It sounds unfair but I was trying to help others not to be infected."

"Such people are dangerous to the community, especially if they are dealing with customers. I don't regret what I did because I believe HIV/Aids victims should not be in workplaces."

"I've been requesting employees to consult their personal doctors for HIV tests since the beginning of 1997, but none of them ever came back with results."

Percy Mahlati, spokesperson for the SA Medical and Dental Association, condemned Van der Merwe's decision, saying his action had to be addressed immediately. "There's nothing wrong about Van der Merwe's HIV-positive employees," he said.

"Most HIV-positive victims are still employed by companies nationwide. Nobody has the right to discriminate against people on the basis of their illness. To dismiss them in this manner is illegal."

## Pastors threaten to sue doctor for revealing their HIV status

By HERMAN LEEUW

Two Sharpeville pastors have threatened to sue a Vual Triangle doctor - Rodney Lindani Bulawayo - for allegedly disclosing their HIV status. According to both men, Bulawayo failed to respect their confidentiality and impaired their dignity.

The angry pastors this week confronted Bulawayo at his surgery, where they claimed damages of R60 000 each.

"He attempted to give us R6 000 each in a bid to silence us but we

have rejected his bribery," said one of the pastors. "We wonder how many people know that we are HIV positive. Our occupations don't necessarily mean he had a right to expose us to the media," he said.

Despite the pastors' anger, Bulawayo was in a relaxed state of mind when he told the *Saturday Star* that he had been furious with the pastors, who, he claims, lied about their names, addresses and phone numbers on their HIV test forms.

"We doctors always experience problems about patients who give us

wrong information," he said in his defence. "It is difficult for doctors to provide counselling for such patients. We are here to help them, but if they don't co-operate with professionals, they are likely to spread their deadly disease wherever they go."

Bulawayo denied he had tried to bribe both of them: "I wouldn't attempt to bribe them because I don't feel guilty for disclosing their HIV status to the media."

Percy Mahlati, spokesperson for the SA Medical and Dental Association,

strongly condemned doctors who disclose confidential information about their patients to the media. "The confidentiality of patients is not merely ethical, but is also a legal duty," he said. "We are going to investigate this case thoroughly."

"Most doctors are bound to be frustrated because they are unable to conduct proper procedures like providing patients with counselling. I urge all doctors to contact the medical association for advice before they take any drastic decisions."

### Some of the shocking figures

- One in five mothers in SA is infected with HIV/Aids.
- 60 000 babies are infected each year - most will not see their second birthday.
- To hospitalise a sick child costs R300 a day or millions a year for all of them currently being treated. Aids babies require frequent and lengthy hospitalisation.
- An Aids baby in a hospice costs R2 500 a month or R30 000 a year.
- Within eight years, a fifth of all South African women of child-bearing age will be dying from Aids.
- 22,5 m children in sub-Saharan Africa have HIV/Aids.
- Fifty times more babies are infected with HIV/Aids in South Africa than in North America.
- 70% of children who die in Johannesburg Hospital do so because of HIV/Aids.
- A third of all children admitted to SA hospitals are HIV positive or have Aids. In some areas figures are higher.

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THAT'S WHAT FRIENDS ARE FOR: Victor Bogopane, alias Doc Shebeleza (left of group), saw a way of giving something back to the community  
Photograph: ANDY KATZ

## Wake up, Africa! Please wake up!

By AURELIA DYANTYI

*Awuvuke wem Africa, awuvuke emaqandeni* – Wake up Africa, wake up: that is the message from South African musicians who are trying to put an end to the spreading Aids epidemic.

Top local musicians who were inspired by the deputy president's Aids speech on partnership against HIV and Aids have come together to make people aware that Aids kills.

These dedicated artists have come up with a CD compilation which will not only entertain their fans but also raise awareness about the dangers of Aids.

From kwaito, maskhandi, gospel, jazz, R&B, mbaqanga and Shangaan dance music, to young and old tastes, the message is short and clear: protect

yourself from Aids by using a condom, or abstain from sex.

Victor Bogopane, alias Doc Shebeleza, conceived the idea and saw it as a way of giving back to the community. It has led to the formation of African Musicians Against HIV and Aids (Amaha) – and they mean business.

Musician and secretary-general of Amaha, Blondie Makhene, is calling on other musicians who are not yet members to join in the fight: "This is going to be an on going process, not just one CD. We believe this project will be around in 10 to 20 years.

"We are going to put together a number of festivals throughout the country that will feature top artists. We have written letters to many musicians urging them to become members of Amaha because we will need them to

participate in other projects that will follow.

"We have asked some musicians to write songs with a message which will also be featured in the CD, and we will launch on January 20.

"Putting together a project of this magnitude needs a lot of money, and we are lucky to have the backing of the SABC and the Department of Health. Music is a most powerful medium and targets all audiences, even the illiterate. They can all listen to music."

"If your valleys, rivers and mountains have turned into burial grounds, what comes to your mind?" go the lyrics of a song written in English, Zulu, Sotho and the lingua franca of the townships.

Among others, the voices of Family Factory, Bongo Muffin, Rebecca Malope and Hugh Masekela are heard.

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# From posh club to shebeen, barmen command respect

QUIET PLACE: Pinky Mosoka, whose kipspruit shebeen is experiencing a boom with the increasing number of tourists pitching up, does not encourage the patronage of hooligans  
Photograph: CHRIS ADLAM

## A new look at what business is doing to RAINBOW QUIZ

STAYER: Quentin Glover, barmen at Melville's Ratz, was going to study with the money he made, but loved the jobs so much that he is staying on a little longer  
Photograph: CATHY PINNOCK

Vivian

(HIV/AIDS)

JANUARY 17, 1999 ★★ ★★

CITY PRESS Woman 2 Woman

25

CC: Ken + Nelly (From Reunite)



LOVING CARE... Dudu Ndlela hugs one of the children she has adopted and which she loves as her own. ■ Pic: GEORGE MASHININI

# Giver of love and hope

**T**HE LAUGHTER of children could be heard from a few houses down the road. It sounded like a place of warmth, love and happiness – qualities that most of the children who had found a home with Dudu Ndlela in Diepkloof, Soweto, were experiencing for the first time.

Ndlela's heart went out to four abandoned babies she saw when visiting Chris Hani Baragwanath Hospital in Soweto.

"I just knew I had to help them in some way, so I decided to adopt them," said Ndlela.

She applied to the Johannesburg Child Welfare Society and thought that her application would be rejected as she was not married.

"I guess since there are so many abandoned babies, welfare looks into single parenting as well," said this former receptionist.

Ndlela, who has three grown children of her own, explained that her love for children led her to start a day-care centre many years ago, which she still runs today.

After the centre opened, parents approached Ndlela and asked her to

Dudu Ndlela's love of children drove her to adopt four abandoned babies – and soon her home was bubbling over with the happy laughter of young children, and also a few tears.

offer a boarding facility.

"My home became a regular nursery with so many children, but I still felt I wasn't doing enough for those who desperately needed help."

She says one of the requirements of the welfare society was to provide as much of a normal home environment as possible so that transition could be easy for the children.

Ndlela depends on her disability grant to support these children, as the government's grant of R300 per child is not enough.

She would like to see these grants reviewed.

"I rely on my relatives for funding most of the time as I have to buy food supplements to nurture

their growth and have to provide all their schooling requirements."

Another battle Ndlela had to fight was to get acceptance from her neighbours.

In creating her home she went against the norms of a traditional black family.

"Lots of black people are under the impression that adoption does not protect cultural and ethnic diversity," she said.

Ndlela explained that different ethnic groups have unique traditions and some believe it is wrong to bring children from different backgrounds into their homes.

She added that some black people feel that accepting a child from an unknown background will result in



By  
Mpoiana  
Komane

bad luck.

What made it worse was the fact that the two youngest children she had adopted were HIV positive.

When one died after a few months, none of the neighbours attended the funeral.

"We need to set an example and show others that these children need a home, food and love."

"It's not their fault that they were born with HIV," Ndlela said.

She added that one did not need to be wealthy to take in a child.

"We are living in a very confused society. The least we can do is to help make things right," she said.

When Ndlela brought her adopted son home he was HIV positive, weighed just one-and-a-half kilograms, and had syphilis and gonorrhoea.

"All I wanted to do was give him the love he had never before experienced."

Ndlela says she had absolutely no doubt that the boy would live.

"Of course I thought about what I would do if he got ill, which made me a bit weepy, but the feeling was so strong that we were meant to be together that I was prepared to take my chances and look after him until his death, if need be," she said. Ndlela took the boy for treatment and after six months he was cleared of HIV and all other illnesses.

"If he had not come home with me I think he would have died of neglect and a lack of love."

Ndlela describes her son as a lively, robust, intelligent little boy. "There are people who still can't believe that he has emerged completely clear of HIV."

Another of Ndlela's adopted children is now a senior sister and lecturer at Baragwanath Hospital.

have been unfairly dismissed and awarded compensation of R3 920. Twelve months later, she was still living on the farm, but had yet to receive a cent of her compensation. In the

All that was left of 10 houses after the farm owner brought in a bulldozer last weekend and flattened the homes of 30 people

PHOTOGRAPH: NKUZI DEVELOPMENT ASSOCIATION

intent on undermining those rights by forcing people off the land," says Kgooa.

The Sunday Independent  
17 Jan 99  
Reconstruct

# Gang rape is fun, say sexually naive schoolboys in survey

Co: Vivian Co: Ken Y.

(AIDS/HIV)

BY CHRISTINA STUCKY

"Jackrolling [gang rape] is fun" and "How do you put on a condom?" were some of the responses from teenagers at schools in the Southern Metropolitan Local Council (SMLC) of Johannesburg during a survey assessing youth's often shocking attitudes to, and experiences with, sexual violence.

The sample of students interviewed by CIETAfrica in this Canadian-funded pilot project included 1 500 boys and girls aged between 12 and 22 at eight schools in Orange Farm and Soweto. Twenty-five percent of the boys said jackrolling, or gang rape, is "fun" and 16 percent thought it was "cool". Forty-three percent of the girls interviewed - the responses were anonymous and confidential - said sexual violence was very common.

Some of the results of this survey were published last week, highlighting in particular the finding that one in three of the girls interviewed had experienced sexual violence at school. Equally disturbing are the findings revealing the attitudes of the boys.

Also, those conducting the survey discovered a lack of basic sex knowledge. When given the opportunity to ask questions after the survey, the pupils asked basic sex education questions. "They asked questions about sex, how to put on a condom, how to deal with sexual pressure, etc. The

questions were very basic. There's definitely a need for sex education," says Marina Penderis, information officer for CIETAfrica.

Given some of the responses of the youths, particularly the boys, regarding sexual violence, Penderis says: "Youth has always had its own culture, which adults or the police can't change. Sexual violence has obviously become a part of that culture."

When the boys were asked, for instance, whether they thought girls believed sexually violent boys were more attractive, 44 percent of the boys said yes, compared with 9 percent of the

girls. Twenty percent of boys said that women's behaviour should be restricted - that they should not be allowed out at night or to wear short skirts. Thirteen percent of the boys believed sexual violence - in which the teens included

slapping, forcing someone to have sex or unwanted touching - was "caused" by girls, while 64 percent believed it was caused by both girls and boys.

On the positive side, 70 percent of the boys said they didn't think they could be sexually violent. The 30 percent who said they could, were asked what they would do and what might be able to stop them. Sixty-seven percent said they would become physically violent, 23 percent said they would impose some kind of "punishment", and 2 percent said they would become sexually violent.

In a survey of adult males and sexual violence, also conducted by CIETAfrica at the end of last year, the same question received often very violent responses. For example, to the question what he would do, one male adult answered: "I would kick her in the vagina."

The majority of the teenage boys (46 percent) said they would only be stopped by their feelings for the girl. Eight percent said nothing would stop them, 10 percent said family or friends could stop them, 4 percent said they would only stop "if she had sex with me", and only 1 percent said the police could stop them.

The pupils were interviewed in an informal setting by "young, hip" questioners trained by CIETAfrica, avoiding a "top-down or adult preaching approach", says Penderis.

The questions were read aloud and then the teenagers were asked to select a response from a list of choices. The response sheets were then placed in a ballot box and shaken up to demonstrate that none of the answers could be traced back to a particular student. Further discussions were also stimulated by role-playing.

CIETAfrica hopes to expand the survey to cover all 500 schools in the SMLC, which includes Soweto, Lenasia and Eldorado Park.

Penderis says the organisation would like NGOs and the police to join it in this venture and eventually take over the method. This year the surveyors will visit 38 schools.

The primary aim is to stimulate debate among the students and assist them in finding their own solutions to the problem of sexual violence by providing them with information and with a forum for discussion. As shocking as some of these findings are, the

majority of the pupils interviewed displayed no violent tendencies. The goal, says Penderis, is to make the views of the majority acceptable to the violent minority.

At the end of the survey, the teenagers were invited to write comments. A 17-year-old girl from Eldorado Park wrote: "Sexual violence is the biggest crime in the community and it is busy destroying every girls' life. You can't be scared all the time."

attach pg 6 article

## SENIOR JOURNALIST

RECONSTRUCT is seeking to fill the position of a **full-time senior journalist**. RECONSTRUCT, a weekly supplement to The Sunday Independent launched in March 1998, focuses on development and transformation issues. Its readership includes policy and decision makers in government and the NGO sector.

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## RECONSTRUCT

*The development paper*

17 Jan 99

(HIV/AIDS)

# Sex education is a question of survival

*Co. Vivian + Kenya (from Review)*

When young men, aged between 12 and 22, say that "gang rape is fun" and, virtually in the same breath, ask "how do you put on a condom?", it sends chills down the spine. Both statements reveal a level of ignorance that South Africa, in the throes of an Aids epidemic and faced with a steady increase of sexual violence, can scarcely afford.

The survey conducted by CIETAfrica at eight schools in Orange Farm and Soweto scratches only the surface of the level of sexual violence that seems to have become the norm among youths. When one in three girls interviewed says she has experienced sexual violence and about 12 percent of boys say they have had sex with a girl without her consent, then it is time to sit up and take notice.

Statements like "jackrolling [gang rape] is fun" by 25 percent of respondents just serve to drive the point home that urgent steps need to be taken to address this mindset of young men before it becomes entrenched and part of the norm. Society must never allow sexual violence of any form to become the standard and abstention from sexual violence the deviation from that standard.

Finding the causes that have led to these attitudes is not a simple, linear exercise. However, one of the fundamental problems that must be addressed is the lack of basic sex education at schools. As much as some parents, particularly religious-minded ones, may balk at the thought of their child being taught how to put on a condom or the basic facts of conception, these few cannot be allowed to stand in the way of educating youths on what should be an integral part of any curriculum. The 3 Rs are useless without the L - lifeskills. And sex education is essential in preparing youths for life.

While government resources are strapped and the education department is grappling with providing books, let alone adding to its load of responsibilities, there are ways in which sex education can become a part of the curriculum without incurring great cost. Civil society organisations could, for example, form partnerships with educators in this venture. In essence, there is no choice in this matter, for it is a question of survival.

## LETTERS TO THE EDITOR

Feeling irked or exhilarated by something you have read in *Reconstruct*? Do you want to share your opinion on a topic highlighted in a recent issue?

*Reconstruct* encourages readers to write letters to the editor, sharing their views and opinions on any of the issues raised in *Reconstruct*.



Land around Maputo

# Ge

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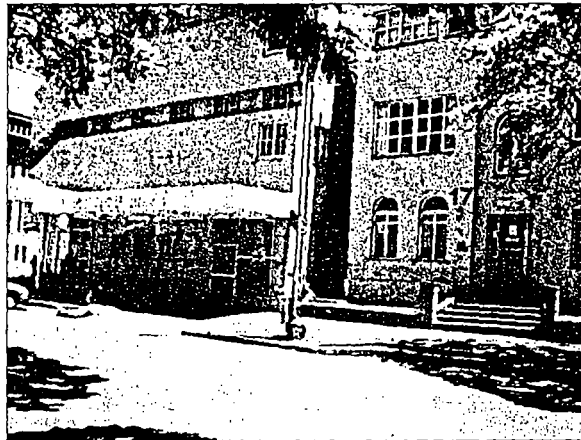
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JANUARY 17, 1999 ★★★★★

City Press (AID-)

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NUMBER 15... Esselen Street centre has waged a war against AIDS for eight years, lately amid severe budget cuts and scant resources.

## Aid needed to help AIDS centre battle epidemic

By MAPULA SIBANDA

WITH up to 10 percent of the total population of Gauteng already infected with HIV, the Esselen Street AIDS Centre in Hillbrow is a much-needed resource that cannot be allowed to fold.

In an interview with City Press, the manager for Greater Johannesburg's AIDS programme, Mary Crewe, this week painted a gloomy picture of a centre that has had to practically halve its resources to accommodate budget cuts.

"We used to be one of the most effective AIDS programmes in the country, but now we have been reduced to a shadow of our former selves," she said.

The centre, which is popularly referred to as "Number 15" or "17 Esselen Street", has for the past eight years offered AIDS education and family planning services for the more than one million migrant inner city population.

Today, only seven of the original fifteen permanent staff members are working as the remaining eight positions had to be frozen.

The centre has to rely heavily on volunteers.

Crewe proposed that it will take up to R5 million a year for the centre to be run effectively.

At present though, the centre has to do with the R600 000 budget offered by provincial government, an amount which Crewe said has not increased in the past four years.

Local government contributes more than one million rand to the centre.

Crewe believes politicians are only paying lip service to the AIDS problem.

"It does not seem as if politicians are making a difference in fighting the epidemic, as there has not been any major policy announcements regarding the epidemic," Crewe said.

Politicians and councillors rarely bother to visit the centre.

On a normal busy day the Esselen AIDS Centre is visited by more than 100 people. Some come for free condoms, some for counselling on family planning, STDs and AIDS awareness, while some come for HIV tests.

Pre- and post-test counselling is offered and the centre also runs outreach programmes for street children and commercial sex workers.

Crewe is worried that the number of people they are seeing has not reduced since the centre was opened, and this can only mean that limited resources and budget cuts are forcing them to fall behind in the prevention of the epidemic.

For Jabu Tshabalala, counselling both HIV negative and positive people about the effects of the disease, has become a regular job in the past four years.

Many have tested positive – sometimes up to four people a day.

Tshabalala cannot remember the first positive case he coun-



NO MORE LIP SERVICE... Government must help fight AIDS, says Greater Johannesburg AIDS manager, Mary Crewe.

selled.

"When I started I preferred giving only the negative results, because telling anyone they were positive was like giving them a death sentence," he said.

Tshabalala said counsellors do not beat about the bush when they deliver the bad news.

"You do not start by enquiring about the weather. You go straight to the fact that they are HIV positive."

"Although I have been doing this for long, I feel bad every time I have to tell someone that they are HIV positive."

Tshabalala also co-ordinates volunteers to cope with the growing demand for AIDS support from inner city communities.

Crewe and Tshabalala agreed that, despite budget cuts and limited resources, the services offered by Esselen Street will continue as long as the epidemic is spreading.

## New batch of unemployed as farm goes under

By MATEFU MOKOENA

THE list of jobless people in South Africa is set to increase as a once productive crop farm near Kliprivier in Gauteng closes down.

The farmer, Joao Conslaves (40), who employed 163 farmworkers at Tongaat farm, said he had to close the farm as he is bankrupt.

He blamed the Johannesburg market for his downfall, saying it allows illegal transactions and that there is corruption and theft in the market.

Conslaves' decision raised fears among workers that he might not pay

them all that is due to them. They also feared that he might evict them from his housing complex.

Workers' representatives said: "Our only request to Conslaves is that he give us our money and allow us to stay here at his complex until we find another job."

Workers are backed up by the Kliprivier ANC interim committee which is still holding negotiations with Conslaves.

Conslaves told City Press he would pay workers all their monies and allow them to stay at his complex until they find jobs.

## Virginty testing is making a comeback

*Cap Africa* A YOUTH CLUB in Ermelo, Mpumalanga, is tackling the spread of HIV and AIDS by reintroducing the ancient custom of virginity testing.

Of the 200 teenagers already tested for virginity in Ermelo and the nearby township of Wesseltown, 196 are virgins, says chairperson of the Vukuzakhe Youth Club, John Mabaso.

"The teenagers volunteer to be tested and we reward them with Virginity Certificates to encourage them to continue behaving themselves," he explains.

He said that the age-old custom had been modified, however, to test boys as well as girls.

The club is assisted by well-known KwaZulu-Natal virginity tester, Fikile Mhlongo, who was responsible for reintroducing the custom in that province.

The founder of the Ermelo club, Catherine Mabaso, says parents in the area had welcomed the revival of virginity testing.

"We like them to be present when we test the teenagers so they can see for themselves if their children are still virgins.

"We can say we are building a nation. We want these children to get involved in sexual matters only when they are married," she says.

The Vukuzakhe (meaning "wake up and build yourself") club will be testing children again at the end of the month, after which local nurses will inform them about AIDS.

"We want the children to be aware of the consequences of indulging in sex before reaching adulthood," says Mabaso. - African Eye News Service



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## Office of the President

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### TELEFAX MESSAGE

TO:

Dr Seth Berkley and Dr Victor Zonana  
IAVI

FROM:

Malegapuru Makgoba

DATE:

8 January 1999

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This is the article that appeared in the Sunday Independent of  
December 27<sup>th</sup> 1998.

# SA at forefront of quest for Aids vaccine

BY ADELEJULCAS

South Africa has become internationally regarded as a key player in Aids vaccine research.

Peggy Johnston, the assistant director for Aids vaccines at the National Institute of Allergy and Infectious Diseases in Washington, said South Africa was "uniquely situated" to make a large contribution to Aids vaccine development.

"If I had to bet on a country in which it's going to happen, my money would be on South Africa. It has the technology, the trained scientists, experience in conducting vaccine trials, the political commitment to do something about Aids, a societal outlook that recognises that this is a serious problem, and a population that desperately is in need of a vaccine."

Johnston said South Africa lacked experience in certain aspects of vaccine development but "it has a strong base and with some collaboration it can help the world move forward quickly".

Dr William Makgoba, the head of South Africa's Medical Research Council (MRC), said the government had allocated to the council R5 million for vaccine development in its next budget. "That's just to kickstart the process," he said. "We know that whole thing will cost between R100 million and R200 million over the next seven years. It's one of the highlights of the health department

to successfully get a group of scientists to work together on a national project, to commit them to a national issue."

Three weeks ago South Africa, whose only hope of countering the spread of Aids is a vaccine, became a partner in a vaccine development initiative based on strains of the HIV virus most prevalent in the developing world.

The collaborations are between the University of Cape Town and AlphaVax, a vaccine company based in the United States, and between the University of Oxford and the University of Nairobi. Their combined \$9.1 million funding, the largest non-governmental Aids research award in history, comes from the New York-based International Aids Vaccine Initiative (IAVI).

This is the first time that Aids vaccine trials will use the HIV strains known as clades B and C from Kenya and South Africa. Over the past 17 years almost all other vaccines investigated in Europe and the US have focused on clade B, the subtype most prevalent in the developed world.

IAVI, an independent non-governmental organisation, was founded in 1996 with money from the Rockefeller and Sloan foundations, UNAids and the World Bank, as well as other donors. Its strategy is to develop multiple vaccines in partnership with vaccine producers and developing countries.

Makgoba said IAVI's involvement

in South Africa's Aids research was "the best thing we could do for this country". He said IAVI had broken new ground in adopting an unconventional, consensual approach to dealing with a scientific issue.

"It's interesting to see how a small organisation [such as IAVI] has such an enormous impact and has decided to adopt a transformational approach to research. Their blueprint will be adopted by countries around the world."

Makgoba said it was fair to say that IAVI, too, had benefited from South Africa's multisectoral approach led by the department of health, with participation from the interministerial committee on Aids, the National Institute of Virology and many other scientists.

"We've never seen this before at a national level. South Africa is leading in that way."

Johnston's institute spends 85 to 90 percent of its funds supporting other organisations - including some that do Aids and vaccine research - and only about 10 or 15 percent doing what she called "intramural research".

"There is some [research] going on in terms of trying to find new designs that work well mostly in animal models, but mostly we support other organisations, such as HIVNet."

HIVNet, which has two South African sites (in Johannesburg and Durban), is the HIV network for

prevention trials, part of a clinical trial network supported by the institute to perform vaccine studies.

The most promising vaccine candidate at the moment as reported in *The Sunday Independent* in September, is still a drug-based gp120, made by Californian company VaxGen. It is in phase-three trials - which for efficacy in humans - in the US. The company hopes to start efficacy trials in Thailand soon.

Another promising phase-two trial - which tests for safety and immunogenicity - now taking place in the US is the "prime-boost" vaccine, using gp120 and a canarypox-based vaccine known as Aiac from Pasteur-Merieux Connaught. The gp120 induces antibodies, which are proteins able to bind and neutralise the virus, while the canarypox induces cell-mediated immunity - cells capable of identifying and destroying other cells infected with the virus.

