## South Africa

# Epidemiological Fact Sheet

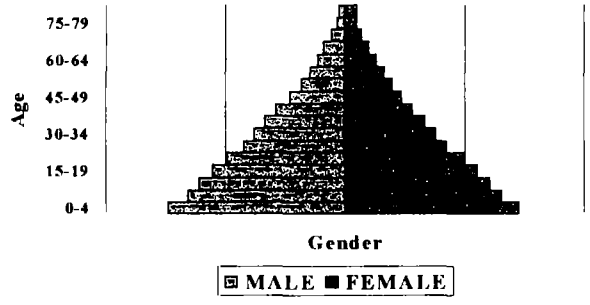
## on HIV/AIDS and sexually transmitted diseases

UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

World Health Organization

# Country information

## Population pyramid, 1997




| Indicators | Year | Estimate | Source |
|---|---|---|---|
| Total Population (thousands) | *1997* | 43,336 | UNPOP |
| Population Aged 15-49 (thousands) | *1997* | 21,717 | UNPOP |
| Annual Population Growth | *1980-1995* | 2.3 | UNPOP |
| % of Population Urbanized | *1996* | 51 | UNPOP |
| Average Annual Growth Rate of Urban Population | *1980-1996* | 3 | UNPOP |
| Net Migration Rate | | | |
| GNP Per Capita (US$) | *1995* | 3,160 | World Bank |
| GNP Per Capita Average Annual Growth Rate | *1985-1995* | -1 | World Bank |
| Human Development Index Rank (HDI) | | 90 | UNDP |
| Real GDP Per Capita Rank - HDI Rank | | -10 | UNDP |
| Gender Related Development Index Rank | | 71 | UNDP |
| Gender Empowerment Measure Rank | | 22 | UNDP |
| Human Poverty Index Value (HPI) | | | |
| % Population Economic Active | | 39 | ILO |
| Unemployment Rate | *1996* | 5 | ILO |
| Total Adult Literacy Rate | *1995* | 82 | UNESCO |
| Adult Male Literacy Rate | *1995* | 82 | UNESCO |
| Adult Female Literacy Rate | *1995* | 82 | UNESCO |
| Male Secondary School Enrollment Ratio | *1990-1995* | 76 | UNESCO |
| Female Secondary School Enrollment Ratio | *1990-1995* | 88 | UNESCO |
| Crude Birth Rate (births per 1,000 pop.) | *1996* | 30 | UNPOP |
| Crude Death Rate (deaths per 1,000 pop.) | *1996* | 8 | UNPOP |
| Maternal Mortality Rate (per 100,000 live births) | *1990* | 230 | WHO/UNICEF |
| Life Expectancy at Birth | *1996* | 65 | UNPOP |
| Total Fertility Rate | *1995* | 4 | UNPOP |
| Infant Mortality Rate (per 1,000 live births) | *1996* | 50 | UNICEF/UNPOP |
| Under Five Mortality Rate (per 1,000 live births) | *1996* | 66 | UNICEF/UNPOP |
| % Population Access to Safe Water | *1990-1996* | 99 | UNICEF |
| % Population Access to Adequate Sanitation | *1990-1996* | 53 | UNICEF |

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## UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance

Global surveillance of HIV/AIDS and sexually transmitted diseases (STDs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, initiated in November 1996, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STDs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are a first output of this close and fruitful collaboration across the globe.

Following a series of consultations, the working group and its partners established a framework standardizing the collection of data deemed important for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV. The data include prevention indicators developed by WHO's Global Programme on AIDS, which aim to measure trends in knowledge of AIDS, relevant behaviours, and a host of other factors influencing the epidemic. Additional indicators – for example, on care and support -- will be included when available.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1997. However, the fact sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact sheets may also be instrumental in identifying potential partners when planning and implementing improved systems.

The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision making and planning.

# Estimated number of people living with HIV/AIDS

In 1997 and during the first quarter of 1998, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1994 (WER 1995; 70:353-360) and recent trends in HIV/AIDS surveillance in various populations. Epimodel 2, a microcomputer programme originally developed by the WHO Global Programme on AIDS, was used to calculate the new estimates on prevalence and incidence of AIDS and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV, taking into account age-specific fertility rates. An additional spreadsheet model was used to calculate the number of children whose mothers had died of AIDS.

The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information. This includes information about infection levels in different populations, and behaviours which facilitate or impede infection.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of the term adult to 15-to-49-year-olds has the advantage of making different populations more comparable. This age range was used as the denominator in calculating adult HIV prevalence.

## Estimated number of adults and children living with HIV/AIDS, end of 1997

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997

| | | | |
|---|---|---|---|
| **Adults and children** | **2900000** | | |
| **Adults (15-49)** | **2800000** | **Adult rate (%)** | **12.91** |
| **Women (15-49)** | **1400000** | | |
| **Children (0-15)** | **80000** | | |

## Estimated number of AIDS cases

Estimated number of AIDS cases in adults and children that have occured since the beginning of the epidemic:

| | |
|---|---|
| **Cumulative no. of AIDS cases** | **420000** |

## Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS since the beginning of the epidemic:

| | |
|---|---|
| **Cumulative deaths** | **360000** |

Estimated number of adults and children who died of AIDS during 1997:

| | |
|---|---|
| **Deaths in 1997** | **140000** |

## Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under age 15) since the beginning of the epidemic:

| | |
|---|---|
| **Cumulative orphans** | **200000** |

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1997:

| | |
|---|---|
| **Current living orphans** | **180000** |

# HIV Sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV data base maintained by the United States Bureau of the Census and are a compilation of data from different sources, including national reports, scientific publications and abstracts. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give the reader an overview of the diversity of HIV-prevalence results in a given population within the country.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. This distinction assumes that capital cities in many countries have specific characteristics related to the prevalence of higher risk behaviour and a concentration of HIV infections. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts. Site/study-specific data on which the medians were calculated are printed in an annex at the end of this fact sheet.

## HIV prevalence in selected populations in percent

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnant women | Major Urban Areas | N_Sites | | | | | | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | Minimum | | | | | | | 0.06 | 0.08 | 0.25 | 0.56 | 1.6 | 1 66 | 3.1 | 6.3 |
| | | Median | | | | | | | 0,55 | 0 85 | 1.745 | 3 035 | 5.95 | 9 | 11.8 | 14.85 |
| | | Maximum | | | | | | | 1.6 | 2 2 | 2.7 | 9.3 | 13 5 | 18.23 | 19.9 | 26.9 |
| Pregnant women | Outside Major Urban Areas | N_Sites | | | | | | | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| | | Minimum | | | | | | | 0 2 | 0.12 | 0.65 | 1.07 | 1.8 | 4.89 | 6 47 | 8.2 |
| | | Median | | | | | | | 0.38 | 1 21 | 1.05 | 2.19 | 6.7 | 8.3 | 15.77 | 18 1 |
| | | Maximum | | | | | | | 1 05 | 6.54 | 3 1 | 4.3 | 12.8 | 16.18 | 25.13 | 22 6 |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex workers | Major Urban Areas | N_Sites | | | | | | | | | | | | | | |
| | | Minimum | | | | | | | | | | | | | | |
| | | Median | | | | | | | | | | | | | | |
| | | Maximum | | | | | | | | | | | | | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Injecting drug users | Major Urban Areas | N_Sites | | | | | | | | | | | | | | |
| | | Minimum | | | | | | | | | | | | | | |
| | | Median | | | | | | | | | | | | | | |
| | | Maximum | | | | | | | | | | | | | | |

| Group | Area | | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STD patients | Major Urban Areas | N_Sites | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | |
| | | Minimum | | | | | 0.8 | 1 9 | 5.1 | 8 6 | 12.7 | 15 8 | 18.8 | | | |
| | | Median | | | | | 0.8 | 1.9 | 5.1 | 8 6 | 12.7 | 15 8 | 18.8 | | | |
| | | Maximum | | | | | 0.8 | 1 9 | 5.1 | 8 6 | 12.7 | 15 8 | 18.8 | | | |

