What Social Studies Teachers Should Know About AIDS in South Africa
by Susie Hoffman

In southern Africa, over 24 million people are currently infected with HIV, representing 71% of the estimated global total of adults and children living with HIV/AIDS. The number of new infections in this region of the world was four million in 1999. Although some African countries have made progress against the epidemic, in many other nations rates of infection have continued to soar, moving through the population unabatedly. In seven southern African countries, it is estimated that approximately 20% of the adult population is currently infected. This includes South Africa, where the rate of infection continues to rise rapidly. South Africa has the largest number of people living with HIV/AIDS in the world today, 4.7 million out of a population of 40 million.

The epidemic in Africa first emerged and took off in the central and eastern regions, in Rwanda, Burundu, Kenya, Tanzania, Uganda and Zaire in the mid 1980s. In contrast, South Africa had an infection rate of less than 1% in 1990. Today, South Africa has an explosive epidemic, one of the fastest growing in the world, even though it is one of the more developed nations in the region. In less than 10 years the rate of infection rose from less than 1% to over 20%.

The impact on the country is already enormous and it will be devastating in the years to come. According to a recent study, AIDS accounted for 40% of all deaths among people between the ages of 15 to 49 years. It is estimated that a youth aged 15 today has a 50% chance of dying from AIDS in the future. Because AIDS kills people in the prime of their working and parenting years, the impact on an already struggling economy is enormous. One area where this is already evident is among teachers. In a country that is trying to educate its young people, many of whom were denied an equal education under the apartheid system, the loss of large numbers of teachers to AIDS is devastating. The same is true for the health care system, where losses of health workers to AIDS will diminish the ranks of those trained to care for the sick and fight the epidemic. Further, an estimated two million children will be orphaned in the next decade, and there are few alternative means to care for them.

In South Africa, as is true throughout the continent, HIV is largely spread through heterosexual relations and from mother to child during pregnancy or delivery. This differs from the dominant modes of spread in North America and Europe - intravenous drug use and sexual relations between men who have sex with men. Because the virus is spread heterosexually, at least as many, and possibly more, women are infected as men. Rates of infection among women soar at a very young age, between the ages of 15-19, whereas among men, rates of infection reach their peak about 10 years later. These differences are due to patterns of sexual behavior and unequal relations between men and women. Many women are infected before their first pregnancy, leading to the transmission of the virus to large numbers of the next generation.

Why has the epidemic exploded?

Epidemics (both of infectious diseases and non-infectious diseases like cancer) are not merely biological events. The emergence of epidemics, their seriousness, how quickly they spread, which population groups are most affected, and how long they last, are determined by social factors, including socio-economic conditions (level of poverty and underdevelopment, economic forces), political conditions (war and social instability), socio-cultural factors (role of women in society), among others.

A number of factors contribute to the AIDS epidemic in South Africa, including poverty, rapid migration to urban areas, the unequal position of women, unemployment, illiteracy and poor education, economic under-development and the debt crisis, civil conflict in surrounding areas and the migrant labor system. In addition, in South Africa there are high rates for other sexually transmitted diseases (STDs), inadequate treatment programs, a relatively early age for the start of sexual activity, a high number of concurrent sexual partners, and low rates of condom use.

The situation is exacerbated because AIDS tends to be a highly stigmatized disease, in South Africa, as elsewhere in the world. Few people acknowledge that they or their loved ones are infected. Deaths are attributed to other, more acceptable, conditions, such as tuberculoses or malaria. Infected people feel shame about their condition and terrified of revealing it. They fear rejection and abandonment by their families and even physical harm or death. Yet, it is this failure to confront the disease openly that so critically limits an effective response.

Labor Migration Fuels the HIV Epidemic

A substantial portion of the South African economy is structured around a system in which men from rural areas have little choice but to leave their homes in order to work in industrial or mining towns. The men live in these areas for long periods of time, away from their wives and families, and return home periodically. Women generally stay in the rural areas where they maintain homesteads which are a source of subsistence agriculture. This pattern of labor migration became a dominant feature of the economy under apartheid, providing a cheap source of labor to work in the gold and diamond mines.