Sam Abdool Karim, the head of research at the MRC, said the most important thing about cell-mediated immunity was that it had been shown to cross-neutralise, meaning that such an immunity may be effective no matter which subtype of HIV is present.

Karim said the scientific community was "waiting with bated breath" for Pasteur-Merieux's new canarypox vector, a more advanced version of the one that as yet only shows great promise in the first two trials.

UCT RECEIVES GRANT

# SA's vaccine breakthrough

**RESEARCH INTO** "one of the most promising new Aids vaccine technologies in the world" is to be conducted at the University of Cape Town. Health Writer JUDITH SOAL reports.

**T**HE first research into an Aids vaccine based on the type of virus found in South Africa is set to begin at the University of Cape Town.

UCT virologist Carolyn Williamson, together with researchers from the University of North Carolina, has received funding from the International Aids Vaccine Initiative (IAVI) to work on a candidate vaccine that will be viable for the developing world.

This project will share a grant of

\$9,1 million with a similar collaboration between the United Kingdom and Kenya.

"These projects are working on the most promising new vaccine technologies in the world," said Jaap Goudsmit, a scientific adviser for IAVI. "They are also far enough along in the developmental process for us to be able to test them quickly on humans."

IAVI is a non-government organisation trying to promote the development of HIV vaccines. Aids activists fear that, left to their own resources, private drug companies will ignore vaccine research — which isn't particularly profitable — or focus only on expensive vaccines that can be used in affluent countries.

The organisation receives funds from diverse sources such as Princess Diana's memorial fund, the World Bank and the Rockefeller Foundation.

It chose the two collaborations

from eight potential projects around the world.

"The approach used by the University of Carolina researchers is very exciting," said Williamson. "What we want to do now is use the same approach with the South African virus."

The US researchers have based their vaccine, which has already been tested on primates, on the strain of HIV found in North America and Europe, known as Clade B. Williamson's job is to choose the best variant of Clade C HIV, found mainly in Southern Africa, on which to build a new vaccine.

"HIV changes rapidly once it is in your body and I need to isolate the variety that is most similar to the one that is sexually transmitted," she said. "A vaccine which is based on that isolate (variation) will have the most chance of being effective." Williamson is working with colleagues from KwaZulu-Natal who are supplying samples of the virus for analysis.

"This breakthrough bypasses a lot of the ethical dilemmas we have been having," said Slim Abdool Karim, the head of the South African HIV prevention network.

"We have been discussing whether or not it is ethical for South Africans to participate in trials of Clade B vaccines. Now we hope to have a promising Clade C vaccine. It shifts the whole programme into second gear."

But there are still a few gears to go.

The vaccine will only be ready for human trials in 2001 at the earliest. These trials then need to run for about six years to get a true measure of the vaccine's effectiveness.

So, even if everything goes right, it could be eight years before the vaccine is widely available.

"People wonder why we bother when we won't see results for so long.

"But unfortunately there are no quick fixes for the Aids epidemic," said Abdool Karim.



# SA and Kenya in R52m AIDS breakthrough bid

Objective is to make vaccine available to all who need it

HEALTH AC 57 - 7

LAURICE TAITZ

SOUTH African researchers are to participate in a search for an AIDS vaccine with US scientists, the non-governmental organisation International AIDS Vaccine Initiative announced in London this week.

Researchers from the University of Cape Town, under the Medical Research Council, will take part in an international HIV vaccine research and development partnership.

In what has been hailed as the largest single non-government research award, the initiative will invest \$9,1-million (about R52-million), to be split equally between a UK-Kenya and a US-South Africa partnership. Both partnership agreements include provisions to ensure that the fruits of the research will be made readily available to the world's worst-hit countries.

The SA group will work on a "Clade C formulation" vaccine to treat the strain of the AIDS

virus found in Sub-Saharan Africa. The project will be one of the first to research a way to combat this strain.

Council president-elect Dr William Makgoba said: "The council will work together with IAVI in the development of suitable and specific vaccines for the people."

Speaking from London, IAVI spokesman Victor Zonana said: "The intellectual property provisions will ensure that if the vaccine is successful it will be affordable in developing countries. It would be criminal if the vaccine was available only in industrialised countries for 10 to 15 years and then trickled down into the developing world."

"This has been the situation from time immemorial. Triple therapy which can prolong life is still unavailable in South Africa."

Zonana said the initiative had a global orientation. "Our contract ensures that companies can charge whatever they want for the vaccine in industrialised countries, but in developing countries they would have to

make it available at a lower cost. Eventually we would like to see it being manufactured in South Africa."

Zonana said South Africa was a good place to develop the vaccine as it had a strong medical infrastructure and research base, a strong manufacturing base and a dire need for the vaccine as 1 500 people were infected with the virus every day, adding to the three million people with HIV/AIDS.

The grant will cover the cost of the research. No local funding is being sought.

President of the Initiative Dr Seth Berkley said: "Our goal is not only to ensure the development of an AIDS vaccine as soon as possible. It is to make it accessible to anyone in the world that needs it."

This move will be welcomed worldwide as treatment of HIV/AIDS infections is extremely costly and the numbers of those infected with HIV/AIDS grow daily.

According to a report by the Joint United Nations Programme and the World Health

Organisation, 5,8 million more people were infected in the past year — about 11 men, women and children every minute. The total number of people living with the virus rose by a tenth to 33,4 million worldwide. Half of all new infections are now among people aged 15 to 34.

Sub-Saharan Africa continues to be the hardest hit.

Since the epidemic began, 34 million Africans have been infected and almost 12 million have died. This year there were an estimated 5 500 funerals a day in the region.

The AIDS vaccine is supported as the best long-term solution to the global pandemic.

The Elton John AIDS Foundation has donated \$150 000 (about R1,4-million) to the effort and the UK National AIDS Trust will contribute \$80 000 from its recent grant from the Diana, Princess of Wales, Memorial Fund to help launch a joint European AIDS vaccine development project with the initiative in London.

The US-SA partnership will be led by Dr Robert Olmstead

and Dr Robert Johnson of Al-phavax Corporation in Durham, North Carolina.

The product will be based on HIV strains from South Africa. Until now most vaccine candidates have been produced from HIV strains prevalent in North America and Europe.

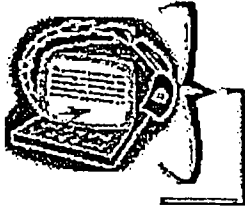
The development partnership was recommended for funding by IAVI's blue-ribbon scientific advisory committee, which selected them after reviewing a range of proposals from around the world.

According to IAVI, the two projects have two of the most promising vaccine technologies in the world, far enough advanced in development that they could be tested quickly on humans.

IAVI's scientific strategy is to ensure that every promising vaccine design is pursued as quickly as possible.

At the launch in London this week it outlined a strategy of moving multiple vaccine candidates forward in partnership with vaccine producers and developing countries.

NEWS

Business Day  
from Revenue

News

05 January 1999

### *Clinic offers anti-AIDS drug*

PREGNANT women attending clinics in Khayelitsha near Cape Town were the first in the country yesterday to be offered the anti-AIDS drug AZT if they were found to be HIV-positive.

Hundreds of young lives will be saved by the treatment, which cuts the likelihood that a mother will pass the AIDS virus to her unborn child by at least 50%.

If the project is successful at Site B and Michael Mapongwana hospitals, authorities hope it will be phased in throughout the province. The project will run for at least 12 months and reach an estimated 5000 women, saving the lives of more than 200 babies.

It will cost R650000 but is expected to save the health service more than R2m because the children will not need treatment for AIDS-related illnesses.

### *Wife killer released after five years*

OUTRAGE greeted the news that convicted wife killer and honorary Italian Consul Guiseppe di Blasi was freed on Christmas eve and deported to Italy after serving only five years of his 15-year-sentence.

Di Blasi murdered his former wife, artist Francesca Gobbi, in Hout Bay in 1992 after three earlier attempts.

Bert Slabbert, spokesman for Correctional Services Minister Ben Skosana said factors considered in Di Blasi's release were his "parole, ill-health, mental state, financial implications to the state and international implications".

A spokesman for the Centre for the Study of Violence and Reconciliation said: "The fact that he has hopped it back to Sicily means that he literally got away with murder."

CC. Ken Y.  
Nelly  
in 503

### ***Historical Cape church gutted***

ONE hundred and fourteen years of history went up in flames when the St Stephen's Anglican Church in Barkly East was gutted yesterday. An electrical fault in the ceiling was blamed for the fire, which destroyed all but the vestry and two front rooms of the church.

Archdeacon Michael Hall said he was woken at 4am by an ambulance driver who had driven past the church and found it on fire. Stained glass windows, plaques commemorating heroes of the First World War, antique pews and an antique organ were destroyed.

### ***SA to host World Bank economist***

WORLD Bank chief economist Joseph Stiglitz is among the speakers billed to address a Johannesburg conference on poverty next week hosted by Anglican Archbishop of Cape Town Njongonkulu Ndungane.

The three-day conference, which gets under way on Tuesday at Kempton Park, east of Johannesburg, will examine ways in which poverty can be eradicated.

It is being organised by the World Bank, the MacArthur Foundation, Cornell University and the World Faiths Development Dialogue. Stiglitz will present a paper on Tuesday, and colleague Monica Das Gupta will speak the following day on social norms, social exclusion and poverty measurement.

REPORTS: Business Day Reporter, Sapa.



# Tempers rising against Zuma

February 5, 1999

By Ann Eveleth

Johannesburg - Minister of Health Nkosazana Zuma's refusal to treat HIV-positive pregnant mothers to reduce the transmission of the virus to their babies has sparked unprecedented protest in international Aids circles.

An international crisis meeting was held this week in a bid to cool rising tempers over the issue. International Aids Society president Mark Wainberg flew to South Africa last week to convince Zuma that the treatment was a cost-effective way of fighting the epidemic. The society also met South African and international scientists in Chicago on Monday in a bid to dampen growing calls for a boycott of the 13th World Aids Conference due to be held in Durban in July 2000.

Wainberg called on President Nelson Mandela, Deputy President Thabo Mbeki and Minister of Finance Trevor Manuel to "support Zuma in recognising that perinatal treatment is a cost-effective way forward, and in making funds available for this. South Africa must consider itself to be at war. Its number-one enemy ... is not some neighbouring country threatening its borders. It is HIV."

Wainberg said his meeting with Zuma left him "encouraged and confident" that new information would spark a shift in the South African position. He said his society and South African researchers agreed to oppose boycott efforts, but warned he would return to South Africa in April and "certainly if we don't have positive signs by then, it may be time to consider another course of action". This follows suggestions from some researchers that Zuma should be barred from participation in the conference if she failed to change the policy.

Local activists said they would "not rule out" a boycott. "The conference is still 18 months away, and it is too early to call for a boycott, but I wouldn't rule out support from local researchers and activists if the government has not significantly shifted its position on mother-to-child transmissions and other Aids policy issues ... by September," said Aids Consortium representative Mark Heywood.

On Tuesday, however, the Ministry of Health turned its back on the most positive research findings yet to emerge on cost-effective means of reducing mother-to-child transmission.

In October, Zuma pulled the plug on a local pilot study of a four-week AZT treatment for pregnant women, claiming the government could not afford the R80-million annual cost of this treatment. Studies conducted in other countries suggested this treatment could reduce transmission by 51. New preliminary findings of a study by UNAids released in Chicago

this week suggest that a one-week treatment of mother and child, beginning at the start of labour, could reduce transmission by 37.

The findings, based on clinical trials of 1 357 mainly breastfeeding women in South Africa, Uganda and Tanzania, suggest the cost of a national programme could drop by 50 to R40-million annually, or 0,2 of the R20-billion national health budget.

The treatment could still save the lives of more than 20 000 babies a year, based on a Department of Health antenatal survey in 1996. Babies born with HIV now represent about 20 of new infections in South Africa.

But Zuma's representative, Vincent Hlongwane, said the government would not reconsider its decision not to fund the AZT programme. "What we are saying is that we don't have the budget for it. That position has not changed. It has not been influenced by the research findings coming from Chicago or anywhere else," he said.

Local Aids activists this week slammed the ministry's response as "autocratic", "extraordinary" and "ludicrous". University of the Witwatersrand Aids Law Project attorney Fatima Hassan said it was "unacceptable that the government won't seriously consider these results ... We were under the impression that the government was waiting for the [UNAids study] results to decide on the intervention."

The ministry's hasty response runs counter to its ongoing efforts to gain preferential pricing for AZT and 3TC - the two drugs needed for the treatment - from the company that makes them. Glaxo Wellcome medical director Peter Moore would not comment on a projected price, but said he hoped to release a statement on the negotiations with the ministry soon.

The decision also flies in the face of Zuma's promise last October that her department would "continuously evaluate the decision as new scientific information on cost-effective interventions appropriate to our situation in South Africa becomes available".

Medical Research Council researcher Mark Lurie said the decision to cut the funding had "closed the door ... to any possibility of introducing a national programme".

Hlongwane said Zuma's position was supported by the Cabinet, which was "fully briefed" on all HIV/Aids developments: "The Cabinet's position is to rather use the money we have for prevention. The majority of South Africans do not have Aids now, but that could change if we don't focus on prevention."

National Association of People with Aids representative Mark Decker said the government was creating a "false division between prevention and treatment".

# Mbeki Government Needs To Speed Up Transformation - Mandela

February 8, 1999

By Charles Pahlane

Cape Town - President Nelson Mandela's state of the nation address to Parliament last week also set the tone for the likely presidency of Deputy President Thabo Mbeki after the general elections in May.

Mr. Mandela's government was a transitional one charged with bringing together the different racial groups in the country and transforming the society from apartheid inequalities.

Indeed Mr. Mandela praised the extent to which the transition from an apartheid government to a democratic government had proceeded in a "commendable" way.

But Mr. Mbeki's government will need to concentrate on speeding up the destruction of the effects of apartheid.

In his speech Mr. Mandela said apartheid and its effects would need to be dismantled completely to achieve true reconciliation. He said prior to the democratic changes South Africans were killing each other from two different camps, comprising blacks and whites.

"Although the physical killings may have ceased, we still slaughter each other in works and attitudes."

"We slaughter one another in the stereotypes and mistrust that linger in our heads, and the words of hate we spew from our lips."

"We slaughter one another in the responses that some of us give to efforts aimed at bettering the lives of the poor."

"We slaughter one another and our country by the manner in which we exaggerate its weaknesses to the wider world - heroes of the gab who astound foreign associates by self-flagellation," said Mr. Mandela.

He set the tone for Mr. Mbeki's presidency which would speed up the pace of delivery - and in the process true reconciliation would be achieved. He said Government policies in place were sufficient for the needs of the moment but the speed and style of implementing them could be improved.

Mr. Mandela said the first two of three ingredients to achieve faster delivery were: partnership with business, labour and communities; and discipline which balances freedom and responsibility so that teachers and students do not go to school drunk, striking workers do not destroy property through violent means and business people do not lavish money in court cases to delay implementation of legislation they do not like.

The third ingredient was what he called the "RDP of the soul." This refers to a moral renewal with respect for life, and pride being the central pillars of all South Africans.

"The foundation has been laid - the building is in progress. With a new generation of leaders and a people that rolls up its sleeves in partnership for change, we can build the country of our dreams," said Mr. Mandela. - Parliamentary Bureau

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# Virginity testing to help combat AIDS and child abuse

February 10, 1999

ERMELO - A group of young girls giggle and wiggle around nervously in the veld. "If you need the toilet, go now," says a handsome woman in Zulu dress. The girls squeal as they strip off their panties and run behind clumps of bushes.

They don't put their panties on again because they are here to undergo virginity testing - a custom that is being revived in Mpumalanga, KwaZulu-Natal and Swaziland to fight the onslaught of HIV and AIDS. "We are so worried about these diseases and hope to prevent their spread by encouraging children not to have sex for as long as possible," explains Virginity Tester, Fikile Mhlongo, who is testing about 50 girls in Wesselton, Ermelo.

Some mothers are present to witness the tests and have brought woollen blankets which are either spread on the ground for the girls lie on, or used to shield the children from any curious passersby. The girls are beside themselves with excitement. If they pass, they get a certificate and if they remain virgins up until the age of 21, a big party will be thrown for them to celebrate their 21st, known as "umemulo". Mhlongo puts on rubber gloves, gets the girls to stand in a semblance of a line and the testing begins. It's over in seconds as the child lies on her back, screws up her face and allows Mlambo to peer between her legs and find the exposed hymen. "Okay! Hambal!" she shouts turn after turn and the mothers ululate, laugh and shout with joy.

The girls skip over to a volunteer who writes their names in a book so they can be issued certificates. Mhlongo, who is based in Newcastle in KwaZulu-Natal, has tested about 5 000 girls over the past 10 years after her mother taught her the tradition and is called upon to do the tests as far as Swaziland. This week, there is a 100 percent pass rate in Wesselton and the group of women and girls make their way to the United Church of God, singing, jumping and waving their arms in the air in celebration. The church has not yet been built, so the girls assemble in a tent where a health department official teaches them about HIV and AIDS and how to protect themselves from the disease. She promises to provide sanitary towels for girls who are menstruating when they undergo tests and to ensure there is a regular supply of rubber gloves for the testers.

The testing was arranged by Reverend Sihliwe Mabaso of the United Church of God and his wife, Catherine, who Mhlongo has trained to conduct virginity tests in the future. The tested girls are all members of the

church's Vukuzakhe Youth Club and the boys are next to be tested. "We would have tested the boys today, but you know boys," chuckles Reverend Mabaso.

"They're always so late, so we'll arrange for them to be tested another time." He says the revival of virginity testing would hopefully not only reduce the spread of HIV and AIDS, but also reveal cases of child abuse and rape. "Often, children are too scared to say anything, but if something is detected during the testing, the children can be referred to social workers," he explains.

The church is trying to raise funds to build a creche for children in the community who are HIV positive or who have AIDS. No such facility exists in Ermelo. To contribute towards the creche or for further information, phone Reverend Mabaso on 082 4233 111.

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# World Bank Wants Governments To Prioritise AIDS

February 12, 1999

HAGUE, Netherlands (PANA) - Governments of developing nations may find it easier to attract funds from the World Bank if they pay more attention to HIV/AIDS control programmes, according to the bank's latest report titled "Confronting AIDS."

The Bank says in the report that the enormous potential of HIV/AIDS to impact on both economic and social development of countries reveals how gains made on a national scale in health status, education, life expectancy and infant mortality are being reversed and productivity and investments are likely to suffer.

The report says the bank has already committed over 800,000 million US dollars to more than 70 projects aimed at preventing and controlling the pandemic, mainly in Africa, Asia, Latin America and the Caribbean.

Though currently the highest concentration of those infected is in Africa, the bank says the greatest epidemics will now occur in China, India and Indonesia.

UNAIDS and the World Bank predict the worst is yet to come, pointing out that since HIV infections take about nine years to develop into full blown AIDS, many of the developing nations are harbouring time bombs.

"The question is, will this pandemic destroy the developing nations hard earned economic gains or will governments get their act together in time," the report asks.

Accelerated labour migration, rapid urbanisation and cultural modernisation that often accompany economic growth are seen as facilitating the spread of HIV.

At the 1998 12th World AIDS conference in Geneva, the World Bank vice president for Africa, Callisto Madavo, said the bank, along with UNAIDS and other partners, is adopting a new strategy to help governments support top-level commitments to AIDS.

# Multi-Billion Rand Corridor Great For Men, Poor For Women

February 14, 1999

Nelspruit - Mamazane Matsemela heads one of the largest women's groups in the country, but has failed to win a single contract on the R12 billion Maputo Development Corridor, and not for lack of trying.

The majority of the tenders to build the toll route on the N4 highway between Witbank in Mpumalanga and Maputo City in Mozambique have been awarded to male-managed business, whether big or small.

Just one woman-owned company has been granted a contract, while others, like Matsemela's Yinhlelento Social Club, find repeated attempts at tendering for projects being turned down.

"We were told we were too expensive, but how can we compete with larger outfits who can charge just a few cents less than us," asks Matsemela whose club, which is based in Mpumalanga, has about 5 000 members in 42 branches across three provinces.

Last year, the province's premier, Mathews Phosa, acknowledged that women may still be undermined during development and challenged the Commission on Gender Equality to gauge the empowerment of black women along the corridor.

The corridor is one of eight spatial development initiatives (SDIs) in the country that are aimed at upgrading infrastructure and encouraging investment in neglected areas.

The Commission launched the Gender Analysis of the MDC last week, a survey of the benefits of the corridor for women on the South African side of the border.

"Just driving down here we counted only one woman working during road works along the highway," said chief executive officer of the Commission, Colleen Lowe-Morna.

She said there was also evidence that women who responded to the increase in traffic on the highway by setting up fruit stalls, were often forced to move by town councils.

**"Sadly, the only industry that appears to be working for women is sex work that has sprung up along the highway, which is unfortunately accompanied by the increase in HIV and AIDS," she said.**

The R95 000 contract for the survey has been awarded to the women-led Limani Consortium who will interview decision-makers, non-governmental organisations and women, especially those who weren't awarded contracts.

"We want to know what the constraints were so we can make recommendations to maximise women participation in the corridor and future projects," explained Tina James of Limani Consortium.

Commissioner, Beatrice Ngcobo, warned, however, that when women are awarded contracts, they seldom get support from the rest of the business world.

"Financial institutions are still hesitant to extend significant credit to companies owned by women, while many legal frameworks still require that a woman's husband co-signs legal documents," she explained.

Suppliers are also less likely to supply goods on credit to a company owned by a woman than a company owned by a man.

The survey is expected to be completed by the end of March, upon which it will be handed to the Commission who will make recommendations to parliament and continually monitor the progress of women empowerment along the corridor, as well as in other projects.

"The survey is not unique to the Maputo Corridor and we'll use it as a case study of other SDIs," explained Lowe-Morna.

Women's groups in neighbouring Mozambique have also shown interest in the findings of the survey.

"We hope it will help with the economic empowerment of women there too," said Lowe-Morna.

# **S.African health minister slams AIDS researchers**

**By Jeremy Lovell**

CAPE TOWN (Reuters) - Medical researchers seeking an AIDS vaccine came under fire Monday from South African Health Minister Nkosazana Zuma for ignoring the region where the disease is most prevalent.

“About 70 percent of the cases of AIDS in the world are in sub-Saharan Africa, but world research into a vaccine is not into the type of virus found in sub-Saharan Africa,” she said.

The United Nations has identified Africa, and particularly South Africa, as being among the most at risk from the AIDS plague that is sweeping the planet.

More than 3 million of South Africa's 40 million inhabitants are already infected with HIV, the virus which causes AIDS. The figure is rising at a rate of 1,500 a day.

Zuma said that in South Africa's eastern province of KwaZulu-Natal one in three pregnant women attending ante-natal clinics were HIV carriers.

Zuma told a media briefing that fighting AIDS would remain a South African government priority into the new millennium.

“We have achieved a lot, but we have not achieved enough. A lot more needs to be done,” she said.

An insurance actuary recently warned that one quarter of the South African population could become infected by the year 2010, with potentially catastrophic consequences for business.

Zuma defended her decision not to offer costly AZT treatment to pregnant women, noting that only 30 percent of women passed on the HIV infection through the womb, and AZT would only reduce that by half.

“We have to prioritize, to look at where the best return is, and that lies in prevention,” she said.

She said her department had made great strides in starting to attack the AIDS epidemic, which was not even officially recognized as a problem under the apartheid era governments.

10:47 02-15-99

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UNCLAS SECTION 01 OF 02 PRETORIA 001359

USIA

USIA FOR I/TGIC-LACOVEY, INFO AF-PATIN, HULBERT, WEINHOLD  
WHITE HOUSE FOR OFFICE OF AIDS POLICY DIRECTOR SANDRA THURMAN

E.O. 12958: N/A  
SUBJECT: GPRA REPORT: SPEAKER SANDRA THURMAN

REFERENCES: (A)USIA 22059; (B)PRETORIA 00510

1. SUMMARY: SANDRA THURMAN IS AN ENERGETIC AND PERSONABLE  
OFFICIAL, AN INSPIRATION TO EVERYONE WHO HAD THE PLEASURE  
AND GOOD FORTUNE OF WORKING WITH HER. SHE WAS ONE OF THE  
FINEST SPEAKERS WE HAVE HAD, AND MADE GREAT STRIDES IN  
CHARTING A COURSE FOR FUTURE ACTION ON AIDS POLICY.

2. A: DESCRIPTION OF ACTIVITY: SANDRA THURMAN'S GROUND-  
BREAKING PROGRAM IN SOUTH AFRICA ENGENDERED DISCUSSION ON  
HIV/AIDS STRATEGY WITH SAG OFFICIALS, NGOS, PVOS, BUSINESS  
AND LABOR LEADERS. HER FACT-FINDING TOUR DREW HER TO  
MIXED AUDIENCES INCLUDING OFFICIALS WHO ARE NOW CHARTING  
OUT GOVERNMENT AND INDUSTRY STRATEGY TO COMBAT A RATE OF  
INFECTION WHICH IN SOUTH AFRICA HAS REACHED 14 PER CENT IN  
ANTENATAL SURVEYS ALONE (THE TIP OF THE ICEBERG), AND  
AFFECTS SOME 2.4 MILLION KNOWN INFECTED INDIVIDUALS.

