WOMEN AND HIV/AIDS: THE CHURCHES' RESPONSE

BY

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NOVEMBER 2002

WOMEN AND HIV/AIDS: THE CHURCHES' RESPONSE

SUBMITTED IN PARTIAL FULFILMENT
OF REQUIREMENTS FOR THE
DEGREE
MASTER OF ARTS
IN THE SCHOOL OF RELIGION AND CULTURE
AT THE UNIVERSITY OF DURBAN-WESTVILLE

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DATE : **NOVEMBER 2002**

SUPERVISOR : **DR J.A. SMIT**

DECLARATION

The Registrar (Academic)
University of Durban-Westville

Dear Sir/Madam

I, Beverly Hariett Houston

Reg. No. 200101568

hereby declare that the dissertation entitled: "Women and HIV/AIDS: The Churches' Response" is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other university.

BEVERLY HARIETT HOUSTON

7 April 2003
DATE

PREFACE

The Future is not some place that we are going to, but one we create. The paths are not found, but made, and the activity of making them changes both the maker and destination.

----- John Schaar -----

I attended a workshop on HIV/AIDS in Newlands East Durban, organised by my church Assemblies of God, South Africa, America and local speakers from the different AIDS Organisations in Kwa-Zulu Natal. It was at that workshop that I became "Positive" about HIV/AIDS. To be honest, prior to that workshop it was just another disease that I had heard about from the media and some folk. The alarming fact was the impact this dreaded epidemic had on the population globally and especially the statistics in Sub-Saharan Africa and Kwa-Zulu Natal. I asked myself the question as to what is the church doing or what was I going to do with the information disiminated that day? I decided to make a difference. I attended a course on HIV/AIDS with Operation Whole in order to educate myself on this dreaded disease and also purchased their manuels. Since then I have being conducting seminars for the many women in the churches in and around South Africa and recently (September 2002) in the villages if India. As a religious leader I have decided to respond with love and compassion and make a difference to everyone suffering and living with HIV/AIDS.

It's not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena...who, at best, knows in the end the achievement, and who, at the worst, if he fails, at least fails while daring greatly.
So that his place will never be with those cold timid souls who know neither victory nor defeat.

----- Theodore Roosevelt -----

DEDICATION

I wish to dedicate this research to my husband, Curt Steven Houston, whose unfailing love has defined husband, friend and companion.

ACKNOWLEDGMENTS

- This research project has only been possible because of the financial contribution of the National Research Foundation. I wish to acknowledge this support and express my sincere heartfelt gratitude to their foundation.

- Dr Johannes A. Smit, my supervisor for his support and guidance throughout the completion of this dissertation.

- My sincere thanks goes to my daughter, Lauren Houston and colleagues, Sharon Williams and Corinne Strydom for their assistance in the typing of my dissertation.

- A final word of thanks and praise goes to my Father, Saviour and Holy Spirit for the strength and patience to endure to the end.

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CHAPTER ONE

RESEARCH DESIGN

1.0. AUTOBIOGRAPHY

My name is Beverly Hariett Houston, I am happily married to a wonderful man, Curt. He supports me 100% in the ministry and whatever I do. We have been blessed with four beautiful children. We are married for 18 years .

I was born and raised in Wentworth, Durban. I have two wonderful brothers, Malcolm and Conrad and two beautiful sisters, Michelle and Colleen. I am the eldest in our family. My mother, Audrey Campbell, raised us up as a single parent. She worked very hard to raise her five children. I remain grateful to her. After I matriculated from Wentworth Senior Secondary School, I started work in 1984 for the Department of Health and Welfare, Administration House of Representatives (Ex. Coloured Affairs). In 1995 we amalgamated with the other 3 ex. Houses(House of Assembly, House of Delegates and Natal Provincial Administration) and became the Department of Social Welfare and Population Development. I studied at M.L. Sultan Technikon for 7 years, where I received a National Diploma in Public Administration, a National Higher Diploma in Public Management and Administration and later I completed my pre-requisite to do my Masters Degree in Public Administration at the University of Durban Westville. The pre-requisite was Research Methodology and Techniques. I did not go on to enroll for my Masters but instead I enrolled at the International Bible School for 3 years and received a Diploma in Bible Theology.

On the 1st August 2001, I received the Voluntary Severance Package from the Department. At present I am a full-time Credential Minister in my church, the Assemblies of God Church, Durban South Africa. I preach as an itinerant minister nationally and internationally. On September 11th 2001 I was Overseas in Canada involved in ministry, where I had the privilege of ministering to the Canadian Red

Indians, better known to me as the "Apaches". I was supposed to stay in Canada for one week but my husband encouraged me to stay for 2 weeks which I did. If I had stayed for only one week in Canada I would then have been scheduled to fly to New York on Tuesday morning, 11 September 2001. If I did not listen to my husband, I would have been a victim in that Terror Attack on America. I flew over the World Trade Center in New York exactly one week later after the Terror Attack and was surprised to see that the Twin Towers was still smoking. I was scheduled to minister in Brooklyn but because America was in mourning and my family was very concerned about my safety, I flew on to England to continue my preaching appointments. That is the joys of the ministry. I also went to India and Dubai in September 2002. I visited and ministered in north, south, east and west of India. India was a phenomenal experience and quite a "Culture" shock.

I am the Chairperson for KwaZulu/Natal Women's Fellowship in the Assemblies of God Church. We as the Womens' Fellowship have networked with over 4000 ladies in the Kwa-Zulu Natal region and nationally. We have conducted various workshops, Womens' Conferences, Womens' Breakfasts and Womens' Rallies. I am apart of the KZN Regional Executive and serve as the Vice Chairperson. I have done two shoots for SABC TV1 for the Programme Compass which was transmitted on Wednesday 6 February and Wednesday 13 March 2002 at 17:00. I am an Alumni of the Haggai Institute of South Africa. I will be attending a Leadership Seminar for the Haggai Institute in Hawai from 5 September - 6 September 2003. The Haggai Institute will take care of all expenses. I have a passion for the ministry of God. Amidst the challenges in ministry, I still enjoy what I do as I receive fulfillment when I see men, women, boys and girls walk in their purpose and destiny God intended for them.

1.1 INTRODUCTION

Since the first woman was diagnosed as having HIV in 1981, women have united in the struggle to end the AIDS pandemic. In many countries, women have been responsible for introducing legislation that aims at protecting the human rights of all

persons living with HIV and AIDS.

Through awareness campaigns and grassroots activism, women have become increasingly more empowered to engage in self-advocacy and advocacy on behalf of other. Yet, today, on every continent in the world, women are still more susceptible to HIV and, once infected with the virus, are more likely than men to die from AIDS related illnesses because of their inferior standing in traditional society, which is still a very patriarchal one. Internationally, women are responding by taking head-on the issues that cause and maintain the HIV/AIDS gender gap. This movement is being spear-headed by HIV positive women of colour and is drawing international attention to the effects of excluding women from AIDS related research, the problem of institutionalised sexism, and the need to change the popular male perception of what it means to be a man (see Lucey et al 1999).

1.2 TOPIC AND RATIONALE

The reason for the choice of this topic was because of the growing number of deaths in the church, especially amongst the women who have died due to an AIDS related disease. The tragedy of these deaths were that many of these women had one sexual partner but their partners were not faithful to them.

HIV/AIDS now outranks every other disease as the top killer in Africa. The health and well-being of women everywhere is of great importance in its own right. It is also key to the health and well-being of their families, communities and societies. But every year, over half a million women in developing countries die in pregnancy and childbirth. HIV presents an enormous challenge to safe motherhood. In 1998, it was estimated that approximately two million HIV- positive women worldwide would give birth. In several major towns in Eastern and Southern Africa, more than a quarter of pregnant women are now HIV positive. In South Africa, about one in eight maternal deaths, a directly due to HIV and it is a factor in other maternal deaths, for instance from bleeding. It is estimated that in Africa and Asia, more that two million children each year will lose their mother or both parents to AIDS. These children can be at especially high risk of poverty, neglect and early

death.

When grandparents or older children are left to look after orphans, they often lack the support or resources to meet basic needs. Empowerment is a process and is not, therefore, something that can be given to people. The process of empowerment is both individual and collective, since it is through involvement in groups that people most often begin to take action and bring about change. Women's empowerment can be viewed as a continuum of several interrelated and mutually re-enforcing components.

- Awareness building about women's situation, discrimination and rights and opportunities as a step towards gender equality. Collective awareness building provides a sense of group identity and the power of working as a group.
- Capacity building and skills development, especially the ability to plan, make decisions, organise, manage and carry out activities, to deal with people and institutions in the world around them.
- Participation and great control and decision - making power in the home, community and society.
- Action to bring about greater equality between men and women.

In Sub-Saharan Africa, heterosexual intercourse and mother-to-child transmission continue to account for the vast majority of HIV infections. A recent study from Uganda found that 60% of HIV positive women were married and monogamous. However, sensitivity to the historical stereotyping of the oversexed African male has led to many AIDS activists to shy away from castigating men for the thoughtless male behaviour of some that has contributed greatly to the spread of HIV in Sub-Saharan Africa. Spreading bigotry won't address the problem, and empowering women has proven to be the key in stopping the spread of HIV; yet, the failure of some men to modify their behaviour persists.

In Sub-Saharan Africa, as in the rest of the world, the ability of women to

realise their rights is directly linked with education and economics. In many circumstances, poverty and dire consequences conspire and contribute to women's ability to avoid infection. Yet, in these very same circumstances, men behaviour and to avoid the transmission of HIV. Almost every case of sexually transmitted HIV involves a man. Men still determine in most cases whether sex takes place and whether a condom is used. Much of the focus of the struggle has rightfully been on empowering women to protect themselves. But persuading men with several partners to use condoms and to limit the number of partners will have a greater impact than enabling women to protect themselves from their only partner.

Although the majority of AIDS related policy is made by men, most AIDS workers are women. We need more policies and platforms aimed at mobilising men and at combatting the stereotypes that perpetuate destructive sexual behaviour. Only men have the power to convince other men that being masculinity doesn't just mean having sexual prowess, it also means protecting one's family from danger and taking responsibility for the consequences of one's actions.

Many people consider HIV to be a 'promiscuous woman's disease', along with all sexually transmitted diseases, particularly men who are looking for someone else to blame. In Uganda, the churches are very involved in the campaigns of the AIDS Control Programme. The message of 'Love Faithfully' was devised by them together for people who are and want to be monogamous. For others, they offer a 'Love Carefully' message. Compromises such as this provide a way forward, acknowledging that what people do goes beyond disagreements about what they ought to do. Whatever their views, people of all ages need safer sex education. Creating spaces where both women and men can talk about sexuality and relationships without fear, separately or together - individually, as partners or in groups is crucial. One session is not enough.

People need time to open up, to talk to their partners and their children, and to be able to come back to discuss what happened and get feedback and support. The combined effects of war, economic recession, structural adjustment policies and political crisis in many countries have led to increasing unemployment, and

women are among the worst hit. Not only are jobs disappearing and salaries and wages not keeping up with inflation. in many countries men and women are forced to leave home to seek work. More women, in turn, are having to fend for themselves and their children, or seek other men to support them.

Some women are being forced into selling sex both at home where men have left and at men's work sites. Others are only seeing their partners one or two days a month or even less often, with the problems this bring for the relationship. The migrant labour system that has evolved out of colonialism in Africa is another example of the interplay between sexuality and economics. Interviews with migrant mine-workers in South Africa, for example, showed that frequent and lengthy absences from their relationships cause them to seek sex elsewhere. In a lonely and hostile environment and separated for long periods from their wives, some of the men seek sexual relationships in nearby towns. Long absence subjects marriages to great strain, divorce and abandonment deprive women of economic support. With access to few opportunities on the labour market, some wives turn to selling sex. These miners expressed constant anxiety at being separated from their wives and children.

Longer-term relationships are more likely because the men no longer work on short contracts or return home regularly as they used to. Many stay at the mines for years and renew their contracts annually. They are forced to take a break in service in order to go home. High unemployment makes them easy to replace and they cannot get their jobs back. Hence, their chances of spending time with their wives can be minimal. Yet employers typically deny that there is a risk of HIV and merely give directives to the workers to use condoms. Men who migrate to cities from rural areas or from poorer to richer countries often do not find work. Studies on sexuality and AIDS that take account of such economic issues point out that sexual machismo, 'having' many women, is a common response among poor and unemployed men who have no other way to prove their worth. Migrant women workers may be the least likely to have access to safe sex education or protection from sexual abuse. Women comprise a fairly large percentage of overseas migrant

workers from the Philippines. In jobs such as domestic work, they often have to have sex with the employer in order to stay in employment. Studies in the Philippines have found a higher prevalence of HIV among returning migrant workers than home-based sex workers.

Most migrant labourers are not permitted to reside in the countries and areas where they contribute to the economy and cannot bring their partners and children to live with them. Whole cities and communities are suffering from age and gender imbalances as a result of these restrictions. Sexual relationships and the social structures which maintain them suffer concomitantly. Professional and white-collar workers probably move for their work as often, yet they would never tolerate the living conditions and separations that are forced on migrant labourers and their families. Government policies are needed to improve migrant labour conditions and employment policies, and give workers the right to bring their families with them, as part of AIDS prevention.

HIV/AIDS education should be an integral part of initial and continuing training for health workers and professionals. Unions, pro-workers and professionals. Unions, professional associations or management could start up discussion groups or workshops for staff to confront their own attitudes, fears and misconceptions, clarify their own values and feelings, and consider the effects of these on people in their care. Such groups could also confront any overreaction regarding the need for safety or any refusal to care for patients with HIV/AIDS. Ongoing education programmes for all staff and specific education for areas such as obstetrics, midwifery and abortion are also recommended (see Marge Berer with Sunanda Ray 1993).

A recent survey states that over the next decade, sub-Saharan Africa will remain the region most affected by HIV/AIDS, accounting for nearly half of the deaths caused by this disease worldwide. Life expectancy in South Africa and Nigeria for example, could be reduced by about 20 years by 2010. The health status of the region therefore, has important economic and social consequences. South Africa is perceived as the epicentre of this HIV/AIDS explosion. About one

out of every 10 of South Africa's highly skilled workforce, and about one out of every five workers, are expected to be HIV positive by 2006. We are told that pending the discovery of an effective cure, the disease is a controllable epidemic. But it will only be controllable if all stakeholders, following the excellent example of the KwaZulu-Natal Cabinet and Department of Health, develop a shared vision of what needs to be done to limit the spread of HIV/AIDS and translate it into action.

The CHALLENGE Facing
Kwa-Zulu Natal is like fighting
a WAR Says Premier

The extent of the challenge facing Kwa-Zulu Natal in combatting and managing the effects of AIDS is such that the Premier of Kwa-Zulu Natal, Mr Lionel Mtshali, likened it, when launching the AIDS Challenge 2000 campaign, to fighting a full scale war. He noted that the AIDS epidemic in this Province alone will match and even surpass the tragedy of the holocaust.

"In addition, the losses we face will be amongst the economically active, the people whose age, skills and experience make the most vibrant and valuable part of any economy. This means we will, within 10 years, have a strangely skewed society, with a death of people in the mid age range from 25 to 50, a huge young population and an aged population trying to provide the direction, parenting and care the younger people will need, " Mr Mtshali stated.

Breaking the SILENCE, Removing the STIGMA

"The World Health Organisation calls in the hard-to-break silence, noting that for all the palpable effects of AIDS, a silence born to shame and blame continues to shroud the epidemic in many of even the hardest-hit countries," the Minister of Health Dr Zweli Mkhize said at the Launch of AIDS Challenge 2000.

Silence can continue to reign even when people with HIV are ill and dying. We must all join our leadership and speak out loudly and clearly about AIDS. We

must seek to demystify it and encourage discussion about safe sex everywhere from the classroom to the boardroom.

It is in countries were this has been done - of which Uganda is probably the best known example in the developing world that most progress has been made not just in putting a brake on new infections, but in ensuring the well-being of those people who are already living with the virus.

PLEDGE made by the CABINET of Kwa-Zulu-Natal

That on this 29th day of October 1999, the Premier and the entire Cabinet of Kwa-Zulu-Natal, in a gesture of casting wreaths into the Indian Ocean at Durban, honoured the memory of those who had lost the battle against AIDS and did pledge that this Government of the Province of Kwa-Zulu Natal would hereafter make every effort to create an AIDS free society in Kwa-Zulu Natal within a generation (WHO'S WHO in Health in Kwa-Zulu Natal. KZN AIDS Challenge 2000).

Do I just sit back, minister the Word of God and pray while the entire world is fighting a full scale war against the HIV/AIDS?

1.3 AIMS AND OBJECTIVES

The objective of Chapter Two is to do a literature survey on the introduction, discovery and understanding the HIV/AIDS epidemic.

1.3.1 To increase men's participation in the struggle against HIV/AIDS by confronting stereotypes, involving more men in on-the-ground AIDS work and by dismantling institutionalised bias that helps to maintain the gender gap.

1.3.2 To argue that policy makers must recognise that African women are particularly vulnerable to HIV because of their inferior standing in traditional society, which is still a very patriarchal one and further an understanding of the various socio-

economic and socio-cultural factors ought to inform our response as it is only with knowledge of such factors that appropriate solutions for the epidemic can be sought.

1.3.3 The objective of Chapter Three is to eradicate the myth that "AIDS is a woman's disease".

"In a world where women are more likely to be infected by others than to be a source of infection, men should do more to shoulder the responsibility for AIDS" (see Sharon L. McPherson 1998).

1.3.4 The objective of Chapter Four is to highlight the fact that women are facing a crisis that requires urgent attention. The response to HIV/AIDS must be two-fold : a short-term strategy that needs to, as much as possible, reduce the spread of HIV amongst women and lessen the impact of HIV/AIDS on Women.

1.3.5 Increasing access to information. Both men and women need to be the targets of messages and campaigns that include human rights and sexual issues such as : women and men have equal rights and women can say no to unsafe sex and/or sex.

1.3.6 To increase the awareness of risk to HIV infection amongst wives-monogamous women - whose partners may not be HIV positive and the importance of good sexual and reproductive health.

1.3.7 To enforce the fact that education empowers women. By increasing women's ability to earn an independent income, education increases women's status in the community and leads to greater input into family and community decision-making (see Marilee Karl 1995:10).

1.3.8 The objective of Chapter Five is a question directed to the church that requires a

response. The church is confronted with many challenges and HIV/AIDS is one of them.

1.4 RELEVANCE OF RESEARCH

The leading cause of death in Africa has now become AIDS according to the World Health Organisation. In 1998 AIDS was the cause of death for one in five of all the deaths in Africa. The United Nations estimate that over eleven million people have died of AIDS in Africa. At least half of these people are women. Statistics released by UNAIDS in March 2000 revealed that :-

- 14.8 million women are living with HIV.
- 2.3 million women were newly infected with HIV in 1999.
- 1.1 million women died of AIDS in 1999.
- 55% of adult infections in sub-Saharan Africa are women.

The UNAIDS report showed that in Africa, where the epidemic is predominately spread through sex between men and women, there are more women than there are men living with HIV. This does not suggest that men are not vulnerable, but that women are more vulnerable due to biological, sexual, socio-economic and macro factors. Women have lower incomes, less access to resources and less control over their own bodies and sexuality. Thus, women's vulnerability to HIV is directly linked to their unequal status.

This vulnerability can be defined as a lack of power, opportunity and skills to make and implement decisions that impact on one's life. Personal vulnerability may vary over a person's lifespan. For example, the girl child and young women are more vulnerable to sexual transmission. Young women may lack information about sexuality and AIDS and may not have developed the skills to negotiate safer sex practices.

This does not discount, the vulnerability of older women however, who may be married and are equally in, no position to insist on the use of a condom. Women's vulnerability is also affected by the negative attitudes of health care

workers towards young people, especially young women, requesting condoms (see Abdool Karim 1998:22).

In a patriarchal society the broader issues of gender inequality impact on all aspects of life, including attitudes towards sexuality, religious beliefs, poverty and these issues have the potential to increase or reduce women's vulnerability. Within the realm of individual relationships, women have less power than men. The extent to which they can negotiate safe sex is directly linked to their vulnerability. Mainstream messages about changing sexual behaviour, reducing the number of partners and treating sexually transmitted diseases apply to both men and women. The question is however, whether women as a group have the power to effect these changes and thus protect themselves. UNAIDS (1998) stated that AIDS prevention campaigns so far have failed women by urging prevention methods that women often have little or no power to apply, namely condoms, abstinence and mutual fidelity. This research will have a positive impact on women now and in the future.

1.5 KEY CRITICAL QUESTIONS

The following are the key critical questions that link up with chapters two, three, four and five.

1.5.1 Are women more vulnerable to HIV than men?

1.5.2 Is there a difference between customary law and human rights?

1.5.3 Is there a link between violence against women and HIV transmission, underscoring the role of gender inequality in HIV transmission?

1.5.4 What are the African attitudes to sex and HIV/AIDS?

1.5.5 Why is women's participation so important?

1.5.6 Is HIV/AIDS a punishment from God? Yes or No.

1.5.7 Is HIV/AIDS primarily a "disease of Poverty"?

1.5.8 Would education and information empower the women and lessen the spread of HIV/AIDS?

1.5.9 What is the Churches' Response to the impact of HIV/AIDS?

1.6 APPROACH AND METHODS

Much of the research will be covered by a literature study. This approach will cover questions 1.5.1 to 1.5.9. This is done with special reference to the critical views of Marilee Karl 1995; Whiteside 1998; Agenda 1998; Pillemer et al 1999; Berer 1993; Mitra 1995; Ahmed 1992; Kapur 1993; Dixon 1994; Foreman et al 1992; Orubuloye 1994; Weisfield 1991; and Mann et al 1992. In addition each of the chapters following is introduced with a theoretical and methodological argument concerning procedures followed in that chapter, progressively developing the theory and methodology throughout the dissertation. Each chapter also has a conclusion which provides the base from which the research in the chapter following is further developed.

1.7 CONCLUSION

The objective of this chapter is to plan or design a blueprint of how I intend conducting the research. The next chapter will look at a literature study from other scholars : how they have theorised and conceptualised on issues in the area of modes of transmission of HIV/AIDS.

CHAPTER TWO

AN INTRODUCTION TO HIV/AIDS EPIDEMIC

2.0 INTRODUCTION

The objective of this chapter is to explain what HIV/AIDS is and why it should be considered as a unique disease.

At the start of the new century, South Africa probably had the largest number of HIV-infected people in the world. The only nation that comes close is India with a population of one billion people compared to our figure of 42 million. The tragedy is that this did not have to happen. South Africa was aware of the dangers posed by AIDS as early as 1985. In 1991, the national survey of women attending antenatal clinics found that only 0,8 per cent were infected. In 1994, when the new government took power, the figure was still comparatively low at 7,6 per cent. The 1999 figure is 22,4 per cent (see Whiteside 2000:Introduction).

HIV/AIDS as a major women's issue has only been officially acknowledged by concerned international agencies since a meeting in Paris in November 1989, where it was given adequate public recognition with World AIDS Day on 1st December 1990, and thus it began to receive adequate professional attention at the eighth International Conference on AIDS in Amsterdam in July 1992. Only since the late 1980s have HIV/AIDS research, public education and prevention and care projects focusing on women began to multiply. What was growing slowly and quietly behind the scenes is now developing at a faster and faster pace, and there is much more hope for the future. The human immunodeficiency virus (HIV), sometimes called the 'AIDS virus' was discovered to be the cause of the disease in 1983. The 'AIDS epidemic' refers to the present outbreak of a previously unknown viral disease, where the rate of new infection is increasing rapidly.

A - Acquired

I - Immune

D - Deficiency

S - Syndrome

A 'syndrome' is a collection of different signs and symptoms. (For example, children with Down's Syndrome have a specific collection of signs and symptoms e.g. a small mouth, a wide space between their eyes, a special crease on the palm of the hand and many other signs). With AIDS, there is also a common collection of signs and symptoms which are caused by the weakness in the immune system. The signs and symptoms of HIV/AIDS will be discussed later in this chapter (see Pronyk 2000:2).

2.1 UNDERSTANDING HIV TRANSMISSION

AIDS (Acquired Immune Deficiency Syndrome) is caused by the Human Immunodeficiency Virus (HIV). In order for the virus to attack a person's immune system, it has to enter the bloodstream and there are three ways in which this may occur:

1. Through sexual intercourse - this includes both heterosexual and homosexual intercourse, although most infections in the developing world are transmitted heterosexually.