# Assessment of epidemiological situation

## Assessment of country epidemiological situation

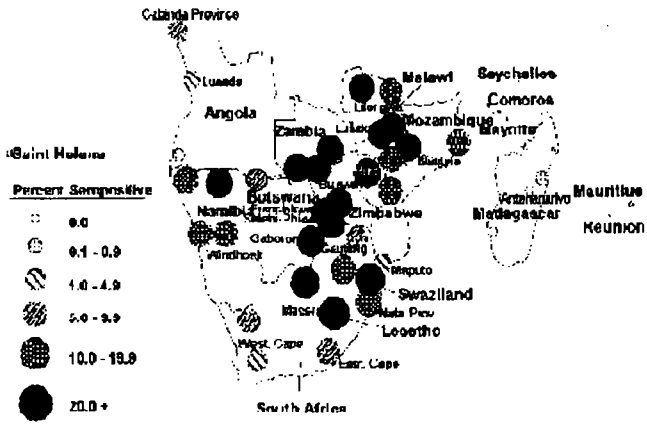
National sentinel surveillance surveys of antenatal clinic attendees have been conducted in South Africa since 1990. HIV information is available by state. In Natal, Western, Eastern and Gauteng States where the major urban areas of Johannesburg, Pretoria, Durban, and Port Elizabeth are located, HIV prevalence among antenatal clinic attendees tested increased from less than 1 percent in 1990 to a median of 15 percent in 1997. In 1997 HIV prevalence ranged from 6 to 27 percent. Age detail is available for the years 1992 through 1995. HIV prevalence among antenatal clinic attendees less than 20 years of age increased from 2 percent in 1991 to 9 percent in 1995. Peak HIV infection occurred among antenatal clinic attendees 20 to 24 years of age. In this age group, HIV prevalence increased from 3 to 14 percent. In Free, North Cape, Mpumalanga, Northern and North West States, HIV prevalence among antenatal clinic attendees tested increased from less than 1 percent in 1990 to 20 percent in 1997. In 1997 HIV prevalence ranged from 8 to 25 percent. Age detail is available for the years 1991 through 1995. HIV prevalence among antenatal clinic attendees less than 20 years of age increased from less than one percent to four percent. Peak HIV prevalence occurred among women aged 20 to 29 years of age.

There is no information available on HIV prevalence among sex workers in South Africa.

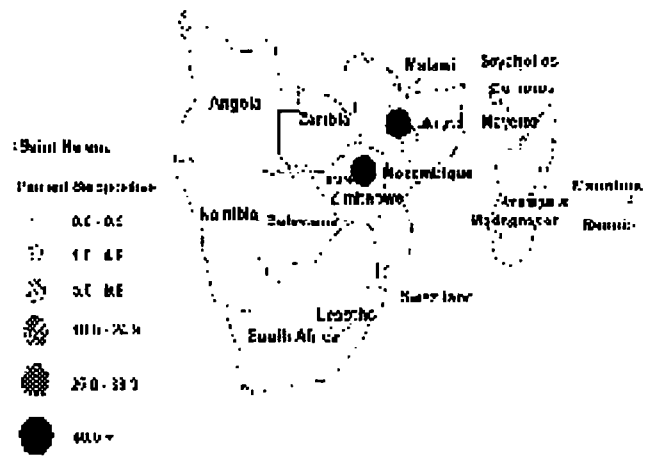
Information on HIV prevalence among male STD clinic patients is available from Johannesburg since 1988. HIV prevalence increased from 1 percent in 1988 to 19 percent in 1994.

## Regional maps

**Seroprevalence of HIV-1 for Pregnant Women Southern Africa**




**Seroprevalence of HIV-1 for Sex Workers Southern Africa**



# Reported AIDS cases

## AIDS cases by year of reporting

| 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | Total | Unknown |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 0 | 0 | 2 | 4 | 8 | 8 | 34 | 51 | 98 | 184 | 345 | 549 | 887 | 1882 | 3816 | 4219 | 738 | 0 | | 12825 | |

Date of last report: 30-Oct-1996

AIDS cases officially reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases in a country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries with fewer resources to more than 80% in most industrialized countries (please also compare with the section on estimates). Therefore, distribution by age, sex and modes of transmission may not be representative for all people living with AIDS in a given country.

## AIDS cases by mode of transmission

Hetero: Heterosexual contacts.
Homo/Bi: Homosexual contacts between men.
IDU: Injecting drug use. This transmission category also includes cases in which other high-risk behaviours were reported, in addition to injection of drugs.
Blood: Blood and blood products.
Perinatal: Vertical transmission during pregnancy, birth or breastfeeding.
NS: Not specified/unknown.

| Sex | Trans. group | <94 | 94/<95 | 1995 | 1996 | 1997 | 1998 | Unkn. | Total | % |
|---|---|---|---|---|---|---|---|---|---|---|
| All | All | | | | | | | | 12583 | 100% |
| | Hetero | | | | | | | | 7600 | 60% |
| | Homo/Bi | | | | | | | | 565 | 4% |
| | IDU | | | | | | | | 3 | 0% |
| | Blood | | | | | | | | 63 | 1% |
| | Perinatal | | | | | | | | 1174 | 9% |
| | Other known | | | | | | | | 0 | 0% |
| | Unknown | | | | | | | | 3178 | 25% |
| Male | All | | | | | | | | 0 | |
| | Hetero | | | | | | | | 0 | |
| | IDU | | | | | | | | 0 | |
| | Blood | | | | | | | | 0 | |
| | Other known | | | | | | | | 0 | |
| | Unknown | | | | | | | | 0 | |
| Female | All | | | | | | | | 0 | |
| | Hetero | | | | | | | | 0 | |
| | IDU | | | | | | | | 0 | |
| | Blood | | | | | | | | 0 | |
| | Other known | | | | | | | | 0 | |
| | Unknown | | | | | | | | 0 | |
| NS | All | | | | | | | | 12583 | |
| | Hetero | | | | | | | | 7600 | |
| | IDU | | | | | | | | 3 | |
| | Blood | | | | | | | | 63 | |
| | Perinatal | | | | | | | | 1174 | |
| | Other known | | | | | | | | 0 | |
| | Unknown | | | | | | | | 3178 | |

## AIDS cases by age and sex

| Sex | Age | <1994 | 94/<95 | 1995 | 1996 | 1997 | 1998 | Unkn. | Total | % |
|---|---|---|---|---|---|---|---|---|---|---|
| All | All | | | | | | | | 12583 | 100% |
| | 0-4 | | | | | | | | 1403 | 11% |
| | 5-14 | | | | | | | | 63 | 1% |
| | 15-19 | | | | | | | | 565 | 5% |
| | 20-29 | | | | | | | | 4558 | 36% |
| | 30-39 | | | | | | | | 3644 | 29% |
| | 40-49 | | | | | | | | 1295 | 10% |
| | 50-59 | | | | | | | | 458 | 4% |
| | 60+ | | | | | | | | 139 | 1% |
| | NS | | | | | | | | 458 | 4% |
| Male | All | | | | | | | | 5975 | 100% |
| | 0-4 | | | | | | | | 749 | 13% |
| | 5-14 | | | | | | | | 31 | 1% |
| | 15-19 | | | | | | | | 83 | 1% |
| | 20-29 | | | | | | | | 1678 | 28% |
| | 30-39 | | | | | | | | 1943 | 33% |
| | 40-49 | | | | | | | | 818 | 14% |
| | 50-59 | | | | | | | | 305 | 5% |
| | 60+ | | | | | | | | 104 | 2% |
| | NS | | | | | | | | 264 | 4% |
| Female | All | | | | | | | | 6504 | 100% |
| | 0-4 | | | | | | | | 639 | 10% |
| | 5-14 | | | | | | | | 32 | 0% |
| | 15-19 | | | | | | | | 480 | 7% |
| | 20-29 | | | | | | | | 2848 | 44% |
| | 30-39 | | | | | | | | 1672 | 26% |
| | 40-49 | | | | | | | | 470 | 7% |
| | 50-59 | | | | | | | | 152 | 2% |
| | 60+ | | | | | | | | 34 | 1% |
| | NS | | | | | | | | 177 | 3% |
| NS | All | | | | | | | | 104 | 100% |
| | 0-4 | | | | | | | | 15 | 14% |
| | 5-14 | | | | | | | | 0 | 0% |
| | 15-19 | | | | | | | | 2 | 2% |
| | 20-29 | | | | | | | | 32 | 31% |
| | 30-39 | | | | | | | | 29 | 28% |
| | 40-49 | | | | | | | | 7 | 7% |
| | 50-59 | | | | | | | | 1 | 1% |
| | 60+ | | | | | | | | 1 | 1% |
| | NS | | | | | | | | 17 | 16% |

# Curable STDs

Control and prevention of sexually transmitted diseases (STD) have been recognized as a major strategy in the prevention of HIV infection and ultimately AIDS. Consequently, monitoring different components of STD control can also provide information on HIV prevention within a country. One of the cornerstones of STD control is adequate management of patients with symptomatic STDs. This includes diagnosis, treatment, and individual health education and counselling on disease prevention and partner notification.