MS. THURMAN ENGAGED IN THREE AREAS OF ACTIVITY: EXPLORING  
EXCHANGE POSSIBILITIES BETWEEN CEOS OF MULTINATIONAL FIRMS  
AND THE BUSINESS COMMUNITY; PLANNING INITIATIVES WITH THE  
SA GROUP INDUSTRIAL HEALTH RESEARCH GROUPS WHOSE AGENDA  
COMBATS AIDS IN THE WORKPLACE; AND DEVELOPING A SYSTEM OF  
NGO EXCHANGE AT THE NATIONAL AND PROVINCIAL LEVELS OF  
HEALTH OFFICIALS TO DEVELOP STRATEGIES.

IN THE COURSE OF HER MEETINGS IN PRETORIA, JOHANNESBURG

AND CAPE TOWN, SHE MET WITH THE DIRECTOR OF THE HIV/AIDS PROGRAM IN THE DEPARTMENT OF HEALTH; THE HEAD OF THE NATIONAL ASSOCIATION FOR PEOPLE WITH AIDS (NAPWA) AND OF THE NATIONAL HIV/AIDS AND STD REVIEW; THE 1997 RECIPIENT OF THE COMMUNITY BUILDER OF THE YEAR AWARD; THE UNAIDS INTERCOUNTRY TEAM DIRECTOR FOR EASTERN AND SOUTHERN AFRICA; THE DIRECTOR OF INTERNATIONAL AFFAIRS FOR COSATU (NATIONAL LABOR UNION CONGLOMERATE); THE DIRECTOR-GENERAL, DEPARTMENT OF HEALTH; THE HEAD OF A COMMUNITY AIDS CENTRE IN HILLBROW, JOHANNESBURG; AND OF THE ETHEMBENI CENTRE (A 24-HOUR FACILITY FOR HIV+ CHILDREN); THE W.H.O. LIAISON ON HIV/AIDS; AND KEY USG OFFICIALS SUCH AS AMBASSADOR JOSEPH, USAID PRETORIA DIRECTOR AARON WILLIAMS, AND CAPE TOWN CG APRIL GLASPIE.

SHE ENDED HER TOUR AT A CONFERENCE AT RHODES UNIVERSITY ORGANIZED IN HER HONOR, AT WHICH SHE MET A NUMBER OF NGO AND RESEARCH CONTACTS.

B: DATE, FY AND QUARTER: JANUARY 18-21; FY 98, SECOND QUARTER.

C: JUSTIFICATION AND OBJECTIVE: WITH AN INFECTION RATE OF 14% BASED ALONE ON ANTENATAL INTAKE DATA, AND A KNOWN POPULATION OF 2.4 MILLION INFECTED INDIVIDUALS, THE PROBLEMS ARE BECOMING DRAMATIC. JUSTIFICATION BASED ON THE HUMANITARIAN ASPECTS AND BILATERAL POLITICAL RELATION DRAW COMPELLING ARGUMENTS FOR PROGRAMMING IN THIS AREA. IN ADDITION, U.S. NATIONAL INTEREST LIES IN COMBATTING THE INFECTION RATE OVERSEAS LEST IT AFFECT THE U.S. POPULATION ADVERSELY IN TURN.

D: CP UMBRELLA THEME: GOAL/PROJECT 10, GLOBAL ISSUES, AIDS. THE AUDIENCE VARIED FROM SAG OFFICIALS TO NGOS TO PVOS TO BUSINESS, LABOR, AND THE AFFECTED POPULATION ITSELF.

E: RESULT/IMPACT: OUTSTANDING. CHANNELS OF COMMUNICATION WERE OPENED AT THE HIGHEST LEVELS. AS PER (A) ABOVE, INITIATIVES WERE UNDERTAKEN WITH CEOS OF MULTINATIONAL CORPORATIONS, THE INDUSTRIAL HEALTH RESEARCH GROUP, AND NGO/PVO EXCHANGE. MS. THURMAN ALSO EXPLORED SUITABLE VENUES AND CONTENT FOR A POSSIBLE DELIVERABLE BY VICE PRESIDENT GORE AT THE UPCOMING BNC MEETING, OR OTHER FUTURE OPPORTUNITIES. MINISTER ZUMA'S OBJECTIVE IS TO PUT HIV/AIDS ON THE NATIONAL POLICY AGENDA. T HIS PROGRAM MADE GREAT STRIDES IN ACCOMPLISHING THAT GOAL.

F: NON-USG SOURCES OF FUNDING: RHODES UNIVERSITY HOSTED A THREE-DAY CONFERENCE IN GRAHAMSTOWN, AND SUPPORTED MS. THURMAN'S VISIT THERE.

G: QUALITY OF U.S. SUPPORT: WE HIGHLY APPRECIATE THE FINE WORK BY CYNTHIA LACOVEY OF I/TGIC. IN ADDITION THIS WAS A UNIQUE PROGRAM IN THAT IT REQUIRED AND OBTAINED HIGH DEGREES OF COOPERATION AND COORDINATION BETWEEN USIA IN WASHINGTON AND USAID IN WASHINGTON AND PRETORIA. GREAT KUDOS ARE GIVEN TO RENEE SAUNDERS, CDC OFFICIAL SECUNDED TO USAID PRETORIA, WHO DID A MASSIVE AMOUNT OF WORK ON THIS PROGRAM.

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UNCLAS SECTION 02 OF 02 PRETORIA 001359

HULL

BT  
#1359

End Cable Text

\*\*\*\*\*  
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301 4th St. S.W.  
Wash., D.C. 20547  
(202) 619-4013  
(Fax) 401-6207  
lacovey@usia.gov  
\*\*\*\*\*

0-54

# Embassy of South Africa

3051 Massachusetts Avenue, N.W.

Washington, DC 20008

Tel (202) 232-4400

Fax: (202) 265-1607

**E-mail: [safrica@southafrica.net](mailto:safrica@southafrica.net)**

---

To: Ms Saneha Thurman

Attn:

Fax: (202) 456-2439 / 38

From: Cristina Sommer - Social Secretary

Date: 21 Sept 99

|                                               |
|-----------------------------------------------|
| Page ____ of ____ including this cover sheet. |
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Message:



Confirmed 9/21/99

In honor of

MRS GRACA MACHEL

THE SOUTH AFRICAN AMBASSADOR TO THE UNITED STATES  
SHEILA SISULU

and

AMBASSADOR AND MRS MARCOS NAMASHULUA  
EMBASSY OF THE REPUBLIC OF MOZAMBIQUE

request the pleasure of the company of

*As Sandra Thurman*

at dinner

on Saturday, 25 September 1999

at 7:00 pm

South African Embassy Residence  
3101 Massachusetts Avenue, NW  
Washington DC

R.S.V.P. by 23 September 99  
T: (202) 745-6645

Business Attire  
Parking available

THE WHITE HOUSE  
WASHINGTON

October 8, 1999

Ambassador Sheila Sisulu  
Embassy of South Africa  
3051 Massachusetts Avenue, NW  
Washington, DC 20008

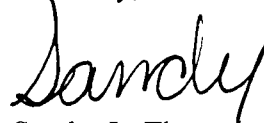
Dear Ambassador Sisulu,

I wanted to thank you so very much for the wonderful dinner in honor of Mrs. Graca Machel at the South African Embassy Residence on Saturday, September 25.

The dinner was truly a delight. I thoroughly enjoyed myself and appreciate the hospitality extended by you and Ambassador and Mrs. Marcos Namashulua.

Thank you again for a lovely evening.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sandy".

Sandra L. Thurman  
Director  
Office of National AIDS Policy

THE WHITE HOUSE  
WASHINGTON

October 8, 1999

Ambassador and Mrs. Marcos Namashulua  
Embassy of the Republic of Mozambique  
1990 M Street, NW #570  
Washington, DC 20036

Dear Ambassador and Mrs. Marcos Namashulua,

I wanted to thank you so very much for the wonderful dinner in honor of Mrs. Graca Machel at the South African Embassy Residence on Saturday, September 25.

The dinner was truly a delight. I thoroughly enjoyed myself and appreciate the hospitality extended by both you and Ambassador Sisulu.

Thank you again for a lovely evening.

Sincerely,

- S -

Sandra L. Thurman  
Director  
Office of National AIDS Policy

C-5A



**HIV/AIDS PREVENTION  
AND CARE DEPARTMENT**

**FAMILY HEALTH INTERNATIONAL  
2101 WILSON BLVD., SUITE 700  
ARLINGTON, VIRGINIA 22201  
USA**

**FAX #: (703) 516-9781  
TELEPHONE: (703) 516-9779  
URL: <http://www.fhi.org/>**

**TO:**

**NAME:** Cheryl

**LOCATION:** Dr. Thurman's Office

**FAX #:** 202-456-2439

**FROM:**

**NAME:** Melissa Vander Kooi

**DATE:** 10-4-99 **TOTAL # OF PAGES:** 3  
(Including this page)

**SUBJECT:** Dr. Nono Simelala's Visit

Thanks for setting things up. If you  
have any questions, please give me a call at  
the above #.

Best Regards,

Melissa

## **THE VISIT OF NATIONAL DIRECTOR OF HIV/AIDS FOR SOUTH AFRICA DR. NONO SIMELELA**

### **US POLICY INTERESTS**

- At the BNC in February, 1999, the Health Working Group of the Bi-National Commission (BNC) focused primarily on HIV/AIDS. The Working Group urged both governments to redouble their efforts against this epidemic, focusing on prevention, awareness, counseling and testing.
- Vice-President Gore and then Deputy President Mbeki reinforced this emphasis in their press conference.
- On July 19, 1999, Vice-President Gore announced that the Clinton Administration will seek \$100 million initiative in funds to fight global AIDS.
- In addition, the Vice-President unveiled a new report assessing the AIDS crisis in Africa as one of the worst infectious disease catastrophes in the history of modern medicine.
- Tasked by President Clinton, the White House Advisor on HIV/AIDS visited South Africa on a fact-finding mission to assess the problem of HIV/AIDS in Africa. South Africa was visited twice by this fact-finding team and a congressional delegation.

### **HIV/AIDS CATASTROPHE IN SOUTH AFRICA**

- In 1998, according to the UNAIDS, there were 33.4 million people infected and living with HIV worldwide. More than two thirds (about 22.5 million) are in Sub-Saharan Africa, and 3.2 million are South Africans.
- In 1998, approximately 165,000 people are living with AIDS in South Africa.
- There were approximately 120,000 AIDS related deaths in 1998. This figure is expected to increase to 450,000 in 2005.
- The UNAIDS estimates that 1 of 7 new infections in Africa takes place in South Africa, the fastest growing epidemic in the world.
- In South Africa, HIV seroprevalence in pregnant women attending antenatal clinics has increased in each of the survey years, from 0.8% in 1990 to 16.0% nationally in 1997 to 22.8% in 1998, a 20 fold increase.
- It is estimated that 1,600 new infections occur every day in South Africa.
- Given the current trends of the growth of the epidemic, it is estimated that:
- Life expectancy of South Africans will fall from 60 years to 40 by 2010;
- Child mortality will triple from approximately 20 per thousand in 1995 to nearly 60 per thousand by 2005; and
- There will be over 2 million children orphaned from AIDS.

### **DR. SIMELELA AND USAID**

- Dr. Simelela assumed her position as the Director of the HIV/AIDS/STD Directorate, National Department of Health (DOH) in January 1999.

- She is the third person to hold this position in the past four years.
- During this time, USAID and Dr. Simelela have developed a strong and effective working relationship.
- This is the first time USAID has had a strong and vital partnership with the National Directorate of HIV/AIDS.
- This is due greatly to the efforts of Dr. Simelela to reach out and build on the technical expertise that USAID has to offer in policy and program development in the area of HIV/AIDS.

## **PURPOSE AND GOALS OF THE VISIT**

- Dr. Simelela is an outstanding professional, however, she is new to working with the international donor community.
- Therefore, USAID/SA thought it prudent that Dr. Simelela visit the US to gain an in-depth understanding about how USAID and its cooperating agencies work.
- USAID/SA is confident that this visit will assist the South African government in reducing the growing epidemic.
- The goal of the visit is to provide Dr. Simelela with a deeper understanding of potential resources available to South Africa and to identify possible areas for collaboration.
- In addition, this visit will continue to strengthen and broaden the growing partnership between the USAID/SA Mission and the DOH.

## **USAID/WASHINGTON**

- USAID/SA would like USAID/W to reiterate from the highest levels of the Agency, USAID's support for South Africa's HIV/AIDS epidemic.

## **OTHER VISITS**

- Dr. Simelela will meet with a variety of US organizations. These include:
- DHHS, NIH, Washington Hospital Center, Whitman Walker Clinic, the US Congress, The White House Office on HIV/AIDS, Food and Friends (NGO), the National AID Hotline Organization and CDC.

U:cconn\hiv\nonobriefer\022.7.99

URGENT Please

**Embassy of South Africa**

**3051 Massachusetts Avenue, N.W.**

**Washington, DC 20008**

**Tel. (202) 232-4400**

**Fax: (202) 265-1607**

**E-mail: [safrika@southafrica.net](mailto:safrika@southafrica.net)**

Q25A  
Trie File  
South Africa

**To:** Sondra Thurman

**Attn:**

**Fax:** (202) 456 - 2439

**From:** Social Secretary's Office -

**Date:** 20 Oct 99

Page 1 of 2 including this cover sheet.

**Message:**

Please find herewith enclosed invitation to luncheon on 22 October. Urgent reply needed please. Thank you

Confirmed 10/21



The South African Ambassador to the United States

MRS SHEILA SISULU

requests the pleasure of the company of

Sandra Thurman

to a luncheon in honor of

FORMER PRESIDENT NELSON MANDELA

Friday, 22 October 1999  
12:30 - 2:00 pm

Embassy of South Africa Residence  
3101 Massachusetts Avenue, NW  
Washington DC

R.S.V.P. by 21 October 99  
T: (202) 745-6620/6613

Dress Code: Business  
Limited parking available

Guests please to be seated by 12:30 pm

Invitation not transferable



Grahamstown • 6140 • South Africa

P.O. Box 7426, 50 Church Street, East London, 5200  
Tel.: (043) 704 7100

E-mail: [rshell@dolphin.ru.ac.za](mailto:rshell@dolphin.ru.ac.za). • E-mail: [rshell@iafrica.com](mailto:rshell@iafrica.com)

# Consolidating Democracy in South Africa

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18–20 August 1999  
Holiday Inn  
Umtata

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# The Silent Revolution: the Aids Pandemic and the Military in South Africa\*

*Robert Shell*

## ABSTRACT

The author explores the importance of the siting of military bases in the primary transmission chain of the HIV/AIDS pandemic in Southern Africa. After reviewing the African comparative literature and attempting a history of the South African military policy to HIV/AIDS, he focuses on two urban regions with military bases. Since the Eastern Cape blood transfusion services only screened blood for HIV in 1988, it is conjectured that the blood supply played an important part in making the pandemic heterosexual. New case-level HIV/AIDS and new mortality data from these regions are used to shed light on the variant rapidity of the spread in certain communities. While traditional vectors – such as truck routes – are common to communities with or without military bases, this new hypothesis of the Trojan Horse army base provides urgent cues for both advocacy and counselling intervention.

## INTRODUCTION

Trucks, monkeys and migrant labour are currently the most popular suspected African vectors of transmission of the HIV/AIDS pandemic, at least in the living rooms of middle class South Africa. While municipal authorities continue to suspect in-migration from rural areas as the most obvious – even time-honoured – origin of all their health problems including

HIV/AIDS, it is quite conceivable that at least some HIV/AIDS vectors might have been internal, i.e. virtually embedded in South African communities near South African Defence Force (SADF) military installations from near the inception of the epidemic in the early 1980s and conceivably, even earlier. One of the main reasons HIV/AIDS has spread so rapidly in Africa is that the continent has been embroiled in twenty years of intermittent military violence in diverse regions such as Angola, Burundi, Congo, Eritrea, Ethiopia, Liberia, Moçambique, Namibia, Rwanda, Somalia, South Africa, Sudan, Uganda and Zimbabwe. War creates the perfect conditions for the transmission of HIV (Van der Vliet, 1996: 81) and war is one of Africa's major businesses.

## 1. REVIEW OF THE COMPARATIVE LITERATURE

Ever since Raymond L. Humphries, an HIV positive soldier at Fort Benning, Georgia, USA, knowingly made several women positive through consensual sodomy and vaginal intercourse and boasted at his court martial to having had unprotected sex with "at least" eight women after his HIV test, American researchers have been rivetted by the military impact on HIV transmission and the culture which prompts such behaviour (Anon., 1998:4). However, the military base hypothesis appears to be new to South African HIV/AIDS researchers but to no others (Lasky et al., 1997; Smallman-Raynor and Cliff 1991; Torres-Anjel, 1992; Webb, 1997). For rhetorical purposes the conjecture that HIV/AIDS is spread by military bases has been termed the Trojan Horse hypothesis.

\*The financial assistance of the National Research Foundation towards the research of the PRU is acknowledged. Opinions expressed in this paper and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF (formerly Centre for Science Development).

### 1.1 Liberia

Military bases in African civil wars are known to have been instrumental in spreading the epidemic. Even peacekeeping missions were guilty. For example, from 1989 to 1995 Liberia had been in a state of civil war. Monrovia, the capital, fell within an area protected by foreign troops. A "Save the Children" research initiative was launched in 1994 due to concern over increasing HIV/AIDS prevalence in the town and that hundreds of women and young girls were involved in sex work with military personnel (Elliott 1996: 254).

Focus group discussions were held with small groups of girls between the ages of twelve and nineteen involved in sex work. There were seven girls to a group. Group discussions were followed up with individual interviews. Interviews were also held with military personnel. However, it was difficult to encourage military personnel to discuss the issue of child prostitution and the number of responses received were limited. All of the girls interviewed recalled that they had had their first sexual experience between the ages of ten and thirteen years and were thereby unlikely to be screened for HIV in traditional antenatal clinic surveillance systems which target fully fecund, indeed only childbearing, women.

Pre-menarche Liberian girls received gifts in the form of cash, food items and material rewards in return for sexual relations with military personnel. Younger girls demanded less in return for sex work than older girls, who demanded money rather than goods. The majority of the girls in child sex work were involved for economic necessity in the absence of any other capacity or opportunities to earn income. Many girls supported families. Some girls had their own children to care for and needed the money for the motherhood for which they were often unprepared. Girls had a very low awareness concerning HIV transmission and prevention. Many believed that condoms caused cancer of the vagina or that condoms would be caught internally. Many of the girls interviewed had been raped during their time as child prostitutes and some endured sexual episodes involving two to five men at once. Military personnel were often resistant to condom use and complained about the irksome latex preventing flesh-to-flesh contact. Other soldiers of other nationalities remained suspicious of their use.

Medical officers of the Ugandan contingent of the troops in Liberia were aware of HIV/AIDS and advocated condom distribution.

It proved difficult to interview the Liberian military on child prostitution, a pattern familiar in South Africa. However, secondary sources indicated that even foreign troops took advantage of the extreme poverty of women and girls in the local setting and ruthlessly exploited their vulnerable economic situations for sex. The soldiers preferred using child prostitutes as they were less demanding with little or no responsibility and they would take whatever was given to them in return for sex. The use of young girls for sex is also seen as a means of avoiding HIV infection. Here one must remember the wide belief of the virgin cure myth in some populations, a belief which predates the HIV/AIDS pandemic (Shell, 1998: 29-30).

Sporadic violence is still endemic in Liberia. Moreover, foreign troops are involved frequently in emergency situations. The author grimly concluded that urgent policy recommendations were needed to ensure that international and local military personnel obtained mandatory training on the United Nations (UN) Conventions on the Rights of the Child and education on HIV/AIDS/STD (sexually transmitted disease) prevention (Elliott, 1996: 254).

### 1.2 Uganda

In a classic paper, Smallman-Raynor and Cliff demonstrated, for the first time using scientific data, that the classic association of war and disease substantially accounts for the observed geographical distribution of reported clinical HIV/AIDS cases in Uganda (Smallman-Raynor, 1991). The authors demonstrate using regression analyses that both the spread of HIV infection in the 1980s, and the subsequent development of AIDS to its 1990 spatial pattern, were significantly and positively correlated with ethnic patterns of recruitment into the Ugandan National Liberation Army (UNLA) after the overthrow of Idi Amin some ten years earlier in 1979.

Their study assumes the estimated mean incubation period of 8 to 10 years for HIV. Their study underlines the need for cognisance of historical factors which may have influenced current patterns of AIDS seen in Southern Africa. The findings may also have important implications for AIDS forecasting and control

in Southern African countries which have recently experienced war. The results were specifically compared with parallel analyses of other HIV hypotheses such as the truck vectors, traditionally advanced to account for the reported geographical distribution of AIDS in Uganda (Smallman-Taylor, 1991:70-71).

There has also been a subsequent study of the effects of mass demobilisation of Ugandan troops which revealed devastating results for the rural areas where the demobilised HIV positive soldiers retired (Ogen and Loy, 1996:473). About 50 000 UPDF (Uganda People's Defence Forces) soldiers have been demobilised, some of them because they were PLWAs (People Living with AIDS). Many of the soldiers with HIV/AIDS have been retrenched from the army over the past two years and returned to their home villages. Positive sero status was a major criterion for demobilisation. However, hardly any counselling was undertaken to prepare these demobilised soldiers how to avoid high risk behaviour as they reintegrated into civilian society.

What are the implications in terms of the spread of HIV/AIDS in Uganda? There are now understandable fears that this may accelerate the spread of HIV/AIDS in rural areas to where most of the demobilised soldiers return. Considering the high incidence of HIV/AIDS in the Ugandan military and the UN determination that a soldier's sero status is a major consideration in being demobilised or mustered out, there is urgent need to prepare soldiers for demobilisation and a return to civilian life. This applies not only to Uganda, but to all other parts of Africa such as Angola, Namibia and South Africa where demobilisation is taking place. The South African military do not demobilise PLWAs but rather "muster them out", i.e. no further combat and no crossing of international borders. This has had the effect of South African military personnel not being anxious to undergo on-base testing.

### 1.3 Angola

Angola has been a country cursed with continuous civil wars since its colonial occupation by the Portuguese in the 15th century. Even in pre-colonial times in the Northern Congo kingdom there is evidence that the area was engulfed in war during the first European contacts. Moreover, the country was probably the most

heavily slaved area in the world. Its three horizontal unlinked railway lines into the interior were built on the old slave trade routes and testify to the continuity of extractive exploitation even during periods of sporadic colonial modernisation. The littoral is characterised by the relics of the wealth of settler domination and a mulatto class while the interior is heavily populated by unmixed African groups. The south-eastern interior is where the diamonds lie while the coastline is dominated by seagoing derricks pumping out crude oil from the seabeds. Broadly speaking, the oil corporations sustain the MPLA while the diamond cartel, De Beers, supports Jonas Savimbi's group in the vast south-eastern quadrant.

When South African troops invaded Angola in 1975, the situation worsened. South African security began to be tied up with Angola's future. When the "Revolution of the Carnations" in Lisbon in 1974 took the South African military intelligentsia by surprise, the South African military quickly moved in with troops and mobile 155 mm howitzers. As Annette Seegers points out, the Portuguese revolution was a gift to the South West Africa People's Organisation (SWAPO) who after 1974 did not have to go through Portuguese lines to get to Ovamboland (Seegers, 1996: 210).

Up to that point, Angola had also been a focus area in the cold war. The United Soviet Socialist Republic (USSR) had supported the coastal MPLA while the Central Intelligence Agency supported the FNLA in the north, and mainland China (and others) supported Savimbi in the south. The USSR believed the South Africans' incursions were being encouraged by the United States (US) and, not to be outdone, sent in their own puppets (Seegers, 1990: 211). Nearly 500 000 Cuban troops (almost as many as the 580 000 the US had sent to Vietnam) arrived through Luanda airport. By the time the last Cuban soldiers had left in 1992, some thought the situation would stabilise and even improve, but it worsened. The simplification of interests did not lead to a resolution of issues. After 1994 the oil corporations and the diamond cartel, De Beers, began to slug it out with the help of ex-South African mercenaries, a horrible example of what free market corporate capitalism does when the developed world is no longer interested for ideological reasons.

Corporate greed, not the dictates of the cold war, now dominates the Angolan landscape. There was a rush to acquire control of Angola's remaining undersea and underground wealth. The people of Angola have not yet emerged from their multiple ordeals and, not surprisingly, are demoralised and dispirited, the perfect breeding ground for the silent epidemic.