2. Directly into the bloodstream through use of a contaminated blood or blood products, or sharing of intravenous drug-injecting equipment.

3. From mother to child - it is estimated that about one third of infants born to infected mothers will be infected. This may occur prior to birth across the placenta, during birth, or via breast milk.

The possible responses to the epidemic are well documented. Risk of sexual

transmission can be reduced by use of condoms and/or cutting down on numbers of partners and treating other sexually transmitted infections. Blood and blood products can be made safer through screening of donors and their blood. Drug users can be encouraged to sterilise or exchange needles. Work on developing means of reducing mother to child infection is underway. One of the crucial points that has to be made about the HIV/AIDS epidemic is that it is different from most other epidemics and diseases, and consequently requires a different and much broader response - one which must encompass far more than the health sector. It is a new epidemic. AIDS was first recognised as a specific condition only in 1981 and it was not until 1984 that the cause (and a test to detect it) was identified (also see Mitra 1995:23).

The factors that make it unique are:

- It has a long incubation period. Persons who are infected by the virus may have many years of productive normal life.
- Although they can infect others during this period. It is not certain how long this latent period is; estimates range from five to fifteen years, with the shorter period being found in the developing world, where people are less healthy and well nourished. It is known that good health and nutrition, and early treatment of opportunistic infections, will extend the period of healthy and productive life. Unfortunately infected children will, for the most part, die before their fifth birthdays.
- The prognosis for people infected with HIV is bleak. At the end of the incubation period, a person will usually experience periods of sickness increasing in severity, duration and frequency, until he/she dies.
- The disease is found mainly in two specific age groups: children under five, and adults aged between 20-40 years. For various reasons, there seems, in the developing world, to be slightly more females than males infected, and women develop the disease at a younger age.
- The scale of the epidemic is also different from most other diseases. This

means that between 20-25 per cent of sexually active adults may be infected.

- HIV is mainly sexually transmitted, which means it is passed on through one of the most fundamental human activities, but one with which we are neither open nor comfortable.
- There are links between HIV and other diseases, most notably tuberculosis, which has further implications for public health.
- In general, the epidemic is still spreading in the developing world, although there are signs that the level of infection may have peaked in some areas. (Considering HIV/AIDS in Development Assistance- A Toolkit-Commission of the European Communities).

The Discovery of AIDS and HIV

In 1979 and 1980, doctors in the United States began to observe clusters of diseases which previously had been extremely rare. These included a type of pneumonia spread by birds (pneumocystis carinii) and a cancer called Karposi's sarcoma. The first public record of the phenomenon was contained in the Morbidity and Mortality Weekly Report (MMWR) of 5 June 1981, a widely circulated report on infectious diseases and deaths produced by the Centers of Disease Control in the USA. The MMWR recorded five cases of pneumocystis carinii. Later, on 3rd July, the MMWR reported a clustering of cases of Karposi's sarcoma in New York. Subsequently, the number of cases of both diseases - which were mainly centred around New York and San Fransisco - rose rapidly, and scientists realised that they were dealing with a new phenomenon. Initially, most cases were seen in homosexual men. Soon, however, there was evidence of cases among hemophiliacs and recipients of blood transfusions. The disease came to be called the Acquired Immunodeficiency Syndrome, shortened to the acronym of AIDS. The name needs some explanation:

The 'A' stands for Acquired. This means that the virus is not spread through casual or inadvertent contact like flu or chickenpox. In order to be infected, a

person has to do something (or have something done to them) which exposes them to the virus.

'I' and 'D' stand for Immunodeficiency. The virus attacks a person's immune system and makes it less capable of fighting infections. Thus, the immune system becomes deficient.

'S' is for Syndrome. AIDS is not just one disease but it presents itself as a number of diseases that come about as the immune system fails. Hence, it is regarded as a syndrome (see Snidle 2001:27 and Badri 1997:1).

Once the new syndrome had been identified, a flurry of scientific and epidemiological activity followed. By 1983 the virus that caused AIDS was identified by a French scientist, Luc Montagnier. Shortly thereafter, Robert Gallo, an American, also discovered the virus. It was named the Human Immunodeficiency Virus or HIV. (1) The reason it was so hard to locate is that HIV is a retro virus, meaning that it is one of the first known viruses to transcribe DNA from an RNA template. (2) In order to exist, the virus has to enter a cell and insert itself into the cell's DNA to reproduce itself. These might be compared to footprints on a sandy beach: they show that a person has been there even though that person has been (and, in the case of HIV, is) infected. Even today, most of the screening and diagnostic tests carried out are based on the discovery of the antibodies rather that the virus itself.

In 1985, a second immunodeficiency virus labeled HIV-2 was identified in humans. HIV-2 is a slower-acting virus, which appears to be found mainly in West Africa. Nevertheless, it is now slowly diffusing into other parts of the world. Insofar as HIV - 1 is concerned, nine different subtypes have been discovered so far in various locations, and we are seeing an increasing spread of each variety. In southern Africa, the dominant strain is HIV - 1 and, henceforth in this dissertation, we shall refer to it as HIV.

People are said to be HIV positive when the HIV antibodies are detected in their blood. It is more difficult to define AIDS. In areas where CD4 (white blood cells, helper T cells) counts and viral loads can be measured, people are regarded

as having AIDS when their CD4 count falls below 200. In most settings, however, the capability to carry out such sophisticated tests does not exist. So AIDS is then defined clinically, i.e. by examining the patient and making an assessment of his or her condition. There are a number of opportunistic infections that take particular advantage of a depleted immune system, some of which are fairly unique to HIV infection. Unfortunately, TB is one disease which is increasingly seen in HIV - positive people. Complicating matters further, the new advanced drug therapies make it possible for people to move back from a state of AIDS, when they are very sick, to being HIV positive and leading normal lives again (see Whiteside 2000:1,2).

Some countries and communities are more vulnerable to HIV infection than others. Of the approximately 40 million HIV infections worldwide (1998), about 90 per cent occur in poor (developing) countries. Of these countries, the hardest hit areas are in Sub-Saharan Africa, where nearly ⅔ of the infections worldwide have occurred. It is unclear where the virus originally came from, but there is evidence that it may have existed for decades before actually being identified. What is clear is that broad socio-economic, cultural and historical pressures from the 1970's onwards have resulted in rapid HIV transmission. In Europe and North America, some of these pressures include:

- New technologies such as blood and blood product transfusion, especially in patients with blood diseases such as hemophilia, contributed to high rates of transmission.
- Changes in social behaviour such as the growing use of intravenous street drugs.
- A liberalization in sexual practices, also resulted in high rates of new infection.
- Poverty plays a major role in transmission also. Minority groups and the poor have especially high rates of infections in these countries.

In many developing countries, this period of history is associated with major changes in the way individuals, families and communities live, putting them at high risk if HIV infection as follows:

- Economic changes result in high levels of people leaving their homes and families in search of work. This system of migrant labour contributes to high-risk sexual behaviour and multiple partners, and harms the traditional stability of family and community life.
- The growing influence of new ideas and attitudes, often linked to the media, television, movies and advertisers, significantly shapes social expectations and behavior, especially in young people.
- The status of women in many countries remains low, and places limits on women's opportunities, decision making and ability to negotiate for safe sex with their partners.
- War, low-level conflict, and the displacement of people within their own countries or as refugees to other countries puts large groups of people at risk of infection.
- Finally, growing poverty and inequality both between countries and within countries serves to create new conditions of vulnerability to HIV transmission.

In many sub-Saharan African countries, up to one in four sexually active adults are known to be HIV positive. Most statistics on the level of HIV infection in a community come from information collected in women who attend ante-natal clinics during pregnancy. In this group, routine blood samples are generally taken to ensure healthy pregnancy. Small amounts if these samples are coded and tested for HIV infection anonymously. This means that the person doing the HIV test has no knowledge of where the blood specimen comes from, and the results are not reported to the patient. Patients who request an HIV test and wish to know the results are generally required to go through a process of pre and post-test counseling.

South Africa is among the countries experiencing the greatest increase in HIV infection in the world. Surveys from antenatal clinic attenders in 1998 indicate that 22.8% of women tested positive. There was some variation between regions, with provinces such as Kwa-Zulu Natal having rates of infection almost twice as high as provinces such as Northern Province or Western Cape. In the absence of strong measures to control transmission, the epidemic will likely peak and stabilize at levels of infection between 25 and 30% nationally, and then decline by 10-20% as people begin to die of HIV/AIDS and its complications. Before AIDS, the average life expectancy in South Africa by the year 2010 would have been 68 years. However, the impact of HIV/AIDS has shortened this by 2 decades, with the average life expectancy approaching only 48 years by 2010 (see Pronyk 2000:2-4 and Martin et al 1992:3).

2.1.1 THE HIV VIRUS AND HOW IT AFFECTS THE BODY

The type of cell affected by the HIV virus is called a lymphocyte. This is a type of white blood cell and is a very important part of the body's immune system - the collection of cells and organs in the body responsible for fighting disease. The virus infects a lymphocyte and multiplies inside of it. The cell is eventually destroyed and many new copies of the virus are released, which go on to infect other lymphocytes.

The particular type of lymphocyte damaged in HIV disease is called the CD4 lymphocyte, also known as a T-helper cell. Many doctors and hospitals test the number of CD4 cells as a way of seeing how advanced a patient's HIV disease is. Lower levels of CD4 cells suggest that there has been significant damage to the patient's immune system (see Pronyk 2000:6).

In order for infection to occur, the virus has to enter the body and attach itself to host cells. HIV attacks a particular set of cells in the human immune system known as CD4 cells, which organise the body's overall immune response to foreign bodies and infections. These T-helper cells are the prime target of HIV. HIV also attacks immune cells called macrophages which engulf foreign invaders and ensure that the body's immune system will recognise such invaders in future. In order for

a person to become infected, the virus particles (called viraemia when they are in the bloodstream) have to enter the body and attach themselves to the CD4 cells and microphages.

Once the virus has attached itself to the cell's surface (like the docking of a space module), it penetrates the wall. Thereafter, it is safe from the body's immune system and cannot be destroyed by the body's defense mechanisms. Inside the cell, it copies its RNA into DNA in order for the door into the cell's nucleus to be opened. There the copied DNA integrates easily into the company of the host's genes and by manipulating the proceedings of the nucleus causes the cell to churn out new HIV viral proteins. These are re-assembled into viruses which break out of the cell. In the process, the cell is destroyed and the viraemia go on to infect more CD4 cells. Thus, the immune systems of infected people are gradually weakened until they fall prey to a host of diseases which they would normally fight off.

MYTH

HIV-infected individuals who show no signs of illness will not infect their partners.

REALITY

People who are HIV positive must be assumed to be infectious at all times. However, immediately after they are infected, and later, as they begin to fall ill, they are more infectious than usual because their viral load is higher.

During the early stages of infection, the antibodies to the virus (what we usually test for) may not be identifiable. This is called the 'window period'. An infected person will be very infectious during this phase. Equally, at this time a person may experience a short bout of illness. The cause is a rapid multiplication of the virus and a correspondingly rapid response from the body. A battle commences between the virus and the immune system, described as the incubation period. During this stage, the viruses and the cells which they attack are reproducing rapidly and being

destroyed as quickly by each other. Eventually, the virus is able to destroy the immune cells more quickly than they can be replaced and slowly the number of CD4 cells falls. As the infection progresses, the number will fall to about 200 or less. At this point, new opportunistic infections begin to occur and a person is said to have AIDS. The infections will increase in frequency, severity and duration until the person dies. It is therefore the opportunistic infections that cause the syndrome referred to as AIDS (see Whiteside 2000:7-8).

The period from HIV infection to illness and death is crucial. It is generally believed that, in the West, people will live for at least 10 years before they begin to fall ill. Without treatment, the normal period from the onset of AIDS to death was a further 12 to 24 months. Now with the development of effective antiretroviral therapies, they can expect to live a reasonable life for a longer time. Indeed, it is hoped that AIDS can be turned into a manageable, chronic disease like diabetes. In this event, people could expect to live a normal life span though they would remain infectious. The incubation period in Africa has been estimated to be between six and eight years. The reason for shorter incubation than in the West is that, given the number of diseases in Africa, people have more challenges to their immune systems and are more vulnerable to opportunistic infection. Hence, their health deteriorates more rapidly. In addition, the period from the onset of AIDS to death is shorter - probably one year or less. The difference between Africa and the West, but also between the rich and the poor, comes down to one basic fact - people who are able to eat enough nutritious food, lead stress-free lives, and are not exposed to multiple infections will stay healthy longer.

Modes of Infection

Fortunately for mankind, HIV is not a very strong virus. Every disease has a reproduction number (Ro) which is the number of other people each infected person would normally infect. In the case of HIV, Ro is around five, i.e. each HIV - positive person is likely to infect five others during his or her lifetime. The Ro for malaria, by comparison, is 100, which is the reason why it can spread so explosively. The

challenge is to reduce the Ro of HIV so that the disease goes into decline. HIV is also hard to transmit. In order for a person to be infected, the virus has to enter the body in sufficient quantities. It must pass through an entry point in the skin and/or mucous membranes into the bloodstream. The main modes of transmission, in order of importance, are:

- Unsafe sex;
- Transmission from infected mother to child;
- Intravenous drug use with contaminated needles;
- Use of infected blood or blood products; and
- Other modes of transmission involving blood including bodily contact involving open bleeding wounds (see Whiteside 2000:9-10).

The major mechanism for HIV transmission in most developing countries is from person to person through sexual intercourse. The virus is found in high quantities in the sexual fluids (semen or vaginal fluid) of people with HIV infection. Although the virus can be found in other body fluids, such as saliva, urine and sweat, the quantities of HIV in these fluids is not sufficient for transmission (see Pronyk 2000:7). HIV infection has not been reported to have been acquired via a healthy mouth or respiratory tract. It also cannot be transmitted through undamaged skin. Individuals who have not engaged in sexual intercourse or received or shared blood (or blood products) have not acquired HIV infection. Children remain free of HIV infection even after intimate contact (hugging, kissing) with their infected parents, and after sharing common utensils, baths, linen, etc.

It has become clear that other genital ulcers or sores, where the mucosa is broken or damaged, assist in the HIV virus in entering the body. Untreated sexually transmitted infections (STIs) such as syphilis, chancroid, or herpes virus infection place individuals at much higher risk of being infected with HIV during intercourse. STIs that cause genital discharge, such as gonorrhea or chlamydia, also irritate the mucosal surfaces and more easily allow the HIV virus to enter. This is a major

problem in women, who often remain asymptomatic with their STIs.

The presence of other sexually transmitted infections (syphilis, chancroid, gonorrhea, etc) makes the sexual transmission of HIV easier.

Anal or Vaginal Intercourse

Anal sex appears to be the sexual practice carrying the highest risk for transmitting the HIV virus. The lining of the anorectal area is relatively easily torn during anal intercourse. This allows the virus to enter the body more easily. Vaginal sex is also an effective form of transmission. Vaginal and anal sex is safer if a condom is correctly used. It is not yet certain whether anyone has developed HIV infection through oral sex alone. Non-penetrative sex, such as sex that involves the thighs or masturbation, is considered safe (see O'Leary 1995:69-70).

HIV and Blood Transmission

Infection can also occur if HIV-infected blood gains entry into the body. For infection to occur, the blood from an HIV-infected person must bypass the barrier of the skin and enter directly into the body. This means that HIV-infected blood becomes a high risk when passed into the body in the following ways:

- Through a transfusion of blood products
- Via blood-contaminated needles, syringes, razor blades and other sharp instruments
- Through intravenous drug use (sharing of needles and syringes)
- It is also possible, but very rare, for HIV to enter the body through an open skin wound or sore.

Health care workers should be aware of and using 'universal precautions' when handling blood or sharp instruments. By universal, it means appropriate measures

should be taken for all patients, whether they are known to have HIV infection or not.

Mother to Child HIV Transmission

A pregnant mother, who infected with HIV, can pass on the virus to her infant during pregnancy and childbirth. Research has shown that in developing countries, there is a 25%-45% chance that the infant will become HIV infected. This means, that if a mother is HIV positive, there is approximately a 1 in 3 chance that her infant will be born with HIV infection. It appears that a woman is more likely to transmit the virus to her foetus during pregnancy if:

- She becomes infected just before the pregnancy (in the first 12 weeks) or during the pregnancy.
- She has symptomatic HIV disease or a low CD4 count.
- A woman who has prolonged rupture of membranes or who undergoes invasive obstetric procedures.

This means that a symptomatic mother is more likely to pass on the virus than a mother who has no symptoms of HIV disease. There are several medications that are becoming available in resource poor settings that can be administered to mother and child around the time of delivery, that have been scientifically proven to reduce perinatal transmission. Depending on the medication used and the duration of therapy, it is estimated that between ½ and ⅔ of these infections during child birth can be prevented. It is likely that these drugs will become used more widely in the near future, with prenatal HIV testing been advocated with the mother's consent as a routine and important part of prenatal care.

Breast Feeding

The virus can also be found in breast milk. Previously, it was felt that the number

of infants getting infected from their mother's milk was very low. However, recent studies have shown that up to 30% of all mother-to-child infections may occur in relation to breast feeding. Making recommendations about breast feeding in HIV positive mothers is difficult. In many resource poor environments, diarrhoeal disease and malnutrition are among the most common causes of death in infants, both of which are much more common in bottle-fed infants. In many areas, women still must walk long distances to gather water and wood for basic needs. As proper bottle feeding requires the milk and bottles to be sterile for feeds several times a day, recommending bottle feeds may prove expensive, time-consuming and dangerous to infants.

There is recent scientific evidence suggesting the HIV positive women who exclusively breast feed' - give their babies breast milk and nothing else - for the first 3 months of life, are at no increased risk of transmitting the virus to their babies. Health workers should be aware of these controversies, encourage HIV testing for pregnant women who don't know their status, and understand the living conditions of people living in their local area in order to give the best possible advice to their patients. The current recommendations (WHO, UNAIDS and UNICEF 1998) are that HIV positive mothers should not breast feed if they can safely use appropriate alternative infant-feeding methods. Breast feeding is recommended for HIV positive women who do not have access to appropriate alternative infant-feeding methods. Casual contact does not appear to spread HIV. There is no evidence that HIV is spread through normal everyday casual contact between individuals.

- HIV virus is not stable and does not survive outside the human body.
- The virus cannot penetrate normal intact skin and does not readily enter through a healthy mouth or eye.
- Also the virus is not present in high enough quantities in the saliva and urine to cause infection.

HIV cannot normally be Transmitted by the following means:

- Airborne routes, such as coughing, sneezing, laughing, talking and kissing.
- Simple skin contact, such as shaking hands, hugging and touching, etc.
- Through food, water or on plates, cups, spoons, toilets, baths, pools and showers, etc.
- Towels, bed linen, clothes, etc.
- Insects, such as mosquitoes, are not known to spread HIV from one person to another (see Pronyk 2000:7-10).

Sexual Transmission

The vast majority of HIV infections are the result of sexual transmission. Initially in South Africa most cases were discovered among homosexual men. This was because HIV first occurred in this group in the West. Moreover, the chances of infection are higher during anal intercourse than vaginal sex. There is a small chance that HIV can be transmitted through oral sex, especially if a person has abrasions in the mouth or gum disease such as gingivitis (see Whiteside 2000:10 and Jackson 1988:46).

MYTH

AIDS can be got through touching and kissing, being close to an infected person and sharing facilities.

REALITY

Blood, semen, vaginal secretions or breast milk have to be involved. The chances of infection from blood spilt in the absence of contact with another person's open wound are minimal. The virus can only survive for a short period outside the human body. However, common sense dictates that contact with blood should be avoided, and people giving first aid should use protective gloves because other blood borne diseases are more easily transmitted.

The presence of sexually transmitted infections (STIs), particularly ulcers or discharges, will greatly increase the odds of HIV infection. An STI means that there is more chance of the skin or membranes being broken, thus allowing the virus to enter the body. Furthermore, the very same cells that the virus is seeking to infect will be concentrated at the site of the STI because these cells are fighting the STI infection.

MYTH

Sexual intercourse with an HIV-infected person will definitely result in infection.

REALITY

HIV is a fragile virus and the chance of infection will depend on a range of factors. However, for normal healthy people, it is quite low. Women are at greater risk than men.

MYTH

A child born to an infected mother will be HIV positive.

REALITY

The chance of MTCT is about 30 per cent and can be greatly reduced with appropriate interventions.

MYTH

Antiretroviral drugs are too toxic to be given to mothers and babies.

REALITY

Obviously, if you do not believe HIV exists, you can argue that no antiretroviral drugs should be given to patients because they are unnecessary as well as being toxic. However, if you do believe the virus exists, then antiretroviral drugs should be viewed in the same light as cancer drugs where their toxicity is weighed against the downside of not using them.

MYTH

Babies should not be saved from catching the virus because it adds to the subsequent orphan problem.

REALITY

Every life should be saved where possible. Bringing down the cost of treatment to stop MTCT is therefore a major priority (see Whiteside 2000:11-13).

Most people with HIV have no idea when they became infected. Many get no sign whatsoever. Some get symptoms that last for a few days or weeks after infection. The most commonly reported are fever, swollen glands, sore throat, skin rash and aches. These almost always disappear, though swollen glands may persist. Because these are common symptoms of colds, flu and other illness, people usually do not realize what has happened. Nor can people find out that they have been infected immediately, even if they are tested. The HIV test that is currently used measures antibodies to HIV in the blood, which indicate the presence of HIV infection. It takes from about two to six months, and sometimes longer, for the blood to produce enough antibodies to HIV for a blood test to detect them. This is called the æwindow period'. A person with HIV can transmit it to others during this period, even though an antibody test may be negative. Hence, protection from infection is important for everyone (see Berer 1993:7-9).

What happens after HIV is in the Bloodstream?

From the bloodstream, HIV travels to other parts of the body. HIV has been isolated in cells in the gastro-intestinal tract, kidney, lungs, bone marrow, certain brain cells, adrenal glands, eyes, heart, joints, liver, skin, and thymus. However, HIV does not necessarily enter all possible tissues. This may explain why some people get certain HIV-related illnesses and others get different ones, and why women and men do not always get the same ones. In men, HIV has been isolated

in the prostate and testes. It is found in varying amounts in the semen of infected men, in some cases at much greater concentrations than is usually found in blood. HIV has also been detected on sperm cells, where it may be able to replicate. There is strong evidence that sperm may contribute to replication of HIV in the lining of the female reproductive tract, especially in the presence of inflammation.

In women, HIV has been isolated in cervical tissue, cervical and vaginal mucus, in the lining of the vagina, in menstrual blood, and in the placenta of pregnant women. In the small numbers of women who have been studies, HIV was only sometimes found in these sites, in small quantities, and not in all the women. The higher the amount of HIV in the semen or vagina of a person who is infected, the more likely it may be that they can transmit the virus sexually. Although HIV has sometimes been isolated in very low quantities in other body fluids, only blood, sperm/semen and vaginal mucus are considered generally infectious in everyone who has HIV.

How can HIV cause Illness?

HIV is a slow-acting virus. Low levels of HIV may remain quietly in the body for years and appear to cause few or no problems. Over time, other organisms that can cause illness will get into the bloodstream, and the immune system is activated. T4 cells are also activated, and those containing HIV produce more HIV. New HIV virus can then enter more T4 cells. This is why maintaining health and getting early treatment for any illness is important for people with HIV.

The more the immune system is activated to fight infections or disease, the more HIV replicates. HIV also slowly seems to prevent the blood from producing new T4 cells. It is not clear whether HIV directly destroys the immune system or provokes the immune system into self-destruction. As fewer healthy T4 cells remain to fight infection, a cycle of HIV related illness begins. Certain potentially fatal organisms, which would normally be controlled by the immune system, are able to cause illness. These infections are called 'opportunistic' because the failing immune system gives them the opportunity to take over.

Does everyone with HIV become Ill or Die?

Some people have had HIV for more than twelve years with no sign of illness. Their bodies may have developed effective self-protective factors, and they may never become ill. Researchers may be able to learn from them how to prevent everyone from becoming ill from HIV. The majority of people with HIV do get HIV-related illnesses, and these can occur irregularly over many months or years. Minor symptoms and illnesses are more likely to appear first, but some people get a serious illness as their first sign of HIV infection. Some people get more that one serious illness, and their health can decline quickly.