## Estimated incidence and prevalence of curable STDs

| | Incidence | | | | Prevalence | | | |
|---|---|---|---|---|---|---|---|---|
| **STDs** | Year | Male | Female | All | Year | Male | Female | All |
| Chlamydia trach. | | | | | | | | |
| Gonorrhoea | | | | | | | | |
| Syphilis | | | | | | | | |
| Trichomonas | | | | | | | | |
| **Comments** | | | | | | | | |
| **Source** | | | | | | | | |

## STD Incidence, men

Prevention Indicator 9: Proportion of men aged 15-49 years who reported episodes of urethritis in the last 12 months.

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| n/a | | | | |
| n/a | | | | |

Comments:

Sources:

## STD Prevalence, women

Prevention Indicator 8: Proportion of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened with positive serology for syphilis.

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| n/a | | | | |
| n/a | | | | |

Comments:

Sources:

## STD Case management (counselled)

Prevention Indicator 7: Proportion of people presenting with STD or for STD care in health facilities who received basic advice on condoms and on partner notification.

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| n/a | | | | |
| n/a | | | | |

Comments:

Sources:

## STD Case management (treatments)

Prevention Indicator 6: Proportion of people presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards).

| Year | Area | Age | Rate | N= |
|---|---|---|---|---|
| n/a | | | | |
| n/a | | | | |

Comments:

Sources:

# Knowledge and behaviour

Information on knowledge and behaviour related to HIV/AIDS is essential in identifying populations at risk for HIV infection. It is also critical in assessing changes over time as a result of prevention efforts. Guidelines and recommendations have been published in the publication: "Evaluation of a National AIDS Programme: A methods package. 1. Prevention of HIV infection. WHO/GPA/TCO/SEF/94.1 Geneva, 1994".

## Knowledge of HIV-related preventive practices

Prevention Indicator 1: Proportion of people citing at least two acceptable ways of protection from HIV infection.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| n/a | | 15-19 | | | |
| n/a | | 20-24 | | | |
| n/a | | 25-49 | | | |
| n/a | | 15-49 | | | |

Comments:
Sources:

## Reported non-regular sexual partnerships

Prevention Indicator 4: Proportion of sexually active people having at least one sex partner other than a regular partner in the last 12 months.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| n/a | | 15-19 | | | |
| n/a | | 20-24 | | | |
| n/a | | 25-49 | | | |
| n/a | | 15-49 | | | |

Comments:
Sources:

## Reported condom use in risk sex (gen pop)

Prevention Indicator 5: Proportion of people reporting the use of a condom during the most recent intercourse of risk.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| n/a | | 15-19 | | | |
| n/a | | 20-24 | | | |
| n/a | | 25-49 | | | |
| n/a | | 15-49 | | | |

Comments:
Sources:

# Knowledge and behaviour

## Ever use of condom

Percentage of people who ever used a condom.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| n/a | | 15-19 | | | |
| n/a | | 15-49 | | | |
| n/a | | 20-24 | | | |
| n/a | | 25-49 | | | |

Comments:
Sources:

## Median age at first sexual intercourse

Median age of people at which they first had sexual intercourse.

| Year | Area | Age group | Male | Female | All |
|---|---|---|---|---|---|
| n/a | | 20-24 | | | |
| n/a | | 25-49 | | | |
| n/a | | 45-49 | | | |

Comments:
Sources:

## Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

| Year | Area | Age group | Rate | N |
|---|---|---|---|---|
| n/a | | 15 | | |
| n/a | | 15-17 | | |
| n/a | | 16 | | |
| n/a | | 17 | | |
| n/a | | 18 | | |
| n/a | | 18-19 | | |
| n/a | | 19 | | |

Comments:
Sources:

# Sources

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# Annex: HIV Surveillance data by site

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnant women | Outside Major Urban Areas | Mpumalanga | | | | | | 0.38 | 1.21 | 2 23 | 2.4 | 12.8 | 16.2 | 15.8 | 22 6 |
| | | North Western Province | | | | | | 1.05 | 6.54 | 0.94 | 2 19 | 6.7 | 8.3 | 25 1 | 18.1 |
| | | Northern Cape | | | | | | 0.2 | 0.12 | 0.65 | 1 07 | 1.8 | 5.3 | 6.5 | 8.2 |
| | | Northern Province | | | | | | 0.26 | 0 48 | 1.05 | 1.79 | 3 | 4.9 | 8 | 8.6 |
| | | Orange free State | | | | | | 0.6 | 1 5 | 3.1 | 4 3 | 9.9 | 11 | 17.5 | 19.6 |
| | Major Urban Areas | Eastern Province | | | | | | 0 44 | 0 58 | 0 96 | 1 94 | 4.6 | 6 | 8.1 | 12 6 |
| | | Gauteng | | | | | | 0.66 | 1.12 | 2 53 | 4.13 | 7.3 | 12 | 15.5 | 17.1 |
| | | Natal | | | | | | 1.6 | 2.2 | 2.7 | 9.3 | 13.5 | 18.2 | 19.9 | 26.9 |
| | | Western Province | | | | | | 0.06 | 0.08 | 0.25 | 0.56 | 1.6 | 1.7 | 3.1 | 6.3 |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex workers | Major Urban Areas | | | | | | | | | | | | | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Injecting drug users | Major Urban Areas | | | | | | | | | | | | | | |

| Group | Area | | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STD patients | Major Urban Areas | Durban | | | | | | | | | | | | | |
| | | Johannesburg | | | | 0 8 | 1.9 | 5.1 | 8.6 | 12.7 | 15.8 | 18 8 | | | |

**Notes:**

To: Sandy Thurman

Dr. See, an internationally respected immunologist, presented his research findings at South San Francisco, CA. on June 6, 1998. The following are notes from his talk:

Dr. Darryl See is Associate Clinical Professor of Medicine at the UC Irvine Medical School. He works in the Division of Infectious Disease, concentrating on unusual and serious immune system disorders (cancer, Chronic Fatigue Syndrome, AIDS, etc.) He has been funded by grants from NIH to study immune system and anti-viral effects. He is one of only three physicians in the country to receive such grants to study potential benefits of natural substances. He has spent the last 5 years studying over 450 natural substances for anti-viral and immunological effects and finds 90% of what he's studied to be placebo or insignificant in terms of immune system effect. Dr. See's research lab is one of very few labs in the country set up to study immune system effects in cell cultures. Dr. See also has a clinical practice where he gets referrals from other doctors of patients with serious disease they have been unable to help.
The FDA has become a frequent visitor to his lab to validate that his testing is being done appropriately.

He began his research with Glyconutritionals (GNs) based on a patient's request to analyze the GNs in the capsule form. She was curious to see what he would find because of the benefits she was experiencing. He pursued testing the GNs in the normal way he approaches such research. He tests for toxicity first and then looks to see if there is any effect in natural killer (NK) cells since this is our main line of defense. Also NK cells are responsible for immune surveillance for abnormal cells. Note: every human has their cells exposed to DNA or other cell damage on a daily basis leading to cancerous cells. The primary reason that the damaged cells do not flourish and develop into cancer is because of the role of the NK cells. Further, the NK cells maintain immune system balance–they make sure that the immune system is not too sluggish and not overly active.

All of Dr. See's glyconutritional study findings were based on a dosage of 4 micrograms/ milliliter (equivalent to 3 capsules/ day). He is currently studying the effects of much higher doses, up to 4 T/ day.

There is research to demonstrate that over the last 16 years, the average, "healthy" American with normal immunity has lost 25% of their NK cell function and the rate of decline is growing due to pollution and toxins. NK cells can be further negatively affected by stress, extreme vigorous exercise, pregnancy, physical or emotional trauma, and burns. In persons with normal immunity, Dr. See has shown with in vitro studies that the function of their natural killer cells was increased by 50% by adding glyconutrients . The effect was more pronounced in patients who had severely decreased natural killer cell function.
NK cell functions were increased by over 400% with the addition of glyconutrients for some of these cases. The abnormal cell function was improved while the normal cell function was left alone. He could find NO toxicity regardless of amount given when testing the GNs. His tests were repeated several times.