It is little wonder then that the country has so little HIV surveillance. The various UNAIDS fact sheets on Angola are virtually empty – series of columns of white space interspersed by boiler-plated paragraphs. These are preceded by a suspicious, indeed unbelievably low, national prevalence of 2.12% (UNAIDS, 1999:3). There is no article on HIV prevalence in the area north of Ovamboland and south of Luanda in any literature that this author could find on Popline.

The suspicion of high southern Angolan prevalence is based on

- the length and ferocity of war there since 1961
- the HIV rate of returning Cuban veterans
- the low rate of returning Portuguese colonists after 1975 and
- the extremely high HIV prevalence in Katimo Mulilo, the SADF headquarters in the Caprivi Strip, that long appendix of land abutting southern Angola, Botswana, Zambia and Zimbabwe (see map).

The Caprivi strip is a busy international corri-

dor of refugees, returning exiles, military personnel of all nations, migrant workers and probably the most important single geographical node of HIV/AIDS transmission in Southern Africa, definitely one of the world's AIDS hot spots.

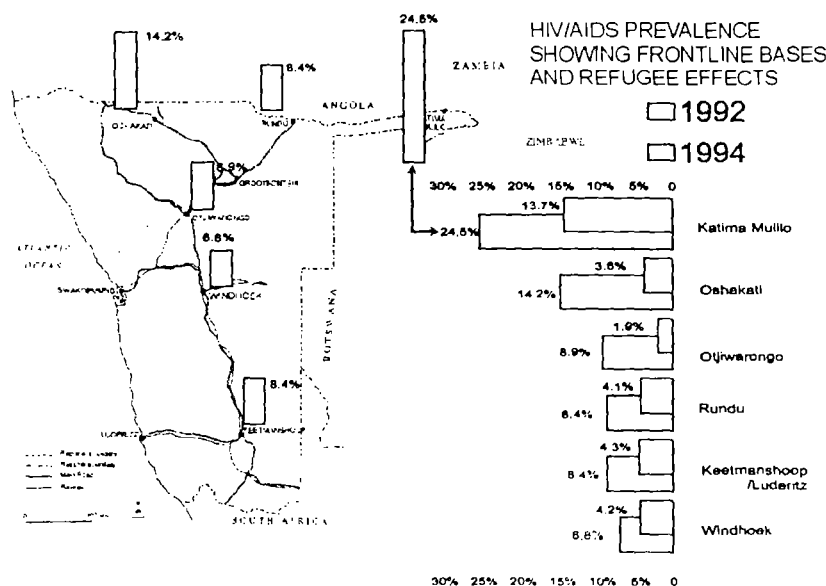
### 1.3.1 Angola and Cuba's forces

The best fix we have on Angolan sero prevalence is the HIV rate of Cuban veterans returning from the Angolan killing fields (1976-1992). But then one immediately has to confront the denominator; how many Cubans were in Angola? The 500 000 figure has been debated. South African sources are inclined to suggest that there were only 50 000 Cuban military in Angola (Scheper-Hughes, 1993:1426).

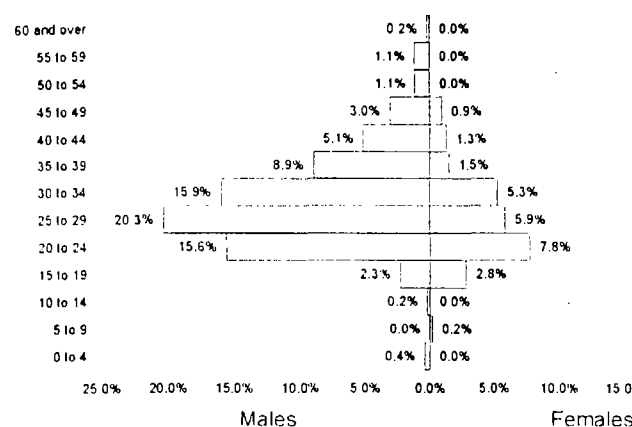
When Cuba received its military personnel back from those areas in southern Angola where European and African South Africans had also served since 1975, all were tested and according to Cuban authorities "a large number" were found seropositive. No more exact figures have ever emerged from the Cuban government. Consequently, remote sensing of Cuban positives is a debate on its own depending on whether you live in Cuba or Miami.

The UNAIDS estimates of Cuba do reveal one anomalous demographic characteristic namely a high sex composition of 298 males per 100 females which is consistent with an all male army returning from an HIV region (UNAIDS, 1998:6).

However, a high concentration of male homosexuals might also partly explain this. However, other neighbouring Hispanic Caribbean cultures (e.g. Puerto Rico and the Dominican Republic) do not reveal such a pattern and it therefore seems more likely to attribute the Cuban sex composition pattern to the male Cuban personnel returning from Angola. The Cuban population pyramid may be regarded as a classic



Cuba's AIDS population: Angolan veterans



arrested Trojan Horse pattern.

Cuba has always enjoyed a long preventative health tradition but also has an ambiguous human rights history. For example, the island was the birthplace of the concentration camp. The *concentrados* were introduced in 1895 by the Spanish military to settle rebellious freed slaves, the concept then being adopted and adapted in the Anglo-Boer War (1899-1902) by the British and then finally perfected by the Germans in World War Two. These two traditions seemed to mesh in Cuba's response to HIV/AIDS with the result that all HIV positives were quarantined in the famous (if you live in Cuba), or infamous (if you live in Miami), *Sanatorios* with approved positives being allowed to go out with an approved partner after six months' intensive training, counselling and surveillance of all sexual behaviour. The inmates are, however, treated with exemplary care (Scheper-Hughes, 1993: 965-967, 942; de Gordon, et al., 1993:1426).

#### 1.4 Namibia

Northern Namibia in the area formerly termed Ovamboland has been particularly ravaged both by the military and HIV. The Ovambo people straddle an international boundary, the Cunene River. Their land has been the site of the stamping ground for the SADF's offensive against SWAPO and also against the Cuban presence in Angola and a staging ground for supporting Savimbi's UNITA. From the mid 1970s the region has been completely transformed by Operation Savannah and the assumption of

hegemony by Special Forces (Spesake).

Douglas Webb, now working for the Save the Children Fund, found that in northern Namibia HIV prevalence was related to proximity to military bases rather than proximity to trucking routes (Webb, 1997:101-108). The most prominent anomalies are those of Ruacana and Eenhana, which are both small military stations. The traffic density was not significant, but the HIV:hepatitis B ratio was moderately

high (1:4 and 1:2 respectively). This clustering of HIV at Ruacana and Eenhana was primarily due to the military bases, where HIV prevalence among blood donors was far higher than in the surrounding population. Sexual relations between the soldiers and students at the local secondary schools – just as in the Liberian case cited above and in Grahamstown, below – probably caused the HIV prevalence to be higher at the schools than expected.

HIV prevalence among blood donors at the secondary school in Ruacana was 3.4% (n=59) in 1993. Ruacana was where Eugene de Kock was stationed in 1977 (Pauw, 1997:37), while at Ombalantu secondary school, approximately 80 kilometres southwards along the main road, HIV prevalence stood at 1.7% (n=174). At Eenhana, the Haimbili secondary school had an HIV prevalence of 4.3% and a HIV:hepatitis B ratio of 1:2 (n=46), well above the area average. This clustering was probably due to the military base, as the settlement is relatively isolated from the main road network and had a low local traffic density of 120 vehicles per day. As Webb points out, the four military bases in the region, of which Ondangwa and Oshakati are the largest, form the nuclei of clearly defined HIV clusters in themselves. The location of these bases reflects the strategic requirements of the SADF during the 1970s and 1980s.

What Webb could not know is that these areas were the same areas where 200 Inkatha Freedom Party (IFP) cadres were trained in the 1980s and early 1990s to destabilise KwaZulu-Natal (Webb was writing before the revelations

of the South African Truth and Reconciliation Commission [TRC]). Why the IFP forces were trained in that operational area is unknown but the fact remains then that those 200 military personnel lived and trained in one of the highest prevalence HIV zones in Africa. This was also the zone in which the notorious Eugene De Kock was based before being posted to Vlakplaas, his job was to command a unit of Koevoet and, it has also emerged, to train the IFP cadres; during his tour he personally killed 550 SWAPO guerrillas (Pauw, 1997:30-31, 37-41). Northern Namibia (including the Caprivi) – as can be seen in the accompanying graphic – was an essential node in the pre-1994 transmission vectors into the whole of South Africa.

## 2. CHANGING VECTORS FOLLOWING THE RETURN OF CADRES FROM CENTRAL AFRICA

Possibly, returning cadres who had served in central Africa and elsewhere on the continent during the struggle before 1994 contracted HIV there (the various homeland armies, Ciskei, Transkei, etc. were also incorporated into the South African National Defence Force (SANDF) at this time, but they were probably not infected). When discussions were being held on the integration of the defence force, it was agreed by the (African National Congress) ANC that there would be no testing of incoming personnel. This followed a revelation by Prison Services public relations director Brigadier Erica van Zyl who claimed that seven of the "security prisoners" at Pollsmoor were HIV positive. An unnamed "senior" ANC spokeswoman claimed that the ANC were "absolutely opposed" to the compulsory testing of exiles (*Cape Times*, 1990). This became a sensitive political issue and it was agreed that there would be no testing, a tragic and conceivable catastrophic watershed event for the history of AIDS in South Africa. A month later, a journal entitled *Armed Forces* ran an article by Dr Steven Hatfill which pointed out that since the US military tested recruits so should South African (Hatfield, 1990:9-10).

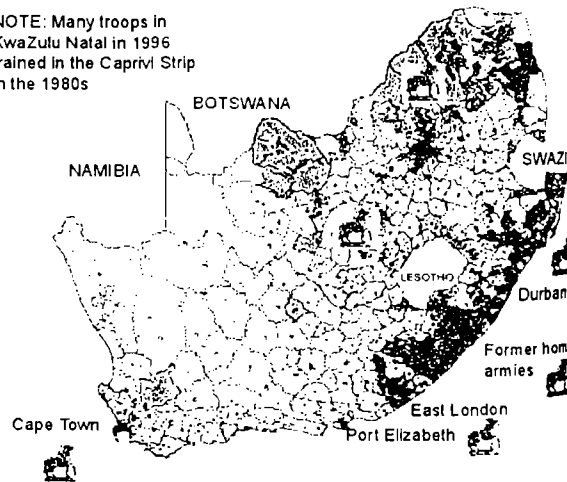
Further, the UN has stipulated that troops who cross borders, or who are involved in combat, cannot be HIV positive. This is an international law. Compliance would imply that mandatory testing would have to be done for every member of every defence force in the world. This testing has not occurred in South

Africa for political reasons (alluded to above) but most of all since career soldiers fear being "mustered out", i.e. taken out of combat roles and especially not chosen for the favoured pool of soldiers who will see combat service in another country. The SANDF – to its credit – does not discharge any people who are seropositive but are obliged to withdraw people with HIV from combat roles. Of the 9000 recruits chosen to go to Lesotho only 2000 were free to go.

Once South African veterans returned to their home country and were incorporated into the new SANDF, they were distributed all over the country and thereby became an almost perfectly randomly distributed set of sites for the incipient epidemic between 1992 and 1994. Recruits who were called up on national service simply returned to their homes. South African HIV researchers are seemingly unaware of the potential of HIV/AIDS in their defence forces.

The trojan horse factor: population living in SA military and police barracks in 1996

NOTE: Many troops in KwaZulu Natal in 1996 trained in the Caprivi Strip in the 1980s



Source: *South SA Census of 1996* and *recreation*

### 2.1 The installation of the heterosexual pandemic

If there had been any testing, the HIV pandemic might have been arrested as it was in Cuba. As it happened there was no testing. To make matters worse, the blood transfusion services went on in their time-honoured way of seeking their donated blood from among other institutions, military establishments. This was after the demobilisation of the Angolan war effort.

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According to the recollection of Dr Santos, who heads up the Blood Transfusion Services in Port Elizabeth, it was the military who requested to withdraw from the arrangement in 1985. HIV screening of the blood supply – according to Dr Etienne du Plessis, the pioneer of HIV/AIDS data collection in the Eastern Cape and director of Health Services in Port Elizabeth – only began in 1988. Thus, the blood supply of the Eastern Cape was wide open to HIV contamination for almost a decade after the first Angolan incursions by South African troops.

Donated blood and blood products serve many clients. One thinks immediately of trauma victims, victims of automobile accidents and gunshot wounds, but by far the largest group of recipients are pregnant women. The unscreened blood supply before 1988 was therefore probably an important vector in helping turn the homosexual epidemic into a heterosexual pandemic.

## 2.2 Suspected infection vectors within South Africa before 1994

The following plan which was never brought up in any TRC court illustrates the views of extremists within the security forces with respect to HIV and AIDS. Eugene de Kock, Willie Nortje and Brood van Heerden are well-known to most South African television audiences. The reconstruction of the following events is based on separate affidavits signed in Denmark by Willie Nortje and Brood van Heerden for Idasa (Pauw 1997: 70-1, 77).

In 1990, four askaris were diagnosed as being HIV positive or suffering from AIDS. Willie Nortje claimed they had become "a problem" because the other askaris would not drive with them or use the same facilities. Eugene de Kock devised a plan: he instructed Brood van Heerden – who by then had left Vlakplaas and was working for a banking group – to find "work" for them in Johannesburg. Van Heerden persuaded the manager of the Chelsea and Little Roseneath Hotels in Hillbrow to employ the infected askaris as security guards. The manager did not know they had AIDS. The four askaris, Ydam, Stretcher, Sebole and Vietnam, were still members of Vlakplaas and were paid by the unit. "De Kock instructed them to infect black prostitutes in the area with AIDS," says Nortje, who "handled" the men and visited them frequently (Pauw, 1997:70-1).

"I had to organise for the askaris to get work as security guards at the hotels, but the real reason was so that they could spread AIDS among the prostitutes," says Van Heerden. Nortje says the arrangement did not last long as they were not "disciplined" enough, whatever that meant.

But De Kock, successfully cultivating the halo of the antihero, now prides himself on having always told the truth when appearing before the TRC. Consequently, he now has more credibility than his henchmen. For example, De Kock claimed it was simply a "lie" that he had ever instructed Nortje and Van Heerden to effect such a plan. De Kock's denial is ingenious: "It is a known fact that the most regular clients of black prostitutes are white men. I wouldn't have achieved anything by infecting prostitutes." De Kock stressed that he was "never a racist" and in mitigation he claimed that he had had his askaris regularly tested for AIDS and had demanded good medical treatment for those who were infected – implying that others had not. Such fastidiousness and care was not restricted to simply testing his askaris but extended to being a buddy in the field of operations. For example, he told Jacques Pauw how he carried a wounded AIDS-infected askari out of Swaziland and personally gave him emergency medical treatment. De Kock said he was afterwards covered with blood and even had to wash it out of his mouth (Pauw, 1997: 70-71).

De Kock admitted that "it was not impossible" that Van Heerden could have concocted such a plan, as he was "a hardened racist," but why Nortje would lie about it, he was unable to explain. Whatever the truth of this astounding allegation – which should receive much more national attention – it would appear that at an early stage of the South African pandemic, some security personnel themselves were thinking in terms of their own Trojan Horse, presumably not just "following orders". The case has now come before the TRC, but the hearing keeps getting postponed.

## APARTHEID FORCES SPREAD AIDS

*Mail and Guardian*

BRONWEN ROBERTS.

JOHANNESBURG, FRIDAY 12 NOVEMBER 1999  
9.30AM.

TWO apartheid-era security officers have asked the Truth and Reconciliation

Commission for amnesty for their part in the use of askaris to spread AIDS in 1990, the TRC said on Thursday.

They have implicated four of their former colleagues and four askaris from the ANC and Pan African Congress.

The applicants, Willie Nortje and Andries van Heerden, will appear before the commission's amnesty committee next week. They were Vlakplaas operatives and worked for the new government's National Intelligence Agency after apartheid ended in 1994.

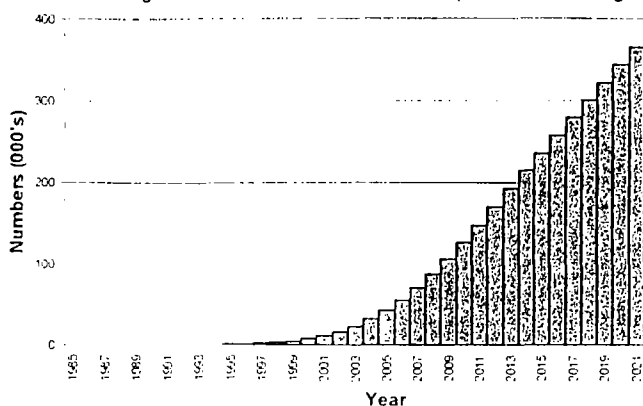
"The askaris who had AIDS were used to spread the disease by infecting prostitutes in two Hillbrow hotels, the Chelsea and Little Rose, in May 1990," the commission said in a statement.

One of those implicated is apartheid assassin Eugene de Kock, who is serving a 262-year sentence for crimes he committed while head of Vlakplaas.

De Kock is seeking amnesty for more than 100 incidents of murder, torture and fraud. — AFP

Nor is this a simple horror anecdote. Anyone familiar with HIV/AIDS component projection models knows that one of the inputs is the small number of seed individuals needed at the outset of an HIV epidemic. For purposes of illustration, an AIDS component model seeded with four positive askaris and four commercial sex workers in 1985 into an HIV-free population of 1 million with the following assumptions: 43% of the 1 million are not at risk and the population has low in-migration (*see Table 1 for assumptions*). The accompanying figure is an ogive, the accumulated AIDS deaths. In the

The Askari ogive: accumulated AIDS deaths up to and including 2021



Askari model the total number of AIDS deaths by the year 2021 could be 365 788. That is the havoc Ydam, Stretcher, Sebole and Vietnam could still wreak.

### 2.3 The Eastern Cape

Jacklyn Cock, a prominent feminist sociologist, writing on the SADF in 1991, does not mention the HIV/AIDS epidemic. However, her book lays bare the machismo of South African defence force personnel and may still be considered a useful exposé of the sexist culture among army personnel before 1994 (Cock, 1991: *passim*). Machismo must be considered in its own right as an important attitudinal vector of HIV/AIDS, and, of course, of any sexually transmitted infection.

One traumatic anecdote from Cock's work on the Eastern Cape armed forces may serve to set the *mis a scène* for that province:

Lena \_\_\_\_\_ (now deceased) did not know her age, but at the time she made the following sworn statement she was estimated to be in her seventies. She has eight children and many grandchildren who are in high school.

I live with my husband at \_\_\_\_\_ Street, Lingelihle (the African township) in Cradock. On Saturday 3 August 1985 I saw two vehicles patrolling the streets around my house. I think they are called Hippos. In the late evening I walked to a relative's home. I was alone. A Hippo drove up behind me and stopped. Two white soldiers jumped out. One said, "Here walks a bitch, alone at night, probably looking for a man. We'll help her." The words were spoken in Afrikaans. One soldier lifted me by my shoulders and one by my ankles. I struggled and said, "Where are you taking me?" The same soldier said, "You'll see." There were other soldiers in the Hippo, but I don't know how many. The Hippo drove to the national road and went towards Port Elizabeth. The soldiers did not speak or interfere with me, but the same two held me. A few kilometres away the Hippo stopped. The one soldier jumped out and the other pushed me out. The two soldiers lifted me

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over the fence and climbed over. The Hippo drove in the same direction. I can identify the spot. The two soldiers were very young. The one held my arms while the other lifted my dress and removed my slip and panties. I said, "What are you doing children?" The one replied 'Ons gaan jou naai. As jy nie wil, gaan ons jou doodmaak [We are going to fuck you. If you don't we'll kill you]. They then pushed me down with my hips on a big stone. The one soldier held my arms over my head on the ground. The other soldier (who had done all the talking) raped me. He was very rough and I was bleeding when he finished. The other said, 'Maak gou! Ek is haastig. Ek wil ook naai [Hurry up. I'm in a hurry. I also want to fuck]. The two men switched positions. The one held my hands over my head. The other raped me. He was also rough. The two soldiers then walked away towards the road, but more towards Port Elizabeth than direct. The first soldier asked me, 'Sal jy vir ons ken?' [Will you recognise us?]. I said, 'Ek sal nie vir julle ken.' [I will not recognise you]. I pulled my dress down, left my slip and panties and walked to Michalsdal [emphasis added] (Cock, 1991: 215-21).

On the following Monday Lena went to the police station:

I saw one coloured and one black security policeman together, and I told them the story in Xhosa. They recorded the facts and asked questions. I was not asked to sign anything. They asked if I knew the soldiers or the Hippo number. They said they would contact me, and have not done so (Cock, 1991: 215-21).

According to a confidential interview with Lena's daughter the old lady succumbed to HIV/AIDS, a ravaging illness and died.

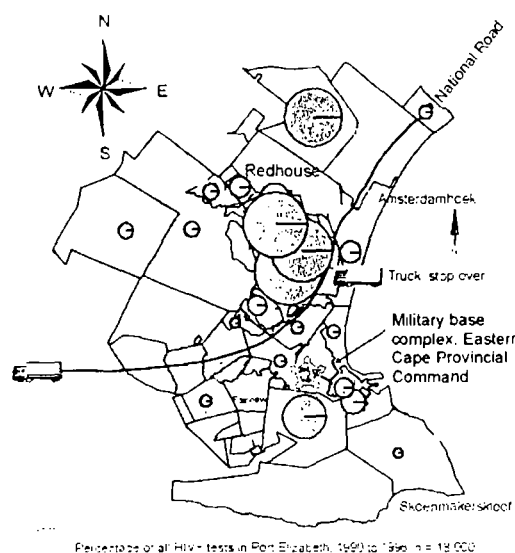
Rape is only one, albeit an important and dramatic vector of heterosexual transmission. It is conjectured on the basis of cases elsewhere in Liberia and Uganda, that returning veterans – among whom were many heroes – all with assured state employment would appear as most admirable suitors to any impressionable young, poor woman consulting her nuptial options. Further research is needed but some local anecdotal evidence lends some weight to this hypothesis. A conversation with a high school teacher in Grahamstown revealed that

the female learners in one school in the region talk of "nothing but the barracks." According to the same source, male army personnel routinely open charge accounts for these teenage conquests at nearby departmental stores, a phenomenon similar to the Liberian model (supra, page 30). According to the Medical Officer of Health of Grahamstown, which has both high unemployment and a large army base (and a town bypassed by trucks), a high proportion of Friday evening casualties involve army personnel fighting over these weekend *affaires de coeurs*. Hospital personnel are specially warned of the dangers of accidental blood infection from wounds from these particular army fights.

There are several military bases in the Eastern Cape, namely Port Elizabeth (EP Command and Group 6), Grahamstown (6 SAI, Group 7), Queenstown (Group 39) and Umtata (Group 46 and 14 SAI). The Kaffrarian Rifles army unit in East London has been closed but the town is still the headquarters of Group 8.

If we look at HIV/AIDS occurrences in the PE area, two clear patterns immediately emerge: first, the trucking hypothesis may be confirmed by looking at the high prevalence adjacent to the truck stop in the diagram.

### Port Elizabeth



Source: A1 CC, Port Elizabeth

Second, one may discern bubbles of infection next to the main military establishment which is clearly not on the national road or even near it.

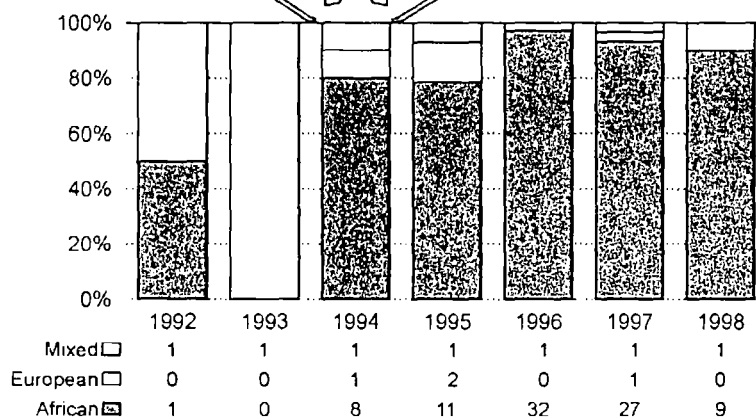
There seems to be a double peak (1992, 1994-

# Surface chart of HIV positive military personnel over time in EC

ANC against AIDS tests for exiles (1990).



Year in which SANDF was formed and all liberation forces (APLA, AZAPO, MK etc.), integrated.