Under the apartheid system, laws were enacted to restrict the influx of Blacks into areas that white South Africans wanted to maintain for themselves. Blacks could only remain in white areas if they were working there, which meant that they were unable to settle permanently near their place of work. There were no provisions for families in the mining towns; only large hostels for the male workers. This system of labor forced the continued circular movement of men between the mining towns and their homelands, shattering family ties and placing stresses on the workers as well as the women and children remaining at home. The migrant labor system involves the movement of workers across national boundaries as well. Even though the apartheid system was overthrown and replaced with a democratic government in 1994, economic choices remain few and the system of circular migrant labor still exists.

The migrant labor system has had profound effects on the health of workers as well as on their families. Miners live in crowded, substandard housing, work under extremely harsh conditions and received few benefits other than minimal medical care. These living conditions help to promote the spread of common infectious diseases such as tuberculosis and measles. Since workers are separated from their wives for long periods of time, they seek relationships with women living nearby, sometimes establishing second households. The presence of large numbers of men living in the mining towns for long periods also fosters the growth of commercial sex work and the spread of sexually transmitted diseases (STDs). With few economic opportunities open to them, commercial sex work provides one of the few sources of income for poor women. In some cases, women exchange sex for basic necessities such as food and clothing for themselves and their children.

If a sex worker is infected with HIV, she can pass the virus to a large number of men in a short period of time. In a country where people were denied basic medical services, rates of STDs, such as syphilis and gonorrhea, were high well before HIV became a problem. If a person has another STD, it increases the risk of becoming infected with HIV. These conditions fueled the rapid spread of HIV among migrant workers and when infected workers returned home, they passed the virus to their partners.

Gender Relations and the Spread of AIDS

In South Africa, as in other countries around the world, gender roles and social norms contribute to behaviors that promote the spread of AIDS. Young men are encouraged to prove their manhood by having sex early and with many partners. Young women are socialized to be submissive to men, which leaves them unable to refuse sex or insist on condom use. Both young men and women lack knowledge about sex, receive little sex education in school and are often denied access to basic reproductive health services and condoms. By the age of 14 many girls have engaged in sex, often with older boys or men. A significant number of women's first sexual experiences are non-consensual, involving force or the threat of violence by their partner. In addition, women's economic dependence on men serves to reinforce their powerlessness in sexual matters. Even within established relationships, women do not believe they have the right to refuse sex or negotiate condom use with their partners.

Early sexual initiation, low rates of condom use, acceptance that young men will force their partners to have sex and engage in sex with a large number of women, and the inability of women to influence their partner's behavior, are all factors that have promoted the spread of HIV. Although there is now a high level of awareness of the disease among adolescents and young adults, this awareness has not translated into perceptions of personal risk or vulnerability to the disease, nor to the widespread behavior changes that could slow the epidemic. In particular, condom use is viewed negatively. Condoms are believed to diminish a man's sexual pleasure, and are seen as a sign of mistrust between partners, a reminder of disease and death and, among some, as a plot by whites and foreigners to transmit HIV. Recently, there is some evidence that young people are heeding the message to use condoms, but it is not clear that these behaviors have taken hold.

Responses to the epidemic

Many of the social conditions and cultural patterns described above are not unique to South Africa, but characterize other African societies as well. While migrant labor and gender inequality are deeply rooted and not easily modifiable, experience has shown that strong leadership and multi-pronged approaches can have an impact. In Uganda, where the president and first lady spoke out early and often about the need for men to use condoms and limit the number of their sexual partners, HIV has stabilized. Other countries have had some success directing prevention campaigns towards sex workers and through sex education efforts that target young people.