In working with T cells, he notes that T cells should be at rest most of the time until notified by T helper cells of a specific function they need to perform. (In people with auto immune disorders, their T cells are chronically active instead of being at rest.) When he observes T cells for a healthy person and he adds GNs, nothing happens–they remain at rest appropriately. With T cells with a virus or bacteria added, the T cells begin to activate. When GNs are then added with the virus of bacteria, the activity as much as doubles or triples. (He's never seen this type of result before.) He has observed that patients with overly active T cell function (e.g. Lupus) and those with under active T cell function respond well to the addition of GNs in their regimen. This was a surprising paradox to him until he started understanding the mechanism of function of the GNs. He wanted to understand how one dietary supplement could help people who had lowered as well as those who had exaggerated immunity. Dr. See studied the supplements in his laboratory for one year before using with patients in his practice.

Dr. See finds that chronic degenerative disease results from two factors:
1. oxidative stress where the cells lose their ability to prevent free radical damage
2. and/or immune system dysfunction. Note: free radicals disrupt the

equilibrium of biological systems by damaging major cell constituent molecules. This disrupts cell membrane function, which n / eventually lead to cell death. Antioxidants are substances that, even in relatively low concentrations, significantly inhibit the rate of oxidation caused by free radicals. This finding regarding the two primary causes of disease are further evidence of Dr. Donald Rudin's discussion of the "Modernization Disease Syndrome" where we are
all subject to one disease with multiple manifestations due to our life style factors dominated by a polluted environment and weakened food sources. The glyconutritional products are working in both arenas--relief of oxidative stress as well as immune system support. Oxidative stress is thought by many researchers to be a primary contributor to the aging process.

Apoptosis is essentially "cell suicide". It is a normal process to protect us from cancerous or autoimmune cells. Apoptosis is mediated by a cell surface glycoprotein gene called fas which stimulated apoptosis. bcl-2 is a part of apoptosis which blocks weak apoptotic signals. In fact, bcl-2 will intercept the message to do apoptosis or not. There is a higher amount of bcl-2 in neurons, renal cells and other parts of the body where the cells can repair themselves. In the immune system there is fast regeneration, 2-3 million cells/ day, so generally immune cells just die and then get replaced. bcl-2 is found to be abnormally high in immune deficient disorders like AIDS and abnormally low in immune hyperactive disorders like Lupus. In AIDS, the cell surface glycoproteins are very defective. The message to do apoptosis bypasses fas and bcl-2 in AIDS, so "cell suicide" happens in normal cells. This results in a very high percent of normal cells being killed daily. In halthy individuals, the normal percent of apoptotic cells in the body is 10%. When glyconutritionals were added, there was no increase or decrease in this percentage of apoptotic cells. In Chronic Fatigue Syndrome, there is 28% apoptotic cells and with the addition of glyconutritionals, this percentage was decreased by 50%. When glyconutritionals were added to a Lupus patient, the apoptotic cell level went from 0% to 5%. When measuring the fas glycoprotein in healthy individuals, the fas factor is 15. Adding glyconutritionals to this healthy individual does not change the fas level. The fas level found in Lupus patients is almost zero, but when glyconutritionals are added the fas level increses to 10.

Adaptogens are substances that helps the body stay in balance or
normalize by helping the body to adapt to whatever negative influences enter the environment or terrain of the body. Medicine has always looked for an adaptogenic substance that could lower "infectability" to 0 when the body is invaded by a pathogen such as a bacteria, virus, etc. None have been found.

To test the infectability/adaptogenic results of GNs, Dr. See adds the HIV virus to blood samples and captures what happens within the blood and what remains in the medium. With his testing he has found that infectability is 100% without any supplementation and with the addition of GNs, infectability drops to 60%. He says this is because of raising the functioning of NK cells as well as the cell
surfaces are armored with glycoproteins that are blocking binding sites for the virus. Further, when he adds a phytonutrient complex with GNs, the infectability level drops to 30%. He finds this complex to be an excellent anti-oxidant. Glutathione (a natural occurring anti-oxidant in the body) levels skyrocket with this complex. When the body is invaded by virus and bacteria as the cells try to battle the invasion, lots of free radicals are released which can cause further
cell damage. If there is a strong anti-oxidant in the body, the damage to the body is lessened with this protection.

When he then adds a metabolically profiled vitamin/mineral with GNs, infectability further drops to 10%! This is explained by the fact that vitamins provide co-factors with enzymes to stimulate a variety of processes in the cell which will include protecting killing off of virus, bacteria, etc. Adding an intestinal cleanse product that includes GNs further drops infectability to the 5-1% range.

Sandy Hurman

Note: These are initial findings in laboratory test. While these results give evidence in support of certain nutritional substances, this information is not intended to give proof of cure of any disease condition or guarantee that any individual will get any particular results or satisfaction when using specific dietary supplements.
Please call for documented scientific validation. John Webb 303-344-1669

John Webb
303-344-1669

Sandy Thurman.

July 23, 1998

# Post-Apartheid Agony: AIDS on the March

**Related Articles**

- Parts of Africa Showing H.I.V. in 1 in 4 Adults (June 24)
- AIDS Prolongs War Devastation in Rwanda (May 28, 1997)

**Forum**

- Join a Discussion on Africa in Transition

**By SUZANNE DALEY**

IZINGOLWENI, South Africa -- One day earlier, the workers from the South Coast Hospice had at least brought food. But this day they had only bad news to deliver.

They had not been able to find anyone willing to donate a coffin for Ennie Gambushe's daughter, Mercy, who had died of AIDS. Nor had they come up with the $18 needed for a traditional burial.

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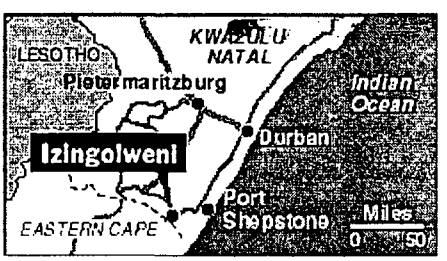


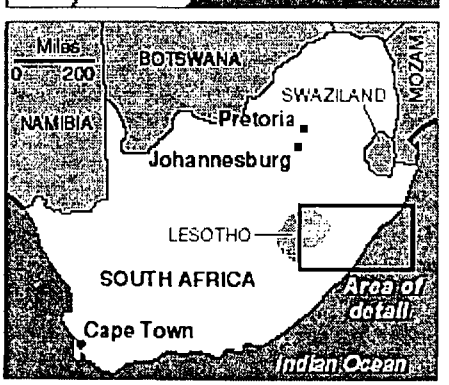


Years after many other sub-Saharan countries, South Africa has finally begun to see its people die from AIDS. In almost every cluster of desperately poor huts tucked into the rolling hills of KwaZulu/Natal Province, the slow wasting fatal disease that few will admit to is wreaking its havoc.

The epidemic in this country is now


The New York Times

In Izingolweni, AIDS is bringing new misery to the very poor.

one of the fastest growing in the world. Experts say South Africa -- protected by apartheid's isolationism from major exposure to infection, and with a health system better than any other on the continent -- had a unique opportunity to prevent the kind of explosion of AIDS cases that has ravaged the rest of Africa.

But in the early 1990s the country was in the grip of negotiating a peaceful transition from white supremacist rule. With the possibility of civil war looming, no one paid much attention to halting unprotected sex.

Even now, many experts say, the government's efforts to combat the epidemic have been slow and marred by scandal.

Today almost three million South Africans -- about 12 percent of all adults -- are infected with HIV, the virus that causes AIDS, more than double the number only three years ago. The rate of infection is highest, at 20 percent, among women in their 20s.

Experts say that it may be only a few years before South Africa's infection rates will equal those of its neighbors Zimbabwe and Botswana, where 25 percent of all adults are infected.

For the time being, experts believe that the virus is most prevalent among South Africa's poor blacks. In some parts of Africa, the epidemic first roared through the urban elite. They had the money to travel and tended to have more sexual partners. But in South Africa, it is poor blacks -- because they search the country looking for jobs and often have sexual partners in their villages and where they work -- that have been hardest hit.

What impact the virus will have on South Africa's economy, the largest on the continent, remains an open question. But there is little doubt that it will bring new levels of misery to the very poor.

This is already evident in places like Izingolweni -- rural areas where the way of life was for decades dictated by apartheid laws. The able-bodied went off to work, forbidden from taking their families with them. But it is here that they came to marry, to celebrate holidays or when they were ill, old or dying.

Down the road from Mrs. Gambushe is an 11-year-old girl who alone nursed her dying parents last year, barely able to keep them clean and fed as their bodies, worn down by the HIV virus, shriveled from dysentery and tuberculosis.

There is a dying mother of nine who struggles with a husband who beats her because he believes she gave him the disease.