Sources: AITCC data for Region A; Grahamstown MOH; Cape Times, 31 Aug 1990

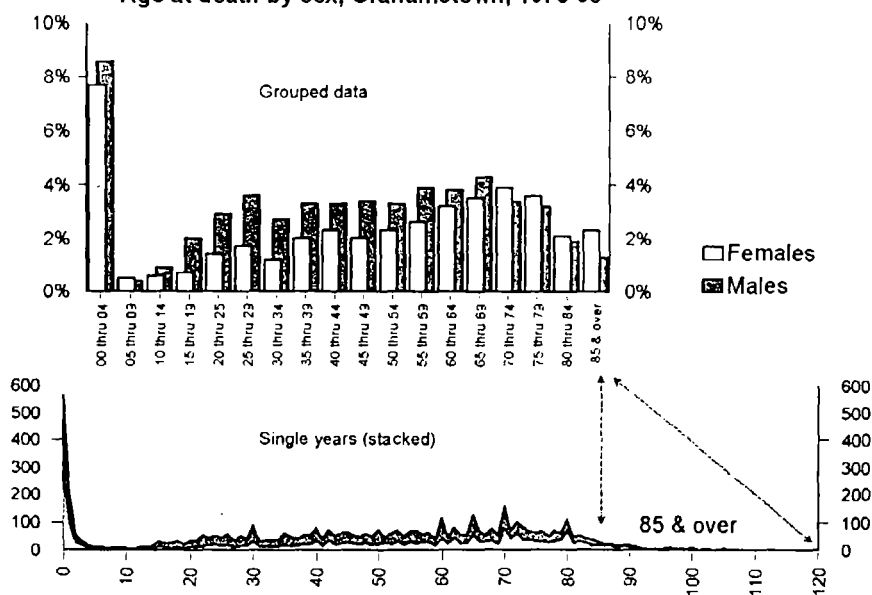
5) in the accompanying surface chart, suggesting that the military and police were already infected and then, after 1994, were again infected, possibly following the incorporation of liberation group cadres in the integration of the SANDF. One should particularly note the high proportion among the small number of the early cases.

## 2.4 Grahamstown mortality

Ms Smons Qaga has assiduously collected mortality cases from the Home Affairs office in Grahamstown for the Population Research Unit as part of her dissertation. The fruits of work are displayed in the following comparative graphic. Her results are consistent with high mortality in working age groups associ



## Age at death by sex, Grahamstown, 1975-98

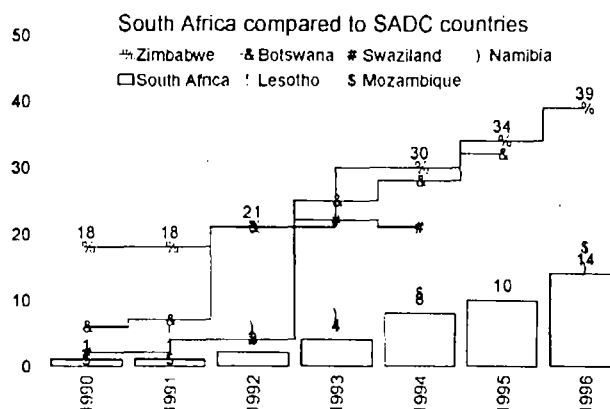


Sources: Grahamstown TLC and funeral homes

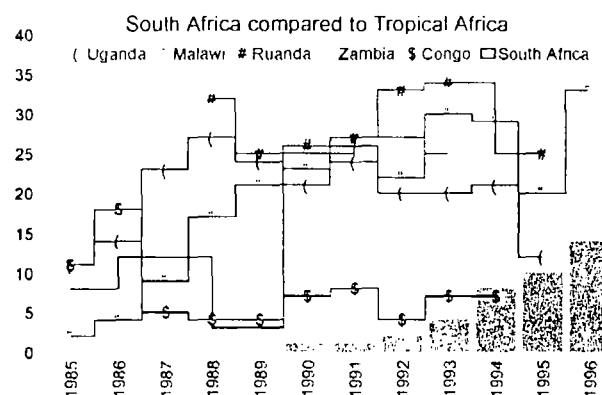
ed with the HIV epidemic. There are many implications for a study such as this. The first is that targeted intervention within South Africa is made easier. There are, of course, other implications about national security. SANDF forces are better off than their neighbours in terms of HIV/AIDS, but the South African forces are quickly catching up as one can see in the accompanying diagrams. The situation seems fraught with insecurity.

## CONCLUSIONS

While AIDS continues to spread throughout the country with literally nothing to stop it, South African researchers seem oblivious, even resistant, to the military epidemiology. Yet nobody has presented a convincing explanation for the pronounced regional variance in the provincial breakdowns and within provinces there seems to be an equivalent ignorance. The Trojan Horse hypothesis should be considered as a key explanatory variable in terms of the uneven spread of the epidemic in any province or sub-region. For example, a city like Umtata with several military bases would seem to be a likely candidate for high infectivity and therefore provide an opportunity for research, counselling and other urgent interventions.



Source: Claire Bisseret, "Africa's Military Time Bomb: SANDF's Military Readiness" *Financial Mail* (11 December 1998): 34-36.



Source: Claire Bisseret, "Africa's Military Time Bomb: SANDF's Military Readiness" *Financial Mail* (11 December 1998): 34-36.

Table 1: Assumptions of Askari model

| Beginning of epidemic<br>in RSA 1985: |           | Beginning of epidemic<br>in RSA 1985: |          |
|---------------------------------------|-----------|---------------------------------------|----------|
| Initial Population (Ix), Year         | 1 000 000 | Other Assumptions                     | Value    |
| Risk Group                            | % of Pop  | Infant AIDS mortality                 | 0.3      |
| CSW=commercial sex worker             | 1.0%      | Median term to death of HIV+ (14-24)  | 10       |
| STD=sexually transmitted disease      | 6.0%      | Median term to death of HIV+ (25-34)  | 10       |
| RSK                                   | 50.0%     | Median term to death of HIV+ (35+)    | 10       |
| NOT at risk                           | 43.0%     | Proportion of perinatal infection     | 0.25     |
| TOTAL                                 | 100.0%    | Proportion infected via mothers' milk | 0.1      |
| Immigration Risk Group                | % of Imm. | Proportion of male births             | 0.507389 |
| CSW                                   | 1.5%      | Rel Male->Fem infectivity             | 2        |
| STD                                   | 6.0%      | Imported infectivity (male CSW) seed  | 4        |
| RSK                                   | 65.0%     | Imported infectivity (fem CSW) seed   | 4        |
| NOT                                   | 27.5%     |                                       |          |
| TOTAL                                 | 100.0%    |                                       |          |

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## Halfway to the Holocaust: The Rapidity of the HIV/AIDS Pandemic in South Africa and its Social, Economic and Demographic Consequences

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*"For though the plague was long a-coming to our Parish, yet when it did come, there was no parish... Where it raged with such violence". - Daniel Defoe, A Journal of the Plague Year, London: Folio Society, 1960 (reprint), pp. 76*

### Abstract

The paper explores the rapidity of the spread of the HIV/AIDS pandemic in South Africa and discusses the consequences of that rapidity in social, economic and demographic terms. The high geographical mobility of the South African population and the extensive migrant labour system are both important in understanding the rapidity of the spread. The paper also discusses the long-term social and military instability of the region and the role of returning veterans and exiles in unwittingly spreading the virus in a systematic way through their distribution to all military bases in the country after 1992.

The paper also discusses the excellent transportation system of South Africa which has provided a ready-made vector network for the virus. The pandemic has caught the new South African state unawares as the state was justifiably preoccupied with the successful transition to full democracy in 1994. The reciprocal effects of the long-standing STD and TB epidemics are discussed as further underlying causes accelerating the pandemic. All these factors have contributed to a new and explosive phase of the epidemic. The author uses modelled estimates from Prof Robert Dorrington's component projection program and from his published work to plot the consequences of the pandemic on South Africa's short term future—to 2009—when 6,000,000 South Africans will have died of AIDS and will have suffered a true viral holocaust.

### Introduction

IF THE HIV/AIDS PANDEMIC WAS A WAR, South Africa would have to consider surrender. The defense forces have been infiltrated by the enemy; the transportation infrastructure has been taken over; the state media have been silenced by the enemy within—denial; the health systems have been compromised to the point of not being able to cope with the casualties; the enemy has targeted women and children; the population has already been decimated—in the strict Roman military sense of losing one in ten; the war

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chest of the state is empty; fighting morale is on the ebb; the people are demoralized. If the pandemic was a war, South African generals would be in tents of ignominy signing articles of capitulation in every single theater of the conflict<sup>2</sup>.

But the pandemic is not a war: if only it were. The pandemic is worse. The virus will not recognize any Geneva convention. Human concepts such as surrender—or divine ones like mercy—are unknown to the virus. The virus has no understanding; it is both remorseless and relentless in its intent; its diabolically engineered genetic code is programmed with a single purpose: to attack vulnerable human immune systems. If South Africa does decide to fight, the country must first understand why its death-seeking enemy has spread so rapidly.

## The Global Pandemic

According to the figures of the World Bank and UNAIDS released in late 1998, Sub-Saharan Africa has more than two thirds of the World's 30 million HIV positives. Underlining the cultural differences in the prevalence and vectors of the pandemic, North Africa and the Middle East have only 210,000 positives (see Figure 1).

South Africans are fond of comparing rates among their nine provinces. For example, for some Xhosa men living in the Eastern Cape, it is consoling to reflect that their circumcised province has lower prevalence levels than the uncircumcised province of KwaZulu Natal. Without denying the advantages of circumcision, or the accuracy of the prevalence rates, the focus of such cosy comparisons must be changed: it is more enlightening to consider that the Eastern Cape city of Port Elizabeth, South Africa's fifth largest city, has more HIV laboratory-confirmed cases than the whole of Australia and New Zealand combined (PE ATICC 1998).

If policymakers in those remote countries believe they have an AIDS problem what do their local counterparts think South Africa is undergoing? The phrase *public health disaster* is already on the lips of AIDS activists. Tomorrow's angry generations of survivors might well deride such phrases as recklessly euphemistic. South Africans must become aware that a partial depopulation of certain communities in their country has begun. They must also know that South Africa is now the epicenter of the world's fiercest pandemic.

## Migrant Labour

HIV/AIDS has been given a free pass to visit the vulnerable zone of Sub-Saharan Africa. There are no tests for foreign nationals coming into South

Africa for work purposes. A high proportion of workers on South African mines are domiciled in other HIV/AIDS devastated countries such as Botswana, Lesotho, Mozambique, Swaziland, Zambia and Zimbabwe. During their bachelor sojourn in South Africa they have a variety of sexual contacts. South African-born migrant workers work, socialize and have relationships in the same pool of sexual partners. Estimates of foreigners from elsewhere in Africa range from 400,000 (Stats SA1996) to figures as high as 4,000,000 being regularly speculated in the media.

## Mobility

South Africa also has a wealthy segment of its population who regularly travel across the world. In short, considering international and local population movements, the South African population is among the most mobile in Africa. In the fragile, frightened new world which HIV/AIDS has wrought, geographical mobility on its own—whether one is a miner, yuppie or refugee—imposes an unsuspected vulnerability. Until the Department of Home Affairs institutes some HIV surveillance system on our borders, the international vectors of HIV/AIDS into South Africa will remain unknown. Perhaps it is time to think of—if not closing—at least checking the floodgates. Cuba has been checking everyone crossing its borders for HIV for over a decade. South Africa should do the same.

## African Wars and AIDS

The conditions of human warfare are the best friends of HIV. Vulnerable people in the path of war have proved easy prey for HIV/AIDS which "travel[s] along societies' faultlines, exploiting weakness and instability" (Van der Vliet 1996: 78). One of the main reasons HIV/AIDS has spread so rapidly is that the African continent has been embroiled in twenty years of intermittent military and civic violence in regions as diverse as Angola, Burundi, Congo, Eritrea, Ethiopia, Liberia, Mozambique, Namibia, Rwanda, Somalia, South Africa, Sudan, Tanzania, Uganda, and Zimbabwe (Van der Vliet 1996: 81; Smallman-Raynor 1991; Webb1997).

War creates the perfect conditions for the transmission of HIV. War—sad to say—is Africa's major business. Thomas Hobbes (1588-1679) describes how war reduced society to the point where there was "no arts, no letters; no society; and which is worst of all, continual fear and danger of violent death and the life of man, solitary, poor, nasty, brutish and short" (Hobbes 1651: c. 13). This is already the lot of all Angolans and many South Africans.

From as early as 1976, South African apartheid soldiers invaded Angola and other neighbouring HIV-infected countries. After apartheid collapsed, approximately 40,000 returning cadres from all liberation groups

no were living in those same frontline countries, and some deeper in HIV-devastated Africa, were incorporated into the new SANDF without a single IV test. After induction, they were distributed to all military installations throughout the country, i.e., in a systematic pattern across the landscape. If we were to design a pandemic, this would be a perfect blueprint (see Figure 3).

## Returning Veterans and the Trojan Horse Argument

Just one thinks this an exaggeration, one must remember that returning HIV-positive veterans from Angola prompted Cuban authorities to start their famous *sanatorios* system in which every HIV positive veteran had to undergo benign incarceration (Scheper-Hughes 1993). South African veterans—both apartheid soldiers and revolutionaries—underwent no such testing and, of course, no isolation. Both sets of soldiers unwittingly became carriers of the virus and returned from their respective wars with a viral infection which by 1999 had been randomly and broadly seeded throughout the country. While the SANDF have instituted counselling for their personnel, there are persistent, albeit anonymous, reports that the prevalence in some units is unacceptably high. Seventy-two percent of the 9,000 recruits who volunteered for the 1996 invasion were unfit. The army will not say what percentage were HIV positive. The South African state through its military has promoted what was a series of epidemics—local outbreaks—to a pandemic.

## Highways of the Holocaust

The virus is not only a camp follower of military campaigns but also travels in style on civilian aircraft, railroads, highways, roads and also spreads humbly by bicycle and foot. Ironically, South Africa's well-developed transportation systems have become excellent corridors for accelerating infection, perhaps faster than elsewhere in Africa. The 1918/9 Spanish influenza epidemic, *Spanish Grip*, killed close to a quarter of a million South Africans, including 10,000 in the remote Transkei in one month—Black October (see Figure 3). This explosive and largely forgotten epidemic spread with an undeveloped transportation system (Phillips 1990, 159). We can therefore readily understand why the South African HIV/AIDS pandemic has progressed so confidently and so deeply via South Africa's improved transportation network in the 1990s.

The excellent SA transportation infrastructure is definitely part of the reason why South Africa has so quickly become the worst hit country on a per capita basis. It is worth noting too, that in absolute terms South Africa is second. Only India has more People With AIDS (PWAs) than South Africa. The Indian subcontinent also has a well-developed transportation infrastructure, widespread rural illiteracy and poverty.

The Triple-decker Pandemic: Tuberculosis, Sexually Transmitted Diseases (STDs) and HIV/AIDS  
Triple-decker pandemic: Tuberculosis, Sexually Transmitted Diseases (STDs) and HIV/AIDS.

The reciprocal effects of the simultaneous TB pandemic and STD pandemics have also to be considered (Meidany 1997:6). There is a greater number of tuberculosis cases in South Africa than ever before. One must remember that half of the Sub-Saharan population has had TB. The STD prevalence is also unacceptably high, and highly correlated with HIV in the poorer provinces (see Figure 4).

The different pandemics—one airborne, the others sexually transmitted—are relentlessly attacking the same population, the poor and lower middle classes. The possible range and arithmetic force of the demographic combinations are unknown and cannot readily be calculated although valiant attempts are being made to model the triple pandemics.

HIV positive people and PWAs provide an open window for the opportunistic invasion of TB. Moreover, once infected with TB, PWAs and PWAs provide a mobile and stable platform for the dissemination of the airborne disease among people without HIV until the former die. HIV will also reactivate "cured" TB. As Barry Schoub, South Africa's leading virological authority on HIV/AIDS chillingly notes:

Tuberculosis, as with other chronic infectious diseases, enhances susceptibility to HIV infection because of lymphocyte activation and immunosuppression. Conversely, the immunosuppression of HIV infection enhances susceptibility to infection with the Tuberculosis bacterium and it also activates latent Tuberculosis in individuals who have previously been infected (Schoub 1994: 82).

With increasing use of antibiotics—and South Africa has one of the highest usages, at least among the wealthier segments of the population—one may expect increasingly virulent variants of TB appearing in the general population. One just has to imagine this combination of factors in economically distressed and disadvantaged domestic settings. One may therefore anticipate that a broad swath of the poor not at risk from HIV will be exposed to enhanced probabilities of TB infection simply because the disease is concentrated in that class. Those unfortunate people who have contracted TB before they contract HIV may expect an even more rapid morbidity. Yet, TB and all STDs—with the exception of AIDS—can still be cured. A national Directly Observed Treatment Short course (DOTS) campaign has to be launched and sustained.

## Failure of the South African State to Intervene

South African state must intervene immediately, dramatically, decisively, loudly, audibly and above all, credibly. It is unanimously recognized that only developing countries have succeeded in managing the HIV/AIDS tide, namely Cuba, Thailand and Uganda. What do these programs from such diverse cultures have in common? Two features are uppermost: first, their sustained aggressive HIV awareness programs; second, the state launched the earliest possible intervention. If the South African state does not act, and act now, one has to agree with the former minister of Population and Welfare, Maudie Frazer-Moleketi, that South Africa is on death row.

## Impact to the State

There will be discrete burdens on the national, provincial and municipal resources. The state, in all its manifestations, has yet to gear up to the costs of the pandemic. An understandable but never-ending fanfare heralding South Africa's successful transition to full democracy has curiously retarded the initial mobilization of SA's new leadership. The colossal triumph of the democratic political process and the coincidental appearance of an already globalized and deadly virus have together led the country into a complex set of dilemmas of the post-apartheid reality. Nobody wishes to spoil the party. Leaders will find the non-intervention of the state difficult to understand and it—with the gift of hindsight—roundly condemn such passivity as both negligent and inexcusable.

The tragedy is that the *same* people, formerly excluded from the democratic process, have now been caught unawares by a silent revolution, a deadly virus with a holocaust potential. The pandemic has become thoroughly globalized (see Figure 5). PWAs will not live to enjoy their just expectations of an African Renaissance, which regrettably, history herself will have to mediate.

## Corporate Costs

The measurement of the impact of AIDS on firms and enterprises is complex. The actual cost of AIDS cases to employers varies greatly. Productivity has already been affected as skilled or experienced staff fall ill, stay absent and eventually die. Medical aid schemes will probably suffer first as their profits are dependent on narrow actuarial assumptions of healthy populations. Most working South Africans will first become aware of the pandemic through increased health deductions from their paypackets as medical aid schemes begin to deduct more to adjust their premiums.

Positives who know their condition—and only one in ten knows they are positive—are unlikely to inform their medical aid schemes for fear that

they will be deprived of further benefits. PWIs and PWAs who do not know their status will be a bigger unknown factor. Costs and expenditure will increase as both employers and employees scramble for safe, supplementary medical aid cover.

Absenteeism, lower productivity and permanent loss of experienced staff will add to the draining costs of HIV/AIDS in the workplace. Training costs will multiply as some employers in certain areas find that one in five of their trainees dies after completing a three-year training course. Technikons and universities and the taxpayers will have to re-examine tertiary sector throughput ratios as 20% of the student body—tomorrow's leaders—will acquire AIDS and die. Students intending to take out loans might reasonably be required to have life insurance.

The pandemic will eventually affect macro-economies through the illness and death of millions of productive members and the diversion of resources from savings and eventually investment to health care. The reallocation of resources will reduce the rate of economic growth over time. Overseas risk investment in South Africa will dry up. One may predict that only the most patriotic or philanthropic capital will stay. Three of South Africa's major local corporations, Anglo-American, South African Breweries and Old Mutual, have already moved offshore, probably on the advice of their worried actuarial departments. Under the massive pressures of the pandemic, the Government's economic policy, GEAR, might buckle. New economic philosophies, totalitarian ideologies and possibly even cults will jostle for supremacy and may challenge the contemporary state.

## Medical Costs

If one accepts the Department of Health's 1999 estimates that there are 3,600,000 HIV positive cases in South Africa and that the currently quoted figure of R4,300.00 for the monthly costs for the AZT cocktail remains stable, one may assume that the minimum costs of medication alone per year for treating advanced AIDS cases in say, five years will exceed R750,000,000,000.00 [sic] (Glaxo 1999: 1). Trials are underway with less expensive drugs but the costs will remain astronomical. Put another way, the cost of treating a single terminal case of AIDS with an AZT cocktail per month is equivalent to placing nineteen schoolchildren in a primary school for a month. This figure does not include any depreciation of the steadily sinking Rand, nor does it allow for an increase in the number of AIDS cases. This is the numbing, budget-breaking burden of the future financing of health services which will impose horrible decisions of triage on every health policymaker of the country.

## False Hopes

The overall result of AIDS will be to reverse hard-won development gains and make all people in the country worse off. It is certain that measurable demographic impacts will last for the next century. The much vaunted “leveling off” which all AIDS experts hope for might be further away than they first thought. One must note too, that the apparent leveling off reported in other parts of Africa is also consistent with the breakdown in expensive national surveillance systems as prevalence jumps into the 40% and over bracket in some areas. Assumptions about leveling off may have been unwittingly, or inappropriately, incorporated from mathematical models of airborne diseases.

Modeling assumptions about “no risk” groups must surely shrink as infants, toddlers, pregnant women and even grandmothers are added to an increasingly horror-filled rape victim pool. According to Mark Welman, the leading national authority on rape, one in three South African women will be raped in their lifetimes (Welman 1999). These new victims must reduce the “no risk” categories in AIDS modeling. But even if we accept the standard “no risk” assumptions everyone must know that the leveling off is far ahead. South Africa is only in the foothills of a quite tyrannical mountain which looms in the future (see Figures 9 and 10).

To hope, or worse, wait for a timely cure is delusional and reveals both a naïvely cheerful belief in the state of virological science and a thorough underestimation of the invasive, intricate nature and katabolic procedures of the HIV virus. Medical science still cannot directly detect the virus. Only certain antibodies provide an index of its existence.

## The Impact on the Population

### *Household and Housing*

Before death, at the household level the impact of HIV infection increases certain kinds of long-term expenditure. If infected persons are income-earning, their illness and certain death will reduce the household income capacity. Special medical treatment, nutrition and, inevitably, funeral costs constitute major financial burdens on the AIDS household budget. This combination of burdens will lead to a further, immediate degradation in the household economic status, adversely affecting the living standard and quality of life of all surviving members.

Housing policy will also have to change. The first AIDS igloo village for 200 people has already been built in Roodepoort, based on a Brazilian model (see Figure 6).

The funding has been provided by the media, not the state. If all the PWs of South Africa in 1999 were housed in such sites, there would have been 18,000 such villages at a minimal construction cost of R3,168,000,000.00.

By coincidence the number of all people living in what Stats SA call “tribal villages” in the Eastern Cape in 1996 was 3,649,541, a number similar to all the people with HIV (Stats SA 1996). This provides a comparative idea of the geographical extent of the land that would have to be used to house contemporary PWs in the new Rainbow Sparrow villages. What must be noted is that the re-segregation of South African society on the basis of health and philanthropy has already begun.

### *Impact on Family Structure*

The people who are now falling ill and dying are the parents and leaders of society, which means that a generation of children will grow up without their care and the role models they would normally have had. If we recall that the children who grew up in the last years of apartheid were called the “lost generation”, we must conclude that there will be two such “lost” generations, one after the other. Few countries have endured such consecutive inter-generational calamities. South Africa will be the first country to undergo this unique degradation of its familial and social fabric—already rendered threadbare by apartheid. Unless the increase is slowed, this inter-generational breakdown will be—for all intents—a perpetual spectre.

South Africa will also be the first country to experience a sudden and widespread breakdown of the main conduit for transmission of social values—the family—as orphanhood and single parenthood become common—if not modal—in certain communities.

Experts are already warning that crime will increase at an exponential rate which will reduce the country in the short to medium term, i.e., five to twenty years, to widespread rapine and social anarchy. Martin Schönteich soberly warns “[g]overnmental policy makers would be well advised to brace themselves for an increase in juvenile related crime as the number of orphaned juveniles increases over the next two decades. Traditional methods of fighting crime, such as tougher laws, more police officers and more prisons will do little to counter this” (Schönteich 1999: 8). As early as 2005, South African society may be living out the gangland values of the Mad Max movie dystopias.

### *Impact on Women*

Household members with AIDS who need special care and treatment may place an extra burden on women, who traditionally take responsibility for the care of family members and children. As mothers or as widowed heads-

ehold, women will bear the brunt of the pandemic. They are also the most vulnerable to infection partly because nature designed the vagina above all as a spectacle.

According to the most recent national sentinel site survey, there is a significant increase of HIV infection amongst women in their teens, which reflects persistent vulnerability in sexual relationships as well as male indulgence in unprotected sex. These vulnerable young people must become aware that they are not just jumping into bed but into a coffin.