Unfortunately, all the signs suggest that the longer a person is infected, even if they feel well, the more likely they are to lose immune function, become seriously ill and die. Different patterns of wellness and illness may occur because certain strains of HIV are more virulent than others, and the virus may also become more or less virulent over a period of time in the same period. Overall state of health can also make a major difference. Treatment can prolong both life and health substantially. Improvements in treatment and care, where available, are making HIV infection a chronic disease that can be controlled for increasing periods of time (see Berer 1993:7-9).

2.1.2 HIV COUNSELING AND TESTING

Our body develops antibodies to most infections. Once a person is infected with the HIV virus, the body's immune system responds to the infection by producing HIV antibodies. Normally, the level of antibodies gradually increases in the first few weeks following infection (see Pronyk 2000:11). An HIV test measures this antibody response - it does not test for the virus itself. It becomes positive once the level of antibodies produced becomes high enough to be detected. Normally, this is in the first 4-12 weeks after infection.

The majority of women in sub-Saharan Africa do not know their HIV status. But if they are to make appropriate choices about how to prevent their children from

becoming infected, they need to have access to affordable confidential and voluntary counseling and testing. Counseling and testing should be offered to both woman and her partner. Both parents are responsible for preventing HIV transmission to their children, not just the mother. Women, however, should never be pressured to include their partner in counseling and testing if they do not wish it.

Counseling

HIV counseling is a confidential and supportive dialogue between a person and a trained counselor. It should focus on both the physical and emotional well being of the person, and help them to make the decisions that are right for them. Counseling is not the same as giving advice or telling people what they should do. The counselor's role is to listen to the individual concerns, raise issues that need to be considered, and provide information, emotional support and appropriate referral. Counselors should avoid judging the person or their partner.

Counseling must be confidential - the person must be confident that the counselor will not talk to anybody else about what they have discussed together. But this does not mean that counseling must only be between one individual and the counselor. It may sometimes be better to counsel people together with their sexual partner. In societies where decisions about health and welfare are taken by the family, shared counseling with other family members can be helpful. Confidentiality is just as important in this situation.

The counselor may be a health worker such as a midwife or a nurse, or may be a layperson. Peer counselors - such as people who are themselves HIV positive - can be very valuable and health workers should welcome their help and involvement. Whoever takes on this role needs to be specially trained and to be a good listener. Counseling should be more about listening than about talking (see Rosser 2000:6 and Collins 1990:91-92).

Pre-test Counseling

Anyone thinking about having an HIV test should always have pre-test counseling.This is not only to ensure that the man or woman give their informed consent to the test, but so that they have the chance to consider the impact that a positive result will have on their life and the life of their family. If, after counseling, the person decides not to have a test, the counselor has no reason to pressurise them. The following guidelines may be helpful:

- Be in a private area for counseling, where you will not be disturbed or overheard.
- Assure the person that everything said is confidential and that you will not talk to anyone else about it. (You could have a poster on your wall making this clear and showing your commitment).
- Talk through the reasons for HIV testing - theirs and yours. Look at both benefits and the disadvantages.
- Remember that they may not know about their partner's risk Ask questions in a sensitive way to find out about current and previous risk behaviour.
- Offer information about HIV and AIDS.
- Offer information about the HIV antibody test, including information about the 'window period' of infection (this is the time between becoming infected and a blood test showing positive results).
- Go through the implications of a positive test result for the person and their family.
- Discuss the person's possible responses to a positive test result. They can think about who they would tell and where they might get support.
- Be aware of what the person's concerns are and let these guide the discussion. For example, if a woman is being counseled and already has children, her major concern may be what will happen to them if she is HIV positive.
- Go through the implications of a negative test result.

- Provide information about how the test is done, how long before the results will be ready, and how they should find out the results.
- Give enough time for them to think about whether or not they want to have the test.
- If they decide to have the test, obtain informed consent.

Post-test Counseling

Counseling after an HIV test is essential, whether or not the result is positive. Always meet with the person to give the result as soon as possible after the test.

If the result is Negative

- Deal with the feelings arising from a negative result and explain about the 'window period'.
- Discuss ways to prevent HIV infection through safer sex and the importance of remaining negative for the rest of the pregnancy, during breast-feeding, and afterwards.

If the result is Positive

- Tell the person as clearly and gently as possible. Deal with their immediate feelings and explain the need for a supplementary test to confirm the result.
- Give them time to understand and discuss the result.
- Provide information in a way that they can understand, give emotional support and help them to discuss how they will cope.
- Discuss how the person plans to spend the next few hours and days. Identify what support they have.
- Discuss who they want to tell about the result. Find out if they intend to tell their partner, help them to decide whether or not to tell them and, if appropriate, how to tell them.

- Go through the ways they can take care of their own health and let them know about any available treatment.
- For a pregnant woman, to through the ways to reduce the risk of transmitting HIV to her baby during pregnancy, labour and after the birth.
- Discuss how she will feed the baby and the importance, if she breast-feed, of exclusive breast-feeding.
- Identify what difficulties or problems the person foresees and discuss how to deal with them
- Encourage them to ask questions.
- Refer the person, where possible, to a community support organisation and for follow-up care and counseling.
- Encourage them to return for another session when they have had time to take in some of the information they have just heard. If appropriate, some information could be written down as the person is unlikely to be able to remember everything that was said (see Rosser 2000:6-7).

Testing for HIV

What is an HIV Test?

Testing is done on a blood sample. Most tests look for antibodies to the virus in the blood. Antibodies are produced by the body as it tries to fight the HIV virus. If no antibodies are found, the person is antibody negative (also called seronegative or HIV negative). If antibodies are found, the person is antibody positive (also called seropositive or HIV positive).The test result may be negative if the person has been infected only recently. It can take up to three months from the time of infection for antibodies to be produced. This is known as thee window period.

Anyone who might have become infected in the last three months should take a second test three months after the first test. Until recently, the most commonly used antibody test was the ELISA (enzyme-linked immunosorbent assay). ELISA testing needs skilled technical staff, equipment in good order, and

a steady power supply (see Rosser 2000:7).

The ELISA Test

The ELISA test is the most commonly used screening test for HIV infection. It is very sensitive at detecting the HIV antibody. If this test is negative, you definitely do not have HIV, or are in the window period. However, in some cases, the ELISA may be too sensitive, and detect antibodies when there really are none. This is known as a false positive result. Because of this, most countries use a confirmatory test after a positive ELISA test.

Confirmatory Testing

Confirmatory testing is done after a positive ELISA. There are a few different types of confirmatory tests available for HIV. The one most commonly used is called the Western Blot test. In general, they are more expensive and more specific. This means that if you test positive with the confirmatory test, the result is truly positive and you have definitely been infected with the HIV virus.

Rapid HIV Testing

There have recently become available several forms of rapid HIV test. These are tests that come in simple kits, require minimal training, and produce results that are available in minutes. Specimen collection range from blood, to finger prick samples, to saliva or urine. The tests are generally highly accurate, and are becoming available commercially in pharmacies as home testing kits.

Such forms of HIV testing may prove very useful in the primary care setting. All routine HV testing requires the patient follow-up in 1-2 weeks to receive their test result and go through the post test counseling. The costs of transport, child care, time off work, or long waiting queues may discourage some patients from returning for their test results. In these situations, rapid testing would be a good alternative for many patients. While useful in the primary care setting, most health workers

involved in the care of HIV patients discourage home testing with rapid testing kits. HIV remains a diagnosis that is often poorly understood by patients. Pre and post test counseling and support is felt to be a necessary part of the process in helping a patient to cope with the stress of testing - whether the results are negative or positive (see Pronyk 2000:12).

Deciding whether to be Tested

Most women living in the developing world do not have a choice about whether to be tested for HIV, because the test is not available to them. It is thought that only one in twenty women in the developing world have been tested and know their status.

For those women who do have a choice, deciding whether to have a test should be done very carefully. The health worker should not try to persuade the woman to have the test - it should be a decision which she takes freely. Because of the fear and misunderstanding that surrounds HIV and AIDS, there is a lot of stigma towards HIV-positive people. There are benefits and risks of testing, and these will vary for each woman. Some of the possible benefits of a pregnant woman knowing she is HIV positive are that she can:

- take the measures available to her to keep herself healthy for as long as possible decide;
- in countries where abortion is available, whether to continue the pregnancy
- take appropriate steps to reduce the risk of transmitting HIV to her baby tell her sexual partner(s) that she is HIV positive, so that they can be tested too.

Some of the possible risks of knowing that she is HIV positive are:

- her family may blame her for bringing HIV into the family and may react violently or make her leave her home;

- she may be stigmatised and looked down on by her neighbours and by health workers (if her HIV status is known about);
- she may become anxious and depressed.

Even where HIV tests are available to all pregnant women, many choose not to have the test. And after having the test done, some women will not return to find out the result.

Being Tested Without Consent

In some places, women find out they are HIV positive through routine testing during antenatal visits, without having been given adequate pre-test counseling and without their consent. This should be avoided if at all possible, but if a health worker is meeting a woman for the first time after she has already been tested, she will need a particularly sensitive approach when being told her results.

Testing Babies

When babies are born they have their mother's antibodies in their blood. So if their mother is HIV positive, the baby's blood will often be positive too, until the baby is about 18 months old. If they do not have the virus, the mother's antibodies go away by this time. So antibody tests cannot tell if babes are themselves infected with HIV until the age of about 18 months. If an earlier test is negative, however, it does mean that the child is not infected. There are tests which can give an accurate result earlier (such as PCR tests) but these are expensive and not usually available in developing countries.

Where to be Tested?

Counseling and testing can be offered as part of an antenatal service or as a separate service. There are advantages in both types. Using the antenatal services may be more convenient for women and so increase the uptake of testing.

But in a separate service there will often be links to ongoing support services for people living with HIV and AIDS. This will mean that continuing care for HIV-positive women may be available. If a woman is tested elsewhere and is found to be positive she should be encouraged to share the information with the antenatal services in order to ensure that she is given appropriate care and advice (see Whiteside1998: 11,12 and Rosser 2000: 6-8).

Testing

This is cheaper and easier to use than other screening methods. It tests for antibodies that are found in serum which has been separated from red blood cells. The serum is placed in a well containing a plastic bead coated with HIV proteins. If the test is positive, the bead will change colour. If the testing is being done for data collection and a diagnosis is not going to be given to the patient, then the ELISA test is sufficient, If, however, the testing is being done for diagnosis, and the test is positive, then it is usual for a second ELISA test to be carried out. If this is positive, then a more sophisticated test known as the Western Blot Test is usually performed. In this test, which is more expensive and complicated, the HIV proteins are laid out on a strip of film, the serum added with an enzyme, and the results read off. A new form of test has been developed, which is noninvasive as it uses saliva. The tests is cheap and easy to use, but is not accurate enough to provide diagnosis. However, it is very useful to measure HIV prevalence, especially in populations who are not prepared to give blood.

All the tests have an accuracy of over 99 per cent. They produce very few false negatives (people who are in fact HIV positive but show up as negative in the test); and even fewer false positives (people who are negative but show up positive). Of course, people who are in the window period and have not yet developed antibodies will not test positive. This is the reason why a series of tests some months apart will be recommended for people who think they have been exposed to HIV. It is estimated that the window period can last up to six months.

MYTH

HIV tests are not accurate

REALITY

They are extremely accurate but for the window period when people have not yet developed antibodies and will therefore test false negative (Whiteside 2000: 16,17).

Individual Rights and Testing

People should always have the right to decide whether to be tested individually and told the results of their tests. In places where HIV is not prevalent in women, it is not unusual for women to be told they do not need a test. Some women have found they cannot get tested even when they are sure they need it. In many developed countries, consent is required. In practice, this is not always obtained. In Zambia, every patient who receives a medical registration card automatically gives consent to medical examinations. This allows practitioners to do tests without consent or even knowledge. This is probably the case in many other countries. Given the stigma, discrimination and sense of hopelessness that may follow from a positive test result, being tested is not always helpful or wanted. Advise about whether to be tested - or told the result - must take into account the person's situation if it is to be in their best interests.

With individual testing, people have the right to know their results. Again, this does not always happen in practice. A doctor in the Congo told a researcher that he did not inform one male patient he might have AIDS because he had only an unconfirmed ELISA test and clinical diagnosis to go on. He sad he would not tell the patient even if the result could be confirmed, since there was nothing the man would be able to do: he could not protect his wife sexually because they were Roman Catholic and would not use condoms. Does a doctor have the right to determine this for a patient? There are arguments on both sides. People also have the right to refuse to know their results. They may decide they do not want to

know once they have actually been tested, especially if they were put under pressure to do it. However, they may return at a later date to ask for the results, and these should be kept available for them.

Partner Notification

That they are at risk if a person has any Partner notification is a breach of confidentiality, but it may protect partners from sexually transmitted disease, including HV. People may HV infection. The law often permits or requires sexual contacts to be informed or may not have the right to refuse to name those contacts, though they cannot be forced. Clinic staff can convince them to cooperate, in the interests of their contacts. People may be given the choice to inform contacts themselves or let the clinic do it.

Partner notification needs more gender-specific study. What may be beneficial for women if women are informed, may be dangerous for women if men are informed. Notification of male partners can lead to blame for infection, abandonment and violence against a women. Women in many situations have given this as a reason why they would be unwilling for partners to be notified. One solution would be for women and their partners to be tested together. Where this is not possible, women's concerns must be taken into account no matter what the law. Some developing countries are considering notification programmes, but there are many medical, legal, ethical and logistic issues to confront, including how many partners to notify, how they will be notified and counseled, and what services will be available for them. Without caution, individual and social harm can be done and can detract from other AIDS prevention and control activities.

Routine Testing

Routine testing has been defined as the systematic testing of all individuals who meet specific criteria. Such testing can be voluntary or mandatory, though the difference can sometimes be unclear. Four types of routine testing may be found:

Testing may be available to people who want it. For example, a family planning clinic can put p a notice saying that testing is available on request. Or an HIV-test site can be opened and people would only go if they want to be tested. Clinics may offer or suggest testing to people they think are at risk or to everyone who attends the clinic, but people decide for themselves whether to be tested. Antenatal clinics, drug-treatment programmes and STD clinics are all examples.

- All members of a specific population group may be tested. They may or may not be informed in advance. They may or may not be given the opportunity to refuse or to decide whether they want to be told the results. In a few countries, antenatal clinics operate this policy. All registered sex workers and all prisoners entering prison are more common examples.
- People may be required to have a test as a condition for something else and given no choice about learning the results, e.g. for studying or getting a residence visa in another country, for a particular job, or to join the military. Many insurance companies require applicants to reveal whether they are at risk or have been tested, and any test results.

Routine testing for HIV is one of the most difficult areas of debate, especially when it edges towards being mandatory. Routine testing can be of value. Each case needs to be judged on its own merits. Routine testing of individuals should not be confused with screening, though it may be. Routine testing of newborn infants might make good sense if tests were accurate for the infants just after birth. In current circumstances, routine testing of infants only provides accurate information about the mother's HV status. At least until this changes, these tests should be voluntary unless done anonymously for screening purposes.

Routine testing has been rejected by most experts as unnecessary for either health workers or patients, because universal precautions are much more effective. However, if one or other has been put at risk, e.g. by a needlestick injury or blood splash, professional bodies may recommend testing of the health worker and the

patient, with or without consent.

Mandatory Testing

Mandatory testing raises many ethical questions and is difficult to justify. Some say people in high-risk situations or with high-risk behaviours ought to tested if they are in a position to infect other people. But knowledge of HIV status is not protection in itself. People still have to protect other voluntarily. Prisoners are often singled out for mandatory testing, including women arrested for sex work or injection drug use. In Belgium and Greece an HIV test is mandatory for prison inmates, while in Austria, France, Germany, Norway and Spain, all drug users in prison are offered an HIV test, and condoms are available to male inmates free of charge.

Sex workers are often subjected to mandatory testing at regular intervals. Yet no on has proposed mandatory testing of sex workers' clients or men with multiple sexual partners, nor even of all injection drug users. The human rights of sex workers seem to be more easily violated that the rights of others, even other stigmatized groups. It is policy in many countries to ban sex workers from working if they are found to be HIV-positive. Women whose only livelihood is threatened by mandatory testing will try to avoid being tested. Those found to have HIV will often move to an area where no one knows them.

Testing for sex workers can have positive consequences if carried out in a programme that supports women's own interests. In the mid-1980s a hospital-based AIDS centre in Athens set up an AIDS education programme for 350 registered sex workers. The women were already required to report once a week to a special STD clinic, as a condition of registration, though it would appear that this was not strictly enforced. In 1985, the women were tested for HIV and other STDs. Since then, they have been tested every three months. At each visit, they are interviewed, counselled and clinically examined. Educational material is given about all STD prevention as well as AIDS. Their work has been protected, their health has improved and the risk of HIV has been reduced. The women have clearly benefitted. However, the question of whether more women would have

access to help if testing were voluntary, remains.

Voluntary Testing

In most European countries an HIV test is offered to all drug users who contact a caring agency. The uptake in this group is much higher than in many others, yet it is voluntary. This is the best evidence available that voluntary testing works when people are aware they are at risk and something can be done to help them.

The disadvantage is that not everyone will be aware or convinced they are at risk, and therefore will not be reached. Even those who know they are at risk may not choose testing when it is voluntary. Men and women (100 each) attending an STD clinic in London were asked why they did not request an HIV test; 64 per cent of the men and 40 per cent of the women said the issue was very much on their minds. The most common reason given by the men was concern about confidentiality. The most common reason among the women was that they could not cope with it. While these fears might be overcome with counseling and support, they are valid reasons not to be tested.

Testing following Rape, Sexual Assault or Abuse

If a man on trial for rape or sexual abuse has been tested for HIV, found to be positive and knew his status prior to the crime, the charges against him and his sentence may be increased, even to include attempted murder in some countries. Many people think that mandatory testing should be done on rapists and child abusers. In the USA, mandatory testing of convicted rapists has become law in many states since 1990. Yet, testing of rapists does not actually help women who have been raped. Only an estimated ten percent of rapes and sexual assaults are ever reported in the USA, and the figure is unlikely to be higher in other countries. The great majority of rapists are never charged for their crime, and if charged, are usually not convicted. In the USA, fewer that 40 percent of reported rapes result in charges, and only three per cent of these result in a conviction. On this basis, only

12 out of every 10,000 alleged rapists could be tested for HIV in the USA, and a conviction may not be reached for up to three years. The women or child would still need to be tested three to six months after the attack, whether the rapist is tested or not.

Anecdotal reports indicate that doctors may dismiss women's fears of HIV risk after a rape and tell them an HIV test is unnecessary. But coping with that fear has become part of the whole experience of rape and sexual assault for many women. One STD clinic in London has found that fear of HIV infection is a principal reason why women who have been raped attend. Although the women are often not explicit about this, they often appear immensely relieved when the clinic initiates this discussion with them. Hence HIV testing and counseling is always offered (see Berer 1993:231-235).

2.1.3 THE DIFFERENCE BETWEEN HIV AND AIDS

2.1.3.1 WHAT ARE HIV AND AIDS?

Disease emerge or re-emerge in different parts of the world from time to time. Occasionally a disease is 'discovered' which may in fact have been prevalent for some time. Such phenomena have in general been limited geographically to certain ecological niches where conditions were conducive for the "new", emerging or re-emerging disease. AIDS, by contrast, is truly a new disease. It' ecological niche seems to cover the whole world. In its wake it has brought many surprises. It has shocked us into reflection.

AIDS Stands For

Acquired (not genetically determined) Immunodeficiency (severe depletion of immune system cells, that is, the cells which defend the body from other, even trivial, infections) Syndrome (an illness which presents itself in various forms)

The origins of AIDS are unknown: however, it was first recognised in the USA during 1981. Initially it was reported among gay men, and was causing death at an

early age. These two aspects were publicized sensationally by the mass media worldwide, etching the nation "AIDS=gay plague" on the minds of people everywhere. The aversion and fear which this notion promoted have remained, despite clear evidence to the contrary. After gay men the next most commonly stereotype group to be affected was intravenous drug-users, thus further reinforcing negative attitudes.

Such prejudices are still alive today, although more and more groups are being affected. AIDS increasingly strikes women, children heterosexuals, and those who have not been sexually active. It strikes not just persons 'out there', but members of local communities, familiar neighbours and even family members. Sadly, many Christians and some churches have shared in the promotion of negative, judgmental and condemnatory attitudes.

By 1982, AIDS had been detected in some African countries (in fact, it was found to have been responsible for high fatality rates there since the 1970s). It was affecting heterosexuals, both men and women, who were neither homosexual nor injecting drug-users. Thus AIDS was known to be transmitted by sexual contact - regardless of gender - and by blood (for example, through needle-sharing or blood transfusions). It also became clear that sexual transmission was related to having many sexual partners. This new connection with sexual promiscuity entrenched self-righteous, negative judgments about people living with HIV/AIDS.

In 1983-84 the virus causing the immunodeficiency was identified. Although previously known by other names, it is now called HIV (Human Immunodeficiency Virus). It has continued to spread without detection among many people in new places. By the time this report was completed, HIV infection had reached nearly all countries of the world; and families everywhere are beginning to be affected by AIDS. It has thus become a pandemic. For people in towns, villages and parishes, it is causing local epidemics. The infection and disease. At first an epidemic (referring to a disease with a rapid and increasing rate of spread), are becoming endemic, that is, entrenched and spreading steadily. Epidemics go away; endemic diseases remain. The chain of transmission of HIV/AIDS is not at all limited to

persons having sexual contact with multiple partners.

- A spouse living in a faithful monogamous sexual relationship may become infected it his or her partner was infected earlier, either through sexual contact or needle-sharing drug use.
- HIV has spread and continues to spread in health-care settings due to unscreened blood transfusions and the reuse of needles and syringes without adequate cleaning and sterilization.
- Infants born to HIV-infected women are also at risk of becoming infected with HIV. This is called "vertical" transmission. Between 15 and 40 percent of infants born to HIV-infected mothers develop HIV infection through vertical transmission.

HIV infection is a silent phenomenon which can be diagnosed only by blood tests. By itself it is not a disease. However, infected persons remain internally virus-infected for life, and they are therefore infectious to others through blood or other body-fluids contact. As a result of prolonged HIV infection the immune system weakens, and as a result of this immune deficiency the person becomes susceptible to secondary diseases. This phase, marked by opportunistic infections, cancers or other debilitating conditions, is generally called HIV disease or AIDS.

In spite of intensive biomedical research no cure has been found for the immune deficiency caused by HIV infection. Although several anti-viral drugs have been developed, the virus has developed resistance against all of them. This is partly due to the ability of the virus to mutate and change through a process of adaptation. As a result of such changes the virus has differentiated into subtypes in different geographical regions. Continuing attempts to develop an effective vaccine against HIV infection have also been unsuccessful so far, and it is generally believed that a single vaccine may not be effective against all subtypes. In short, a biomedical cure or vaccine for HIV/AIDS remains an elusive goal.

At the individual level, HIV infection is potentially preventable if one avoids

the risk factors which facilitate the transmission of infection. In sexual activity, partners exchange sexual secretions and, along with them, microbes that are normally present in abundance on the genital mucosal surfaces. These are called the normal microbial flora; we acquire them normally from our environment during the physiological processes of growth and development. Having sex with a single partner in mutual monogamy ensures that both partners have only the normal flora.

Pathogenic microbes that cause diseases such as syphilis, gonorrhea, genital herpes, chancroid and so on can be acquired only from another infected person through sexual contact. These are known as sexually transmitted diseases (STDs). Because HIV is sexually transmitted, AIDS is also an STD. Unlike most sexually transmitted diseases, HIV/AIDS does not cause disease of the local genital mucosa and skin. However, the presence of an STD, particularly one with an ulcerative lesion, facilitates the transmission of HIV between sexual partners if one of them has the infection. Since HIV is transmitted less readily and less often in the absence of any local lesion, the early detection, diagnosis and correct treatment of all other STDs will reduce the risk of HIV transmission, even when one of the partners is infected with HIV.