Unfortunately, denial and inaction have characterized the South African government's response to the epidemic. HIV rates rose dramatically during the period when the country was just emerging from 50 years of apartheid rule and was struggling to create new democratic structures and processes. In 1994, when Nelson Mandela became the country's first black president, an estimated 8% of the adult population was infected. That number grew to over 20% when he left office in 1999. It is now widely accepted that the new government's initial response to the epidemic was slow, timid and inadequate. Although mass media and school-based educational efforts are now underway, these efforts may be too little, too late. Furthermore, the impact of these efforts has been undermined by the actions of current South African president, Thabo Mbeki.

President Mbeki has consistently downplayed the seriousness of the AIDS epidemic, even questioning statistics obtained by his own government. In the face of a worldwide scientific consensus, he has questioned whether HIV is the cause of AIDS, citing poverty as the factor underpinning the high rates of death in South Africa. He has also questioned whether western approaches are suitable for a developing country like South Africa and has said that anti-retroviral drugs, which have extended the lives of millions worldwide, could be as "dangerous as the disease itself" and too costly for the government to administer. Mbeki opposes universal implementation of a policy to treat all HIV-infected pregnant women with nevirapine (an anti-retroviral drug), even though research has demonstrated that this can reduce the transmission of HIV from pregnant women to their unborn infants by 40%.

Fortunately, South Africa is now a democracy, where people have the right to organize against views and policies they oppose. The Treatment Action Campaign (TAC) has begun to address the needs of People Living with AIDS by confronting multi-national drug companies (as well as their American government supporters) which refused to lower drug prices for underdeveloped countries. They forced the companies to lower prices substantially and to drop a lawsuit against the South African government, which was attempting to bypass international patent laws and develop locally-produced generic versions of the anti-retrovirals. The campaign is currently confronting the South African government, which still refuses to offer anti-retrovirals in government run clinics and hospitals despite a high court ruling that this is unconstitional. Leaders in three provinces have already announced that nevirapine will be offered in local clinics. In addition, Nelson Mandela has spoken publicly in opposition to the government's stance on treating HIV-infected pregnant women.

Although richer than most of its neighbors, South Africa faces enormous problems. Besides fighting the AIDS epidemic, it is struggling to house, educate and create the conditions for gainful employment for all of its citizens. These demands far exceed the available resources in this part of the world. Kofi Annan, Secretary General of the United States, recognized this problem when he called upon the nations of the world to donate to a Global Fund for AIDS. To date, the Bush Administration has promised to contribute, but the amount offered, relative to the U.S. budget, is far less than what other nations have pledged.

THE FACES OF AIDS IN AFRICA

AIDS in Africa – Death Stalks a Continent (*www.time.com/time/2001/aidsinafrica*). Photographs for TIME Magazine by James Natchwey/Magnum.

A Broken Landscape: HIV & AIDS in Africa (*www.christian-aid.org.uk/news/gallery/aidsafri*). An exhibition of 60 photographs by Gideon

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High School Level Activities ***(Prepared by Melisa Baker)***

H.I.V./AIDS – Whose problem is it?

H.I.V. Region by Region

Despite prevention efforts, H.I.V. infections around the globe continue to rise (Source: UNAIDS).

Region of the World	Total pop. with H.I.V./AIDS	New infections in 1998	% of Adults Infected	Modes of Transmission in order of prevalence
Sub-Saharan Africa	22.5 million	4.0 million	8.0%	Heterosexual Sex
North Africa, Middle East	210,000	19,000	0.13	Intravenous Drug Use Heterosexual Sex
South & South East Asia	6.7 million	1.2 million	0.69	Heterosexual Sex
East Asia & Pacific	560,000	200,000	0.068	Intravenous Drug Use Heterosexual Sex Men having Sex with Men
Latin America	1.4 million	160,000	0.57	Men having Sex with Men Intravenous Drug Use Heterosexual Sex
Caribbean	330,000	45,000	1.96	Heterosexual Sex Men having Sex with Men
Eastern Europe & Central Asia	270,000	80,000	0.14	Intravenous Drug Use Men having Sex with Men
Western Europe	500,000	30,000	0.25	Men having Sex with Men Intravenous Drug Use
North America	890,000	44,000	0.56	Men having Sex with Men Intravenous Drug Use Heterosexual Sex
Australia & New Zealand	12,000	600	0.1	Men having Sex with Men Intravenous Drug Use