There is an escalating war against women accompanying the epidemic. Researchers are beginning to suspect that it is not a coincidence that South Africa has the worst HIV rates and the worst rape statistics in the world. Welman has begun a new HIV rapist profile. Township residents already know one: they term such people "Jack Rollers" which another national authority defined in a glossary as:

Township youth who purposefully infect young women with HIV by raping them. This is a relatively new phenomenon in South Africa and the youth who do this are said to be unemployed and frustrated young men who have found out that they are HIV-positive and say that they want to "die with others" (Taylor 1998: 116)

Enough women are raped every day in South Africa to fill three jumbo jets (Welman 1999). There are now confessions by rapists on police stations in Grahamstown claiming they were seeking "a cure" with a virgin. This is a fresh manifestation of an ancient and diabolical myth, which has been urged throughout Africa in the popular but misinformed backwash of the pandemic (Shell 1998: 28). No pandemic in human history has entwined sex and death so intimately and inextricably.

## Orphans

The problem of children orphaned by AIDS is increasingly becoming an everyday domestic issue with disturbing reports of ostracism and even abandonment of HIV positive infants. In Mutare in Zimbabwe, a newspaper reported an eleven year-old head of household who had the melancholy and arduous task of burying his own parents on the premises as there were no municipal services to remove the parents' cadavers. Overworked grave diggers provide voluble primary evidence of the inception of the AIDS decades of the pandemic and the end of the initial asymptomatic HIV decade. Orphans are a visible and permanent feature of South Africa's street life. No doubt they will see them as a nuisance.

One of the worst consequences of AIDS is that large numbers of children are orphaned because both their parents will die from AIDS. In normal times, full orphanhood is rare as even if one parent dies, there is at least a surviving parent. South Africa might expect 100,000 "full" orphans in 1999 as a direct result of AIDS deaths. The health, development and nature of these children may be neglected as grandparents, extended families, fictive kin and even communities may not be willing—or able—to carry the burden of so many orphaned children.

## Impact on the Individual

Loneliness and depression are already recognized as the twin companions of People With HIV (PWHs) and PWAs. The psychology of both PWHs and PWAs is not well studied and is consequently unknown. Without question the main coping strategy for most individuals, both positive or negative, has been denial. This is the traditional and historic pattern throughout the literature of the various plagues whether one consults Daniel Defoe or Albert Camus. The biblical spectacle of the stoning to death of Gugu Dlamini, a self-declared PWA, has served as a rallying call—at least in the media—for a new awareness that has to come if the country is to confront the pandemic. Zambia is the first country to admit that it will lose half of its population due to AIDS (Sunday Times 31.8.1999). The first step is for every South African to recognize and face the pandemic. Denial must be discarded as an unsuccessful coping strategy at both the state and individual level.

## A Brief History of the Pandemic

The first two AIDS cases in South Africa were diagnosed in 1982 with the first recorded death occurring in 1985. There were undoubtedly thousands before which went unnoticed. By the end of 1990 the heterosexual pattern had overtaken the homosexual/bisexual pattern as the dominant form of transmission of the reported cases. Homosexual transmission appears to have peaked around 1990. By February 1993 all but two of the 46 cases diagnosed as AIDS from 1982 to 1986 had died. At the end of 1995 some 9,000 cases had been reported of whom some 8,000 were still alive. But this was the tip of the iceberg. Estimates from component projection models suggest that barely more than 5% of all cases were reported and only slightly more than 1% of the deaths. At that time it was estimated that over 1.8 million people were infected with HIV.

The Department of Health estimated in 1996 that up to three per cent of the total population and 7.5 per cent of the sexually active population were infected by HIV. In 1996 approximately 700 people were becoming infected each day with the rate of new infections doubling every fifteen months. By 1998 these projections had proven too modest according to the same source.

partment of Health 1998: 6). In terms of numbers of people infected with / South Africa in 1998 is almost two-thirds toward the holocaust figure of 10,000 Jews killed in the thirties and forties. The HIV figure now stands at million (Department of Health 1998: 6).

One can appreciate some of the effects by looking at some key numbers “before and after” the first AIDS deaths.

By the end of 1990

Life expectancy had risen to 63 years  
Fewer than 1,000 AIDS deaths had occurred over the year  
Child mortality rate was 67 per 1,000  
The probability of a 15 year-old dying before 60 was 27 per 1,000  
Less than 0.5% of the population was infected with HIV.

By the end of 1999

Life expectancy will drop to 56.5 years  
Between 140,000 and 150,000 AIDS deaths will have occurred over the year  
Child mortality rate will rise to 91 per 1,000  
The probability of a 15 year-old dying before age 60 will be 40 per 1,000  
1.5% of the population will be infected with HIV  
There will be AIDS sick, in other words, 8 major illnesses per AIDS patient per year  
There will be 2,500 new infections per day  
There will be between 100,000 and 150,000 children orphaned due to AIDS over the year

## 2 Impact of the Pandemic on Population Structure

The impact of HIV/AIDS on population structure is dramatic and dynamic. There will be a decline in the number of people in specific age groups, namely 15-24 year-olds and 15-34 year-olds. In other words, AIDS increases mortality in the age groups that historically have enjoyed the lowest mortality rates. Since AIDS is primarily spread through sexual transmission, the majority of people will be infected in their late teens and early twenties and will fall ill and die in their late twenties and early thirties. The peak ages of HIV infection are between 18 and 25; the peak ages of AIDS deaths are five to ten years later. There is some evidence that HIV in Africa develops faster to fully blown AIDS than in the rest of the world. This is probably due to the endemic TB, poverty and illiteracy of the continent.

The concentration of AIDS deaths in these age groups has important consequences. HIV-positive pregnant women might infect their newborn children during delivery or through breast-feeding. Infant and child mortality

rates will increase since most of these HIV positive infant children will develop AIDS and, almost without exception, die within five years of birth. Although the potential increase in the infant mortality rate is estimated at about five infant deaths per 1,000 live births, the net impact will be smaller since some children might die from other causes. However, about a twenty per cent increase in the under five mortality rate could be expected sooner rather than later.

In a few years time, HIV positive mothers might be counseled to contemplate abortion on grounds of cost even if cheaper drugs such as AZT are administered by the state. Over time, these age groups will move up the age pyramid and so—with increased mortality and deferred births—the structure of the age pyramid will visibly change. As early as 2009 AIDS deaths will have surpassed the holocaust figure of 6,000,000 (see Figure 7).

## Impact on Life Expectancy

Life expectancy is particularly sensitive to AIDS because deaths occurring among young adults, young children and infants result in a large number of years of life lost. Before the AIDS pandemic, South Africa had been enjoying a drop in mortality and an increase in life expectancy. AIDS has insulted this progress. People who are under ten now will probably end their lives in a demographic regime similar to that of a Roman slave whose life expectancy was estimated as 30 years of age. Figure 8 shows that the life expectancy from birth, of a cross-section of those born in the last 100 years, falls to 40 years by the year 2010. In terms of mortality, it is as if the South African population had been put in a gigantic time machine and slammed back 2,000 years. If one remembers the childhood game of snakes and ladders, then this must be the biggest snake on the demographic board (see Figure 8).

## The Absence of Hard Data

The above figures are estimates based on a model that was calibrated on the basis of the annual antenatal clinic (ANC) HIV prevalence figures. The model reproduces the ANC figures closely until last year: the model predicted around 20% prevalence whereas the recorded figure was a startling 22%. Without having access to the data it is difficult to know how to adjust the model. To model the pandemic in future it is important that we find other data against which to calibrate the model. In this regard it would be useful if the national mortality data could be published more timeously. AIDS deaths became significant enough to be noticeable at a national level from about 1997 yet the most recent data is for 1995. The current author was unable to obtain the recent ANC dataset as the Department of Health has refused to release them to any other *bona fide* researcher. One must conclude that the President’s “partnership against AIDS” is itself moribund. Without any interventions the

idemic will follow the awful contours in the accompanying graphics (see figures 9 and 10).

## Aspects

Even if a cure is found, the main immediate intervention which must now be templated is the swift and effective dissemination of specific knowledge about prevention and the management of the pandemic. This is, of course, easier said than done. But things can be done. In the USA the Postmaster General reached every household with a national AIDS booklet. The various South African radio services can reach the illiterate in the remotest village. The pandemic poses profound cultural problems of communication which are compounded by the nature of AIDS, its intimacy with death and the human time associated with every sexually transmitted disease. Yet every person, from the youngest to the oldest, in Southern Africa must become aware of this, the fiercest pandemic in human history. Biblical plagues and even the Black Death of Europe in the fourteenth century do not compare. The primary hope for individuals in the population is a shield of knowledge for which every individual in the society must take a daily—and more important—nightly responsibility.

## Interventions

Figure 11 gives an idea of the impact of three possible interventions on the prevalence of HIV in the population. The first line assumes that AZT is given to pregnant mothers with partial success resulting in a 25% decrease in mother-to-child transmissions. However, the cost of AZT is out of proportion to the other interventions. The second line assumes that the rate of sexual transmission is reduced through the use of condoms. The third line assumes that a national campaign manages to treat half of those with STDs. The combination of all three is included in the fourth, dotted line (see Figure 11).

## Conclusions

The HIV/AIDS pandemic has proven difficult to predict. Early forecasts have been too cautious. All policy-making authorities must understand the immense complexities of South Africa's future. All one can say with sober certainty is that the pandemic will profoundly change society in ways one can neither fathom nor foresee. None of these changes will be progressive or come. National life will become more complicated, sooner rather than later. Civil rights will be compromised, sooner rather than later. The constitution will come under pressure, sooner rather than later.

South African expectations of a rebirth of a nation will certainly be dashed unless the state and all South Africans come to grips with their

vulnerabilities to the pandemic and start auditing the social costs. A new, omnivorous, silent and invisible monster is striding across the South African landscape, collecting infants, toddlers, students, adults, schoolteachers, in short, most ordinary people of all ages. The progressive revolution of 1994 is being rolled up like an unwanted carpet in preparation for the *jours mauvais*. As we write, there seems to be nothing to stop the expansion of this preventable, and therefore unnecessary, network of death.

## Notes

<sup>2</sup> The author would like to thank Prof. Robert Dorrington for access to his program ASSA600C and for many of the graphics and data in this piece. The author has relied in particular on a poster presented at the Annual DEMSA conference at the Saldanha Bay Military Academy in 1999 entitled "AIDS TNT: AIDS, Then, Now and Tomorrow" published by the MRC. Mistakes in the application of the program and all interpretations of the data are the author's sole responsibility. The staff of the Cory Library have provided timeous help and many references. Sandra Rowoldt, Barbara Valentine, Jacques Van Zuydam and Michael Whisson, have read drafts and contributed substantially to new insights.

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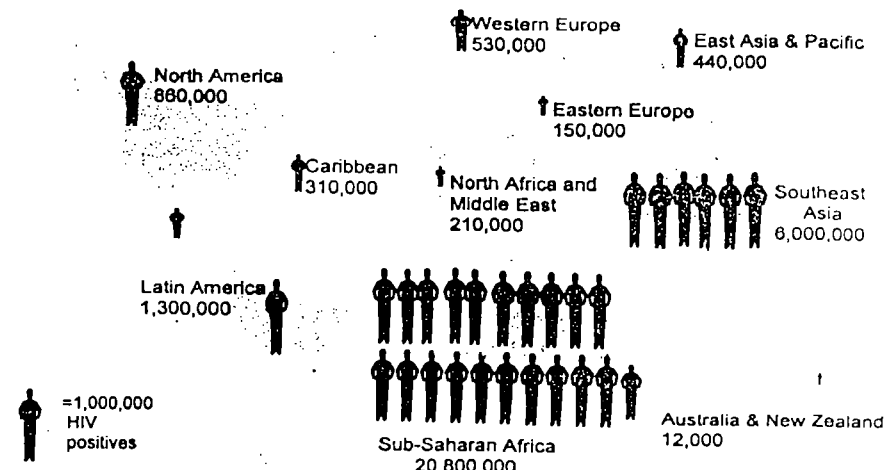
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Figure 1: The World's fiercest pandemic



Source: UNAIDS (October 1998)

Figure 2: Population living in SA military and police barracks in 1996

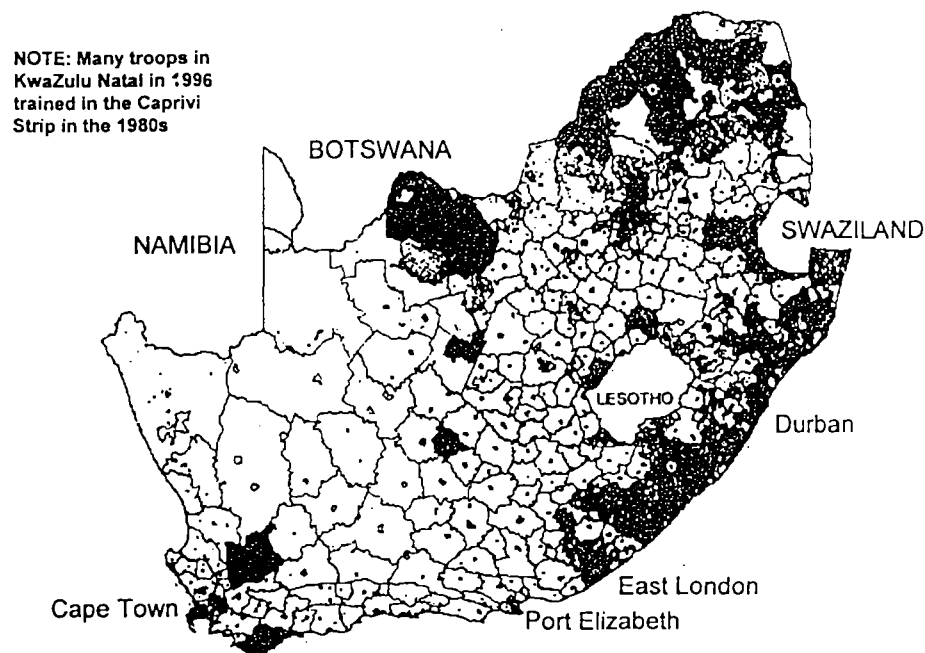


Figure 3: Spanish Flu, Spaanse Griep, Black October, 1918/19



Source: Burgher, October 1918/19

Figure 4: HIV and STD rates among pregnant women in South Africa's poorest province, the Eastern Cape

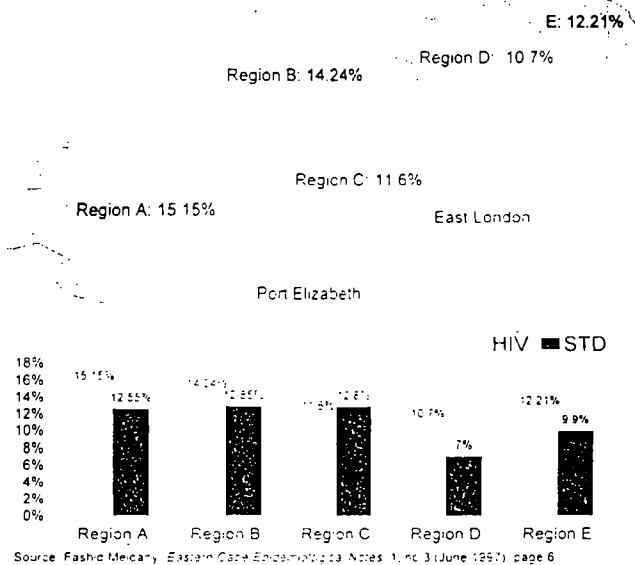
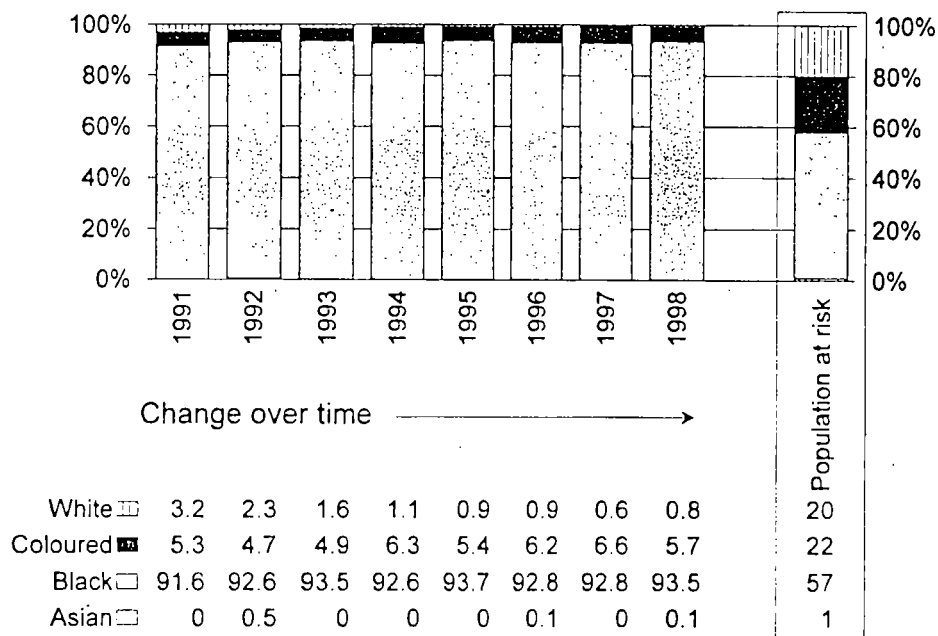


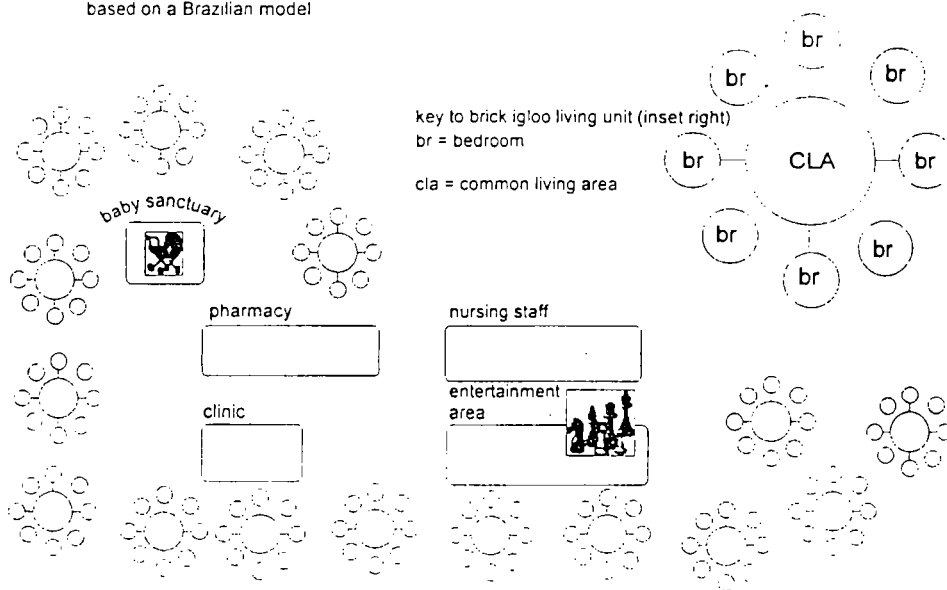
Figure 5: Ethnic composition of HIV infection over time in a typical SA city



Source: Port Elizabeth ATICC, 1998

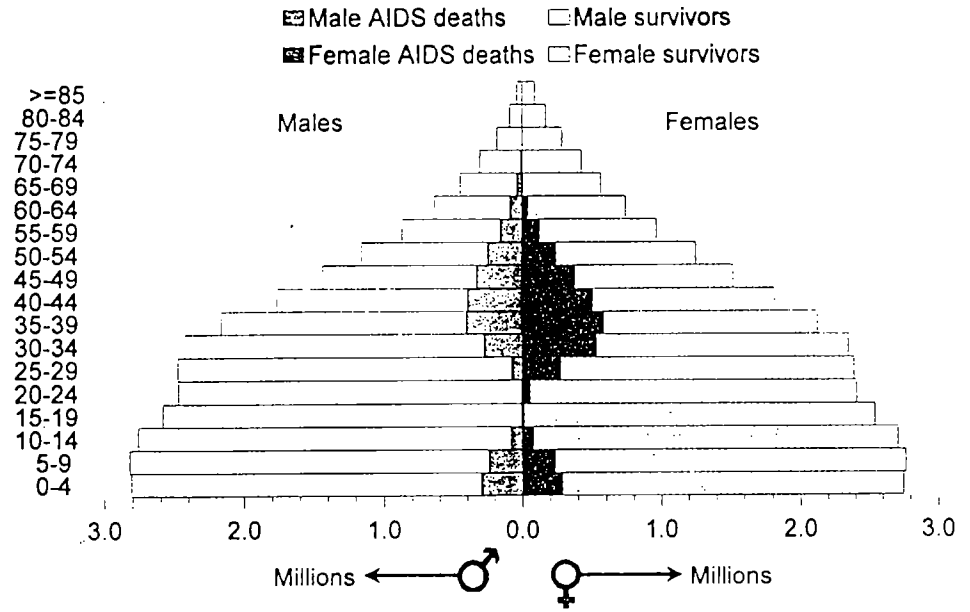
Figure 6: Sparrow Rainbow Village for 200 AIDS clients

6.2 hectares, Roodeport, SA 1999  
based on a Brazilian model



Source: *Sunday Times* (22 August 1999): 15 (artist's impression)

Figure 7: Age and sex of 6,094,529 AIDS deaths in 2009



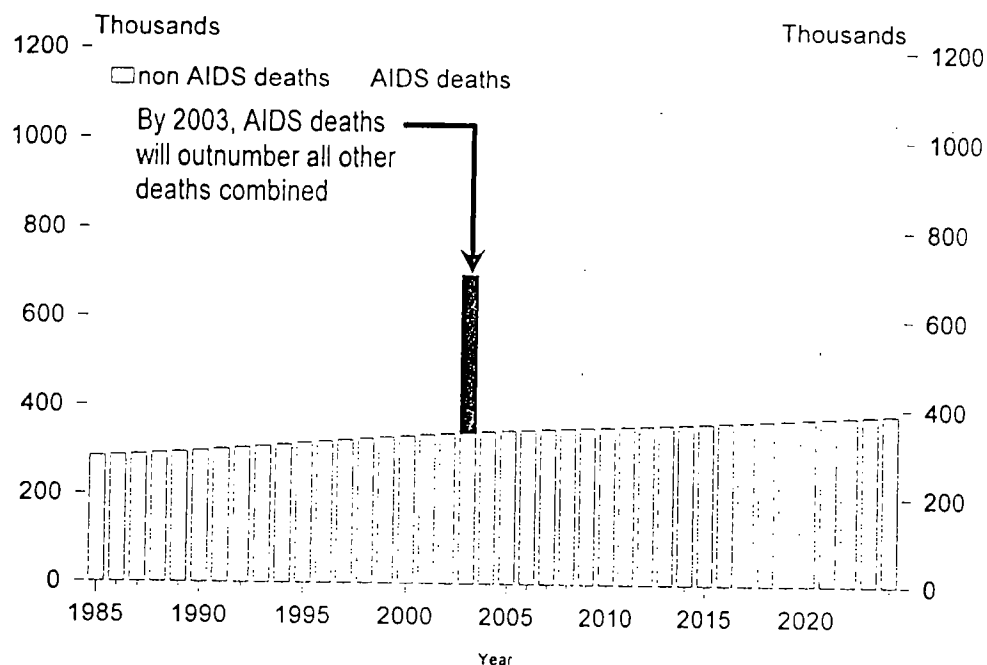
Source: ASSA600c component projection, courtesy of Prof. Robert Dorrington, UCT

Figure 8: The AIDS dystopia: predicted SA life expectancy, 1985 to 2009



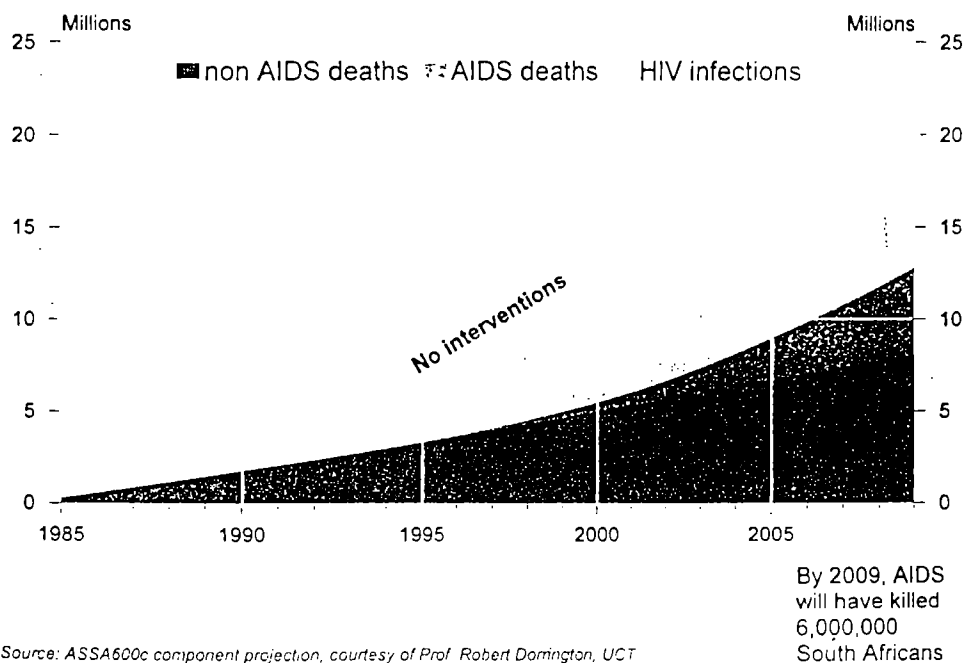
Source: ASSA600c component projection, courtesy of Prof. Robert Dorrington, UCT

Figure 9: AIDS deaths and non-AIDS deaths, 1985-2025



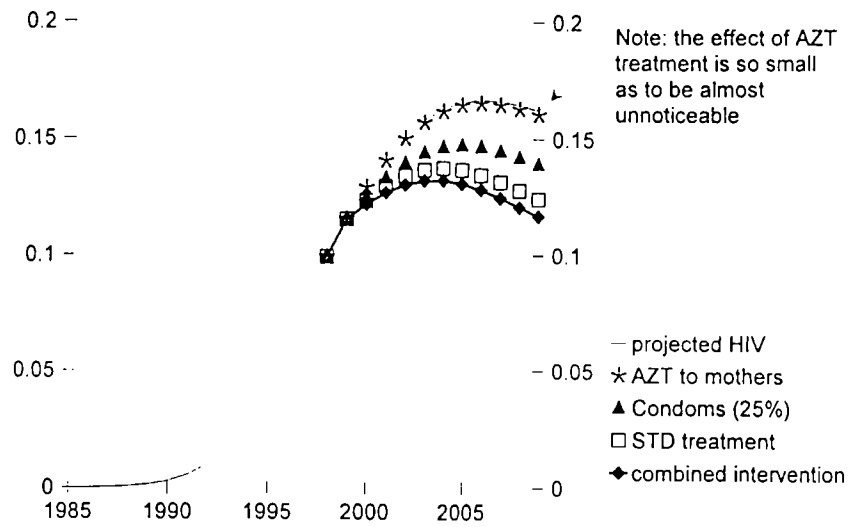
Source: ASSA600c component projection, courtesy of Prof. Robert Dorrington, UCT, Actuarial Science Dept.