The chance of sexual transmission of any pathogen, including HIV, is minimal or none if an effective barrier is used to prevent physical contact between the mucosal surfaces of the sex partners. This is the principle behind the use of condoms to prevent HIV transmission. The condom is to be worn by the male partner; a condom to be worn by the female partner has also been designed and field tested (see World Council of Church's 1997: 6-11). HIV is a new virus. Much remains to be learned about its effects, especially in women, and there are many unanswered questions. HIV is not the first virus in the world, not the first sexually transmitted disease, not the first potentially fatal one. All the issues which AIDS raises about sexuality and relationships, women's health and health care, pregnancy, birth control, and women's personal and professional lives were already there. HIV and AIDS merely add to a new dimension which must be taken into account. AIDS was killing women before it had a name and before a cause for it

had been found. It had become the leading cause of death among women of reproductive age in many parts of the world by the second half of the 1980s. Yet it was only on 1 December 1990 that World aids Day called the whole world's attention to the extent of a problem women had been living with and dying from for more than a decade. Not all women are equally vulnerable when it comes to illness and its consequences, and HIV and AIDS are no exception. Poor and marginalized women are being hit worst all over the world. All of the inequalities and injustices that affect women's health and access to health care also occur with HIV and AIDS.

However, HIV does not recognize gender, race, class or national borders. Because of how it is transmitted, all of us are potentially vulnerable. We and those close to us may personally be at risk or already have HIV. Given the extent of this epidemic worldwide, we should not imagine that we are divided into those who have HIV/AIDS and those who do not. In fact, we are divided into those who know they are affected by HIV/AIDS and those who do no know. This virus and its defeat belong to all of us. We can only act once we recognize that all of us are living with HIV and AIDS - for as long as some of us are.

2.1.3.2 WHAT IS HIV?

HIV stands for human immunodeficiency virus. HIV is a sexually transmitted disease. Like some other sexually transmitted diseases, it can also be transmitted through blood and during pregnancy. Like herpes, it is a virus. Like syphilis, it affects the whole body, can take few or many years before it causes serious damage, and can be fatal.

HIV cannot live on its own, or in the air or water. People can get a cold, the flue or pneumonia just being near someone who has them. People can get hepatitis A or salmonella from contaminated food or water, and malaria from being bitten by mosquitoes. People do not get HIV in any of these ways. People do not get HIV from living in the same house or room with someone who has HIV. People do not get it from being at school, at work or socializing with someone who has HIV. No one has been known to get HIV from kissing.

HIV is mainly transmitted through:

- Unprotected sexual intercourse, both vaginal and anal;
- Infected blood or blood products given by transfusion or injection;
- Sharing or re-using injection drug equipment containing infected blood without cleaning it between uses;
- Pregnancy and possibly childbirth.

In the coming years, 90 per cent of new HIV infections will occur through unprotected sexual intercourse. Heterosexual, bisexual and homosexual women and men are all at risk of infection in this way. Preventing HIV transmission is the key to the solution of the AIDS epidemic.

HIV is a New Virus

In the late 1970s doctors began to recognize that a new pattern of illness was occurring in a growing number of people and that a new type of infection was spreading. AIDS was recognized as a syndrome of illnesses in 1981, and HIV, the virus which causes it, was identified in 1983.

HIV is a new, complex virus. No one knows how it evolved into its present form. Before anyone knew it existed, it was being passed from one person and country to another and had spread worldwide. The earliest cases of people who died of HIV-related illnesses were identified in the 1980s from stored samples of tissue and fluids. They include a seafarer from England, who died in 1959; a teenage boy from the USA, who died in 1969; a sailor, his wife and their youngest daughter from Norway, who began to develop HIV disease in the mid-1960s and had all died by 1976; and a blood donor from 1959 in Zaire.

Sporadic cases of AIDS in people who had contact with West Africa date as far back as the mid-1960s. No one understood at the time why these people had become ill and died. 'It is not unusual for new viruses to [appear suddenly], nor is HIV the first virus to cause a serious epidemic. For example, the Spanish Flu virus

in 1918-19 killed 20 million people in a widespread epidemic, and then appeared to die out. The appearance of new viruses, and the occurrence of new forms of disease, are natural events.

Viruses easily change or mutate, and two viruses may combine to produce a new one. HIV, itself has at least two major strains (HIV-1 and HIV-2) with numerous variations. In the search for a vaccine or cure, it may be helpful to know how the virus developed into its present form, and whether it came from another species of animal. This might provide clues for tackling the problem medically. However, for most of us these questions are not important in a practical sense. It is not the question of where the virus came from, but where it is going to, that should be of most concern' (see Berer1993: 5-7).

2.1.3.3 DOES HIV CAUSE AIDS?

There has been some questioning in South Africa of the link between HIV and AIDS in recent months. There is no debate among the vast majority of scientists, and the number who put forward these counter arguments are very few and on the fringe. The argument that HIV does not cause AIDS rests on four key elements:

1. HIV has never been isolated and identified. This is incorrect, as there are numerous photographs taken with an electron microscope of, among other things, the virus coming off the T-cell surface.

2. AIDS is a new name for old diseases and the wider spread of these diseases today is due to factors such as drug use and malnutrition and is not due to a new virus. The truth is that numerous laboratory studies and clinical research show that there is a positive correlation between the level of HIV production and viral load on the one hand and AIDS prognosis on the other. The treatments with antiretroviral therapy cause the immune system to recover, viral loads to drop and in many cases the clinical manifestations of AIDS to disappear.

3. AIDS can occur without HIV. It is true that there have been cases of immunodeficiency similar to AIDS without HIV being present. However, the number of documented cases is minute.

4. Some HIV-positive individuals do not develop AIDS. The fact is that the average period from infection to developing AIDS is eight to 10 years in the absence of treatment. It follows that there will be individuals who, for some reason to do with their immune system, will live for longer-than-average periods with HIV infection.

5. Some may be fortunate to survive indefinitely without treatment. But they are exceptions-the vast majority of people will not be so fortunate and will eventually fall ill.

Obviously, dissident viewpoints cannot be ignored. For, as the great 20th-Century Austrian philosopher, Karl Popper, observed, a scientific hypothesis can never be conclusively proved-only disproved. In other words, the door should always be open for conventional wisdom to be overturned. Max Planck, for example, revolutionised physics with his theory of energy coming in discrete packets. In 1900, when he put forward his theory, he was in a class of one (see Whiteside 2000:3). However, his hypothesis quickly gained credence and is now the basis of the mainstream science of quantum physics. Can the dissident school on AIDS achieve the same success?

As things stand, we believe not. Max Plank's theory took off because it explained the goings-on in the world of elementary particles better than any previous theory. In fact certain observed phenomena, such as line spectra from excited atoms, could only be explained in terms of his model. We don't think the nonviral explanation of AIDS fits the facts as well as the assumption that a virus exists. Indeed, facts like hemophiliacs dying of AIDS through tainted transfusions of blood, and this phenomenon ceasing after proper screening of blood was put in

place, cannot be explained by the nonviral model.

MYTH

There is no evidence that HIV exists as a virus. Therefore it is not responsible for causing AIDS. AIDS has been around a long time and is due to factors such as poor living conditions, malnutrition, trauma and stress.

REALITY

While science can never be as certain as mathematics, the majority of the world's leading virologists believe that the HIV hypotheses is correct

2.1.3.4 THE ORIGIN OF HIV

There has been a great deal of ill-informed speculation as to the source of the virus. It has been suggested that it was man-made by either the Russians of the Americans (the choice depending on the ideology of the person doing the selection!). An alternative theory is that it came from outer space. Neither of these propositions need be taken seriously. It is now believed by scientists that HIV is a virus that crossed the species barrier into humans. It is related to a number of Simian (monkey) Immunodeficiency Viruses (SIVs) found in Africa.

If the evolution of the virus is traced through a 'family tree', HIV-1 is closely related to Chimpanzee SIV and HIVB-2 to Macaque SIV. Both are more distantly related to African Green Monkey SIV. How did HIV enter the human population?. An important point to note is that the spread of diseases from animals to man is not unique to HIV. Congo fever which occurs sporadically in South Africa, is a tick-borne disease which does not kill its animal hosts, but is extremely serious when people are infected. The influenza virus, for example, evolves in birds - waterfowl to be exact. The latter are what virologists call 'reservoirs' for influenza (see Whiteside 2000:3-4). They carry nearly all known types of influenza, with no ill effects, and spread them to the rest of the animal kingdom through their faeces. Hence many kinds of animals can get flu - horses, ferrets, seals, pigs, among others- as well as human beings. However, viruses can only infect and take over

a cell if an appropriate 'receptor' is present. As far as we know, human beings do not have a receptor to contract avian flu directly. What is needed for human infection is for another species to act as an intermediary; it can play this role by having a receptor for avian flu and humans having a receptor for its flu. Pigs are one such species. The process can be as simple as a flu-contaminated duck dropping faeces into the dirt a pig is rolling around in, thus infecting the pig which, in turn, passes the virus on to a farmer. It can also be more complex. It is possible for a pig to be infected with one kind of flu, say human flu, only to contract another avian flu. The pig then has two types of flu simultaneously. When the pig reinfects the human, it passes on a pig-bird-human influenza. The Hong Kong Flu, for example, held seven genes from a human virus, and one gene from a duck virus, that met inside a pig to produce an entirely new hybrid.

MYTH

HIV is a unique virus inflicted on mankind as a punishment for the wicked.

REALITY

HIV is like any other virus except that it attacks the immune system itself. If only people would see that there is nothing mysterious about HIV, we could remove the stigma surrounding it and combat it more openly and effectively.

By comparison with other viruses, HIV is a simple virus. At some point in time, it entered the blood of humans and then spread through sexual contact from person to person. It has been suggested that the current HIV epidemic had its origin in an infection across the species barrier in the 1930s. Interestingly, the transfer of the virus from an animal into a human may have happened on a number of previous occasions. However, because on those occasions each infected person did in turn infect more than one other person, the potential epidemic petered out. There could have been a pool (or pools) of infected but isolated people in some parts of Africa for many years.

What was different about the crossing of the species barriers in the 1930s

(and the subsequent pattern of the epidemic) was the environment into which the virus was introduced. The upheavals of the colonial and post colonial periods and development of a modern transport infrastructure allowed HIV to spread out into the global community very quickly.

How did the transfer from one species to another physically take place?. It is not hard to imagine a hunter butchering a monkey and in the process contaminating a cut on his hand with the monkey's blood. Indeed, in February 2000, when two cases on Congo fever were reported in the North West Province, one of the virologists interviewed by the SABC warned that there was a chance that the fever could be transmitted through butchering domestic stock. Thus, it is quite possible that SIV evolved into HIV through such an event. A somewhat different explanation is given in a recent book by journalist Ed Hooper (The River, Penguin, London, 1999). In it, he suggests that the polio vaccination campaigns of the 1950s, during which the vaccine was cultivated on monkey kidneys, may have inadvertently spread HIV in certain populations in Central Africa.

MYTH

AIDS is the result of people having sex with monkeys.

REALITY

The disease is likely to have originated from monkeys in Africa, most probably from contact between human blood and the contaminated blood of a monkey. It is not the first, nor will it be the last, disease to cross the species barrier.

When all is said and done, the debate about the exact origin of the epidemic is academic. What matters is that the virus has reached mankind and is spreading fast (see Whiteside 2000: 3-7).

2.1.4 THE PROGRESSION OF A PATIENT FROM ASYMPTOMATIC HIV INFECTION TO AIDS

2.1.4.1 HIV INFECTION TO AIDS

The process of immune system and lymphocyte destruction by the HIV virus is a slow one, and occurs over many years. Once the CD4 count gets very low, the patient with HIV begins to suffer from infections. At first, these infections are the type that are often seen in healthy patients-such as vaginal thrush, TB or bacterial pneumonia. However, eventually, the destruction of the immune system becomes so bad that the patient begins to get infections that are only very rarely found in patients without HIV infection. These are called 'opportunistic infections' and would normally be fought off very easily by a healthy immune system.

In addition, patients with late HIV disease also get certain types of cancers. These are cancers which are also the result of infections and a poorly functioning immune system. As a patient moves from the early, asymptomatic stage of HIV infection to the later staged where he/she becomes affected by opportunistic infections and aggressive cancers, they are classified as having AIDS.

Will everyone with HIV Infection go on to Develop AIDS?

It is not yet clear whether every HIV-infected persons will progress to develop illness and AIDS. Approximately 80% of HIV-infected people will have developed AIDS within 12 years of acquiring the infection. On average, it takes about 8 years from HIV infection to AIDS. It seems likely that most HIV-infected people will eventually develop severe immune-deficiency and symptomatic disease, even if this takes 5 - 20 years.

A small percentage of patients are termed "long-term survivors". These are rare patients who have been infected with the HIV virus for a long time, yet show no signs of AIDS. The reason for this are not well understood and are being investigated by scientists. The existing health status of an individual may determine how long it will take to develop immune-deficiency and symptomatic disease. Diseases like malnutrition, measles, tuberculosis, malaria, etc, may further depress

the immune system, and serve to quicken the progression from HIV to AIDS.

2.1.4.2 THE STAGES OF HIV INFECTION

Early HIV Infection

This occurs at the time when the HIV antibody test usually converts from being negative to positive, so the clinical condition is referred to as the sero-conversion illness. Because the problem is non-specific, the sero-conversion illness is often mistaken for a "flu-like", viral illness or glandular fever. It often passes unnoticed by the patient.

The HIV antibody test usually becomes positive 4-12 weeks after infection. Often, for the first 1-5 years, the HIV test may be the only indication that a person has HIV, with no other signs of illness. After the initial non-specific symptoms of HIV infection and sero-conversion, the patient usually remains well and asymptomatic. This is often called the latent or "silent" phase of HIV infection.

Latent or "Silent" Infection - The Asymptomatic Phase

The HIV-infected person usually experiences a period of good health in which the virus remains "silent" or latent. The phase may last between 3 and 7 years (even up to 10 years). However, even though the infection is clinically "silent", the virus is active in the body and the person is able to spread the virus during this phase (see Catalan 1999:27).

Minor HIV-Related Symptoms-the Minor Symptomatic Phase

Between 3 and 7 years after the infection, some individuals may develop 'minor' symptoms and signs secondary to the HIV infection. In general, these symptoms are not specific to HIV disease. They are generally things that are found occasionally in healthy individuals, but occur commonly in patients with HIV.

These may include the following:

- Weight loss
- Occasional fevers
- Chronic swelling of the lymph nodes, which are commonly felt in the neck, axilla and below the jaw (often called persistent generalised lymphadenopathy)
- Skin rashes, such as folliculitis, seborrhoeic dermatitis and chronic itchy skin
- Fungal nail infections
- Recurrent oral ulcerations (aphthous), angular stomatitis, chelitis
- Herpes zoster
- Recurrent upper respiratory tract infections

HIV-Related Disease-the Symptomatic Phase

After about 5-8 years following HIV infection, the immune system continues to deteriorate and the person becomes more immune-deficient. Signs of more sever HIV-related disease begin to appear. These signs and symptoms are usually due to overgrowth of some of the body's natural flora with fungal infection and reactivation of old infections (such as TB and herpes). They may also be due to uncontrolled multiplication of HIV itself. The most common signs and symptoms of this stage of HIV-related disease are as follows:

- Oral or vaginal candida infection (thrush) - this is usually persistent and recurrent
- Hairy leukoplakia on the tongue
- Recurrent herpes simple infection-'cold sores' or genital herpes infection
- Herpes zoster (shingles)
- Acne-like bacterial skin infections
- Persistent and unexplained fevers and night sweats
- Skin rashes

- Generalised lymphadenopathy or shrinking or previously enlarged lymph nodes
- Persistent diarrhoea
- Weight loss (more that 10% of usual body weight)
- Reactivation of tuberculosis may also be associated with this stage of infection, especially in people from low socio-economic communities, where tuberculosis is common (endemic)

Severe HIV-Related Disease-

AIDS, the Severe Symptomatic Phase

The symptomatic phase usually progresses over the next year or 18 months into the fully developed AIDS phase of the disease. This stage has the development of severe opportunistic infections, some cancers and HIV-related organ damage. These conditions are therefore referred to as "AIDS defining" illnesses and are listed in the WHO Staging System for HIV infection and Disease.
The following are diseases that occur in patients who are HIV positive that suggest advanced disease (AIDS):

Infections

- Candidiases of the GI tract or lung
- Fungal infections including toxoplasmosis (brain, eye) or cryptococcus (meningeal)
- Viral infection including disseminated Herpes virus (HSV), chronic herpes ulcers of the skin or GI tract, Cytomegalovirus infection (CMV)
- TB of the lungs or other organs in the presence of HIV, atypical forms of Mycobacterial disease
- Pneumocystis carinii pneumonia (PCP) of the lungs
- Persisted diarrhoea caused by uncommon organisms (cryptosporidium, isospora belli)

Cancers

- Lymphoma, especially of the brain
- Invasive cervical cancer
- Kaposi's sarcoma

(see Pronyk 2000: 16-19)

No gender differences have been described in the frequency, severity or time of appearance of minor signs of infection. However, as women's health advocates note, medical professionals may interpret symptoms in women differently from in men. For example, may early symptoms of HIV infection may be attributed to depression, stress or overwork. Women themselves may not view their own symptoms as seriously as they do the symptoms of others. Often, mothers who are obviously ill go to a clinic only when their children are ill, and may not expect attention for themselves.

2.1.4.3 EFFECTS ON MENSTRUATION AND FERTILITY

Many women with HIV have reported changes in menstrual patterns, most commonly irregularity of periods. A USA study compared 17 HIV-positive and 20 HIV-negative women with similar histories of injection drug use. Loss of periods was reported by 24 per cent of the HIV-positive women and 13 per cent of the HIV-negative women. Bleeding between periods was reported by 18 per cent of the HIV-positive women and 6 per cent of the HIV-negative women. Drug use was probably not the primary cause of these differences.

A controlled study in Uganda found loss of periods and possible lower fertility to be more common in several hundred women with HIV. Five per cent of the HIV-positive women had no menstrual periods, compared to two per cent of the HIV-negative women. The HIV-positive women had an average of four living children compared to five in the HIV-negative women, though their ages and other factors were comparable. A study in Rwanda reported that the fewer children

women had, the more likely they were to be HIV-positive, but did not examine this as a fertility issue. A large, controlled, three-year study of women who had just given birth in Zaire found reduced fertility in each year in HIV-positive women compared to HIV-negative women. The biggest difference was among the women with AIDS. Figures were adjusted to take account of use of birth control.

If women with HIV stop having unprotected intercourse, which is not uncommon, fertility as measured by number of pregnancies will be reduced. This is different from possible adverse effects of HIV on the reproductive organs, which may affect the ability to become pregnant. None of the studies described here took account of this distinction. Loss of periods, menstrual changes and effects on fertility could be caused by sexually transmitted diseases, frequent use of heroin, weight loss, the effects of immune deficiency on hormone production, or damaging effects of HIV itself on sperm, ova, or the reproductive organs. There may also be an association with specific AIDS-related diseases.

Ovarian cysts associated with cytomegalo-virus were found in a women who had died of AIDS, and this had previously been reported in two other women with other causes of immune deficiency. As HIV disease advances, the number of mature sperm and sperm cells in the male testes declines. In a small group of men who died from AIDS, no sperm at all was found. Other anecdotal reports of reduced fertility exist. For example, a man and women, both with HIV, who had both previously had children with former partners, unsuccessfully tried for a pregnancy for several years. Investigations indicated that the woman had ovarian cysts and the man had abnormal sperm. Her immune function was at the lower end of normal, while his was somewhat lower.

Although this evidence is sketchy, all major illnesses cause fertility to decline. Whether and how quickly this may occur with HIV infection is relevant to women's decisions about pregnancy, and more research is needed. We also need to ask if there are adverse effects on the breasts, uterus, fallopian tubes, ovaries or ova in women with HIV or AIDS. Women may or may not know their HIV status when they attend for health care. Asymptomatic women who are healthy may attend clinic for

antenatal, family planning, infertility, pediatric or other reasons. They may have conditions that fail to respond to treatment, e.g. a reproductive tract infection, or following minor surgery, or may have a poor pregnancy outcome due to underlying HIV infection.

Management of the majority of asymptomatic patients and those with minor HIV-related conditions by primary care clinicians and other health-care providers is no more difficult than management of the other illnesses treated by clinicians every day. Many people with HIV may need little or no treatment for long periods of time, but HIV-positive patients may require more medical attention on average than others in their age group.

Decisions have to be made about what conditions can be cared for at which levels of a health system. With the addition of only a few drugs, treatment of some manifestations of HIV can be decentralized to a lower level, provided staff are given guidelines, training, and appropriate quantities of drugs. Few studies indicate which parts of health services women first approach with HIV-related complaints. In one health district in London, of the 81 HIV-positive women who presented for care up to 1990, the majority first went to an STD clinic or drug dependency unit specifically to ask for an HIV test, or had been tested at an antenatal clinic during pregnancy. The remainder had complaints that indicated possible HIV infection-mainly reproductive tract infections, swollen lymph glands, flu-like illness and general malaise-though they were not necessarily aware of the link. They went to a private or hospital gynaecologist, STD clinic, chest clinic, or general hospital clinic. Two had an HIV test prior to blood donation, and one was tested when her baby was found to have HIV at a post-natal clinic.

In Zimbabwe, both rural and urban women present mainly through primary health centres with babies who are failing to thrive, or when they themselves have reproductive tract infections, swollen glands, shingles or chronic diarrhoea. Most do not ask for an HIV test but have it suggested to them by senior staff.

Women who go to district hospitals or infectious disease hospitals are likely to present initially with TB. Many women travel to urban centres when they are

chronically ill, because their partners work there and because they believe, often mistakenly, that treatment will be better. Such studies are valuable because they indicate how early after infection women seek medical care. This information can be used for educational campaigns to encourage women to seek medical advice as early as symptoms occur. They also help health services with planning, to ensure that at each level of care, health workers are aware of what kind of complaints women with HIV first come with and which parts of health services they are likely to present to.

2.1.4.4 LATER STAGES OF INFECTION

Patients with one or more AIDS-related conditions require hospital and/or home care. Temporary cure of most major infections is possible, but patients often relapse or require lifelong treatment. Complex treatment is often required by those with advanced illness, whose health may fail unexpectedly and repeatedly. In many cases, outpatient and home-care teams could reduce hospital stays and provide pain relief, care and treatment.

For patients who are terminally ill, hospital, hospice or supported home care are options. Caregivers at home will need simple training in handling of blood and body fluids, hygiene and how to cope with problems like diarrhoea. It should be remembered that people may be living in overcrowded conditions with poor sanitation and that the women (and men) who are assumed to be providing daily care at home may well be ill themselves. Some patients have no one to care for them at all, let alone a place in which to be looked after. Volunteers who support the work of professionals, families, partners and friends have been invaluable in helping to provide basic care, practical and emotional support. This improves quality of life for people who are ill and for their caregivers (see Berer 1993: 17,18,25,26).

2.1.5 THE CLINICAL MANAGEMENT OF HIV/AIDS

The clinical management of the person living with HIV/AIDS is an important part of primary care. As the epidemic affects a greater number of people, clinics will be assuming an increasing responsibility for the care of these patients. Many people think there is not much that can be done for a patient with AIDS. This is wrong. There is a lot we can do as health care workers in improving the quality of life of a patient with AIDS by treating infections early, treating troublesome symptoms and providing support. In most situations, simple and basic measures can provide enough support to these patients to reduce suffering and maximize the quality of their life.

The following basic points in management are appropriate recommendations for all patients living with the disease:

- Bath every day if possible
- No smoking
- No alcohol or other drugs
- Dental care: brush teeth twice dally
- Regular exercise but not during acute illness
- Healthy diet including plenty of fruits and vegetables
- A multivitamin supplement daily
- Weigh the patient each visit
- Antidepressants or sleeping tablets if necessary
- PAP smear yearly
- Check WR (Widal test for syphilis) and if positive by confirmatory test, give Benzathine Penicillin 2,4 mu x 3 doses
- Vaccinate for influenza and pneumococcus if available
- Condoms and contraception. Avoid IUCDs
- Advise patients to seek help early in the event of illness

2.1.5.1 PREVENTION OF COMMON AND SERIOUS OPPORTUNISTIC INFECTIONS HIV-POSITIVE PATIENTS

Early in HIV infection, there may be few symptoms. Most patients feel fairly well overall. However ,as the immune system function deteriorates (as lymphocytes are destroyed) the patient becomes vulnerable to a number of infections, Many of these infections can be prevented with some commonly used medication which is available at most clinics and is inexpensive. Most recommendations for prophylaxis target patients with low CD4 cell counts. As this test is not available in most clinks and health centers, a clinical assessment of the patient becomes more important in assessing whether they have late HIV infection.