And there is a young man, rail thin, who worked for a while in the city of Durban, but who has come home to die now. He is not accepted by his family because they suspect he has AIDS and are afraid that they too will catch it. Though the young man is allowed his hut nearby, he must tend to himself. Many days he is too weak to fetch water from the river and the workers find him lying in filth.

Most of the time, such people receive few services. The South Coast Hospice originally began as a non-profit organization working out of a small house in a white neighborhood, catering largely to middle class people dying of cancer in the seaside town of Port Shepstone.

But 18 months ago, the group began trying to reach out to the black population dying of AIDS. At first, the hospice concentrated on delivering pain killers as it had for whites. But soon they were carting food, clothing and whatever else they could into the hills.

"What good does it do to bring pain killers when you find that the caregiver in the household doesn't have the strength to roll the patient over because she is starving," said Kathleen Defilippi, the director of the non-profit group. "So we didn't want to, but we had to get involved in handing out food parcels and whatever else was needed."

Mrs. Gambushe's difficulty in providing a coffin for her daughter is not unusual, the hospice workers said. Many these days are buried wrapped only in sheets despite the deeply held Zulu belief that those who are not put to rest properly will come back to haunt their families.

"A lot of times, we even have to give them the sheets," said Judy Ndaba, who visits patients four days a week. The fifth day, she receives counseling as do all the other workers, because what they see is so draining.

As the workers, try to tend to patients they must often do so without acknowledging that the patient has AIDS. Here as elsewhere in the country patients are too ashamed and too frightened to tell anyone their diagnosis. Often enough, they die with their secret. Mrs. Gambushe, for instance, does not know that Mercy died of AIDS. Mercy did not want to tell her, and the health workers are bound to follow her wishes. Another of Mrs. Gambushe's daughters died last year, and she does not know why. It is the children of both daughters whom Mrs. Gambushe is now looking after.

Another patient, Nomusa Dlamini, who has been ill for three years, has also not told her family that she has AIDS. She does not fear only for herself. She worries that if her sisters knew, they would be too frightened to take care of her two young children after she dies.

Typically, even wives are afraid to tell their husbands they are infected with H.I.V. Because the women, run down by the hard lives they lead and the many children they bear, are most likely to show symptoms first, husbands will not believe that they have been faithful and sometimes throw them out of the house or beat them like Esther Xolo. Her husband now believes that their last two children are not his.

On a recent visit, Ms. Xolo burst into tears, begging the workers to talk to her husband, who has taken to living on his own and hoarding the food the workers take to the family.

Even though the disease is often not acknowledged, the villages have seen enough AIDS so that suspicion runs high.

Some patients live in virtual isolation because of it. Vusumuzi Tabhu, who has told no one he is suffering from AIDS, has gotten little help from his family since he came home last year. On a recent day he greeted the workers will a grin. He had been feeling better in the last few days and had done his laundry.

They teased him about having found a girlfriend, an exchange that he clearly enjoyed. But the workers say he suffers a great deal. Even when the workers bring him food, family members often take it from him. They, too, are hungry, and he is far too weak to stop them.

"You sometimes go into the household and you see that the person is isolated," said Dr. Terry Gilpin, the director of nearby Murchison Hospital. "You'll see that the sick person's plate and utensils are in the corner away from everyone else. You see it a lot. People are ignorant about the disease."

Murchison, like many other hospitals in the province, is already overwhelmed by the numbers of AIDS patients. Most nights, 15 patients sleep on the floor. While infection rates are rising throughout South Africa, the hardest-hit area is KwaZulu/Natal, which includes a port city and many truck routes connecting it to neighboring countries. What Lies Ahead? 'Great Misery' Since there are no similar models to study, economists say it is impossible to predict what is likely to happen to South Africa's economy.

Some predict that the bigger corporations will be able to adapt to a decline in the labor pool. Most are already in the process of shedding employees as they mechanize, computerize and in general try to become more competitive.

In addition, the growing mobility of the international labor pool means that South Africa could go outside the country to fill gaps that arise.

But already it is clear that the measure of hardship in this society will rise sharply. Young people will be dying at a time when they are usually contributing to a family's income. And many will be leaving children behind.

"The jury is still out on what the macro level impact will be," said Alan Whiteside, an economist at the University of Natal in Durban who studies such issues. "But at the micro level you will see great misery. '

Despite South Africa's relatively advanced public health services, the country is still struggling financially and the Government is not even discussing providing treatment for AIDS itself. Few of the private medical insurance companies will pay either.

Peter Bassey of the National Association of People Living With H.I.V./ AIDS says fewer than 1 percent of South Africa's infected are being treated with life-prolonging drugs like AZT. And most of those are paying for the drug themselves.

Nor are there any national programs to try to block the transmission from mother to child, either by offering AZT to infected pregnant women or by

providing formula so they can avoid transmission through breast feeding.

The government has made progress, though, in dispensing condoms -- about 140 million last year -- and in offering treatment for other sexually transmitted diseases, which helps reduce the spread of AIDS.

Also, about one-tenth of the country's secondary school teachers have been trained to teach youngsters about the disease and how to avoid it.

Still, the Government's two most visible steps against AIDS were both headline-making fiascos.

The first was an ill-fated traveling musical, "Sarafina II," meant to warn the illiterate about the dangers of AIDS. As soon as it opened, AIDS experts called some of its dialogue dangerously inaccurate and its message unclear.
The Health Minister And Her 2 Fiascos

It then turned out that the show had cost a relative fortune -- nearly $3.3 million. Health Minister Nkosazana Zuma commissioned a friend to write it, bypassed bidding rules to give him the job and then lied to Parliament about the whole affair.

Then last year, Dr. Zuma announced that South African scientists had made a major breakthrough in the search for an AIDS cure. She invited researchers who claimed to have discovered the miracle cure -- a drug called Virodene administered by a skin patch -- to bypass the Medicines Control Council, the equivalent of the Food and Drug Administration, and take some of their cured patients before the Cabinet to plead for funding.

Medical experts, including the control council, were aghast when they found out that human trials had been performed secretly, especially when they learned that the Virodene contained a poisonous solvent. Since then, Dr. Zuma has dismantled the council. She continues to back Virodene research.

These days the South Coast Hospice workers visit more than 300 patients a month, though they have yet to secure financing for next year and may have to shut down. The workers are particularly worried about the fate of the children they see.

The 11-year-old girl who nursed her parents, Kugu Sengane, spent most of last year alone with them and her toddler brother. Her relatives showed up only in the last few months -- ready, it seems, to take over the two shacks her parent built. These days the workers are worried about the girl. She seems afraid to speak in front of her aunts and appears to do most of the housework.

There is also little possibility that the 15 children in Mrs. Gambushe's care will go to school anytime soon. They will all be living on her pension now, less than $80 a month. The school fees and mandatory books and uniforms amount to about $120 a year for each child.

Sitting motionless on the straw mat inside her virtually empty house, Mrs. Gambushe answered questions about the future in a monotone.

"I don't know what I will do now," she said. "I don't know."

**Other Places of Interest on The Web**

- Offical Webcast of the World **AIDS** Conference.
- ASD Online, the World Health Organization's Office of HIV/**AIDS** and Sexually Transmitted Diseases.

# A Post-Apartheid Agony: AIDS on the March

João Silva/Sygma, for The New York Times

Nomusa Dlamini, 38, clutching AIDS medications. The disease is starting to wreak havoc in South Africa.

By SUZANNE DALEY

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The epidemic in this country is now one of the fastest growing in the world. Experts say South Africa — protected by apartheid's isolationism from major exposure to infection, and with a health system better than any other on the continent — had a unique opportunity to prevent the kind of explosion of AIDS cases that has ravaged the rest of Africa.

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*Continued on Page A8*

Continued From Page A1

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## Rural Scenes Of Ghastly Neglect

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## Taking the Diagnosis Into the Grave

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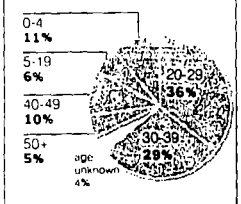
**BREAKDOWN**

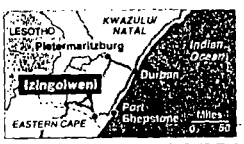
### AIDS at Every Age

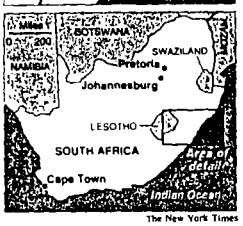
In South Africa, AIDS afflicts every age group. But the majority of cases occur among people who are in their 20s and 30s.




Source: World Health Organization

The New York Times

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## What Lies Ahead? 'Great Misery'

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In addition, the growing mobility of the international labor pool means that South Africa could go outside the country to fill gaps that arise.