Figure 10: Accumulated annual totals, non AIDS deaths, AIDS's deaths, HIV infections



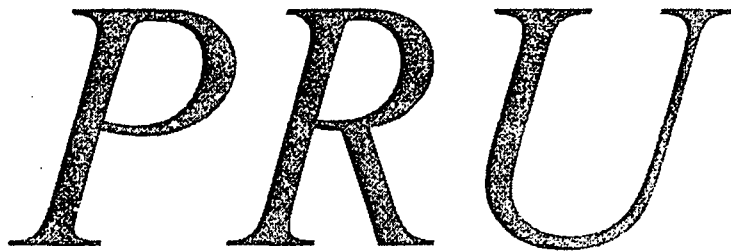
Source: ASSA600c component projection, courtesy of Prof. Robert Dorrington, UCT

Figure 11: Four interventions



Source: ASSA600c component projection, courtesy of Prof. Robert Dorrington, UCT

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Presented at the South African Epidemiological Conference, Friday 25 February 2000, 10:15am.

#### 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*

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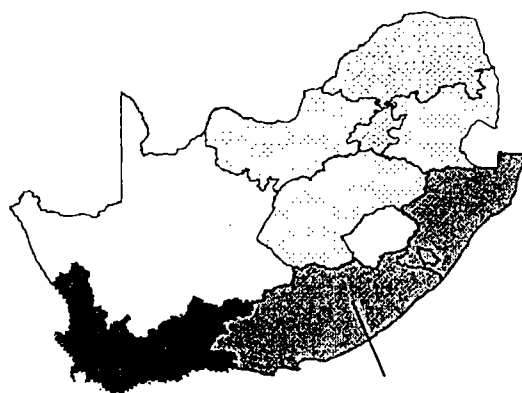
## POSITIVE OUTCOMES:

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

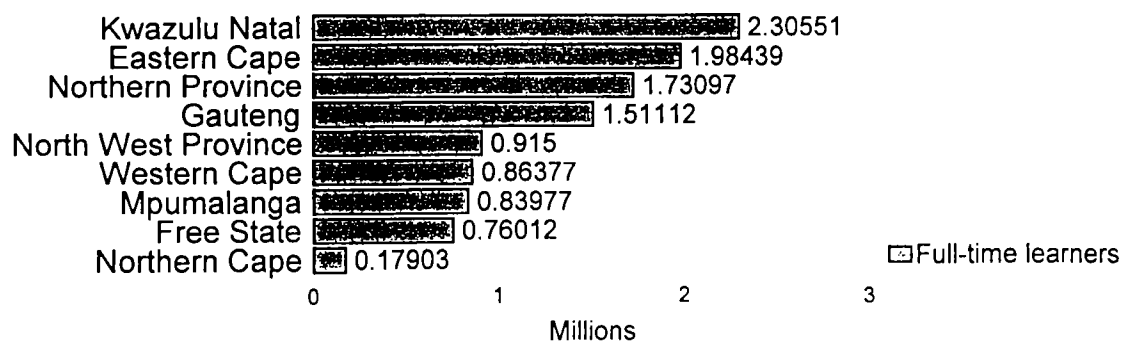
The Eastern Cape is among the most populous of all the provinces (StatsSA 96). The province is a source of out-migration for young males seeking employment. Consequently there are a greater proportion of women and children in the province. The number of children studying at school is very high in proportion 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

The Eastern Cape has  
1,984,390 full-time learners



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

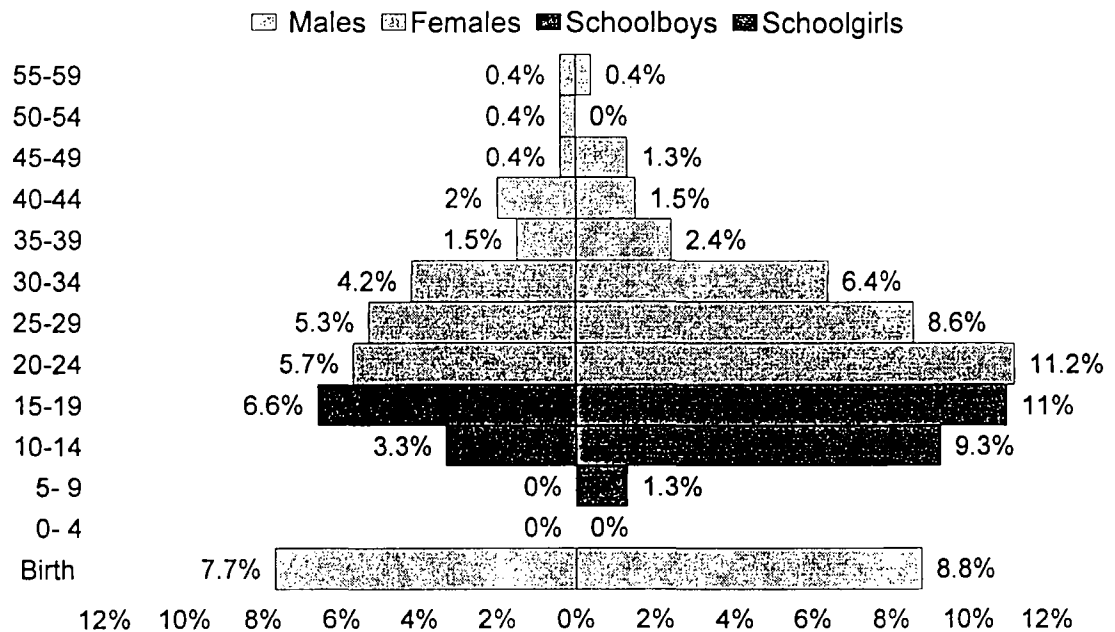
This review shows clearly that the educational systems of Africa and South Africa are not providing nearly enough adequate reproductive health counselling. Even the Ugandan system had flaws. Intervention had to be intensive to work at all. As leading epidemiologists have concluded: “Education does not, of itself, confer protection from HIV infection” (Meidany 1998: 9 and “[c]learly, education on its own is 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



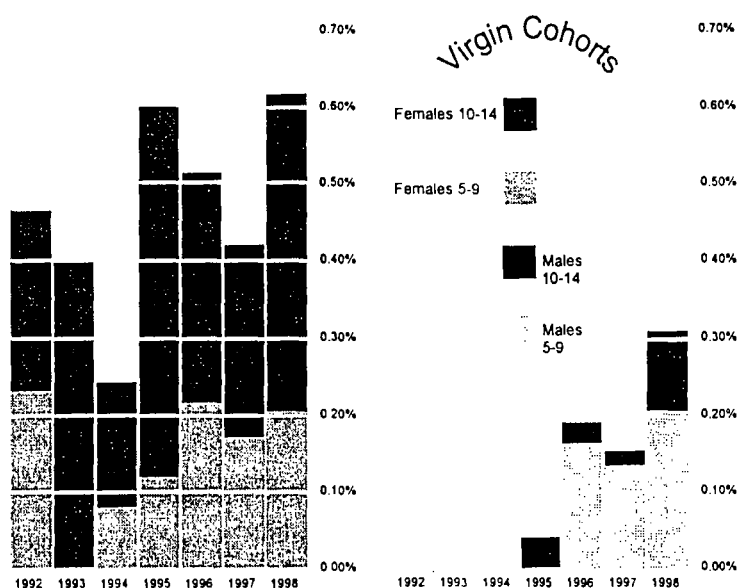
N=454; source: Port Elizabeth: Aids Training, Instruction and Counselling Centre (ATICC), 1998

## 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

|                           | <i>Females</i> | <i>Males</i> | <i>Total</i> |
|---------------------------|----------------|--------------|--------------|
| <i>5 to 9 years old</i>   | 26             | 17           | 43           |
| <i>10 to 14 years old</i> | 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.

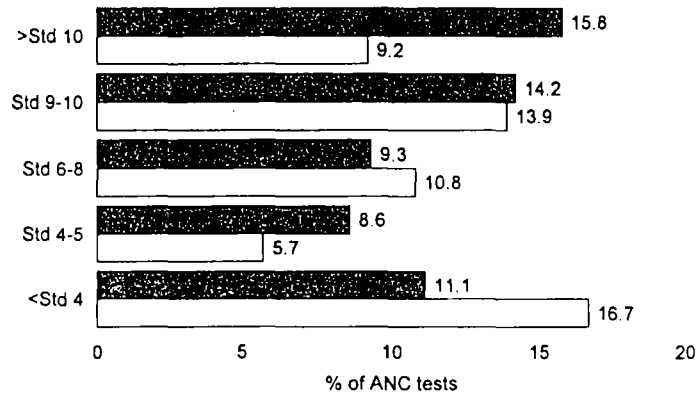
### Correlation between years in school and HIV infection

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.

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

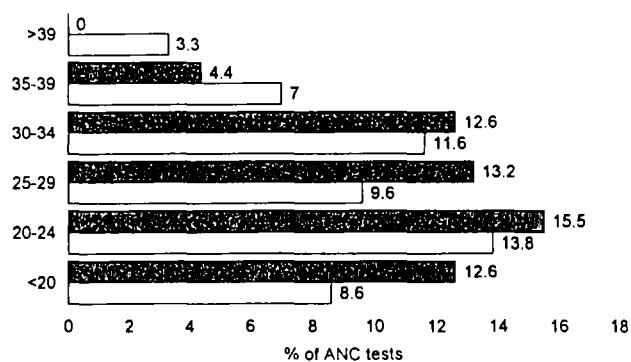


Source: Meidany 1998, 9

■ HIV □ Syphilis

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

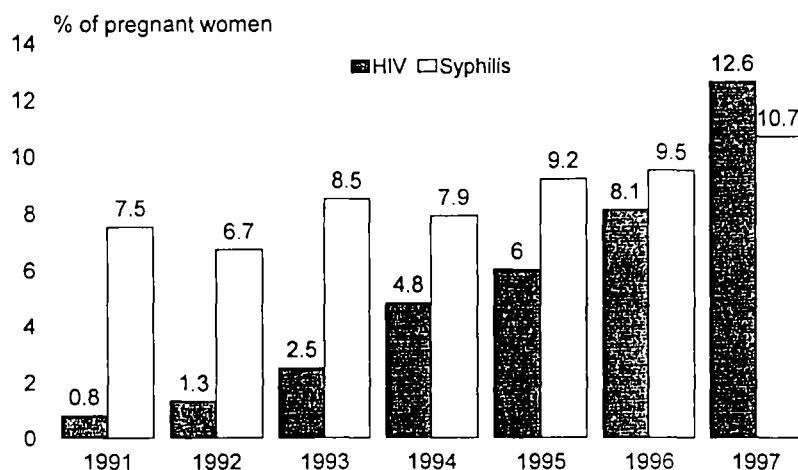


Source: Meidany 1997, 8

■ HIV □ Syphilis

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

### HIV and syphilis 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 9<sup>th</sup> 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 works 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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( South Africa )

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## South Africa failing to tackle AIDS, warns bank

By Steven Swindells

JOHANNESBURG, April 10 (Reuters) - South Africa, with one of the world's highest HIV infection rates, is failing to act quickly enough to keep AIDS from ravaging the country, a leading investment bank warned on Monday.

The criticism by bankers ING Barings was the latest assault on Pretoria, which has been criticised for questioning the causal link between the Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

"The government really needs to formulate an AIDS strategy. It doesn't help when the government debates whether HIV causes AIDS. We can't waste any time," Kristina Quattek, chief economist at bankers ING Barings told Reuters after the bank presented a study of the future economic impact of AIDS.

South Africa's government has incensed the scientific world by inviting AIDS dissidents – scientists who question the link between HIV and AIDS – to an international AIDS conference in July and allowing them on a panel of international experts.

Pretoria also attracted controversy by refusing to give the AIDS-retardant drug AZT to HIV-infected pregnant women or rape victims, citing conflicting scientific reports and its cost.

President Thabo Mbeki, who succeeded Nelson Mandela last June, questioned the efficacy of AZT in preventing infection and reducing the likelihood of transmission in the womb.

The country's health minister has also fanned the flames by accusing the scientific community of using South Africa as a dumping ground where drugs could be tried but most people would never benefit from them because they were unaffordable.

The need for a clear policy was made all the more pressing by the estimated 1,700 South Africans who become infected each day with HIV.

According to government statistics, about 12 percent of the country's 40 million people are HIV positive.

ING Barings' report, a year in the making, forecast that HIV infection rates would peak at almost 17 percent by 2006 and AIDS related deaths top off five years later at 256 AIDS deaths per 100 normal deaths.

AZT treatment could significantly change the future growth of HIV-AIDS, the bank said.

"The fact that there is a lack of policy response means that the AIDS epidemic is a dark cloud on the horizon," said Quattek.

The ING-Barings study showed that the population growth rate would stagnate by 2010, by which time 2.5 times as many South Africans would die of AIDS than any other causes.

16:03 04-10-00

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## AIDS to hit S.African growth and investment -Barings

JOHANNESBURG, April 10 (Reuters) - South Africa's escalating AIDS epidemic is set to dampen economic growth, exacerbate a skills shortage, increase inflation and squeeze savings and investment, ING Barings said on Monday.

In a report entitled "The economic impact of AIDS in South Africa – a dark cloud on the horizon," the investment bank predicted that the epidemic would reduce gross domestic product (GDP) growth by 0.3 to 0.4 percentage points.

"The lower growth and higher risk profile for South Africa will not bode well for financial markets and may well deter foreign investors," it said.

South Africa has one of the highest rates of HIV infection in the world. An estimated 1,700 people are infected every day and according to government statistics, about 12 percent of the 40 million population are HIV-positive.

ING Barings forecast that the infection rate would peak at almost 17 percent by 2006 for the overall population – but said it could reach 26 percent among the economically active population and 30 percent for the unskilled and semi-skilled.

Using a model constructed by the Actuarial Society of South Africa, ING Barings predicted that the total population would be 23 percent lower by 2015 than without AIDS.

"South Africa is already battling with a skills shortage which will be further exacerbated by the AIDS epidemic raising remuneration and replacement costs for companies," it said.

If costs would be passed onto consumers and increase consumer price inflation, the report said, exerting upward pressure on interest rates. ING Barings also predicted the epidemic would shave two percentage points off domestic savings as a percentage of GDP, forcing South Africa to rely even more heavily on foreign inflows that it already does.

"Should foreign inflows not materialise, a savings-investment crunch will ensue, pushing interest rates markedly higher and further slowing GDP growth," it said.

The report said transport and storage and catering and accommodation were the sectors most exposed to the AIDS risk, given their reliance on skilled workers with a high infection risk who were expensive to replace.

The bank, which said it believed this was the first time such in-depth macro-economic modelling had been done on the impact of AIDS in South Africa, also said the fiscal deficit would increase due to higher health spending and lower revenue.

ING Barings urged both business and government to formulate better AIDS strategies. The government recently became embroiled in controversy after it invited scientists who question the link between HIV and AIDS to take part in an expert panel.

"So far, no clear strategies have been forthcoming from either, but they are urgently needed in order to mitigate the destructive effect of the epidemic on all parts of the economy and society," the report said.

12:35 04-10-00

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Africa

APRIL 3, 2000, MONDAY, FINAL EDITION

**SECTION:** NEWS; Pg. A1

**LENGTH:** 1179 words

**HEADLINE:** South African Leader Enters AIDS Controversy;

He queries biochemist who denies HIV link

**BYLINE:** Louis Freedberg, Chronicle Washington Bureau

**BODY:**

It isn't every day that David Rasnick, a biochemist who lives in Saratoga, gets a call from a foreign president.

Truth be told, it had never happened until South African President Thabo Mbeki, Nelson Mandela's successor, called on his cell phone two months ago to discuss Rasnick's controversial stance that the human immunodeficiency virus, or HIV, does not cause AIDS.

Mbeki has not said one way or another whether he believes Rasnick's unconventional views.

But just reaching out to him has triggered an uproar in South Africa, where AIDS advocates worry that it will set back efforts to combat the disease there.

And it has also caused concern among AIDS officials in Washington, who wonder what signal it will send to the U.S. Congress, which is debating several bills to increase support for AIDS prevention efforts in Africa.

Rasnick believes that what is diagnosed as AIDS in Africa is really a new label attached to old ailments -- such as persistent coughs, diarrhea, parasitic diseases and tuberculosis -- in developing countries.

**THEORY LONG AGO DISCREDITED**

AIDS researchers say they are alarmed at Mbeki's interest in a theory they thought had been discredited years ago.

"It gives them a platform to espouse theories that are absolutely unsupportable," said Thomas Coates, director of the AIDS Research Institute at the University of California in San Francisco. "And they don't get many platforms in the world because they are considered to be on the lunatic fringe."

Rasnick, 52, who has a doctorate in chemistry and founded two Bay Area companies that manufactured protease inhibitors, is a former president of a loose confederation known as the Group to Reassess the HIV/AIDS Hypothesis. He has made it something of a crusade to challenge the conventional wisdom that HIV causes AIDS.

"**President Mbeki** asked me for my personal support in his efforts to explore all things related to AIDS," said Rasnick. "He said he wanted to start from scratch, and wanted my thoughts on what is making Africans sick -- what we know, and what we can do about it. And he wanted to know if (anti-AIDS) drugs do more harm than good."

To most scientists working on AIDS, the question of what triggers it was settled more than 10 years ago. In 1988, a committee of experts set up by the National Academy of Sciences concluded definitively that HIV causes AIDS. That position was corroborated by a presidential commission in the same year.

"We don't have the time and energy to get bogged down in these kinds of discussions at this point in the pandemic," said Sandra Thurman, President Clinton's adviser on AIDS policy.

## CONFERENCE HEIGHTENS CONCERN

Another major concern is that South Africa will host the biannual International Conference on AIDS this July, the first time the meeting will be held in a developing nation. Up to 15,000 AIDS researchers, policy makers and activists are expected to attend.

Thurman worries that Mbeki's flirtation with unorthodox views could cast a shadow over the proceedings. "We don't want our deliberations to be held under the cloud of accusations and discussions about whether HIV is causing AIDS," she said.

Next month, Mbeki will be in Washington for his first state visit, which will give President Clinton the chance to talk to him directly about the issue. But officials are hoping that the controversy will be defused by then.

Mbeki apparently stumbled across Rasnick's work on the Internet. He then asked Rasnick to respond to a questionnaire he had sent to his health minister probing the causes and treatment of AIDS.

In preparing his response, Rasnick solicited the help of Charles Gesheckter, a professor of African history at the California State University at Chico who last November visited South Africa and met with Mbeki's health minister.

In an interview, Gesheckter argued that the incidence of AIDS in Africa has been vastly exaggerated. He cited World Health Organization statistics that indicate only 794,444 reported AIDS cases for the entire continent from 1981 to 1999 -- a stark contrast to the 2 million annual AIDS deaths now routinely cited in dramatizing the catastrophic effects of the disease there.

Both Gesheckter and Rasnick are on the board of directors of the Group to Reassess the HIV/ AIDS Hypothesis. Also on the board is Peter Duesberg, a UC Berkeley biochemist who is the best known proponent of the view that HIV doesn't cause AIDS.

## OTHER STATEMENTS WORRISOME

What worries AIDS watchers is that Mbeki's discussion with Rasnick is just the latest in what they view as a series of disturbing statements and actions emanating from Pretoria.

Late last year, Mbeki told Parliament that he had come across a "large volume of scientific evidence" that showed that AZT, the anti-AIDS drug routinely administered in the West, may be toxic, as a justification for his government's policy not to administer it to pregnant women who test HIV positive. Several studies have shown that AZT can reduce the transmission of AIDS to children by as much as 50 percent.

"As activists and doctors, we are asking ourselves: Is this government taking the disease seriously?" said Ashraf Grimwood, chairman of the National AIDS Convention of South Africa. He said Mbeki's flirtation with "the long dead dinosaur" that HIV does not cause AIDS has "made a major dent on (the government's) credibility to deal with the epidemic."

But Glaudine Mtshali, the counselor for health in the South African embassy in Washington, D.C., and a former senior official in the Department of Health in Pretoria, said Mbeki is simply opening up the debate to further strengthen what the government is doing.

"Let us hear all views; let us make up our own minds within the scarce resources we are faced with," she said.

## MORE CONTROVERSY FROM MBEKI

So far, Mbeki shows no signs of backing off. In an opinion page article last week in *Business Day*, a leading South African newspaper, Mbeki spokesman Parks Mankahlana insisted that the president is committed to fighting AIDS. But with no cure, approaches such as expensive drug therapies -- which are out of the reach of most African countries -- have done little to stop its march across the continent, he said.

"HIV/AIDS is not going to succumb to the machinations of the profiteering pharmaceuticals and their propagandists," wrote Mankahlana, using incendiary language that presumably was cleared by Mbeki. "Like the marauders of the military industrial complex, the profit takers who are benefiting from the scourge of HIV/AIDS will disappear to the affluent beaches of the world to enjoy wealth accumulated from humankind ravaged by the dreaded disease. And we shall continue to die from AIDS."

Mbeki has announced that he will set up an international panel to broaden the search for solutions. In the meantime, Mankahlana said, Mbeki "needs the support -- not the abuse -- of all of us."

Rasnick is one person whose support Mbeki can count on. "He is an extraordinary man, and I am at his disposal," he said.

**GRAPHIC:** PHOTO, Thabo Mbeki will come to Washington next month for a meeting with President Clinton.

**LOAD-DATE:** April 3, 2000

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### FOCUS<sup>TM</sup>

**Search: General News;President Mbeki**

To narrow this search, please enter a word or phrase:

*Example:* House of Representatives

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C-3002  
Africa

February 15, 1999

TO: Jim Babbitt, OVP

FROM: Alex Ross, USAID

SUBJECT: Perspectives on What Can Be Done Re: AIDS and South Africa  
:

Below are some of my perspectives on how to contribute to South Africa in fighting against AIDS.<sup>1</sup> The basic principle that USAID, and I, apply in working with South Africa on HIV/AIDS issues is that it is the South African's responsibility to mount an effective campaign against this disease. We, the USG, are available to help and to advocate for a more intense response, but the leadership and desire must come from them. My general observation has also been that South Africans (public and private sectors) have been planning quite a bit over the past few years—yet, their weak point is implementation. The South African National HIV/AIDS, STD Review (July 1998) supported this finding (of which I was a part). This is not a comprehensive list, but hopefully it will help you in your efforts.

### **AIDS in South Africa**

**Fact:** AIDS is out of control in the country. This year, the national average of women who visit prenatal clinics and test positive for HIV is 21%--a 4-5% increase over last year alone (1 in 5 pregnant women). The percentage in Kwazulu Natal is over 30%: 1 in 3 pregnant women. Currently, this is the only reliable source of data in the country. More information is needed. We do not know what the rate is in the military [as a counter example: the vast majority of Zimbabwe's military is infected].