The following evidence suggests advanced disease, and that prophylactic therapy should be started:

- Weight loss of > 10% body weight
- Oral thrush unrelated to antibiotic use, oesphagaeal thrush (most patients describe burning on swallowing), recurrent vaginal thrush
- Diarrhoea of >1 month
- TB of the lungs or any other organ
- The onset of new skin rashes, especially shingles
- Fever lasting > 1 month
- Oral hairy leukoplakia

The following infections can be prevented in HIV positive patients:

- Pneumocystis carinii pneumonia (PCP) and Toxoplasmosis

Both of these infections can be prevented with the use of Bactrim (co-trimoxazole) which is inexpensive and safe. The prophylaxis recommendation is as follows:

- co-trimoxazole (480-960 mg), 2 single strength tablets daily for 3 (Mon-Wed-Fri) or 5 days a week (Mon - Fri).

- Alternatives to co-trimoxazole are:
- Dapsone, 1OOmg three times a week, can be used if there is sensitivity to co-trimoxazole.
- In some cases, monthly pentamidine inhalations (very expensive and not widely available) are used for prevention of PCP pneumonia only.

Patients with HIV are more prone to allergic drug reactions than non-HIV positive patients. Symptoms and signs vary but common manifestations include itching or any form of rash. In these situations, the drug should be stopped and an alternative found if available. Prophylaxis with co-trimoxazole may also protect patients against getting chronic diarrhoea or recurrent bacterial pneumonia, both common in HIV positive patients.

Candidiasis

Prophylaxis should only be Started if a patient is suffering from recurrent Candida infections. Anti-fungals should be used on a daily or alternate day basis, beginning with the least expensive preparations. In advanced immune deficiency, the more powerful agents may be needed on a continuous basis.

Prophylaxis Recommendation

One of the following is recommended for prophylaxis:
Mild candidiasis (thrush):
Use one of the following on a. daily basis;Amphotercin B lozenges (Fungizone)
Chlorhexidine 0.02% solution
Mycostatin oral suspension
Co-trimazole oral suspension
Miconazole gel,

Severe Thrush:

In more severe infection, especially in the presence of immune deficiency, the above may not be effective. The following (if available) can be considered:
Ketoconazole (Nizaral). daily or alternate days or
Fluconazole (Diflucan), daily or alternate days-

Severe and Recurrent Herpes Infections

If herpes infection is recurrent, severe and very debilitating prophylaxis should, if possible, be considered. Unfortunately, the medications are extremely expensive and nog generally available at clinics and health centers. The following is recommended:

- Prophylaxis recommendation
  Vakklovir, 5OOmg daily orally
  Acyclovir, 400-800mg 12 hourly-
- Pneumococcal Infection and other vaccine preventable conditions Streptococcus pneumonia is a bacteria that can cause very severe pneumonia, infection of the blood scream and shock in any patient. Patients who are immune-compromised from HIV are especially at risk. Immunisation against this infection with pneumococcal vaccine (repeated 5 yearly) is effective in reducing disease caused by this bacteria.
- Yearly Immunisation against influenza should also be considered.

Other vaccine preventable infections should also be considered for prophylaxis if they are common in an area i.e. hepatitis B Immunisation can be considered in endemic areas and for high risk groups health care workers); Haemophilus influenza should be considered where available.

2.1.5.2 TUBERCULOSIS PREVENTIVE THERAPY

Tuberculosis is the most common infection and number one cause of death in

people living with HIV/AIDS. The risk of a person infected with the bacteria coming down with active disease is 10% per year - so in a 5 year period, the person has a - chance of being sick with TB. TB can be prevented in people living with HIV/AIDS by offering isoniazid prophylaxis (TB preventive therapy). In these individuals, TB preventive therapy decreases the risk of TB disease and should be part of a package of care for people living with HIV/AIDS. TB preventive therapy should only be offered by a health service if it does not interfere with the detection and cure of infectious pulmonary TB cases and if patients can be followed monthly to exclude active TB disease.

Eligibility for TB Preventive Therapy

TB preventive therapy has been proven to prevent TB in HIV-positive patients. An HIV-positive individual should be counseled on TB preventive therapy. The counseling should explain that TB preventive therapy decreases the risk of getting TB but that TB may still occur during or after the preventive medication. It should also explain that there is a small risk of hepatitis as a side effect of taking isoniazid.

If the individual would like to receive TB preventive therapy the following steps should be followed:

Screen for TB Symptoms

Determine if the patient has symptoms of TB. The symptoms of pulmonary TB are the same whether patients are infected with HIV or not:

- Cough (with or without sputum or blood) and /or chest pain
- Fever, weight loss, night sweats
- Tiredness and weakness

If the patient does have TB symptoms, investigate for TB or refer to health services for diagnosis and treatment.

2.1.5.3 FOR HIV-POSITIVE PATIENTS WITH NO TB SYMPTOMS

- Give isoniazid (INH) 5 mg/kg (maximum 300 mg) daily for 6 months.
- Give a 1 month supply to the patient at a time. Ask the patient to return on a monthly basis.
- Advise the patient to return immediately if TB symptoms develop.
- At each monthly visits monitor adherence and determine if the patient has symptoms of TB or is experiencing side effects to isoniazid (major; jaundice, or vomiting and confusion from hepatitis, minor: burning sensation in feet from peripheral neuropathy).
- If, at any time during the 6 months of TB preventive therapy, the patient develops TB symptoms, stop TB preventive therapy and investigate for TB.
- If the patient develops any numbness or tingling of the extremities (a neuropathy), give pyridoxine 25 mg daily

Summary

- Make certain the patient has no symptoms of active tuberculosis
- Give isoniazid 5 mg/kg (maximum 300 mg) daily for 6 months
- See the patient on a monthly basis to screen for TB symptoms and monitor adherence
- If TB symptoms develop, stop TB preventive therapy and investigate for TB
- If the patient develops hepatitis, stop TB preventive therapy and refer to a medical officer.

In South Africa, TB Preventive Therapy is being piloted in various parts of the country. It has not yet been recommended for widespread use at the PHC level. However, it is likely that these recommendations will be implemented on a wider scale in the near future. (01/2000).

Basic Management of Common Problems Associated with HIV/A1DS

Candida

- **Oral Thrush**

  90% or more HIV positive patients will develop oral thrush during their lifetime. Its presence is a very important indicator of disease. Three forms of oral Candida are described:

  - white plaque lesions anywhere in the mouth,
  - smooth, red or bleeding patches usually over the palate,
  - red cracks and fissures at the corners of the mouth,

Recommended Treatment

Mild or initial oropharyngeal candidiasis:

Topical therapy only-

Nystatin suspension, 2m1 "swish and swallow" TID QT-

Clotrimazole or amphotencin B lozenges, I tablet QID (prn) and

Chlorhexidine 0,2% mouthwash (or equivalent), daily.

Extensive or recurrent oropharyngeal candidiasis*:

Topical and systemic therapy as above

Ketoconazole, 700mg daily p.o. x 7- 14 days (intermittent therapy)

Fluconazole, I 50 mg stat or 100mg daily p.o, 7- 14 days (intermittent therapy)

- **Oesophageal Candidiasis**

  This condition more commonly occurs with severe immune deficiency and is an AIDS defining condition. Symptoms include:

  - difficulty with swallowing
  - regurgitation of thick, white, mucous-like material

- pain on swallowing (odynophagia)
- burning, central chest pain especially when eating
- oral candidiasis is almost always present on inspection of the oral cavity,

Recommended Treatment

Effective therapy usually requires systemic anti-fungals which are often costly and not widely available in primary care clinics.

Ketoconazole, 200mg daily p.o, x 14 days
Fluconazole, 150 stat is sometimes adequate
or IOOmg po daily for 10-14 days
Referral to specialist centre may be required.

- **Genital Thrush**

  Vaginal thrush often presents earlier than other opportunistic infections and is very common. Usual symptoms include vaginal discomfort, pain with intercourse and local sores. Sometimes the infection is related to systemic antibiotic use, diabetes or the contraceptive pill. Treatment is effective, but it may need to be re-started as the condition often reoccurs.

Recommended Treatment

Mild or initial vaginal candidiasis:
Topical therapy:
Nystatin or clotrimazole vaginal suppositories (cream)
daily x 7 days (or)
Boric acid vaginal suppositories 600mg BID x 14 days
Severe or recurrent vaginal candidiasi:

Topical therapy as above, plus ketoconazole, 200mg daily p.o. x 14 days (monthly x 5 days, thereafter as required).

Lung Infections

- **Tuberculosis**

  It is important to note that the presentation of TB may differ somewhat in HIV positive individuals. Some differences include:

  Less cavity formation
  Diagnosis is difficult as there tend to be less AFB's in a patient's sputum
  The cough may be non-productive
  The patient may not be very short of breath
  More often have other organs involved with disease, especially the lymph nodes

TB can be managed in patients with HIV/AIDS in the same way that it is managed in non-HIV infected patients - depending on whether or not it is their first presentation of TB (Regimen I), or if they are re-treatment patients (Regimen II). Please refer to the manual on RESPIRATORY DISEASE for details of tuberculosis therapy-

- **Pneumocystis Carinii Pneumonia**

  Symptoms of PCP include:

  - a chronic, non-productive cough
  - fever, sweats, chills
  - dyspnoea (shortness of breath)
  - loss of weight
  - gradual onset and progression
  - fine crackles (crepitations) may be heard, especially at the bases with more sever cases

Diagnosis

Confirmation of the diagnosis is often difficult and treatment is often given on clinical

suspicion. The organism is hard to identify by sputum sample and doctors at specialist centres often perform a test called bronchoscopy to find the infectious agent. X-ray may be useful, especially in excluding other forms of pneumonia.

Recommended Treatment

Mild/moderate PCP:
Co-trimoxazole (give 20mg/kg of the trimethoprim component)
e.g Bactrim, 3-4 single strength tablets or 2-3 double strength tablets p-o. QID x 14 - 21 days.-

Moderate/severe PCP

Bactrim (or equivalent), 3 ampoules IV, 6 hourly x 14 - 21 days and cortisone therapy if the patient is very short of breath. Give IOOmg hydrocortisone IVI, 6 hourly until the hypoxia has resolved. Oxygen therapy. Consider referral of patient to larger centre. It is important to note that the high-dose Bactrim given to suspected case of PCP pneumonia also kills other bacteria that cause pneumonia. In practice, the major other infection that is not treated by Bactrim is tuberculosis. Therefore, patients who present with lung disease and HIV are generally created for PCP while they await sputum results for AFB.

Summary

At the PHC level, patients presenting with lung disease and mild symptoms can be treated with Bactrim 4 tabs 4 times daily. The patient's sputum should be sent off for AFB x 2 specimens. If the patient does not respond to Bactrim or the symptoms worsen, they should be referred immediately. If the AFB comes back positive, the Bactrim should be stopped and the patient started on TB treatment. Any patient who presents with moderate 10 severe pulmonary symptoms should be referred immediately.

Diarrhoea

Diarrhoeal disease is very common in HIV-positive patients. Persistent diarrhoea is defined as diarrhoea lasting longer than 3 weeks. The onset of this persistent diarrhoea often indicates severe immune deficiency with a poor prognosis. In most cases of acute and short lived diarrhoea, bacteria are more commonly the cause. However, in more advanced HIV/AIDS with persistent diarrhoea, other organisms such as Cryptosporidium, Isospora or viral infection (HSV,CMV) are more common. Note that causes of persistent diarrhoea that occur in healthy patients such as amoeba, giardia, worms or intestinal billharzia should also be considered.

Recommended Treatment

Symptomatic Treatment

Drugs:

Loperamide (Imodium), 2mg p.o. BID (prn)
Codeine syrup/tablets, 15-30mg p.o. BID (prn)*,

Diet:

- Encourage frequent small, bland meals (maize meal, grated peeled apple, peeled potatoes)
- Dehydration as necessary

Antibiotic Therapy:

- at the PHC level, combination antibiotic therapy is a useful and practical approach to most causes of diarrhoea. Try the following:

Bactrim 2 tabs bds x 10 days and Metronidazole (Flagyl) 400mg tds x 10 days

- give antihelminthics (Vermox) and/or praziquantal (Biltricide) if worms or bilharzia are suspected

Skin Infections

HIV/AIDS patients are prone to many types of skin infection. Acne/folliculitis and seobrrhoeic dermatitis are especially common. Other infections such as Herpes Simplex (HSV) or shingles also occur more frequently. These can all be treated as usual but may need a longer course. Please refer to the manual on SKIN DISEASE for treatment guidelines.

Lymphadenopathy

Early H1V: lymphadenopathy is common and due to the generalized stimulation of the immune system caused by infection with the virus. The nodes should have the following characteristics:

- rubbery
- non-tender to touch
- discreet and easy to identify individually on palpation
- non-matted or stuck together
- symmetrical on both sides of the body
- patients often have nodes that involve >2 extra-inguinal sites

If you are confident that the nodes have the above characteristics, no treatment or referral is necessary. Later HIV: Nodes are made up of lymphocytes and should go away in late HIV infection. In fact, in a patient who previously had swollen nodes return and the swellings are going down, this is a sign of worsening immune system function, In these later stages of disease, any lymph node enlargement suggests that there is something abnormal inside the nodes causing them to be enlarged.

The following conditions most commonly do this:

- Tuberculosis
- L/mphoma
- Kaposi's Sarcoma

In general, the nodes in these conditions have are asymmetrical, firm or hard to touch, matted or stuck together and non-discreet i.e. they are difficult to identify individually on palpation. These patients should be referred for evaluation.

Headache

A new progressively worsening headache that doesn't respond to simple treatment with panadol or brufen should be referred. It may be due to a meningeal infection such as tuberculosis or cryptococcus. Also, there are many brain conditions that people with AIDS get (toxoplasmosis, lymphoma) that can present with headache. All of these also require referral.

Weight loss

Frequent small meals, vitamin supplements.

Care of Patients with Terminal HIV/AIDS

Pain and discomfort is common in the later stages of HIV/AIDS. Through the use of relatively simple medications, most patients can be made to feel more comfortable. Health workers should be familiar with these protocols to better manage the suffering of patients who are dying from AIDS and its complications. Note that some medications can only be prescribed by a doctor. It is important to stress that approaching the care of the dying is always based on a team approach, and good communication is essential for this to be effective.

Pain

Pain can be managed using a stepwise approach that moves progressively from non-drug management to the use of medications-

- Non-drug measures; massage, local heat. splints, music, company
- Regular analgesia:

- Non-opioids: aspirin, panadol, Brufen given up to every 4-6 hours
- If not enough, add: Weak opioids: codeine with aspirin/panadol Dihydrocodeine (DFII8)
- If not enough, add: Strong opioids: morphine syrup 20mg/5ml given po or rectally. Use 10-30 mg 4-6 hourly increasing if needed to 60mg 4 hourly.

NB. Give laxatives and anti-emetics with opioids as they often lead to nausea and/or constipation.

- **Co-Analgesics**

  The following medications are useful for specific types of discomfort as outlined. They are generally prescribed by a doctor, but all health workers should be familiar with their indications for effective use.

  - Brufen for bone and joint pain
  - Steroids for oedema, inflammation (e.g. Nerve compression)
  - Valium for muscle spasm
  - Aniolytics such as valium, haloperidol or tryptanol
  - Nerve pain: amitryptiline

Abdominal Cramps

- laxatives, buscopan

Nausea and Vomiting

- Stemetil, Maxalon, Phenergan

Headaches

– Analgesics such as panadol 2 tablets every 4-6 hours and/or Brufen 400mg every 8 hours.

Itching

- prevent/treat dry skin with moisturizers (Vaseline), cooking oil in the bath, mild steroid cream
- Anthihistimines such as phenergan or Atara

(see Pronyk 2000: 25-35).

2.1.6 THE PREVENTION OF HIV/AIDS

There is no cure for AIDS, nor is there a vaccine available to immunise against HIV. However, we know how HIV/AIDS is spread, so we can try to prevent the spread of the virus by informing and educating everybody about the disease and how to prevent it. This is our only hope for reducing the incidence of terrible disease. Primary Health Care Workers need to inform individuals and the community about preventing this disease (also see Evian 1993:241). We need to use every opportunity to inform people about AIDS and its prevention. We can talk to people in our hospitals and clinics, in the schools, factories, women's groups, churches, and many other places.

- The health sector cannot work alone in the fight against AIDS. Other sectors must be involved, e.g. Mass Media. Education, Employers, Community Organisations, Churches, Governmental and Non-Governmental Organisations.
- Find out what services are available in your area and contact them for help in your AIDS education programme.
- Health Education on HIV/AIDS needs to be ongoing and repetitive if it is to have any long term impact. Different Health Education methods can be used to inform and educate about HIV/AIDS. Eg.Talks,Workshops, Dramas, Role-plays, Songs, Puppets, Posters, leaflets etc.

Here is some advice that you can share with patients and the community about preventing HIV/AIDS infection:

In the Community:

- People need basic information about HIV/AIDS and how it is spread. There are many myths In the community which need to be corrected.
- People need to know what is meant by "safe sex" and how it can prevent the spread of AIDS;

People should use condoms for all sexual contacts. Condoms are the only way to prevent the exchange of bodily fluids between partners during sexual intercourse. Do not be judgmental, people need advice on ways to practice safer sex regardless of their sexual habits and orientation. We should encourage couples to come for HIV testing before they decide to stop using condoms. A condom will help to prevent contact with infected semen, vaginal fluid or blood so preventing the spread of HIV

- Health Workers must educate people on how to use a condom properly by demonstrating how to do so.
- Condoms must be easily and freely available at all health services.
- Inform people on other methods of enjoying sex without penetration:
  e.g.- Masturbation.
  Exploration of each others bodies without penetration
  Body Sex (where the man ejaculates between the thighs, abdomen etc not in the vagina, anus or mouth)
  Sex Toys eg.Vibrators

From a Christian perspective, unfortunately the Bible is silent on masturbation, sex toys and exploring of each other bodies without penetration, therefore it is dangerous to be dogmatic. Although we are sympathetic with those who would remove the time-honored taboos against the practice, we would like to suggest the following reasons why we do not feel it is an acceptable practice for Christians:

1. Fantasizing and lustful thinking are usually involved in masturbation, and the Bible clearly condemns such thoughts (Matthew 5:25).
2. Sexual expression was designed by God to be performed jointly by two people of the opposite sex, resulting in a necessary and healthy dependence on each other for the experience. Masturbation frustrates that designed dependence.
3. Guilt is a nearly universal aftermath of masturbation unless one has been brainwashed by the humanistic philosophy that does not believe in a God-given conscience or, in many cases, right and wrong. Such guilt interferes with spiritual growth and produces defeat in single young people particularly. To them it is usually a self-discipline hurdle they must scale in order to grow in Christ and walk in the Spirit.
4. It violates 1 Corinthians 7:9 "For it is better to marry than to burn." If a young man practices masturbation, it tends to nullify a necessary and important motivation for marriage. There are already enough social, educational, and financial demotivators on young men now; they don't need this one.
5. It creates a habit before marriage that can easily be resorted to afterward as a cop-out when a husband and wife have sexual or other conflicts that make coitus difficult.
6. It defrauds a wife (1 Corinthians 7:3 "Let husband render to his wife the affection due to her, and likewise also the wife to her husband"). No married man should relieve his mounting, God-given desire for his wife except through coitus. She will feel unloved and insecure, and many little problems will unnecessarily be magnified by this artificial draining of his sex drive. This becomes increasingly true as a couple reach middle age (see LaHaye 1997: 269, 270).

Are Condoms Safe Sex?

From a Christian perspective, the Bible doesn't have a chapter on condom use. But we can see a few principles that can help. The media, today, gives the message

that condoms allow 'safe sex'. But recent medical reports indicate that they are not as 'safe' as we have been led to believe. These reports suggest that the condom at best has a success rate of only 70%.

Firstly, the Bible gives clear instruction about the sanctity of marriage. Marriage is a God-designed relationship. God tells us to be faithful within marriage and abstinent outside marriage. We should do everything possible to promote choices and lifestyles that show obedience to god's standard.

Secondly, the Bible gives clear instruction about sanctity of life. Life is sacred to God, so we should do all we can to protect and preserve life. We must try to balance these two principles as they relate to this issue of condoms.

Condom use by married couples: The purpose of using condoms within marriage (when one or both spouses is HIV positive) is to allow the discordant couple to enjoy their physical relationship and to reduce the risk. By preventing the transmission of HIV to the uninfected spouse or by preventing continuous re-infection if both spouses are HIV positive, the couple is protecting and preserving each other's life (see A Handbook for Christian Leaders: 23, 24).

People need to know what sexual activities involve a high risk of catching HIV/AIDS

- Anal Sex is the most risky form of sexual activity,
- Having unprotected sex.
- Oral sex may lead to transmission of HIV especially if there are sores or bleeding in the mouth.

Lifestyle Skills

- People need to know how to deal with difficult situations in relationships e.g. A partner who is demanding sex without a condom. This should be taught in schools from an early age, but health workers must also be able to give advice.

- People need to know they should only take injections from recognised health services as needles may not be sterile elsewhere.
- Warn people who inject themselves with drugs about the danger of spreading HIV-
- Educate the men who run the bush schools in areas where traditional circumcision is done. These circumcisions should only be done with sterile instruments.

In the Health Services

- Always use sterile instruments, syringes and needles.
- Use gloves for all procedures involving bodily fluids.
- Disinfect or boil all infected linen and bed clothes.
- Wash hands with disinfectant after handling dirty linen, infected or bleeding wounds or blood-stained instruments. Wear gloves.
- During operations avoid unnecessary contact with blood. Use gowns and gloves and plastic aprons, if possible.

- All blood should be checked for HIV infections before being used in blood transfusions.
- Check/test that blood donors do not have AIDS and that they are not carrying the virus.
- Report any needle-stick immediately to the person dealing with occupational health
- There should be a dedicated person In each health facility and a protocol dealing with needle stick injuries.

2.1.6.1 SOME IMPORTANT POINTS TO REMEMBER ABOUT AIDS

AIDS is a new disease. It is also a deadly disease. It is not surprising that there is a lot of confusion and misunderstanding about AIDS. Below are some important

points which may help to clear up any confusion. AIDS is not spread by breathing, talking, coughing or skin contact. People with AIDS can be touched and caressed, Experts-also believe that normal dry kissing will not spread the disease, 'Wet kissing' may help to spread HIV-HIV carriers should abstain from sexual contact or, if they don't, they should always use condoms during sexual intercourse. Anyone can get AIDS. AIDS is not only a disease of homosexual men. Heterosexual men, women and children are also able to contract the disease. 80 Percent of all HIV infections are due to heterosexual sex.

2.1.6.2 ANYONE CAN GET AIDS BUT ANYONE CAN ALSO PROTECT HIM/HERSELF AGAINST GETTING AIDS

AIDS is not spread by mosquitoes or other insects. Condoms prevent AIDS if used at every sexual contact. HIV is only spread through infected semen, vaginal fluid or blood. If the mother is infected with HIV, her breast milk may also be infected with HIV. AIDS can spread through the placenta and infect the foetus. There is lot of research ongoing to help us understand AIDS better and to find a vaccine against the disease (see Pronyk 2000:1-38).

The magnitude of the problem and the current speed of expansion of the HIV pandemic make prevention a primary concern. Since the beginning of the pandemic, knowledge about the best methods of preventing the transmission of HIV has increased tremendously. The learning process has been difficult and painful. Many approaches have been unhelpful or even damaging, and the implementation of effective methods have often been slow, or has suffered from insufficient funding. These obstacles have cost the lives of countless people. After careful evaluation of the successes and failures, of many approaches and programmes, a number of effective interventions are now available. These include the following-

1. ***Information, Education, Communication***

The prevention of HIV transmission requires first and foremost that people

are properly informed about how the virus can - and cannot- be transmitted from one person to another. Understanding these facts should enable people to make responsible choices that will prevent this transmission. But information alone is not enough to determine human behaviour, which is related to deep emotions, to socio-economic conditions and to cultural and traditional norms and values. And in many situations freedom of choice is absent, so that persons are prevented from acting wisely. Participatory approaches are required in which education is linked to experience. Key elements to be borne in mind in planning information, education, communication programmes are:

- the educational messages must be clear and easy to comprehend, using appropriate media targeted especially on the groups to be educated;
- the most effective educators are people directly affected by HIV/AIDS;
- the community must be involved in identifying the cultural and social practices which increase or decrease the risk of HIV transmission, and in formulating education programmes appropriate for its situation;
- peer groups - persons from the same age range who are acquainted with the social and cultural environment of the target groups - are much more effective in education than people coming from "outside".