Questions to consider:

1. What regions are represented in the chart? In which region is the United States located?
2. How many people are infected with H.I.V./AIDS in Western Europe? In South & South East Asia?
3. Which region has the largest number of people infected with H.I.V./AIDS?
4. Which region has the fewest people infected with H.I.V./AIDS?
5. In 1998, how many people were infected with H.I.V./AIDS in Latin America?
6. What percentage of adults are infected with H.I.V./AIDS in North America?
7. What are the main causes of H.I.V./AIDS infection in Sub-Saharan Africa? North America?
8. According to this chart, is there one cause that is more common than any of the others?
9. What conclusions can you draw about the AIDS pandemic from this chart?
10. In your opinion, whose problem is the AIDS pandemic?

Follow-up assignment:

Write a letter your local newspaper demonstrating your knowledge about the spread of H.I.V./AIDS and your ideas for combatting the AIDS pandemic.

Fighting the Disease
by Geoffrey Cowley, Newsweek, January 17, 2000 (edited)

Can AIDS be stopped in Africa? The temptation, when we confront suffering on such a ghastly scale, is to assume it's beyond human control. But it's not. We know we can contain the spread of HIV, because vulnerable nations have already succeeded. Senegal has held its infection rate below 2 percent throughout the epidemic. And Uganda, once the plague's epicenter, cut its infection rate by half during the 1990's. Replicating such victories won't be easy; every community is different. A strategy that succeeds in one nation can fail in another. But researchers have learned a lot from the successes of the past two decades. Here are some prescriptions for slowing the devastation.

1. Break the silence. The first challenge is simply to face reality. Until recently, few African leaders acknowledged that AIDS was a problem. The disease still carries a strong stigma, but the official silence is breaking. The presidents of Zimbabwe and Kenya are now calling AIDS an urgent problem and many governments are teaming up with corporations and community groups to raise public awareness.

2. Promote safer sex. The greater challenge is to change the behavior that spreads the disease. If people only lacked information, a good leaflet might end the epidemic. The trouble is that no one, rich or poor, makes health choices on the basis of information alone. The most successful prevention efforts have aimed not just to inform people but to change social norms.

3. Target women. Unfortunately, African women are often powerless when it comes to protecting themselves from infection. Women account for 55 percent of the continent's HIV infections, and teenage girls suffer five to six times the infection rate of boys. "Empowering women is critical to controlling the epidemic," says Barry Bloom, dean of the Harvard School of Public Health.

4. Develop a vaccine. The ultimate weapon against any virus is a preventative vaccine. And on that front, progress has been slow. Drug development has flourished spectacularly during the past 15 years, but until recently no vaccine had even entered human clinical trials. The hurdles are political as well as technical. Of the estimated $200 billion the world now spends on AIDS research, care and prevention each year, only $300 million goes into vaccine research. However, trials for two experimental vaccines are now beginning to be backed by private foundations as well as national governments. No one expects miracles from these early vaccine candidates. We can only hope they lead to better ones before Africa loses another generation.

Questions to consider:

1. What are some of the strategies suggested to help slow the devastation caused by AIDS in Africa?

2. According to this article, why were some African governments reluctant to break the silence about the AIDS pandemic?

3. Why is it difficult to change people's behavior even when they are at risk of acquiring a disease like AIDS?

4. What do you think is the best solution to the AIDS epidemic in Africa? Do you agree with the suggestions made in the article? What would you add or change?