**Action:** South Africa has the fastest growing epidemic in the world. We cannot wait for national and health systems reform to be completed and have sole priority. Time is of the essence and a well-coordinated, sustained, and meaningful response is needed now. This requires leadership at all levels.

**Action:** Secretary Cohen may bring up the issue of AIDS in the military with his SA counterparts. Surgeon General Satcher is to meet with the SA Surgeon General for the military next week during/after he BNC. AIDS will be discussed. In addition, a South African NGO, the Civil-Military Alliance, was formed last year. This organization may be helpful in advocacy and development of plans. It receives some small funding from the national Dept of Health.

US DOD can share its approach on how it dealt with AIDS in our military; we could also sponsor Thai military officials to visit South Africa to discuss their strategy and success.

**Fact:** The AIDS issues are very complicated. People's motivations to change sexual behavior and their attitudes towards AIDS requires time, but also is based on broader considerations such as the state of society around them, their degree of hope for the future, poverty, and cultural values. Stigma and denial are major problems in South Africa now.

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<sup>1</sup> My perspective is based on my experience in working with AIDS in the US and internationally over the past 14 years, which has included work in: California (UCLA-RAND); the US GAO; the World Health Organization Global Programme on AIDS; the US House of Representatives' Energy and Commerce Committee (Chairman Dingell); the US Dept. of Health and Human Services (Asst. Secretary for Health); and finally USAID. My views also reflect my health planning and policy background.

Also, please recall that it took the US many years to respond. In addition, the epidemic in the US now is shifting to being an epidemic of poverty disproportionately affecting minorities (African Americans, Latinos, and American Indians). But, the problem in South Africa is greater than anything experience in the US.

**Action:** Sustained and consistent discussion and dialogue from the top leaders on-down is required to help set the tone. An anti-stigma/discrimination campaign is required. However, *to reduce stigma also requires that services are available for those infected and that legal/police protection is in place.* In the US, it took years to de-stigmatize the problem and it required an infected child's focus (Ryan White and others) and key celebrities (Magic Johnson, Rock Hudson, others) to establish more acceptance.

**Fact:** South Africa is preoccupied with national societal reforms and health sector reform. The latter is characterized by the national Department of Health planning and implementing an integrate package of primary health care services and reallocating health budgets across the country to redress historic patterns of funding (that benefit the white population). Qualities of care and health workers attitudes toward their clients are a major problem in SA: overall as well as for AIDS.

**Fact:** At the provincial level there is often only one person responsible for AIDS. AIDS is treated as one of many issues without adequate attention (Gauteng province is an exception). This person is also often a junior and occupies a low level in the bureaucratic chain. In addition, current decentralization issues (provincial to municipal) are interfering with AIDS efforts as a result over confusion of roles, funding, etc. Provincial and national departments are reluctant to hire additional staff or even reassign them to AIDS. I am also concerned that the South African government is losing institutional memory with the departure of key national level persons as well as some provincial level officials.

**Action:** The SA government needs to place the same or greater emphasis on taking action now for AIDS as it does on the broader health sector reform issues. As the public sector must respond, the bureaucracy needs to place more importance on the issue. This means that the National Dept of Health, Provincial Depts of Health in particular, and the new municipal health departments must allocate additional personnel and resources, as well as increase the visibility of AIDS at the provincial and municipal levels.

USG can support technical assistance on organizing and mounting an effective public sector response. SA government can be encouraged to either a) increase internal resource allocation for AIDS (as well as assigning sufficient staff to manage those resources) and/or b) seek out additional donor support as well as a World Bank loan (as did Brazil) to obtain more resources. Note: USAID cannot provide cash assistance directly to government; EU does some, but not sufficient. SA Govt has resisted loans. Yet, more resources are needed.

**Fact:** The religious community in South Africa has been largely untapped. Religion was a major force in the anti-apartheid struggle. Approx 2 years ago, I organized a meeting for Archbishop Winston Ndungane (who succeeded Bishop Tutu) during his first official visit to the US in his new capacity at USAID that included State, USAID, HHS, and Ms. Thurman. AIDS was one of his top two issues. More needs to be done to cultivate the religious community. The SA Dept of Health has funded an NGO umbrella group (the Religious AIDS Programme) that is focused on religions' response to AIDS—but it isn't sufficient.

**Action:** 1) You can meet with Archbishop Ndungane (his seat is in Capetown). 2) USAID can support religious groups to do more on AIDS. 3) The Washington Episcopal Diocese Bishop is about to

visit South Africa. He will be discussing women and AIDS issues. 4) To the extent possible, the USG can support religious organizations by providing them with technical assistance on AIDS issues.

**Fact:** With the new Partnership Against AIDS campaign the SA Government has instructed all sectors to undertake HIV/AIDS programming. However, most if not all of the non-health sectors are asking technical help from the Dept of Health (since they don't know AIDS). The DOH is quickly getting overwhelmed.

**Action:** The USG could help in providing some technical assistance to specific sectors either through a) providing help to the SA Dept of Health to assist and/or b) to link US Departments with their subject area counterparts in sharing lessons within the given sector).

**Fact:** The success of Uganda was not based on providing massive amounts of AZT and drugs. It relied on a mixture of consistent Presidential on-down discussion of AIDS and its priority; active engagement of the religious community and leaders to do more education, de-stigmatization, and community organizing; availability of voluntary testing and counseling; and its linkage to the availability of low cost psycho-social AIDS services. The success to reduce transmission occurred in the context of a large epidemic and a population that had lost hope to due to many years of war and death.

**Action:** The message that we can do something to turn this around in South Africa is key. Testing and counseling are available in urban areas, but is not being accessed anywhere near the need for more testing. The availability of community-based services for persons with HIV and AIDS, and their families is very poor in South Africa. The country needs to do more to provide services to those infected. USAID is developing a new \$11 M project to help NGOs deliver community based services. Your support for this will help leverage USAID support for the program. But, South Africa itself needs to do more.

**Fact:** US multinational companies are active in South Africa. They include Dow Chemical, Ford, Levi Strauss, consulting firms, and many more. Ford and Levi Strauss are taking action to support AIDS work in their workplaces, as well as in the community (with their own funds).

**Action:** VP Gore, Ms. Thurman, and other influential US personnel should encourage US businesses active in South Africa to do more. We at USAID and HHS/CDC can assist them in how to approach the issues and provide technical assistance.

**Fact:** There are three principal donors assisting with HIV/AIDS in South Africa: USAID, the British DFID (HIV/AIDS as part of a broader reproductive health program, tech assistance to the Dept of Health, and STD treatment assistance), and the European Union (condom procurement, financial assistance to the Dept of Health). However, the South African government has not forcefully brought the donors together to discuss how to maximize their contributions. USAID does work well with the other donors on its own initiative.

**Action:** Encourage the SA Government to better orchestrate the resources and talent brought into the country from donors.

## SUMMARY RECOMMENDATIONS

- ◆ AIDS represents an immediate threat to the well-being of the country and its citizens, given the figures and growth in the epidemic.
- ◆ The South African response to date is in the right direction, but is insufficient. Not enough attention has been placed on implementation.
  - The Partnership Against AIDS (predominately mass media and public information is a step in the right direction).
- ◆ The bureaucracy has not responded in kind (personnel or resources) to the level of threat that AIDS poses to the country. Presidential action is required to increase their responsiveness.
- ◆ Emphasis on HIV/AIDS programming needs to be placed on (for SA Govt, as well as USG assistance)
  1. Public information and advocacy to key stakeholders in the country
    - Focus on the statistics and impact on the country
  2. Developing and implementing anti-stigma measures
  3. Development of community-based (low cost) services for persons with AIDS and their families. This includes issues such as social support, food banks, transport to clinics, availability of drugs to treat opportunistic infections, and so on.
  4. Training for health workers and other public servants on their attitude towards AIDS and persons with AIDS.
  5. Working with the military (US DOD, Thai military, advocacy to SA military to pay attention)
  6. Working with the SA religious community (affiliated and unaffiliated Christian, Islamic, Jewish, Hindu, others)
  7. Working on the maternal-child transmission issue for AIDS (not just AZT availability, but the broader issue of breastfeeding, targeting women at risk, etc).
  8. Availability of condoms.
  9. Targeting migrant labor (mines, truckers, etc) for education and service interventions
  10. Targeting commercial sex workers for STD and AIDS treatment.
  11. Vaccine research (NIH support for biomedical, and limited USAID support for scientist exchanges, etc)
  12. Assistance to deal with tuberculosis (SA has one of world's highest epidemics)
  13. Long term discussion and consideration regarding vaccine and drug production in South Africa for the country and region.
  14. Development of rational policy to deal with provision of drugs such as AZT.
- ◆ USG is helping NOW by:
  1. USAID's provision of \$10 M bilateral (5 years), \$1.5 M for AIDS and children (3 years), consideration of new additional \$11 M NGO program, and additional existing resources (approx \$2 M) for TB and developing information for various sectors to respond to AIDS.
  2. NIH's \$1 M + /year assistance to two research sites in South Africa.
  3. CDC provides some technical assistance, with USAID financial help.
  4. Private US business increasing their assistance (e.g., Ford and Levi-Strauss)
  5. US religious organization linkages to South Africa beginning to take shape—more needs to be done.
  6. Key US leaders encouraging the South Africans to do more.
- ◆ USG can do MORE by:
  1. Increasing advocacy to South Africans by key US public and private sector leaders
  2. Support for new USAID \$11 M NGO program for community based services
  3. Possible increase in NIH support for research
  4. Using Sandy Thurman and others to encourage private sector business, union and religious leaders to do more.
  5. Enlist American Chamber of Commerce in South Africa to do more on AIDS.

6. Authorizing and encouraging US DOD to work with South African military. Develop strategies to deal with soldiers being infected with AIDS, including treatment; dealing with command and control issues; and, working with related populations e.g., commercial sex workers, and home leave.
7. Develop coordinated US response that links US Departments such as DOT (for transport), DODCommerce (for business), DHHS (health: research, prevention, and drug regulation), DOSState (diplomatic, USIA), Peace Corps, DOL (labor issues), DOJ (anti-discrimination legislation enforcement), DOEducation (schools), and so on.

The US response would identify how various departments could contribute to an overall effort, based on South African requests. Rather than making this a large bureaucratic enterprise (which it can become), authorize Sandy Thurman and the NSC?, with help from USAID, to convene a working group. Issues of funding would need to be dealt with—however, the goal is predominately identifying sources of technical assistance on as-needed basis.

8. Seek production facilities for AIDS drugs and vaccines in other countries (e.g., Russia)—longer term
9. Based on high level discussions with Deputy President Mkebi, discuss additional aid possibilities with US Congress (including Congressional Black Caucus). Key issue to be raised here is not only the threat to the “South African experiment” but to the fact that South Africa is key to the development of the region (which AIDS threatens).
10. Provide technical assistance to South African business and South African government sectors (apart from health) on AIDS problem assessments and programming.
11. Working with the Southern Africa Development Community (SADC) to become increasingly involved with HIV/AIDS issues.
12. Intensifying South African religious community response.
13. Assisting South African Dept of Health and other government sectors to assess the potential impact of AIDS.
14. Helping the South African government with better epidemiological tools.

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FACSIMILE TRANSMITTAL SHEET

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TO: *Sandy Thulman*

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NOTES/COMMENTS:

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International Panel of Experts (confirmed as of 4/24)

| NAME                                                                 | E-MAIL ADDRESS                                                               |
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| Andrew Herxheimer <i>Chr for Evidence-Based Pharmacotherapy - UK</i> |                                                                              |
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| Christian Fiala                                                      |                                                                              |
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| Claus Koehnlein                                                      |                                                                              |
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| D Sam Mhlongo                                                        | Smhlong@iafrica.com <i>? informed consent is light years away for Africa</i> |
| Stepano Bertozzi <i>UNAIDS</i>                                       |                                                                              |
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| George Perez <i>works in S. Africa</i>                               |                                                                              |
| Helena Gayle                                                         |                                                                              |
| Souleymane M'Boup <i>Senegal</i>                                     |                                                                              |
| William Makgoba <i>S. African Medical Res. Council</i>               |                                                                              |
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| Slim Karim <i>works in S. Africa w/ Zena</i>                         |                                                                              |
| * Stefano Vella                                                      |                                                                              |
| D Manu Kothari <i>Cancer is unresearchable and untreatable</i>       |                                                                              |
| Valeri Mizrahi                                                       |                                                                              |
| Sinonssi                                                             |                                                                              |
| * Robert Gallo                                                       |                                                                              |
| DA Gradkari <i>works in India w/ Tom Quinn</i>                       |                                                                              |
| Praphan Phanuphak <i>Thailand</i>                                    |                                                                              |

\* Cliff Lane (NIH)

# Withdrawal/Redaction Marker

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04/20/00 19:48 2025953673 AFRICAN AFFAIRS 002/003

Sandy:

Good memo. Thanks for asking our views. Just a couple of proposed changes and additions:

**Page 1, para 3, middle:** Delete "Unfortunately, this has not occurred in South Africa." and replace with: "Unfortunately, while Mbeki has shown

*Considerable* ~~considerable leadership (including by highlighting HIV-AIDS as one of the major challenges facing post-apartheid South Africa in his inaugural address); his recent statements, and interpretations of his positions, have meant that the public message has grown inconsistent and confusing.~~

**End of same para:** Delete last line ("It is in this context..." and replace with new para:

*The domestic and international focus on President Mbeki's views unfolds in this context, but also in the context of major economic challenges facing South Africa. Unfortunately, little attention is being given to some of the important points made by Mbeki, including the link between poverty and the scale and scope of the AIDS crisis in sub-Saharan Africa. At one level, the South African and other African governments are grappling with the challenge of addressing a major epidemic, for which current therapeutic treatments are costly, in economic environments which find the majority of their citizens unable to afford even aspirin, and without access to health care facilities. In post-apartheid South Africa, the needs and aspirations of the poor majority are paramount – but are as yet unmet. In part, we believe that Mbeki is wrestling with the fact that to do more than address the tip of the HIV-AIDS iceberg in South Africa could require not just increased health spending, but the fundamental re-orientation of national economic priorities. He is also, we believe, posing an important challenge to all of those engaged in the fight against HIV-AIDS, and particularly those of us from wealthier nations: that the international community and Africa must simultaneously fight HIV-AIDS and poverty, or the two will combine to wipe out Africa's future. This point has been obscured by other, more controversial statements, but does reflect one of the real challenges we face.*

**Page 2, para 1, middle: add sentence, in parens, after "...will wait to see how this debate plays out before taking much needed action.":**

*(You should be aware, however, that South Africa has not halted or suspended any of its ongoing HIV-AIDS education, prevention or treatment programs).*

The domestic and international focus on President Mbeki's views unfolds in this context, but also in the context of major economic challenges facing South Africa. ~~Unfortunately, little attention is being given to some of the important points made by Mbeki, including the link between poverty and the scale and scope of the AIDS crisis in sub-Saharan Africa. At one level, the South African and other African governments are grappling with the challenge of addressing a major epidemic for which current therapeutic treatments are costly, in economic environments which find the majority of their citizens unable to afford even aspirin, and without access to health care facilities. In post-apartheid South Africa, the needs and aspirations of the poor majority are paramount - but are as yet unmet. In part, we believe that Mbeki is wrestling with the fact that to do more than address the tip of the HIV/AIDS iceberg in South Africa could require not just increased health spending, but the fundamental re-orientation of national economic priorities. He is also, we believe, posing an important challenge to all of those engaged in the fight against HIV/AIDS, and particularly those of us from wealthier nations: that the international community and Africa must simultaneously fight HIV/AIDS and poverty, or the two will combine to wipe out Africa's future. This point has been obscured by other, more controversial statements, but does reflect one of the real challenges we face.~~

face. In a society where most cannot even afford a pin,  
~~and the costs of~~ <sup>run</sup> ~~the~~ drugs for exorbitant capital  
 health spending; per capita income. We believe that  
 there is nothing with the reality that an appropriate assault  
 on ~~the~~ may ~~not~~ require not just increased health  
 spending, but a reorientation of national economic

The USG now spends \$225 million for HIV prevention and AIDS care programs in developing countries. UNAIDS estimates that an effective prevention and care program for Africa alone would cost at least \$2 billion – with all donors and host countries currently spending approximately \$350 million. Clearly much more needs to be done. A top legislative and budget priority for the Administration is to ensure enactment of the \$100 million increase for the LIFE initiative proposed in the FY2001 budget. However, additional opportunities now present themselves and should be explored and exploited – consistent with Administration policy.

During this session of Congress, more than ten global AIDS initiatives have been introduced. Committees of jurisdiction in both chambers have favorably reported global AIDS legislation ranging from \$510 million for FY2001 in the Senate to \$1 billion over 5 years in the House. Ideas vary from enhancing existing bilateral efforts through USAID to creating a new multilateral AIDS Trust Fund at the World Bank. Currently, there seems to be considerable momentum on the Hill for moving a global AIDS initiative either freestanding or as part of the Foreign Assistance or African Trade bills.

The Administration should proactively work with Congress to maintain a leadership position and to ensure that this new energy for action is crafted in a manner that supports or enhances the Administration's program. ONAP, OMB, and Legislative Affairs will coordinate the Administration's response to pending legislative so as to maximize FY2001 global AIDS funding without undermining antipoverty/AIDS priorities such as HIPC.

Some themes and issues illuminated by the recent report:  
"To the Edge: AIDS Review 2000" by Hein Marais.

*The Reality of Now and Next Five Years*

- "AIDS could have a more devastating effect on this country than apartheid."
- "More than 100,000 people were expected to contract AIDS in 1999."
- "A risk scenario conducted by the Metropolitan Life insurance firm estimates that more than 6 million South Africans will be infected by 2005."
- "Statisticians have reduced South Africa's average life expectancy from 65.4 yrs to 55.7 yrs."
- In KwaZulu-Natal, where HIV prevalence rates have edged past the 30% mark, deaths now outstrip births."
- ~~If current trends persist, by 2005 only 13% of the population could live to celebrate their 40<sup>th</sup> birthdays.~~
- According to UNAIDS, more than 700,000 AIDS orphans will be created by the AIDS epidemic countrywide."
- According to Dr. Malegapuru Makgoba, president of the Medical Research Council, ~~"there is no economic recovery without tackling AIDS. If we don't stop AIDS, there will be no African renaissance."~~

*Linking paradigms*

According to Marais, what still is eluding South Africa is an answer to the following questions:

- ~~"What might be an effective response to a disease that is, in discursive terms, as complex as AIDS in a country as divided, as wracked by contradictions and stereotypes, and as filled with silence as ours? Exactly what interventions should practically constitute that response? How can the disease be decoded in terms that prompt people to act in accordance with such a response?"~~

- “But, as a disease intimately tied to poverty, unemployment, migration and gender discrimination, AIDS has resisted responses that rest squarely on a faith of Reason.” P. 10
- “What still eludes us are how to merge the paradigms of the medical and the political, the scientific and the social.” P. 10

### *Understanding HIV/AIDS in the context of a social phenomenon*

- “As a disease intimately tied to poverty, unemployment, migration and gender discrimination, AIDS has resisted responses that rest squarely on faith in Reason.”
- “Bids to situate AIDS in its social context tend to feed off, and into populist explanations of behavior and knowledge. But they do not create an understanding of the disease as a social phenomenon. In fact, the early forays were decidedly anti-intellectual, blanketing with scorn the light researchers and academics sought to shed on the epidemic and the society through which it spreads.” p. 10
- “The response of South African social theorist to AIDS has been timid. Equally lacking has been the encouragement for them to rise to their duty. As a result, we stand deprived of cogent understandings of many of the social dynamics that help the disease spread... We relish describing our society and content ourselves with the false notion that we therefore understand it.” p. 10
- “Our AIDS response has been compromised by the failure to confront and critique the ways in which notions of cultural traits and community values have colluded with the epidemic and sabotaged effective interventions. We don't know how people culturally and socially process a phenomenon as complex and frightening as this disease.” P. 10
- “The result of all of this is a society that is trapped between two misfortunes. On one hand, there is the health and medical establishments' failure to deal with the disease (in the form of service, treatment and counseling). On the other, there is the ideological failure of politician, intellectuals and AIDS workers to decipher the social, economic and political mechanics of the disease. Instead of remedying these failings, the moralistic overtones of prevention messages and AIDS workers' rhetoric have an alienating effect, allowing people to deflect the disease onto the Other. Consequently, we see a population that is manifestly aware of AIDS—to the point of being bored, dismissive and fatalistic—but that lacks the conceptual tools for effective behavioral and attitudinal changes. P. 11

### **Lessons Learned?**

#### *The Bureaucratic Trinity: Capacity, Budgets, and Political Will*

*The tragedy of South Africa and the AIDS epidemic is that the time at which something could have been done was also the time of the transition. So, despite the warnings and the*

*incredible research contained in the 1994 document, the Plan effectively went onto the backburner.*

- "Warnings about practical difficulties in implementing the Plan came mostly from officials who had worked in or with the apartheid state, and so such warnings were largely unheeded. These officials were familiar with the Byzantine tendering, financing and organizational procedures that had to be traversed to implement the plan. But rather than offer routes around these obstacles, they tended to emphasize the impossibility of implementation. At the same time, the implementation strategy of the Plan paid too little heed to existing posts, preferring to base it on a wish list of new posts and structures. Inevitably, "lack of capacity" became a recurrent complaint." P. 15
- "[The Plan] highlighted, too, was the need to base the AIDS program in the President's Office, with regional authorities working out the nine provincial premiers' offices. The aim was to locate it as close as possible to the pinnacle of executive power, a move that could add great symbolic weight to the program, as well as increase institutional power needed to implement the Plan's various provisions. However... Dr. Zuma believed that the AIDS program should be a function of the Department of Health." P. 15
- "The location of the Plan in the Department of Health highlighted the tension between the medical and social understandings of HIV/AIDS. The emphasis would be on the biomedical, behaviorist model of health intervention. This model hinges on aiding and persuading individuals to make certain behavioral choices despite the constraints created by social status." P. 15
- "There was also some resentment by new bureaucrats of the need to adhere to regulatory and procedural systems—driven by a tendency to associate these themes with illegitimate apartheid state rules." A sometimes-flippant attitude toward the need for checks and balances ensued (when the priority, after all, was to carry out mammoth tasks quickly). Delays became endemic, as inadequately prepared documents and submissions were returned time and time again for correction." P. 16
- "A range of problems have retarded provincial departments' efforts to carry out their mandates effectively. Achievements have been highly uneven and correlate strongly with the degree of political will demonstrated and applied in different provinces. In several provinces, HIV/AIDS work has been sustained largely by NGOs and CBOs." P. 17
- "Whereas a degree of capacity and stability was being achieved in the national directorate by mid-1997, a much more desultory state of affairs continued at provincial level. Eighteen months after their formulation in 1994, only two of the nine provincial health departments had set up formal AIDS programs." P. 17
- "Despite having the second-highest HIV prevalence rate in the country, Mpumalanga in the 1996/1997 financial year had an AIDS budget of only R2 million (of which only 4% was spent)." P. 17
- The 1998 report entitled HIV/AIDS and Human Development: South Africa still found political commitment and public leadership lacking in most provinces, with the Free State the main (albeit qualified) exception. It noted that the Gauteng

provincial government's responses "seems to have been largely health-sector driven with minimal involvement of other sectors", despite the fact that Gauteng's budget allocation for HIV/AIDS work almost matched that of the National Directorate. In KwaZulu-Natal, the Eastern Cape and the North-West, political commitment was found to be weak." P. 19

- "Since 1996, Trevor Manuel's finance ministry has matured into a *de facto* super-ministry in government. By diligently setting and patrolling the fiscal perimeters of government, the finance ministry effectively established the limits within which other department policies and activities occur. This affects not only the resources which the Department of Health can devote to HIV and AIDS programs, but also the extent, speed and character of restructuring in the health care system broadly. Thus, health department official could (in late 1998) buttress Nkosazana Zuma's decision not to fund free AZT treatment for pregnant women (citing budget constraints) by adding that, even if the finances were made available, primary health infrastructure in the country remained inadequate to guarantee the success of such a program." P. 24

• "The poor and faltering implementation of the Plan appears not to be linked directly to government funding. From 1994 to 1997, Schneider notes, "the AIDS program consistently under spent on its allocated budget."

#### *At the Top:*

A reason for questioning: Mbeki's questionable reasoning.

#### AZT:

- "Referring to claims that AZT treatment could spare 15 out of 100 babies vulnerable to HIV infection, Hlongwane said: "We don't doubt these findings, but are not influenced by them." In other words, lowering the price of AZT would not have changed government's decision, or would the availability of another, cheaper treatment of equal or better efficacy. Yet, simultaneously, there were reports that the Department of Health had underspent its budget by R90 million and that this money would be used to introduce the haemophilus influenza which prevents meningitis in children.