Generally speaking, messages using fear and negative images of AIDS have not been effective in producing or sustaining changes of behaviour.

2. ***Reduction of Sexual Transmission***

Sexual transmission of HIV can be prevented by avoiding sexual behaviour which leads to an increased exposure to HIV. The safest options are sexual abstinence or mutual faithfulness in stable sexual relationships (also see Beyrer 1998:119). If these options are not possible for some people, the proper and consistent use of late condoms offers a high degree of protection against HIV and other sexually transmitted diseases.

3. ***Early Diagnosis and Treatment of Other Sexually Transmitted Diseases***

Since infection with other sexually transmitted diseases greatly increases the risk of HIV transmission, early diagnosis and effective treatment of these diseases is an important method of risk reduction.

4. ***Safe Blood Transfusions***

HIV can be transmitted in health-care settings by the transfusion of blood from infected to uninfected persons. This risk can be minimized by giving transfusions only when necessary, avoiding them in situations in which alternative treatments suffice. All blood to be transfused should be tested and found negative for antibodies against HIV.

5. ***Proper Sterilization of Needles and other Skin-Piercing Instruments***

Scalpels, needles, razor blades or traditional instruments which have been contaminated with HIV carry the risk of transmitting the virus if they are used to penetrate the skin of uninfected persons. Sterilization using standardized techniques can prevent this way of transmission. Health-care institutions must establish strict policies and practices for the prevention of all nosocomial (hospital-acquired) infections.

6. ***Provision of Sterile Instruments for users of Intravenously Applied Drugs***

Needle-sharing by injecting drug users is another risk factor for HIV transmission. The availability of individual equipment for injecting, disinfection of equipment before usage and needle exchange programmes can remove the risk of transmission of HIV and of other blood-borne infections such as viral hepatitis B or C .

7. ***The Link Between Cure and Prevention***

Comprehensive physical, emotional and spiritual care for persons living with HIV/A1DS has been shown to be a very important and effective contribution to prevention. Appropriate care is a precondition for gaining their confidence and co-operation: and a comprehensive process of care helps families and communities to face the issues raised by HIV/AIDS and to consider and understand its implications for themselves.

8. ***Reducing Discrimination***

Stigmatization of persons because of their social status, sexual orientation or addiction to drugs makes them more vulnerable to risks, including the risk of infections. If such persons feel excluded and are afraid of having their identity revealed, they are less likely to seek care and counseling, to have access to health information and to co-operate with AIDS prevention programmes. Thus resistance to all forms of discrimination and advocacy for the rights of people who are vulnerable in HIV are not only ethical demands but also a contribution to effective prevention.

9. ***Empowerment of Persons who are particularly Vulnerable***

Persons who have no power to make decisions about their own bodies in regard to sexual relationships are at a far greater risk of being infected 'with HIV, even if they have received effective education for prevention. This applies particularly to women, who must be empowered to resist cultural and economic pressures to engage in unwanted sexual relationships.

10. ***Prevention of HIV Transmission from Mother to Child***

Anti-viral treatment of pregnant women and their new-born children has recently been shown to reduce by about two-thirds the risk of vertical

transmission. However, this treatment is not yet universally available because of its high cost (see World Council of Churches Study Document 1997: 10-13).

2.2 BEFORE PARENTHOOD

Young people, women and men, need advice about HIV and about pregnancy long before they consider becoming parents.

2.2.1 AVOIDING INFECTION

Health workers can play an important role in educating people about HIV/AIDS and how they can protect themselves against infection. This may involve working with teachers, youth groups, women's groups and others, to help people to understand HIV better and find ways to encourage and support behaviour change. Improving women's status in society is also crucial only then will women be able to negotiate with their partners for safer sex.

2.2.2 REPRODUCTIVE RIGHTS AND CHOICES

All women, regardless of their HIV status, should have the right to choose whether and when to have children and how many they would like to have. A woman who knows she is HIV positive needs information about the HIV-related risks of pregnancy for herself and her baby and how they can be reduced. But she must still be free to make her own decision about whether or not to have children, and should be supported in her choice.

2.2.3 IMPROVING ACCESS TO CONTRACEPTION

In an ideal world, every pregnancy would be a wanted pregnancy. All women and men should have access to safe and reliable contraceptives, which include barrier methods, such as condoms. Condoms prevent sexually transmitted infections (STIs) including HIV, as well as unwanted pregnancy. When women choose other ways

to prevent pregnancy, they should still be encouraged to use condoms as well, to protect against HIV and other STIs. Couples should also be advised to use condoms to avoid infection throughout pregnancy, breast-feeding and afterwards. Even when both partners are HIV positive, they should still use condoms to avoid other STIs and the possibility of re-infection with HIV. Many women find it difficult to negotiate male condoms with their partners and more female controlled methods, such as the female condoms, are needed. The female condom is already available in many parts of Africa, but often women find it expensive to buy and difficult to use. Female condoms need to be made more affordable and accessible with better information on how to use them.

2.2.4 ABORTION

HIV status should never be used as a reason for forcing a women to have an abortion. In many parts of Africa abortion is illegal. In places where it is available, an HIV-positive women may decide to end her pregnancy. If she does, she should be supported in her decision. Any decision must be made freely, without pressure from health workers or family members.

2.2.5 GETTING PREGNANT

Getting pregnant involves a risk of transmitting HIV if either partner has been exposed to infection. Couples trying to conceive can minimise the risk of transmission by only having unprotected intercourse(without a condom) during the few days each month when the woman is most likely to be fertile. Research is being done to develop vaginal microbicides (Chemical substances that can be used in the vagina to reduce transmission of STIs including HIV). It is hoped that some microbicides will prevent pregnancy by killing sperm, and also kill sexually transmitted infections such as HIV. It is also hoped that other microbicides will develop which will kill HIV and other STIs without killing sperm, so that couples can become pregnant without risking HIV infection. However, it is likely to be five to ten

years before any microbicides are on the market.

2.2.6 CARING FOR WOMEN WHO KNOW THEY ARE HIV POSITIVE

For women who know they are HIV positive, additional care may be available.

Antiretroviral Therapy

Most women in sub-Saharan Africa do not have access to long-term combination ARV treatment for their own health or the necessary support services to ensure its correct use. If an HIV- positive women is on combination therapy, she should continue to take it during pregnancy after talking to her doctor about any changes which might be needed.

Treatment of HIV-Related Infections

Even if combination ARV therapy is not available for women, many women do have access to treatment for HIV-related infections such as TB and Herpes zoster. There are also plenty of locally available, relatively cheap and effective treatments for symptoms of opportunistic infections, such as diarrhoea, weight loss and skin infections. Health workers need to be aware of what treatments women in their community are using-including traditional treatments-so that they can promote ones which are effective and warn women against false and dangerous treatments. Providing a safe, supportive environment in which to raise concerns and fears is an important part of care, and can also help HIV-positive women stay health (see Rosser 2000 :3-5).

2.3 CONCLUSION

The objective of this chapter was to dispose a number of myths and present real facts on HIV/AIDS. Women face many hurdles as they enter motherhood with HIV. Frequent clinical check-ups for the women, and after delivery, for the child are constant reminders of HIV infections. Waiting up to 18 months to find out if the child

is infected, and coping with illness in an infant and not knowing whether it is HIV-related, are stressful. Uncertainty is present all the time and continuing support is needed. If the child is infected, it is a hard blow. Health care staff and support organizations are very important at this time. A women might fear if the child was not infected during pregnancy, it can become infected later. Women need reassurance that holding and showing love to a baby and giving normal care cannot pas HIV.

People's fears of infection make it difficult for an HIV-positive women to tell others that she has HIV and that her child may also. Many women keep this knowledge to themselves, though they are always aware of their own child's situation and what it is doing. Women say they try to guide the child's behaviour so that it cannot possibly harm other children and this can be very isolating. Children very quickly become aware that something out of the ordinary, and they look for reassurance from their ordinary, and they look even more pressure on the women, who is probably already stressed because of her own HIV infection. If clinicians and public health officials concerned with preventing pregnancy-related AIDS focus solely on the prevention among women at risk for HIV, their programmes are likely to conflict with the desire of the women to become mothers and raise issues of the reproductive rights of minority and disenfranchised women. For every infant with HIV acquired in pregnancy, there is also a woman with HIV infection. Mother and child are a unit whose best interests are served by preventing HIV infections in a women to begin with, and by developing comprehensive clinical and supportive services for women who are already infected. Infection with HIV is not necessarily an early death sentence, and certainly not an immediate one. People with HIV are living full lives, often for many years, if the resources to help them are there when needed (see Berer 1993 : 10,98,107).

CHAPTER THREE

GENDER AND HIV/AIDS

3.0 INTRODUCTION

This chapter is concerned with the men and the role they play in society with effect to HIV/AIDS. Gender indicates the way in which communities or societies believe that men and women, boys and girls must behave. Gender is something we learn, for example, girls are trained to do domestic work and nurture children, while boys learn to be aggressive and control the world in which they live. These ideas can vary and change from community to community and from generation. Girls play with dolls so that they can learn to look after children; boys play with guns so they can be soldiers. In some societies these roles are reversed. In society certain groups are discriminated against and oppressed by other groups. Gender, like race, is used to discriminate against women. The new constitution tries to guarantee this will not happen.

The South African Constitution promises to Everyone:

- Equality before law
- The right to equal protection and benefit of the law.

The Constitution States:

- The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, region, conscience, belief, culture, language and birth.
- To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons,

disadvantage by unfair discrimination may be taken.

3.1 WOMEN ARE THE VULNERABLE ONES, BUT MEN'S BEHAVIOUR IS THE PROBLEM

'The HIV epidemic is driven by men,' says Calle Almedal, a senior official with the joint United Nations AIDS Programme (UNAIDS). His opinion is shared by other AIDS experts and is confirmed by statistical analysis of the disease. Worldwide, women and adolescent girls may be more affected by the consequences of HIV/AIDS, but it is the sexual and drug-taking behaviour of a large minority of men which enables the virus to spread. If the spread of HIV/AIDS is to be halted, then a wider definition of gender will need to be understood and applied to preventative activity (see Foreman 1999:2).

Men are involved in almost every case of sexual transmission of HIV. With more sexual and drug-taking partners than women, men have more opportunity to transmit HIV. More often than not, it is men who determine whether sex takes place and whether a condom is used. Men are more likely to have two or more concurrent or consecutive partners and are therefore at greater risks both of contracting the virus and passing it on. Women are more likely to be faithful to men from whom they contract HIV and less likely to pass it on. Not every man is likely to transmit HIV to others. Perhaps no more than a quarter of men endanger themselves and their female or male partners in this way. Yet, that one in four represents hundreds of millions of men who, it appears, regularly act without thought and leave women to deal with the consequences of their actions. Woman are vulnerable to HIV; men are at risk. That generalisation reflects the different circumstances in which both sexes contract the disease. Most women are vulnerable because they have limited opportunity to protect themselves. Even when they are aware of the risk of contracting and transmitting HIV, many men fail to protect themselves and their partners. It is likely that the widely accepted concepts of masculinity that underpin the behaviour of millions of men across the globe are the root of the issue. It is

tempting to blame men. This may provide a short-term emotional outlet, but it frequently diverts attention from measures that would reduce the impact and extent of the disease. Blaming men would be likely to have a negative effect (see Foreman 1999:2).

'Women and AIDS, HIV/AIDS impacts on the most vulnerable in society: the poor, marginalised and displaced people. AIDS is a crisis for women.' Although the first women worldwide was reportedly diagnosed with AIDS in as early as 1981 in the United States, it was only in the late 1980's that any significant response targeting women was mounted (Patton,1994). By then, it was arguably too late.' In South Africa, the gender response has been equally ineffective. While the NACOSA AIDS plan cited gender as a key principle, and mainstreamed gender in all seven sections (prevention and education, human rights, STD management, counseling, care, welfare, research and surveillance) this did not filter through into interventions. It is also problematic that the issues of women, gender and AIDS did not feature prominently in the initial desktop reviews or Interviews of key informants at national or provincial level in the 1997 AIDS review. This clearly indicates the visibility of gender, women and AIDS issues in interventions and advocacy. Recently, however, the National HIV/AIDS and STD Directorate has appointed a gender consultant whose task is to advise on ways to address the gendered aspects of the epidemic. A national training of gender trainers' programme was started in October 1998. The training programme needs to take place in all provinces. 'The NAPWA gender projects aims to empower women to exercise their rights and is organising a network of women who are infected and affected by HIV. However a serious gap has been the lack of communication and collaboration between AIDS organisations and gender/women's organisations in dealing with the gendered aspects of AIDS and its implications for women.

Why is AIDS a Crisis for Women?

'Throughout the world the number of women living with HIV/AIDS is growing at an alarming rate. UNAIDS(1997) cites the following:

- Almost four-fifths of all infected women live in Africa;
- In sub-Saharan Africa, there is a ratio of six women to five men infected;
- In the 15 - 24 year age group the risk of HIV infection for young women is even more disproportionate, with young women out-numbering young men by a ratio of 2:1.

Peter Aggleton (cited in Patton,1994:iv) noted that the most striking characteristic of the epidemic has been its capacity to reinforce social inequalities of gender, social status race and sexuality.

Women's Vulnerability

- Mann and Tarantola outline three types of vulnerability which impact on HIV infection namely, personal, programmatic and societal. While they do not give a gender-specific definition of vulnerability, these are concepts that can be used to understand women's vulnerability. By focusing on women's vulnerability to HIV, it is not suggested that men are not vulnerable, but instead that women are more vulnerable. Vulnerability refers to a lack of power, opportunity and ability(Skills) to make and implement decisions that impact on one's own life. The article by Quarraisha Abdool Karim (Page 15), drawing on epidemiological and behavioral studies in Kwazulu-Natal, examines possible reasons for women's vulnerability to AIDS and the implications this has for intervention strategies. Personal vulnerability refers to cognitive behaviour and biological issues that put people at risk. These include:

- The lack of access to information, including HIV/AIDS and sexuality: many women are not exposed to accurate and relevant information on AIDS.
- Personal Characteristics, such as attitudes towards HIV, and perception of own-risk. Many women, e.g. Married women, believe that they are not at risk even though they may be aware that their husbands have other partners.

- Personal skills such as the ability to negotiate safer sex. A speaker at the 10th African AIDS and STD conference, held in Abidjan in December 1997, summed up the vulnerability of women by posing the question:
  How many women face sex encounters with no free will, especially in their youth? For how many does this continue all their lives?
- Relationship dynamics- for example violence and abuse in the relationship- would make women vulnerable, including faithfulness of partners coupled with the use of condoms for any other sexual encounter they have outside the marriage. According to UNAIDS(1997) studies in Africa and elsewhere, married women have been infected by their husbands (as their only partner). Simply being married is a major risk for women who have little control over abstinence or condom use in the home.
- Biological vulnerability, including having other STIs.

Programmatic Vulnerability

Programmatic vulnerability refers to the contribution of HIV/AIDS programmes towards reducing or increasing vulnerability. UNAIDS (1997) states that AIDS prevention campaigns have, to date, failed women by urging prevention methods that women often have little or no power to apply, such as condoms, abstinence and mutual fidelity. AIDS programmes have a responsibility to ensure that gender is an integral part of every programme and project- from design, to implementation and evaluation. Furthermore, good gender practice must be evident in the management and structures of organisations (for example, the number of women in decision-making positions, gender breakdown in terms of staff/committees at all levels). Catherine Campbell, Yodwa Mzaidume and Brain Williams pointed out that interventions targeting migrant workers in a mining community with factual information have been unsuccessful. They argue that peer-education provides a context where women can engage issues, particularly women who have been unable to exercise preferred choices for health. They emphasis the role of existing women's support networks, visible organisation and public meetings, where women

can begin to stand up publicly and state their wish to use a condom and to live a healthy life.

Societal Vulnerability

Societal vulnerability refers to the broader context that impacts on the lives of women, including political, cultural, traditional, gender relations, attitudes towards sexuality, religious beliefs and poverty. Gender reframing may be more useful in explaining women's reaction to HIV. Examples include an understanding of the reason why women are less likely to leave their HIV + partner than men is greater commitment to the relationship, rather than a lack of power. Similarly, the fact that women are more likely to be tested and are less likely to give 'informed consent' (understand what may be involved in having an HIV test), does not reflect a lack of power. Rather this reflects discrimination on the part of the health care system.

It is now widely recognised that marginalisation, discrimination, alienation, impediments to the development of one's full potential are factors that contribute to increased vulnerability to HIV infection. Nowhere is this more starkly demonstrated than in South Africa- black people, particularly black women, are being the hardest hit by this epidemic. The power imbalances between men and women and gender roles are recognised as crucial contributing factors to women's excess vulnerability. Low social and economic status compounds women's dependency on men and influences their position in requesting or negotiating safer sexual practices.

Status of Women in Society

The vulnerability of women to HIV and their sexual and reproductive health status is centrally related to the context of their lives within a patriarchal society. Male dominance pervades every aspect of women's lives including family, social, religious, legal and institutional and influences their ability to be assertive and to protect themselves. Although the root of women's vulnerability lies in the imbalance of power between men and women, biological and sexual practices play an

important role in the more efficient transmission of HIV in women compared to men.

Marriage and Monogamy

Current safer sex message targeted at men and women such as the use of male condoms, monogamy, non- penetrative sex, reduction in partner numbers, celibacy and treatment of STIs assume that all is equal in sexual interactions. Women of both communities reported that most married women and women in permanent relationships accept that their husband or partners have other partners. Because of a lack of education and skills, women have been forced to become and remain 'sexual slaves' to their men. Male condom use was rare and influenced by issues of love and trust and was perceived to be used with casual partners and not with regular partners. Marriage is rare, but women often involved in a series of monogamous relationships. Increasingly, we are observing, through research and at health services, that it is monogamous women are victims of their partners' risky behaviours.

Sex Work

Women's exclusion from the formal economy has forced them into exploring other options including sex work. Understandings of what constitutes sex work are complex and include formal and informal. Formal sex work is found in a variety of settings such as escort agencies and truck- shops. Again black women are to be found in the lowest rung of what is still an illegal activity but are at the upper end of risk.

At the informal level, sex is exchanged for gifts and other favours. When women as well as street children of both sexes find themselves in economic hardship, they may supplement their income by trading sex for money or goods (see Ngweshemi 1997:92). To quote a 45 year-old woman from an informal settlement who aptly describes the situation for many women. A woman may go to look for employment all day and fail. On her way back home she might meet a man who

wants to have sex with her. She will accept any amount of money in exchange for sex in order to purchase meals for her children. She could get AIDS from that person. Research experience with women working at truck-stops where prevalence of HIV can be up to 60 percent, indicates that male condom use is rare in the average of 23 sexual encounters per week. Insistence on condom use results in violent reactions by clients, loss of clients and loss of income- as much as 25 percent of the fee for insisting on the use of condoms.

3.1.1 ATTITUDES AND BEHAVIOUR

Many if not most men who fail to protect themselves and their partners do so less from conscious choice than because that is how men are expected to behave. Most boys grow up believing, implicitly or explicitly, that their identity as individuals, is defined by their sexual prowess. Attitudes towards sex are in a state of flux almost everywhere, but in many societies men are still expected to have frequent intercourse with their wives or regular partners and occasional or regular intercourse with casual partners. Women are expected to accede to men's demands, abstinence is seen as harmful, and condoms are seen as unmasculine or as restrictive to a man's pleasure. While men - and women - are influenced by such concepts of masculinity, HIV will continue to spread. In recognition of their vulnerability, women have been the target of many AIDS prevention programmes. But men determine the path of the disease. Only prevention programmes that directly address men's sexual and drug-taking behaviour can significantly reduce the rate at which the global HIV/AIDS epidemic spreads. The major defense in Africa against HIV/AIDS transmission is likely, for years to come, to be modifications of sexual behaviour: specifically reductions in the numbers of sexual partners and the use of condoms in high-risk sexual situations (see Orubuloye 1994:117).

3.1.2 BREAKING THE CHAIN

Persuading ten men with several partners to use condoms, sterilise needles or have fewer partners has a far greater impact on the epidemic than enabling 1,000 women to protect themselves from their only partner. The ten men are at the beginning of a chain of infection; the 1,000 women are its last link. Nevertheless, this does not mean abandoning prevention programmes. It is precisely to assist women to protect themselves that men must also be a focus for prevention activities. Programmes that succeed in changing men's behavior protect both the men and their partners. A big part of halting the spread of HIV is deep-rooted behaviour change that leads to sustainable safe sex patterns.

However, many current efforts, from social marketing to public service posters, continue to reinforce traditional masculine stereotypes are unlikely to involve negotiate between partners. It is only when partners can negotiate sexual relations that sustainable safe sex is likely to take place. Changing men's behaviour is not easy - not all men behave alike. Yet even if relatively few are responsible for their sexual behaviour. A first step in that direction is to encourage greater understanding of the relationship between men, HIV/AIDS and the societies in which both men and women live.

3.1.3 MEN CAN MAKE A DIFFERENCE

Men can change the course of the AIDS epidemic, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS). All over the world, women find themselves at special risk of HIV infection because of their lack of power to determine where, when and how sex takes place, what is less recognised, however, is that the cultural beliefs and expectations that make this the case also heighten men's own vulnerability. HIV infection and AIDS deaths in men outnumber those in women on every continent except sub-Saharan Africa. Young men are more at risk than older ones; about one in four people with HIV is a young man under the age of 25.

Since the onset of the HIV/AIDS epidemic 15 years ago, the virus has infected more than 47 million people in the world. With more than 2.2 million deaths in 1998, HIV/AIDS has now become the fourth leading cause of mortality and its impact is going to increase. Over 95% of all cases and 95% of AIDS deaths occur in the developing world, mostly among young adults and increasingly in women.

Many men may not engage in risk behaviour, but without men, the virus would have little opportunity to spread. Over 70% of HIV infection worldwide occur through sex between men and women and a further 10% through sex between men and men. Another 5% or so takes place among people who inject drugs, four-fifths of whom are men. Engaging men as partners in fighting AIDS is thus the surest way to change the course of the epidemic. Through the World AIDS Campaign, UNAIDS and its partner worldwide will work and both women and men, with NGOs, governments, the United Nations system and the media to bring about a new, and much-needed focus on men (see Who's Who, In Health in KZN 2000:18).

3.1.3.1 CUSTOMARY MARRIAGE

A customary marriage in South African law is a marriage contracted under the rules of African custom and tradition. Customary marriages are contracted frequently by people living in rural areas. People who live according to African custom and tradition in urban areas also enter into customary marriages. The Recognition of Customary Marriages Bill of 1998 proposes a recognition of all customary marriages in South African law. This includes those that already exist, and those that will be contracted in the future, provided that they comply with its provisions.

Features of a Customary Marriage

At present Customary marriages may include some or all of the following features:

- Payment of lobola
- No age restriction on parties who enter into this type of marriage (Section 3(1)(a) of the Recognition of Customary Marriages Bill, 1998 (the Bill)

provides that the parties should be above the age of 18 years).

- All customary marriages are potentially polygamous (Section 2(3) of the Bill provides for the recognition of polygamous marriages).
- Parties to a customary marriage may enter into a subsequent civil marriage.
- Property rights usually vest in the husband, although in some areas, such as KwaZulu-Natal, the woman has limited rights to her house. The Bill provides that both parties are equal and that means that the wife can now own property and make decisions on it jointly with her husband).
- Registration of the marriage is not a legal requirement. This usually presents many problems for the woman, either on dissolution of the marriage or on the death of the husband. (The Bill provides that customary marriages must be registered within a reasonable time).
- The woman does not inherit directly from her husband as succession rules say that males and male children inherit from the husband (The Bill does not cover succession, but there is a separate Bill that regulates succession).

South African Law

Customary marriages in South Africa are governed by the Black Administration Act of 1927 as amended outside KwaZulu-Natal. The KwaZulu Code of Zulu Law and the natal Code of Zulu Law govern customary law in Kwa Zulu Natal. Some former homelands had their own legislation on African Customary Law. Essentially the first three laws govern customary marriages. This will remain so until the Recognition of Customary Marriages Bill becomes law. This law will bring many changes to the existing laws on customary marriages. The Constitution recognises customary law, but is also upholds principles like gender equality that are in conflict with customary practices. Where the marriage is polygamous, it is not easy to talk of equality.

Polygamy

Polygamy is a customary practice whereby a man marries more than one wife. A man who lives under the rules of customary law and tradition and marries the first wife under customary law, is permitted, if he so wishes, to take another wife or wives. The proposed Recognition of Customary Marriages Bill recognises polygamy provided that in the case of future customary marriages, a contract is entered into between the parties, including other existing wives, regarding the rights to property.