But already it is clear that the measure of hardship in this society will rise sharply. Young people will be dying at a time when they are usually contributing to a family's income. And many will be leaving children behind.

"The jury is still out on what the macro level impact will be," said Alan Whiteside, an economist at the University of Natal in Durban who studies such issues. "But at the micro level you will see great misery."

Despite South Africa's relatively advanced public health services, the country is still struggling financially and the Government is not even discussing providing treatment for AIDS itself. Few of the private medical insurance companies will pay either.

Peter Bassey of the National Association of People Living With H.I.V / AIDS says fewer than 1 percent of South Africa's infected are being treated with life-prolonging drugs like AZT. And most of those are paying for the drug themselves.

Nor are there any national programs to try to block the transmission from mother to child, either by offering AZT to infected pregnant women or by providing formula so they can avoid transmission through breast feeding.

The government has made progress, though, in dispensing condoms — about 140 million last year — and in offering treatment for other sexually transmitted diseases, which helps reduce the spread of AIDS.

Also, about one-tenth of the country's secondary school teachers have been trained to teach youngsters about the disease and how to avoid it.

Still, the Government's two most visible steps against AIDS were both headline-making fiascos.

The first was an ill-fated traveling musical, "Sarafina II," meant to warn the illiterate about the dangers of AIDS. As soon as it opened, AIDS experts called some of its dialogue dangerously inaccurate and its message unclear.

## The Health Minister And Her 2 Fiascoes

It then turned out that the show had cost a relative fortune — nearly $3.3 million. Health Minister Nkosazana Zuma commissioned a friend to write it, bypassed bidding rules to give him the job and then lied to Parliament about the whole affair.

Then last year, Dr. Zuma announced that South African scientists had made a major breakthrough in the search for an AIDS cure. She invited researchers who claimed to have discovered the miracle cure — a drug called Virodene administered by a skin patch — to bypass the Medicines Control Council, the equivalent of the Food and Drug Administration, and take some of their cured patients before the Cabinet to plead for funding.

Medical experts, including the control council, were aghast when they found out that human trials had been performed secretly, especially when they learned that the Virodene contained a poisonous solvent. Since then, Dr. Zuma has dismantled the council. She continues to back Virodene research.

These days the South Coast Hospice workers visit more than 300 patients a month, though they have yet to secure financing for next year and may have to shut down. The workers are particularly worried about the fate of the children they see.

The 11-year-old girl who nursed her parents, Kugu Sengane, spent most of last year alone with them and her toddler brother. Her relatives showed up only in the last few months — ready, it seems, to take over the two shacks her parent built. These days the workers are worried about the girl. She seems afraid to speak in front of her aunts and appears to do most of the housework.

There is also little possibility that the 15 children in Mrs. Gambushe's care will go to school anytime soon. They will all be living on her pension now, less than $80 a month. The school fees and mandatory books and uniforms amount to about $120 a year for each child.

Sitting motionless on the straw mat inside her virtually empty house, Mrs. Gambushe answered questions about the future in a monotone.

"I don't know what I will do now," she said. "I don't know."

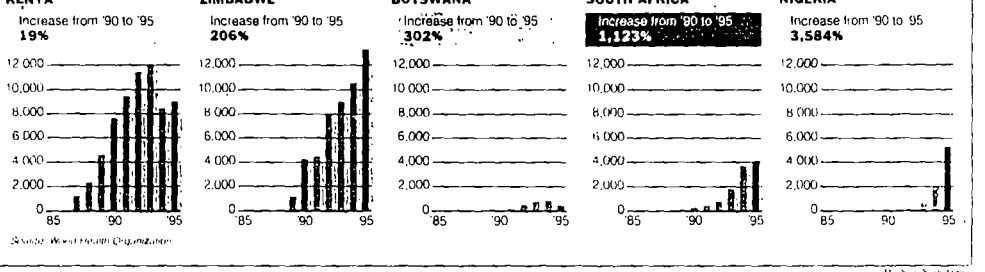
João Silva/Sygma, for The New York Times

Ennie Gambushe looks after 15 grandchildren since her daughters died of AIDS. The epidemic in South Africa is one of the world's fastest growing.

**BY THE NUMBERS**

### For South Africa and Its Neighbors, a Losing Battle Against AIDS

Across Africa the number of new AIDS cases reported each year is skyrocketing. Even so, the data substantially underrepresent the number of people with AIDS, in some countries, as few as 10 percent of the cases are reported. Here is a look at the general trends.




Source: World Health Organization

The New York Times

# BBC News Online: World: Africa

## Aids widespread among pregnant South Africans

Thursday, March 19, 1998 Published at 04:00 GMT



**Aids widespread among pregnant South Africans**

Nearly one in six pregnant South African women were last year found to be infected with the HIV virus, which causes Aids.

The country's health minister, Nkosazana Zuma, said 16% of women attending government antenatal clinics in 1997 had the virus, 13% more than in 1996. The number infected had more than doubled since 1994.

Mrs Zuma said South Africa was believed to have one of the fastest growing HIV epidemics in the world. He told Parliament recently that nearly 50,000 South Africans were becoming infected every month.

Testing at antenatal clinics is one of the few ways of assessing the spread of the disease. The 1997 survey involved 12,343 women.

The United Nations HIV/Aids programme UNAIDS estimates that around 2.4 million of the country's 38 million people are already infected - more than the total number of people with HIV in the whole of the Americas.

Local experts say the opening of South Africa's land borders since the end of the apartheid era has significantly contributed to the increasing rate of HIV. East Africa is particularly hard-hit.

Despite the upward trend, Mrs Zuma was optimistic South Africa could reverse the course of the pandemic. He pointed out that although the figures were rising, the rate of increase was slowing. In 1990 it had been doubling almost every 15 months, she said.

Mrs Zuma predicted that dealing with Aids and HIV would cost South Africa more than 8bn Rand ($1.6bn) by 2,000. The cost would probably be even higher if Aids orphans were accounted for.

## Relevant Stories

ANC probed over banned Aids drug (06 Mar 98 | World)
World Aids Day highlights plight of children (08 Dec 97 | World)

INDEPENDENT online
The Star

# 200 HIV-positive babies are born in South Africa each day

By Anso Thom Health Reporter

At least 200 HIV-positive babies are born in South Africa each day and it is estimated that, within the next 10 years, up to 3 million children could be infected or or-phaned by the epidemic.

Most babies contract the Aids virus from mothers who are HIV positive, during birth or through breastfeeding. And, every day, about 1 200 new infections are recorded among adults mostly in the 15 to 49-year age group.

Dr Daya Moodley, senior research scientist at King Edward Hospital in Durban, said the hospital recorded about 12 000 births a year, and 28% of the mothers were HIV positive.

The Star has established that three HIV-positive babies are born at Chris Hani Baragwanath Hospital in Soweto every day, about one every second day at Johannesburg Hospital, and three a day at King Edward Hospital.

Dr Glenda Gray, director of Chris Hani Baragwanath's peri-natal HIV research unit, confirmed that, of the 20 000 women giving birth at the hospital in a year, 4 000 were HIV positive.

Aids specialists agree that about 6% of all babies in South Africa are born with HIV. The Department of Health con- firmed that 1,3 million babies were born last year, which means that 78 000 babies were born HIV positive 214 a day.

Aids consultant Dr Clive Evian said: "About 20% of women who give birth in public health hospitals are HIV infected. One out of four women then pass it on." He said 30-40% of the babies died within the first year.

Last year the Department of Health undertook the eighth in a series of unlinked, anonymous surveys of women attending antenatal clinics of the public health service. Of 12 343 specimens screened, 1 976 (16,01%) were infected with HIV.

The epidemic places a strain not only on the health system but also on the welfare system as hundreds of thousands of children are orphaned by the disease.

Gray said the country would need thousands of hospices to treat Aids children. "We need clear guidelines on how to take care of them. A model for some form of home-based care is going to be essential," she said.

Reva Goldsmith, assistant director of Cotlands Baby Sanctuary, said the realisation that there "were too many children we couldn't reach" had forced the organisation to turn to the fostering option.

Cotlands was in the process of launching an HIV infant care programme which would, if successful, result in the orphans being absorbed into the community.

Gray said 30% of all paediatric cases treated in the four medical paediatric wards (160 beds) were HIV related. She claimed that, in Soweto alone, 20 out of every 100 people were HIV positive and that "it is going to get worse".