Polygamy in Africa

Western health care professionals mostly frown upon polygamy in African societies, but polygamy often helps to prevent or reduce unfaithfulness, prostitution, SIDs and HIV. Mbiti (1969) is of the opinion that polygamy is particularly valuable in modern times when African men are often forced to seek work in the cities and towns. If a husband has several wives, he can afford to take one at a time to live with him in the town, while the other wive or wives remain behind to care for the children and family property. Polygamy often provides a healthy alternative or solution to problems inherent in certain cultural customs. In some African societies, for example, sexual intercourse between a husband and his wife is prohibited while she is pregnant and this abstinence is observed until after childbirth or in some cases even until after the child is weaned. In such situations, polygamy prevents husbands from turning to casual sex.

In societies where polygamy is practised, AIDS educators are wasting their time when they try to advocate monogamy. Much more will be achieved by emphasising loyalty and fidelity between a husband and all his wives and by discouraging sex outside that group. Polygamy is, of course, only safe if all the partners in the relationship are HIV negative (see Ng'weshemi 1997:91).

South African Law

South African law now recognises polygamous marriages in the same manner that

it recognises customary marriages. This does not mean that there are no longer any problems with customary marriages. The fact that the law recognises polygamy makes it important that women continue to check that their rights are not badly attached.

The Significance for Women

The Recognitions of Customary Marriages Bill has not been passed and is not yet law. Some of the important changes proposed are:

1. Polygamous marriages will be recognised by law, but they will have to be registered as soon as possible.
2. Existing and future customary marriages must be registered. Women must ensure that this happens to protect their rights.
3. A customary marriage will have the same status as a marriage in community of property and the woman's rights will be protected where the husband wants to sell any property that is part of the joint estate. (Community of Property means that the husband and wife each have an individual half-share in each other's property).
4. Women in customary marriages will have equal status with the husband. This means that they can:-

    - Make joint decisions on matters affecting their rights within the marriage.
    - Equally share guardianship and other rights over children.
    - Enter into contracts with third parties and bind the joint estate provided that the husband gives his consent.

5. When the husband wants to take another wife, he must get the consent of his wife/wives, otherwise the marriage will not be valid.

6. When the husband enters into another marriage, their joint estate must be divided first, so that he only remains with his half share for the subsequent marriage. (This means that the first wife's half-share of the property is protected) (see Pillemer 1999:44-49).

3.1.3.2 TRAPPED BETWEEN THE BIBLE AND THE AFRICAN CULTURE

I wish to argue that African-South African Christian women living in the post-apartheid HIV/AIDS era, find themselves trapped, whether consciously or not, between two significant canons or measuring rods: the African culture (of particularly proverbs on womanhood/manhood and relationships between men and women) and the canon of the Judeo-Christian Scriptures, that is, the Christian Bible. I chose to use canon in both cases because in my view, irrespective of how liberated women may claim to be in our African settings, the African culture, which is inherently patriarchal, continues to impact on our understanding of womanhood. This culture continues to shape our understanding or rather lived experiences of the relationships between women and men, particularly in a marriage relationship.

With regard to the canon of the Bible played, whether for good or for worse, in the political and missionary history of South African peoples, there is no need to explain the usage of the term with regard to African peoples, there is no need to explain the usage of the term with regard to African Christians, particularly women. The latter have embraced the Bible so heartily that some of them will hardly figure out life without guidance from the Bible. The unfortunate part however, is the observation that the Bible has mostly been interpreted for them by foreigners to their gender, male preachers and teachers. We have been so socialized to these male interpretations of the Bible that any attempt by women liberationist scholars and preachers to make the Bible message more accessible to women, is still most likely to meet with disapproval.

I am arguing that for African Christian women who choose to remain faithful to the two canons in the HIV/AIDS era, life becomes close to unbearable. I intend to show how patriarchy, nurtured by the Bible (of particularly, the received

interpretations of the Bible) and the African culture, continues to reign supreme, thus, worsening the condition of women by making them to be the more susceptible victims of the HIV/AIDS epidemic. An important question to ask would then be : Given this state of affairs, what role should the Christian church play to improve the situation of women?

Listening to Voices Relating to the Present Topic

The following quotations capture the core of my investigation in this paper:

Aids has spread in sub-Saharan Africa because of cultural beliefs, and in particular the belief that men need, and are entitled to, frequent sex with a variety of partners. Even if we can immunise against AIDS, even if we find a cure for AIDS, issues such as commercialisation of sex, the expectation among men that women have a duty to provide them with casual sexual gratification, the belief among young women that their worth is determined primarily by satisfying the demands of their partners.

Women are expected to remain faithful to their spouses while in contrast, males can engage in extra-marital relationships with the silent approval of society. Society empowers men to demand sexual favours from his wife and any reluctance on her part is met with disapproval and chastisement. Women on the other hand, have no word in decisions over their sexuality. They are unable to enforce or demand safer sexual practices, even when they are aware their husbands have many sexual partners. In this new setting, she is no longer her own person, she belongs to the man and his family, obviously, even her sexuality belongs to the man. However, his sexuality in this culture (as in Israel) does not belong to him only. As a matter of fact, it is understandable in the Northern Sotho culture that a married man's sexuality can be shared with other women outside the family, but this does not apply to married women. A variety of proverbs bear witness to this:

Monna ke thaka, o a naba, literally, A man is like a pumpkin plant, he spreads. A married man can have many concubines. Monna ke tshwene, o ja ka matsogo a mabedi, literally, a man is a baboon, he eats with two hands; which means that though a man is married, he can have other women outside the

marriage to satisfy him sexually. It can thus be argued on the basis of these observations that in the Northern Sotho culture a married man can engage in sex outside marriage without "polluting" anyone or without being deemed a pollutant.

It is normal. It is moreover sacred (of the fact that it is endorsed by the words of the ancestor). On the other hand, a woman who complains about such a man will be reminded that ga se more, ga a fehlwe, literally, she is not a tree, she cannot be eaten up by a moth. The underlying meaning: A woman must not be worried by the absence of her husband, one day he will come back and will find her still intact. One would not want to think about the severe repercussions of such a lifestyle on the women concerned, particularly in view of the high incidence of HIV/AIDS in the country (see Masenya 2001:199). Many women are becoming victims of Aids due to unfaithful men and husbands that spread it by moving from one woman to the other. Christian marriages are being threatened. Women feel that they are bound to this particular man even when he is unfaithful; on the other hand, they are scared in case the husband is already affected. This in particular is a problem in rural areas where most of the women try to be faithful to the husbands who are working in urban areas. They come home and wives are unsure.

In search of Identity: Ideal Womanhood from an African-South African Cultural Perspective

It is a well known fact that in the traditional African culture, a woman becomes fully human when she is married. That also applies to a man. What differentiates the two in marriage however, is the privilege that a man enjoys in the patriarchal culture: differentiation in terms of gender roles. As the initiator of marriage, one expected to give out (not pay according to the traditional sense of the word) lobola to the girl's family, head of family, a man has full control over his wife and her body.

Such a view of husband-wife relationships is basically cemented in many African Christian contexts by the received interpretations of biblical texts like Ephesians 5:22-24; 1 Cor 7:5 and 1 Cor 11:7-9 "For a man ought not to wear anything on his head, for he is the image and glory of God; but woman is man's

glory. 8 - For man was not from woman, but woman from man. 9 - Neither was man created on account of or for the benefit of woman, but woman on account of and for the benefit of man" to name but three. A look at some of these texts will be in order at this stage.

In Ephesians 5:22-24 we read: "Wives, be subject to your husbands as you are to the Lord. 23 - For the husband is the head of the wife just as Christ is the head of the church, the body, of which he is the Saviour. 24 - Just as the church is subject to Christ, so also wives ought to be, in everything, to their husbands". One other popular text in the circles of African Christian men is 1 Corinthians 7:5: "Do not deprive one another except perhaps by agreement for a set time, to devote yourself to prayer, and then come together again, so that Satan may not tempt you because of your lack of self-control".

Given the male-oriented understandings of statements from both canons (the African culture and the Bible), a wife's body becomes the object of control by the man involved. With such an understanding of women's sexuality and the control which it deserves to receive from a man, rich soil becomes cultivated for the entry and the spread of the HIV/AIDS epidemic. I have argued at length about this problematic theme of the unilateral control of the bodies of married women by their husbands both in the Old Testament (cf passages on Woman Stranger in Proverbs 1-9) and in the Northern Sotho African culture (2001: 185-202). I have shown that there are close similarities between the Judahite post-exilic culture and the African Norther Sotho culture with regard to the control of women's bodies, particularly bodies of married women. Some of the similarities highlighted in that article are listed below:

1. In both cultures, there is a unilateral control of the sexuality of married women by their husbands. It is argued that the system of dowry and or lobola, contributes a great deal towards such an unfortunate view of the relationships between men and women in terms of their sexuality.
2. Women whose sexuality is not under the legitimate control of a particular

man (husband and father) become easy prey by men to satisfy male lust (prostitutes and single women will fall in this category).

3. A married man's sexuality can be shared with other women outside marriage without such an exercise being viewed with ridicule. Adultery therefore is a word more applicable to married women than it is to their male counterparts. What therefore counts is not people's devotion to God's commandments than satisfying the needs of those who are in power.

It is in this context, that an African Christian woman who decides to remain faithful to the cultural expectations of men's control over her sexuality as well as the androcentric interpretations of the Christian Bible, finds herself in a fix: remaining faithful to both, implies that she will have no option but to engage in unprotected sex with her husband. Many men in the culture, like in man cultures of the world, do not take religion (the Christian religion in our case) as seriously as their wives do. The Bible may be used as long as its interpretation helps to endorse the patriarchal status quo. In such contexts, the African culture (cf particularly proverbs supporting male promiscuity), remains an important canon. As can be expected, many such men, will have nothing to do with the demands of the Christian Bible that marriage be honoured and that monogamous marriage is the preferred option. A woman is thus confronted with a hard choice (if any) to make: Choosing life (in line with the biblical theme of life, cf Jn 10:10), will mean her taking control of her own body contrary to the dictates of the patriarchal status quo. It will mean her being frank to confront her unfaithful husband with two choices:

1. Abstinence (which will obviously deny the faithful woman of her conjugal rights).
2. Recommending the use of prophylactics.

For a typical African man, any of those options is not likely to be welcomed. Such a stance on the part of a woman, particularly if she is persistent, may ultimately lead

to the dissolution of the marriage (see Masenya 2001:2-7). People need to have knowledge, then change their attitudes and finally alter their behaviour. People are encouraged to stick to one partner, delay the first experience of sexual intercourse, and use condoms if they have more than one partner. This is the classic ABC message A - abstain; B - be faithful; C - condomise if necessary (the Christian view of the classic ABC message A - abstinence; B-be faithful in marriage; C- Christ) (see A Handbook for Christian Leaders: 21,22). The problem is that, even if people have the knowledge, they may not have incentive or the power to change their behaviour. Sexual behaviour is in turn determined by economic, social and cultural factors. For example, a truck driver on the Durban-Johannesburg-Durban run might have sex with commercial sex worker because he is bored; he feels his job is dangerous and he deserves some compensation; he is frequently away from his wife and family; he experiences peer pressure from his fellow drivers to engage in this activity; and he has the necessary money. The commercial sex worker, on the other hand, is driven by poverty and the need to feed her family (see Whiteside 2000: 19,20). Social cohesion is a concept that needs further explanation. It is partially derived from civil society, that part of society which occupies the space between the individual and the state and the degree to which there are perceived and acted-on community interests.

The argument is simple: societies with high levels of social cohesion and high incomes will not experience a serious epidemic (the US, UK and France); those with high levels of social cohesion and low incomes will see only a slow-growing epidemic (Senegal and North African Countries); those with low levels of social cohesion and low incomes will have severe epidemics but they take time to develop (Uganda and Rwanda). It is countries with low levels of social cohesion and relatively high incomes that face the most rapidly growing epidemics and highest levels of infection. In applying this conceptual framework to South Africa, one can explain why the epidemic has been so severe to date; why it is located where it is; and what may happen.

Under the apartheid system, the country was subjected to extreme social

engineering, designed for the benefit of the minority white population. The state sought to control who could live and work where. Government policy stated: 'Bantu are only temporarily resident in European areas for as long as they offer their labour there. As soon as they become, for some reason or other, no longer fit for work or superfluous in the labour market they are expected to return to their country of origin. The 'country of origin' included both the homelands and the neighbouring independent countries. South Africa's black population was forced into crowded, impoverished homelands which led to the breakdown of traditional cultural structures.

Adults, mainly men, migrated to the urban areas to work in white-owned factories and mines and to live in single-sex hostels. They were prevented by law from bringing their families. This created a culture of urban and rural wives and prostitution - not necessarily for cash but as part of a survival strategy. Many children were cared for by adults other than their parents; and in, in the wake of family break-ups, child abuse and child prostitution became a new phenomenon. Health services were limited, which meant many diseases including STIs went untreated.

At the peak in 1985, there were 1 833 636 South Africans working as migrants. This meant that they were not regarded as resident in the areas where they worked. Of these, 771 397 came from the 'independent' homelands of Transkei, Bophuthatswana, Venda and Ciskei; and 1 062 239 from the 'self-governing' homelands of lebowa, Gazankulu, Qwa Qwa, KwaZulu, KwaNdebele and KaNgwane. In additions, there were 27 814 Batswana, 139 827 Batswana, 139 827 Basotho, 30 144 Malawians, 68 665 Mozambicans and 22 255 Swazi employed officially as migrants in South Africa. Equally, one must not overlook many illegal migrants, mainly employed in the agricultural sector. Although there are now fewer migrants and South Africans can live where they choose, the legacy of apartheid remains.

In some industries, particularly mining, employment conditions have improved considerably and a greater proportion of the labour force is drawn from

local residents living in the neighbourhood of the mines. Nonetheless, migration is a way of life for many workers and the mines still provide hostel accommodation for them. Of course, it must be acknowledged that for foreign workers and their governments the ending of the migrant labour system would be a mixed blessing. Although the numbers are declining, migration remains an important source of employment for tens of thousands Southern Africans. Suffice it to say, the pattern of men moving away from their families for long periods, living in crowded and alien conditions with little power over their lives, created the ideal situation for the spread of all STIs.

3.1.3.3 INEQUALITY

In 1993 in South Africa, the richest 10 per cent of the population received 47,3 per cent of the income; whereas the poorest 40 per cent of the people had only a 9,1 per cent share. Land inequalities meant that 71 per cent of the rural population - mainly black - lived on 14 per cent of the land, while the balance of farmland was owned by only 67 000 farmers, almost all white. Inequality assisted (and continues to assist) in the spread of HIV because poor women had few financial resources and were forced into sexual relationships to ensure the survival of themselves and their children.

3.1.3.4 CONFLICT

The apartheid system could not last. But, during its final years, the cycle of oppression and resistance led to the almost total disruption of civil society. The slogan 'make the townships ungovernable' was to have far-reaching consequences. In addition, there was a militarisation of the society. Armed forces included the defence force, homeland armies, liberation movements, self-defence units and political militias. Apart from the internal conflict, there were wars being fought in Angola and Namibia. Conflict between the armed wings of the political parties continued up to the 1994 election, and in KwaZulu-Natal continues still, albeit at a much lower level. It is well known that military forces have higher levels of infection

that the general population; refugees are particularly susceptible to HIV; and conflict results in the inability to absorb and act on messages contained in educational programmes on HIV. The subject has little immediacy to those involved. All this may go some way to explaining the fact that KwaZulu-Natal has the highest level of HIV in South Africa. Indeed, one astonishing fact that emerged from the Truth and Reconciliation Commission was the use of HIV as a weapon. According to submissions made by two apartheid-era security officers, Willie Nortje' and Andries van Heerden, at the TRC in 1999, askaris (former ANC operatives who had gone over to work for the apartheid state security forces) were used to spread the disease.

People who were known to be HIV positive were employed at two Hillbrow hotels, the Chelsea and Little Rose, in 1990, with the explicit instruction to infect sex workers. The ending of apartheid, and in 1994 the election of the new government, resulted in the relaxation of the draconian controls on society. But they were not immediately replaced by a strong civil society - hardly surprising, as this is something that has to be built over time rather than imposed. In addition, there was no immediate redistribution of resources or a lessening of income inequality (see Whiteside 2000:61-65).

3.1.4 MEN CAN CHANGE THE COURSE OF THE AIDS PANDEMIC

WORLD AIDS DAY

AIDS: Men Make a Difference is Theme of Year 2000 Events

"We all know this disease is spread by men," William Malekgapuru Makgoba said last July at the International AIDS conference in Durban. He is president of the Medical Research Council of South Africa, a counterpart of the U.S. National Institutes of Health and newly elected Vice Chancellor of Natal University. The low social and legal status of women contributes to the spread of HIV in much of the world. Makgoba said that attention should be paid to "disempowering" the male in this process.

"We need to focus upon men, their biology and their sociology."

WORLD AIDS DAY: 1 DECEMBER 2000

STATEMENT BY DR GRO HARLEM BRUNDTLAND, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION, ON WORLD AIDS DAY, 2000

A Call on Men to Make a Difference in HIV/AIDS

The global epidemic of HIV infection is causing unprecedented destruction. It eclipses most other health issues and casts a long shadow over our future. On this first World Aids Day of the new millennium we must look afresh at the epidemic. We must find a better and more effective response.

Today, tens of millions women, men and children are vulnerable to HIV. Many, particularly women and children, cannot easily protect themselves. In most societies men have more power than women. When women are dependent on the men who have sex with them, they face particular risks. The short term consequences of refusing sex can be more threatening than the long-term health risks associated with compliance. Men Make a Difference is the theme of this year's World AIDS Campaign. 'As fathers, grandfathers, brothers, sons, friends, husbands and partners, men determine the shape of the epidemic.' The campaign recognizes that men could have greatest impact on the speed with which the epidemic subsides. Men are also well positioned to address the consequences of IV infection and to ensure adequate care for those who are affected.

' Some 20 years ago, when AIDS was recognized, the response was triggered by men who have sex with men. These men initiated action to reduce the risk of HIV by promoting healthy sex, caring for those affected by AIDS and advocating for more attention to HIV throughout society. Men must continue to make a difference through the strengthening of effective prevention of HIV spread.' Men have a key role to play in controlling HIV epidemics among injecting drug users. The

overwhelming majority of injecting drug users in all regions are men, particularly young men. Men usually control drug injecting situations. In drug sharing occasions usually the men inject first, passing the potentially contaminated injecting equipment onto their female injecting partners, increasing the partner's exposure to HIV and other blood-borne infections.

There is evidence from Brazil and the USA that, given the opportunity, male drug injectors will also change their behaviour to protect both themselves and their sexual and drug-using partners. More - and urgent - action is needed. We must reach men through networks of peers, providing information on ways to reduce risks of HIV infection, encouraging healthy behaviours and ensuring that they can access condoms and - if they are injectors - sterile injecting equipment.

However, until men take responsibility for preventing HIV, the epidemic will continue to grow. This means that men must face up to realities of sexual experiences, gender stereotypes and the coercion of women - often through violence - to act against their will. To achieve sustainable change, we must focus on boys; the values they learn and the way they develop - starting before they are sexually active and drawing on their openness, their creativity and their willingness to take responsibility for themselves and others. Men - whatever their age and wherever they live - can make a difference. It is the least we can expect of them.

Recognition of the Need to Change

Before people can change any particular behaviour, they first need to recognise this need to change that behaviour. The factors that often contribute to the realisation that high-risk sexual behaviour should change are:

(1) the individual's self-description of being at risk;
(2) the perception of an individual's own susceptibility or vulnerability to HIV infection;
(3) the perception that the disease will have serious consequences and that it will affect the person's whole life;

(4) the belief that performing a specific behaviour will reduce susceptibility to (or the severity of) the illness;

(5) a concern about good health in general;

(6) experiencing the symptoms of illness;

(7) personal contact with somebody who is HIV - infected or who has AIDS; and

(8) an HIV-positive diagnosis.

Be Specific about the Behaviour you want to Change

The health care professional should be absolutely specific about the behaviour that needs to be changed. Talking to people about 'safer sex practices' in general will rarely have any effect on their behaviour because the concept 'safer sex practices' is vague and refers to a whole category of behaviours instead of to one specific behaviour. A specific behaviour that one would like to change in an individual should therefore be identified (in co-operation with the individual concerned). Thus, for example one might (together with the client) construct the following definite statements: 'I must always use a condom', 'I should have only one sex partner ' , or 'I must always use sterile needles for injecting drug use.'

Identify the action, target, context and time of the behaviour that you want to change. One should recognise the vital conceptual differences between buying and using a condom (action), latex versus non-latex condoms (target), a primary long-term relationship and casual sex (context), and casual sex once a week or casual sex once a year (time). Prevention strategies will vary according to the particular aspect of behaviour that one is considering. It is also important to remember that a prevention programme which was developed to change sexual behaviour (e.g. a strategy to increase or to decrease a specific type of behaviour) will not necessarily be effective every time the person has sexual intercourse). Cognitive factors associated with the initiation of specific behaviour may be totally different from the factors that are associated with the increase, decrease or maintenance of that same behaviour.

If one wants to develop sexual behaviour change programmes that are

successful, one must focus on behaviour that is under the control of the individual - rather than behaviour which is dependent on external factors. If a (disempowered) woman has no power to negotiate the use of male condoms with her unwilling partner, a counsellor should rather concentrate on convincing her to use the female condom (this might at least be an action that she is able to control).

Intentions to Perform a Specific Behaviour

If individuals want to change their behaviour, they must first develop the intention of changing that behaviour. According to the theory of reasoned action, a person's behaviour can be predicted if one can determine whether he or she has an intention to carry out that specific behaviour. Intentions are indications of how hard people are willing to try, or how much effort they are planning to put into the performance of a behaviour. As a general rule, we can say that the stronger the intention or the commitment to do something, the greater is the probability that a person will perform that behaviour.

AIDS educators should therefore also concentrate on people's behavioural intentions in their HIV prevention programmes. The same principles that apply to behaviour change (in terms of specificity, action, target, context, and time) should also be taken into account when one is trying to change or reinforce intentions. In order to change behaviour, it is necessary to reinforce the intention that directly corresponds to the specific behaviour. If the desired behaviour is 'to use a latex condom every time the person has sexual intercourse', the intention to be reinforced will be the intention 'to use a latex condom every time the person has sexual intercourse' and not the intention 'to practise safer sex' or merely 'to use a condom' (both of the latter are too vague to be of any use).

It is obvious however that intentions do not always predict behaviour. When people do not have control over their own behaviour (as in the case of disempowered women who cannot negotiate condom use with their sex partners), the best intentions in the world may not necessarily translate into behaviour. Good

intentions are also often hampered by the unavailability of opportunities and resources such as time, money, condoms and the necessary skills.

Attitudes Towards the Specific Behaviour

The intention to change sexual behaviour (by using condoms, for instance) depends on a person's attitudes towards that particular behaviour (e.g. condom use). If people truly believe that condom use will have a positive outcome for them, then the probability that they will actually use condoms will be much greater. If however they feel negative towards the use of condoms (or find the use of condoms problematic, for whatever reason), then a great deal of explanation, negotiation and persuasion may be required before such people will actually use condoms (the desired behaviour). It is therefore of the utmost importance for te counsellor to establish a person's attitude towards the specific behaviour that needs to be changed before one can expect the change to occur.

Strongly positive attitudes, attitudes which are the end product of a lot of thinking, and attitudes which have great personal relevance and have been formed in the crucible of direct and personal experience, are far stronger predictors of behaviour than vague, generalised attitudes that have been formed as a result of exposure to impersonal second-hand and indirect information. The prediction of behaviour change can be made more accurate when one considers attitudes towards alternative courses of action.

Thus, for example, you can more accurately predict whether or not a person will use condoms if you measure both the person's attitude towards condom use, as well as his or her attitude towards not using condoms. If our prediction of attitudes is to be successful, we need to know what a person's attitude is to all alternative forms of behaviour.

Self-Efficiency or Perceived Behaviour Control as a Predictor of Behaviour Change

To have an intention to change behaviour is not enough: people should also believe that they have the ability to perform the desired behaviour. Low self-efficacy has been identified by many researchers as an obstacle to sexual behaviour change. Low self-efficacy has been found to correlate positively with high-risk sexual practices, with an unwillingness to change behaviour, and with relapses from low to high risk behaviour (recidivism). On the other hand, subjects who were categorised as being in the lowest category of risk for HIV infection generated the highest self-efficacy scores.