She said most pregnant women could not afford the expensive treatment which could prolong life. "If they are lucky, we get them onto a clinical trial."

A paediatrician at Johannesburg Hospital, who asked not to be named, said the hospital was struggling to find beds for cases unrelated to Aids. "We have only 36 beds in the hospital for paediatric medical cases and a lot of these beds are taken up by sick HIV babies," she said.

Amos Masondo, outgoing Gauteng health MEC, earlier this year revealed the burden the epidemic was placing on hospital resources.

Between 15 and 20% of hospital admissions about 115 000 admissions last year were for HIV-related ailments. It was estimated that there would be 300 000 HIV-related admissions in 2002.

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**MISSION STATEMENT:** *"It is a mission of Motion Piktures, Inc. to produce a video documentary entitled 'On the Frontline: Community Answers to a Global Crisis,' featuring and benefiting community-based and non-governmental approaches to HIV/AIDS in South Africa and Denver, Colorado, USA."*

**NAME OF DOCUMENTARY PROJECT:** "On The Frontline: *Community Answers To A Global Crisis*" A *Motion Pictures* Production

**PRODUCTION CONTACT:** Kellie Gibbs, Executive Producer
**PHONE:** (303) 274-4901; (303) 767-4552-pager
**E-MAIL:** OutPress@aol.com
**MAILING ADDRESS:** 88 South Garland Street, Lakewood, Colorado 80226

**PROJECT CONCEPT:** The documentary is in support of and in collaboration with a series of exchange programs under development by Sandra L. Thurman, Director of the Office of National AIDS Policy at the White House, in which leaders, activists, health professionals and experts in the fight against HIV/AIDS in communities in South Africa and the United States are brought together to witness each other's community based programs and exchange ideas, experiences, and concepts. *"On the Frontline"* will highlight how specific communities, cultural leaders and organizations confront the challenges of HIV/AIDS based on available resources, cultural beliefs, and the influence (or lack of) outside sources. By offering the opportunity to witness unique cultural practices regarding HIV/AIDS healing practices, universal audiences will have their own viewpoints broadened and enriched.

**PURPOSE:** To bring the unique experiences and practices of select CBOs, NGOs and individuals, via the video documentary, to people working on the frontlines of HIV/AIDS and populations at risk for contraction of HIV/AIDS who otherwise would not be able to benefit from such knowledge. It is our belief that by giving a visual "face" to those on the frontlines of HIV/AIDS in two culturally diverse international locations, and by presenting the experiences and personal accounts of people living and working with HIV/AIDS, we will: 1) raise an awareness and deeper understanding of the common (and uncommon) issues that affect internationally diverse cultures and communities confronting the HIV/AIDS crisis; 2) facilitate the sharing of innovative, resourceful and distinct approaches to HIV/AIDS prevention, treatment and education; and 3) as a result of the above, enhance the effectiveness of community and cultural efforts that impact HIV/AIDS education, prevention and treatment.

**PROPOSED DISTRIBUTION:** The documentary is to be distributed to a broad range of groups in the USA, South Africa and other countries including youth groups, community organizations, programs, leaders and experts, schools, businesses, agencies and individuals working on the frontlines to affect positive change in HIV/AIDS in their communities. Wherever possible, project staff, youth volunteers and community leaders will be trained to attend project screenings and facilitate discussion. Because the 13th World Conference on AIDS will be held in Durban, South Africa (where filming in 1998 is scheduled to occur), efforts are being directed toward a special screening/presentation there in the year 2000 at the Conference.

As of May 2, 1998, the project has also received commitments to air or be screened (with discussion) multiple times on cable access station Q-TV and DC-

TV, PBS station KBDI, at the 1999 U.S. Conference on AIDS, at the annual AIDS, Medicine & Miracles Conference, and at the Gay & Lesbian Film Festival in Colorado and distributed to other cable stations, PBS stations and film festivals in cities across the U.S.

**HIV/AIDS SPONSORING 501(C)(3) AGENCY:** The Colorado AIDS Project, Denver, Colorado and the Colorado Chapter of the Names Project.

**SOUTH AFRICA SEGMENT:**
South Africa segments to be largely determined by Sandra L. Thurman, Director, Office of National AIDS Policy and representatives of OSHANA, an international development network. Sample footage to include: South African tribal healing rituals of people living with HIV/AIDS (PLWAs) and highlights of the immediate and visible impact of HIV/AIDS in areas where up to one quarter of the population is infected. Will film OSHANA workshop with tribal healers and its projected impact on local business, cultural/familial changes, roles of men, women, children, and local efforts.

- The project may cover highlights of a four-day "Intercultural Communications and Planning Methodology" workshop developed and implemented by OSHANA (in conjunction with the Florence R. Kluckhorn Center) during which tribal healers and biomedical professionals are brought together in interactive sessions. AIDS in Africa has reached pandemic proportions with incidence rates higher than on any other continent. In South Africa, AIDS currently affects upwards of 25% of the population, making it impossible for modern health facilities to properly treat AIDS. Because of religious and cultural taboos discouraging the open discussion of sex and related issues, parents and teachers are often afraid to provide youths with general and useful information about sex. Early sexual activity has contributed to the widespread presence of sexually transmitted diseases and 63% of reported HIV-positive cases in the age range of 15-24 are female.

With no cure in sight or economically feasible pharmaceutical treatment, health promoters must look to other avenues for coping with AIDS-related problems. Currently, traditional healers are one of the primary health care providers for AIDS patients. Historically, traditional healers have been proficient in the treatment of many AIDS-related illnesses. In addition, traditional healers play an important role in counseling PLWAs and their families and have been successfully trained and utilized for AIDS control and prevention campaigns in many African countries.

OSHANA workshops are designed to have the following outcomes: 1) improved understanding by traditional healers of AIDS and its treatments; 2) improved understanding by biomedical professionals of the methods used by traditional healers; 3) enhanced collaboration among traditional healers and biomedical professionals in dealing with AIDS; 4) recommendations and plan of action for enhanced program effectiveness, and; 5) a trained local facilitator in the methodology. By including portions of the OSHANA workshop in our documentary, we will bring the experiences and beliefs of biomedical professionals and traditional healers in South Africa and the interdynamics of the two groups to a broad range of individuals.

**Sandra L. Thurman, Director**
**Office of National AIDS Policy**
**Denver, Colorado**
**July 26 - 27, 1998**

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*FYI: You have received an invitation from a few of the people you will be meeting at this event to participate in the AIDS Walk Colorado 1998 event on September 13, 1998. Your calendar probably will not allow you to attend as you have already committed to being in Atlanta that week for the housing conference.*

*Also, Kellie has asked that you write a short note of appreciation for a woman named Karen Patterson who is dying from ovarian cancer. We are working on that and will have it out by the beginning of next week.*

*Note: There is a press conference with the Mayor on Monday at 10 AM to initiate July 27th as 'Kate Shindle Day' in Denver. You will have already left.*

## Sunday, July 26th

| | |
|---|---|
| 2:50 - 4:26 PM | American Airlines Flight #619, Seat 21B (aisle)<br>Departing Chicago Ohare, Terminal 3 en route Denver |
| Transportation | Peter Saylin, head of the Ryan White Program in Denver, will be picking you up at the gate. He knows what you look like. |
| Hotel | Marriot Courtyard<br>C# 82483181<br>934 16th Street<br>Denver, CO 80202<br>P: (303) 571-1114<br>F: (303) 571-1141<br><br>Note: This is the same hotel that Kate will be staying at. |
| Event Location | Wynkoop-Mercantile Room, LoDo<br>1634 18th Street, Denver |
| 6:00 - 7:00 PM | Private Reception |
| 7:15 - 9:00 PM | General Agenda: |

- Director of film project, Valerie Garis, will speak briefly about the role and potential of film to reach large numbers of people internationally and present useful information and understanding about the epidemic
- Executive Director of Colorado AIDS Project, Julian Rush, and the Director of Education, CO Chapter of NAMES Project, Michael Shiut, will speak about the changing face of HIV/AIDS at the local level and Denver's involvement in the film
- Tara Lumpkin and Phillip Gibbs (Kellie Gibbs uncle), Co-founders of OSHANA (an international development agency, conducting workshops in South Africa and Namibia with traditional healers and non-governmental agencies regarding HIV/AIDS) will speak about traditional healing and cultural practices as they relate to their workshops, international work experience and the film.

- David Goldberg, former PR Director at the Colorado AIDS Project, will introduce you. They would like to hear about 5 - 10 minutes about the 'global AIDS problem' with a possible emphasis on the 12th World AIDS Conference in Geneva', South Africa, African orphans and the implications of the epidemic on children and your support of the film. You are also to introduce Kate.

- Kate Shindle will speak on her platform, education, prevention, support of the film for about 15 minutes.

## Monday, July 27th

| | |
|---|---|
| 6:00 PM | Sue Geissler, Director of the Mayor's Office of HIV Planning will be picking you up from your hotel |
| 8:12 - 1:22 PM | United Airlines Flight #300, Seat unassigned<br>Departing Denver Airport en route Washington Dulles |
| 1:22 PM | Car pick up from Dulles baggage claim en route 736 Jackson Place |

## Contacts

| | |
|---|---|
| Kellie Gibbs | (303) 274-4901/Pager: (303) 767-4552 |
| Sue Geissler | (303) 285-5601 |
| Sarah Holewinski | (202) 395-1441/H: (202) 588-5476 |
| Garage | (202) 757-1467 |
| Travel Office (non-emergency) | (202) 456-2250 Jack, Kurt, or Ken |

**Emergency Travel: 800-847-0242/Code KC52**

MICHAEL R. SINCLAIR, PH.D.
SENIOR VICE PRESIDENT

THE HENRY J. KAISER FAMILY FOUNDATION

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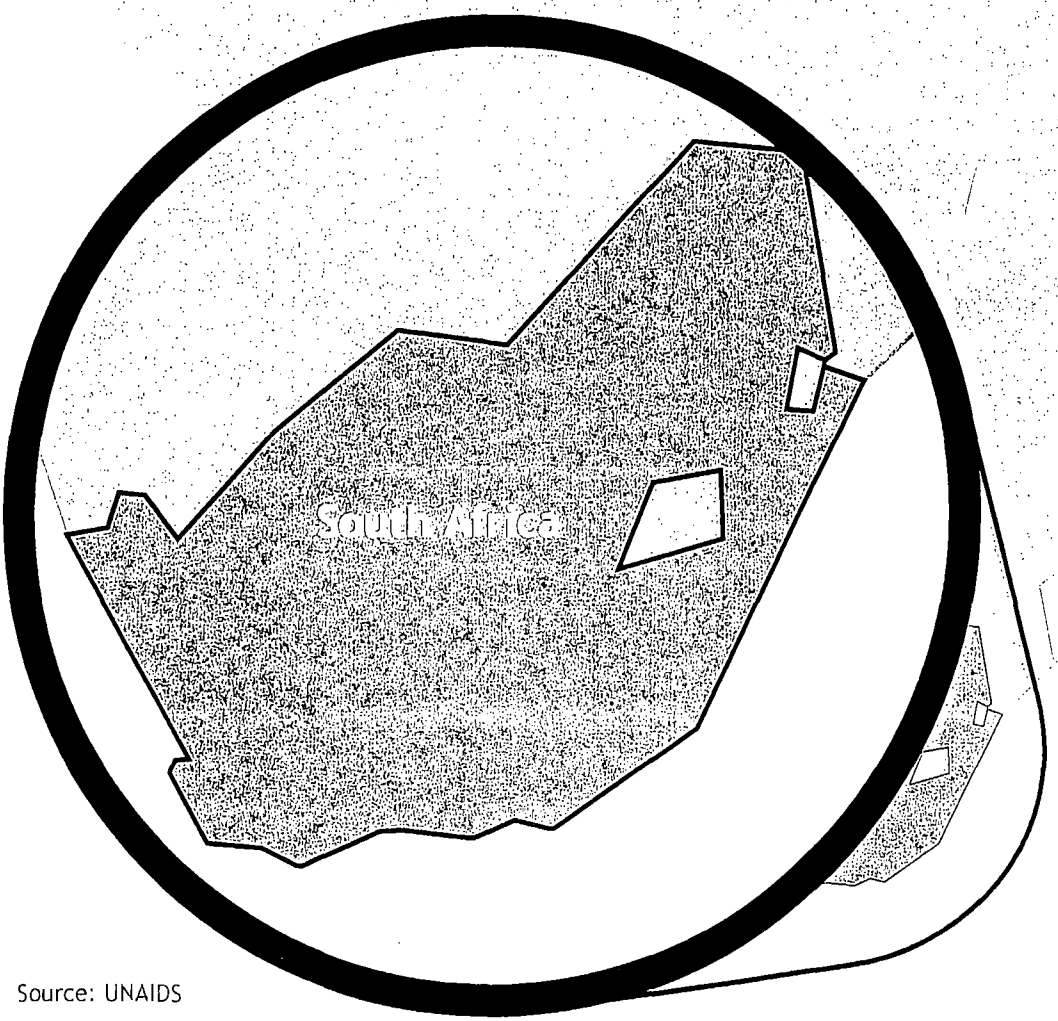
# South Africa HIV/AIDS Statistics

Currently:

- 3.5 million people are HIV positive

In the next five years:

- 5.6 million people will become HIV-infected
- 2.1 million people will have died
- 18% of the workforce will be infected




Source: UNAIDS

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# HIV/AIDS IN S H AFRICA:

AIDS HELPLINE

DEPARTMENT OF HEALTH

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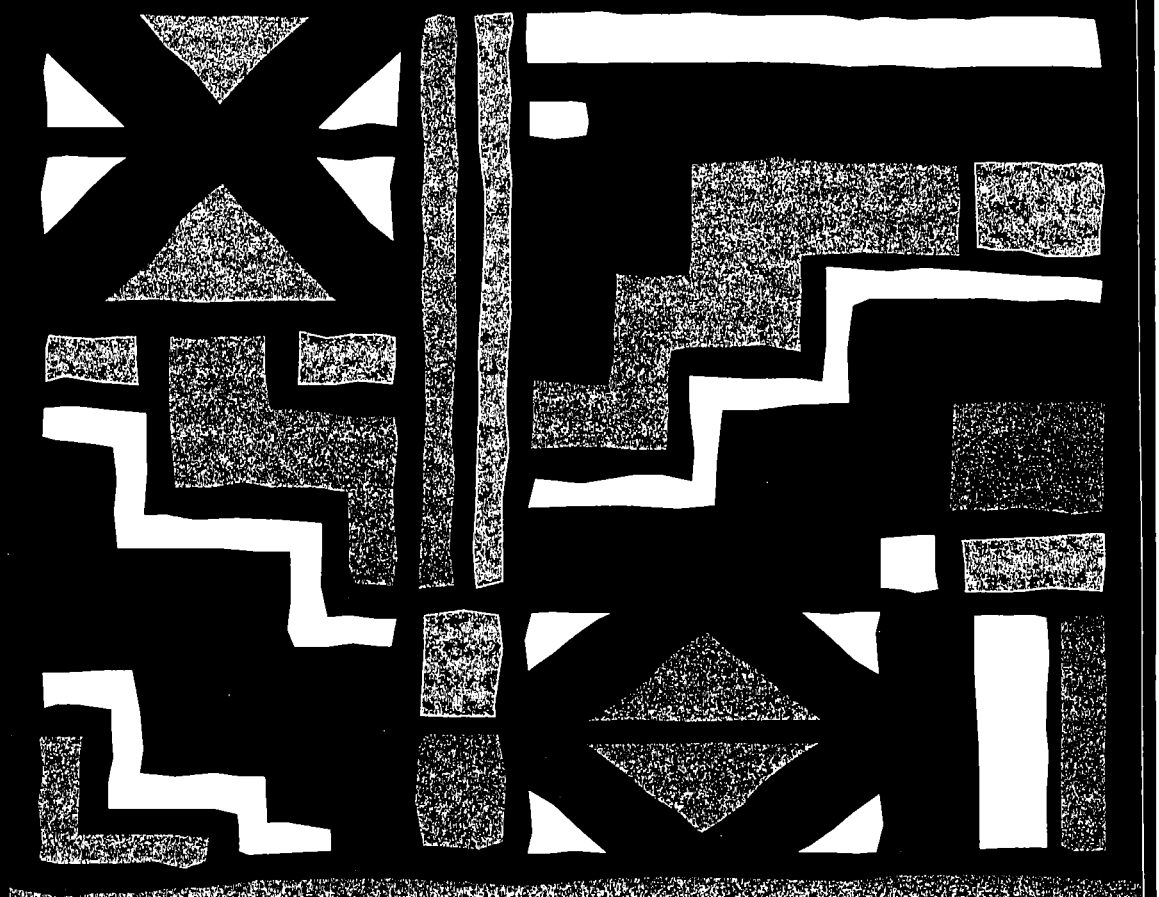
# Program for Health and Development in South Africa



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