AIDS educators must not underestimate the importance of self-efficacy in their programmes. They should increase or reinforce people's self-efficacy by making sure that people possess the required communication, negotiation and problem-solving skills to carry out the desired actions and that they know exactly how to apply their newly acquired behaviour (e.g. how to use a condom). The person's belief in his or her ability to use a condom and to discuss condom use with partners should also be reinforced. Researcher found that both intentions to change behaviour, as well as perceptions that the behaviour can be controlled (high self-efficacy), significantly increased the probability that behaviour could be changed for the better.

The chances that a person will change his or her behaviour (e.g. by using condoms) are much better if that person (1) forms a strong intention (in this case, to use condoms), (2) demonstrates a favourable attitude (in this case, towards condom use), (3) possesses positive subjective norms and (4) also possesses a high level of self-efficacy and the perception that he or she can control his or her behaviour. Intentions, attitudes, subjective norms and perception of behaviour control may all however become undermined if a person becomes discouraged and disheartened by (perceived) obstacles or difficulties that seem to block his or her progress towards behaviour change.

Obstacles and Rewards that Impede or Encourage Behaviour Changes

One of the main reasons why people do not change their behaviour is that they perceive the existence of obstacles that (in their perception) hinder and obstruct the possibility of behaviour change. Research into the prevention of HIV infection identified the following factors as obstacles that hindered sexual behaviour change:

- People abandon all attempts to use condoms if they find it stressful to initiate or to maintain the behaviour.
- Society's intolerance towards certain sex practices and safer sex makes it more difficult for people to change their behaviour.
- Unsupportive sex partners and peers lead to abandonment of all attempts at safer sex. Research found that people often do not use condoms because they do not want to offend their sex partners, because sex partners don't 'like' condoms or because they are afraid that the partner will leave them. Partners often refuse to use condoms because it 'feels different' and because of the stigma attached to the use of condoms (in some circles). Condoms are often associated with syphilis, filth, uncleanliness, unfaithfulness and family planning.
- The lack of communication skills is one of the greatest obstacles that stands in the way of behaviour change. People find it difficult to ask partners to use condoms - especially if they do not know the partner well. They are also often afraid that the partner may think that they have AIDS. Women, in many cases, do not have the power to negotiate condom use with their husbands or partners.
- People find it difficult to handle a partner's refusal to use condoms.
- It is very difficult for people to change their sexual behaviour if they are not offered alternative sex practices which can replace risky behaviour. (See 'General safer sex rules' on page 142 for examples of alternative sex

practices).

- A fatalistic attitude to life hinders sexual behaviour change. Many young South Africans, for example, currently believe that they are at much greater risk from the possibility of violence than from the possibility of infection by HIV. As one student puts it: "With AIDS I still have a chance to live for many years. My neighbourhood is so dangerous, I am not sure that I will still be alive tomorrow morning.'
- The use of alcohol and recreational drugs diminishes the power of individuals to make responsible decisions. Even subjects who possessed a firm intention always to use condoms and who had often used condoms in the past, reported that they often had sex without condoms when they had been under the influence of alcohol or drugs (their responsibility threshold was drastically lowered).
- Condoms are often not available and accessible. People, especially young people, do not use condoms if they are not readily available. They are either ashamed to ask for condoms over the counter, or else they don't have the money to buy them.
- Cultural norms and religious beliefs are often not conducive to condom use (see Weisfeld 1991:90).

A Summary of the Theoretical Principles of Behaviour Change

A person will be more likely to change his or her sexual behaviour if he or she:

- realises the need for behaviour change (e.g. feels vulnerable to HIV infection if he or she has sex with multiple sex partners).
- knows exactly what specific behaviour needs to be change and how to go about changing it (e.g. he/she knows that a new condom should be used for every act of intercourse).
- has the intention or commitment to perform the behaviour (e.g. the intention to use a condom every time he or she has sex).

- has positive attitudes towards the behaviour (e.g. he or she believes that condom use will prevent HIV infection, and that condoms are quite comfortable to use).
- has the support of friends in changing the behaviour (e.g. his/her peer group totally accept and approve of condom use).
- has a strong belief (high self-efficacy) in his or her ability to perform the specific required behaviour (e.g. he or she knows exactly how to use a condom effectively and easily, or is able to insist - without fear or retribution - that a condom be used every time he or she has sex).
- knows exactly how to perform the behaviour effectively (e.g. how to use the condom in such a way that the condom will not break or leak).
- perceives that many more benefits and rewards will accrue from the new behaviour (e.g. condom use) than obstacles.
- has the necessary skills to perform and maintain the behaviour (e.g. the communication, negotiation and problem - solving skills to make condom use an acceptable behaviour).

3.1.4.1 WHAT MAKES A MAN

Masculinity brings with it privileges and, in many societies, freedoms denied to most women. Such privileges, however, impose burdens, with many men having sex and refusing condoms because they are conditioned to do so rather than because they want to. Furthermore, subconsciously, some men resent the obligations imposed on them; that resentment is often manifested in anger and violence towards women and other men. It is, however, irrelevant whether a man places himself, his partners and his future children at risk because he welcomes the privileges offered by his masculine status, or whether he is driven to do so from fear of losing that status. The problem, in terms of HIV/AIDS prevention, is less the attitudes of individual men than those of the societies in which they live - attitudes which lie at the heart of the epidemic.

Out of Control

Many people believe that a man's need for sex is beyond his control, with young men in particular suffering physical and mental damage if intercourse is denied. Thais of both sexes say men "have strong sexual desire and need some outlet". South African miners claim that regular intercourse is essential for a man's good health, and in Indian society "it is considered natural for men to be 'lustful'". This viewpoint appears universal. One US commentator refers to the common notice that "males, straight or gay, are at the mercy of biological forces beyond their control, forces that impel us to seek as many partners as possible". An Australian commentator claims that men's sexual behaviour is subconsciously driven by their simultaneous desire for, and fear of, loss of control.

3.1.4.2 "REAL MEN DON'T GET SICK"

The need to prove themselves masculine propels men towards risky behaviour; abstinence is seen as unnatural and refusal to use condoms is rationalised in many ways. "It is only really sex when you ejaculate into a woman," says a Zimbabwean man; "real men' do not get sick," says a Brazilian adolescent. As Mexican sociologist Jose' Aguilar and Luis Botello point out on in this book, condoms represent safety and are therefore inherently unmasculine. Furthermore, they add, "Many young and older men reject (male) condoms because in the middle of sexual conquest they can't put one on without feeling ridiculous." Many men allege that male condoms reduce sensitivity. This may be true, but refusing to wear a condom on such grounds is to suggest that immediate pleasure is more important than the risk of illness and death. Sensitivity can be restored or increased by applying water-based lubricant, where available, to the inside tip of the condom, and prevention programmes across the world have devised means of making condoms both acceptable and erotic (see Foreman 1999: 14-22 and Klepp 1995:29).

Men are the Missing Link

'My father and his father had many women' (see 23 year-old man, Kwazimba). Our minds are pre-conditioned in a sense that a man must take a leading role in life... such that woman must be subordinate. For a man to take that role he must have more experience in life than a woman (see 25 year-old man Kwazimba) (Abdool Karim 1998:27). A study conducted amongst rural and urban men on perceptions of rights of women to insist on safer sex practices, decision-making within sexual relationships and communication with female sexual partners, underscores the importance of involving men in interventions designed to reduce women's risk of acquiring HIV (Abdool Karim et al, 1998). Given the powerful role of men in society, HIV/AIDS interventions and strategies targeting men who will have a substantial impact on reducing the vulnerability of women to HIV. The need to shift the balance of power, within relationships and society, between men and women remains paramount. This shift can be expedited by targeted interventions at men that clarify misconceptions about HIV and perceptions of self-risk to HIV. Research and evaluation of AIDS interventions need to address sexual and women's reproductive health issues and men's responsibility within relationship particularly with respect to disease prevention and the rights of women.

3.1.4.3 NEW PARTNERSHIPS

Partnerships across sectors - Government, non-government and private - need to incorporate activities that address women's rights, sexual and reproductive that lifeskills programmes, specifically for young women, become an integral part of socialisation and address abstinence and postponement of sexual debut. Behind the numbers presented are the faces of young men and women. Whilst the numbers highlight opportunities to prevent new infections, even with miraculous break throughs large numbers of men and women are and will continue to die (see Abdool 1998:23). These indications are encouraging, but it is worth noting that orphans are very mobile, and that the most mobile (and therefore the hardest to

follow up in a study) may also be the ones who are most vulnerable. While it seems that traditional coping mechanisms are rather robust in rural areas, it should be borne in mind that researchers are unlikely to capture information on the households that don't cope - those whose children become street children or whose mothers become itinerant sex workers, for instance.

Long-established systems of care and fostering centred on the extended family are certainly able to absorb a certain amount of the shock of the increase in orphanhood due to HIV, a virus which is contributing over 40 per cent of orphans in some rural populations. But falling fertility, ubanisation and the migration of labour, often across borders, is eating into the extended family structures that provide the cushion. All coping mechanisms have a limit, and the appearance of child headed households in Zimbabwe suggests that in some areas those limits are already being reached. The situation will get far worse as HIV decimates the pool of care-takers and we start to see the orphaned children of the current generation of orphans, who will have no grandparents to care for them. Left to care for themselves, they may be unlikely to complete their schooling. Unless society can support them in a constructive way, they may have to resort to theft, gang membership and sex work to survive. Community-based support for the ways in which families have always taken care of their own will become increasingly important. Plans must be made for the needs of the dislocated orphans of migrant workers, for instance, and for a time when there are more children in need of care than there are adult households willing or able to care for them. Children are not able effectively to lobby on their own behalf - adults in government and the community must take the lead (see Abdool 1998:23).

3.2 GENDER DISCRIMINATION

In South Africa, as in the rest of the world, we are just beginning to understand the enormous impact of HIV/AIDS on our society, and especially on our children. HIV/AIDS is forcing us to prepare children to urgently face this crisis. Children are left orphaned, in need of care and support, and have to face death and dying at an

early age. This is not living a normal life, as older people expect their children to outlive them (see Marcus 1999: 2).

3.2.1 THE LOST CHILDREN - GIRLS

Barely heard and hardly seen, hundreds of millions of children endure grave and multiple violations of their rights. Among these children are the millions who labour on farms and in factories, who are trapped in commercial sexual exploitation, child soldiers, the millions not registered at birth, those lacking access to clean water and education, those not immunized and the millions living on the streets. The plight of all these children demands far more than the muted response it has so far evoked from the global community.

Breathtaking numbers of children are lost every day around the globe. Far too many - 30,500 each day, 11 million each year - die from largely preventable causes. But as heartbreaking and senseless as those deaths are, it is not about them that I write, I am speaking of the millions upon millions of children who are lost among the living. Made virtually invisible by the deepest poverty, not registered at birth - and thus denied official acknowledgement of their name and nationality and the protection of their rights - they endure in profound obscurity. The lost children are the most exploited, the poorest of the poor: child soldiers, girls in brothels, young bonded workers in the factories, sweatshops, fields and homes of our seemingly prosperous globe. They are robbed of their health, their growth, their education - and often even their lives.

Of the estimated 250 million children between the ages of 5 and 14 who are economically active, some 50 million to 60 million between the ages of 5 and 11 are engaged in such intolerable forms of labour. Many of the lost children are girls. Gender discrimination combines with poverty to crush girls' sense of autonomy and self, as well as their potential. In many poor families, for instance, when choices are made about whether to send a daughter or a son to school, it is gender that tips the scale against the girl. As a result, millions are shunted away from education onto the well-worn path of domestic work, labouring at home for their own families or

outside their home for others. They are among the lest visible of all children exploited in this manner, because the domestic tasks performed by girls and women are often not even dignified with the label of 'work'. The obscurity and low status of their toil put girls at further risk: many are both physically and sexually abused. Then, in one of the most brutal extremes befalling these lost children, millions - primarily girls - are forced into the nether-world of commercial sexual trafficking and exploitation. The abuse these children endure has long-term, life -threatening consequences, including psychological trauma, the risk of early pregnancy and its attendant dangers, and HIV/AIDS and other sexually transmitted infections (see The Progress of Nations 2000:27-28).

Deceived by Appearances Girls Face Disaster

Recent surveys conducted in 34 countries are revealing how little young people particularly girls, know and understand about HIV/AIDS. In 15 of the countries, 50% or more of girls aged 15 to 19 do not know that someone who looks healthy can be infected with HIV and transmit it to others. Girls' vulnerability to HIV infection, already higher than that of boys the same age for a number of physical, social and cultural reasons, is further heightened by this information deficit (see The Progress of Nations 2000:7).

3.2.2 THE TIME TO SOW

Poverty continues to enslave huge populations, denying 1.2. billion people - 600 million of them children aged one to five years - good health and productive lives. To change this painful situation, the world needs to begin with children, assuring every one of the 130 million born each year the best possible start in life. We are finally understanding how enormous our children's promise is from the moment of birth, how well-prepared infants are to survive, thrive and learn.

They depend on us adults; they beguile, charm and demand that we give them the time, nurturing and attention they seem to know that they need. When

they receive the essentials, they reward us all along the way, from their very first smile into the next generation. The building blocks are fairly modest: Children need health care, sound nutrition (with an emphasis on breastfeeding), a safe and hygienic environment and playful and loving interaction. This is the minimum; it is neither extravagant nor exhorbitant. Yet from ths simple foundation, they go on to astound us with their achievements, mastering language, arts, sciences and the complexities of life (see The Progress of Nations 2000:11-12).

Women Setting Agendas

To this end, while collective action and collective learning, and indeed positive peer support, can usefully be fostered among men and within mixed groups, there is still place for women's groups to continue to define objectives and to ensure that a genuine mutuality of interests is kept to the fore. Women need to be vigilant to ensure that prevailing gender relations are not simply heightened insight and assumed responsibility of individual men. Deeper structural changes are needed, especially a transformation of gender relations. The paradox offering promise is that, although the nature and severity of its impact is a consequence of inequalities of power, AIDS can serve as a leveller of conflicting interests. Both rich and poor are among those afflicted. If women are most vulnerable, men are not spared. AIDS threatens the future by claiming the lives of the young. In this sense the epidemic exerts a strong persuasive influence, illustrating the illusory nature of any vested interest in maintaining a status quo which can bring harm to so many (see Baylies 2000:196).

Heart of Development

We squander our children's innate capacities and stint their care in those critical early years at grave expense. In violating children's rights by denying them the essentials they need and deserve, we harm them and ourselves, permitting and encouraging the seeds of poverty, alienation, hatred and despair to take root. Both

poverty and gender discrimination replicate themselves from generation to generation. By ensuring children good early care, based on gender equity, we take vital and giant steps in breaking these cycles of discrimination and deprivation and unleashing new creative powers. What does effective early child-hood care entail for the vast majority of the world's estimated 1 billion children between the ages of zero and eight years? It recognizes the interaction among health, nutrition and the emotional well-being of children and their primary caregivers. To care for a child by necessity means being concerned about the conditions a woman faces at home and in society at large. There are many reasons why countries do not honour the most basic rights of children. In some, war has destroyed infrastructure, economies and communities; AIDS is rampant, particularly in Africa, and it is very dangerously eroding already fragile social structures ad the abilities of communities and nations to respond. Corruption drains the coffers n many others. And in far too many, the spiral of increasing and self-perpetuating debt strains already threadbare budgets and translates into disaster for children (see The Progress of Nations 2000).

3.2.3 BEYOND THE ORPHANS

Policymakers and other service-providers may have a special interest in planning for the needs of those people who have no way of helping themselves. Since HIV infects people who are young and sexually active, it more likely than most fatal diseases to target parents and to leave behind orphans. The extent to which orphans need special care will vary depending on cultural and social coping mechanisms as well as the level of orphanhood.

Levels of orphanhood depend on several factors, including the state of the epidemic, adult mortality and the interaction between HIV and fertility. Cohort studies in rural populations with similar levels of prevalence calculate that between seven and 15 per cent of children have lost at least one parent. As noted, lower fertility generally leads to higher orphanhood. However, the picture is complicated by evidence that HIV itself cuts fertility. Those most likely to die of HIV - related causes are also likely to have borne fewer children and therefore leave fewer

orphans. Mothers who transmit HIV to their offspring will not increase the orphan pool much, since babies infected at birth do not generally survive long. In one study, orphans under the age of five were six times as likely to be HIV - infected as children with both parents alive. Few of those infected children will make it to school age. In South Africa, where health services are more developed than elsewhere in sub-Saharan Africa, the increasing use of the drug AZT during pregnancy may reduce vertical transmission and so increase orphanhood (see Whiteside 1998: 126-127). South Africa's population is young: 54 per cent are below 25 years of age and 12 per cent are below five. Changes in population structure where young to middle-aged adults are lost will result in large numbers of orphans, as well as children in adoptive families, growing up with less adult attention than might otherwise have been the case. In some situations, children will receive little or no adult attention. Such is the lot of increasing numbers of street children and the small but growing number of 'child-headed' households. Nearly one million South African children under the age of 15 would have lost their mothers to AIDS by 2005. This is estimated to increase to around two million by 2010, according to the Department of Health. The difficulties surrounding the definition of orphans were discussed in the previous chapter so that these figures, if anything, may underestimate the scale of the problem.

Studies have been conducted on the plight of orphans and their caretakers in various African countries. Among the findings are that:- families which foster children in Kenya usually live below the poverty line; and orphan households in Tanzania have more children, are larger, and have less favourable dependency ratios. Children who lose a parent to AIDS suffer loss and grief like any other orphan. However, their loss is exacerbated by prejudice and social exclusion, and can lead to the loss of education and health care. Moreover, the psychological impact on a child who witnesses his or her parent dying of AIDS can be 'more intense than for children whose parents die from more sudden causes. HIV ultimately makes people ill but it runs an unpredictable course. There are typically months or years of stress, suffering or depression before a patient dies'.

For a child living with a parent who has AIDS, the disease is especially cruel as HIV is sexually transmitted. Consequently, once one parent is infected, he or she is likely to pass it on to the other parent. Children who lose one parent to AIDS are thus at considerable risk of losing their remaining parent as well. For children, therefore, AIS will, over time, cause a major diminution in social capital in the form of lack of social skills, knowledge and unclear expectations. It will also lead to detectable and quantifiable declines in levels of formal education. A bleak future is predicted by Martin Schonteich of the Institute for Security Studies in Pretoria. He warns that 'AIDS and age will be significant contributors to an increase in the rate of crime in South Africa over the next ten to twenty years.

'There will be a dramatic increase in South Africa's orphan population during the next decade as the AIDS epidemic takes its toll. Growing up without parents, and badly supervised by relatives and welfare organisations, this growing pool of orphans will be at greater than average risk to engage in criminal activity. Moreover, in a decade's time every fourth South African will be aged between 15 and 24. It is within this age group where people's propensity to commit crime is at its highest.' Thus, an increasing number of AIDS orphans, who grow up without parental support and supervision, may turn to crime. 'Crime will increase because of the disintegration of the fabric of our society. It will be made worse by the lack of guidance, care and support for AIDS will have no role models in the future and they will resort to crime to survive.'

A series of interviews undertaken in 1998 with young South African men serving jail sentences, or involved in crime, by the centre for the Study of Violence and Reconciliation found that most of the interviewees were 'abandoned or kicked out of their homes, or had to live with a stepfather or mother who rejected them. Many expressed feelings of being unloved.' Schonteich argues that the major predictor of crime will be the age structure of the population. During the next ten to twenty years, the number of juveniles and young adults as a proportion of the general population will peak. This will exert an upward pressure on the crime rate as juveniles and young adults are proportionately more likely to commit crime that

children or adults. At about the same time, South Africa will also experience a rapid increase in the number of children growing up with no parents or only one parent because of the effects of AIDS. Most will grow up without adequate parental supervision, guidance, and discipline under impoverished conditions - an environment which will increase their temptation to engage in criminal activity at an early age. In other parts of Africa, like Sierra Leone and Liberia, this neglect has already spawned a multitude of boy soldiers who are seen touting around rifles, rocket-launchers and other weapons (see Whiteside 2000:95-97).

3.2.4 THE ORPHANS' DILEMMA

HIV and AIDS are increasing adult mortality and so orphanhood in many African minors. But it is worth bearing in mind that in much of the continent, social and cultural institutions were formed against a backdrop of very high mortality. Extended families are the norm and child fostering, by relatives and others, is common.

One study in rural Tanzania found that over a third of children whose parents were alive did not live with both their biological parents, and over one in 10 lived with neither surviving parent. Two households in five were home to children who were neither indigenous to the household nor orphans, nearly three times as many as those housing orphans. And a significant proportion of orphans were living away from their parents before they became orphaned. Some 40 per cent of children who had lost one parent were not living with the surviving parent, especially if it was the mother who died.

Grandparents very frequently cared for both foster children and orphans, and rarely had any significant outside support for their charges. Orphans were very often found in households headed by women. It has frequently been assumed that orphans and foster children get less care than biological children, but that seems not to be the case, at least into the teen years. By their teens, children not living with their biological parents are more likely to drop out of school. A longitudinal study found little evidence that orphans were more likely to die than non-orphans

once age and HIV status are taken into account.

These indications are encouraging, but it is worth noting that orphans are very mobile, and that the most mobile (and therefore the hardest to follow up in a study) may also be the ones who are most vulnerable. While it seems that traditional coping mechanisms are rather robust in rural areas, it should be borne in mind that researchers are unlikely to capture information on the households that don't cope - those whose children become street children or whose mothers become itinerant sex workers, for instance. Long - established systems of care and fostering centred on the extended family are certainly able to absorb a certain amount of the shock of the increase in orphanhood due to HIV, a virus which is contributing over 40 per cent of orphans in some rural populations.

But falling fertility, urbanisation and the migration of labour, often across borders, is eating into the extended family structures that provide the cushion. All coping mechanisms have a limit, and the appearance of child-headed households in Zimbabwe suggests that in some areas those limits are already being reached. The situation will get far worse as HIV decimates the pool of care-takers and we start to see the orphaned children of the current generation of orphans, who will have no grandparents to care for them. Left to care for themselves, they may be unlikely to complete their schooling. Unless society can support them in a constructive way, they may have to resort to theft, gang membership and sex work to survive.

Community-based support for the ways in which families have always taken care of their own will become increasingly important. Plans must be made for the needs of the dislocated orphans of migrant workers, for instance, and for a time when there are more children in need of care than there are adult households willing or able to care for them. Children are not able effectively to lobby on their own behalf - adults in government and the community must take the lead (see Whiteside1998:127-128).

AIDS has both direct and indirect effects on children. The direct effects result from infection and illness of either or both the child and his or her caregivers.

The projections of the number of AIDS orphans, shocking in their own right, refer to the number of children affected directly by parental death. However, as illustrated by the story of Maria, there is a substantially larger number of children who will suffer indirectly as a result of the HIV/AIDS epidemic. Indirectly affected cases are mostly unreported, and the impact of illness and death is incremental. Worst it are communities who are already poor, with no savings, inadequate infrastructure and limited access to basic services. Not taking into account the effect of the AIDS epidemic on socio-economic conditions, it is estimated that 61% of children in South Africa live in poverty. It is these children whose family and household conditions are further exacerbated by the distress and need associated with the HIV/AIDS epidemic. HIV/AIDS affects children across a number of interdependent dimensions as described below, citing data mostly from studies "AIDS orphans" and other directly affected children.

In several countries, incomes in orphan households may be 20 - 30% lower than in non-orphaned households. Studies in urban households in Cote d'Ivoire, for example, show that when a family member has AIDS, average income falls by 52 - 67%, expenditures on health care quadruples, savings are depleted, and families go into debt to care for the sick. Food consumption has been found to drop by 41% in orphan households. Loss of income of breadwinners, asset selling to afford care, and debt incurred to pay for funeral costs may deplete all current and future reserves of households.

As households become progressively more affected and caregivers die, children may suffer the loss of their home through the sale of livestock and land, as well as asset stripping by relatives. Affected and orphaned children have traumatic psychological reactions to parental illness and death; they suffer exhaustion and stress from work and worry, as well as from insecurity and stigmatisation, because it is often assumed that they too are infected with HIV. Loss of home and dropping out of school, separation from siblings and friends, increased work load and social isolation, may all be associated with adverse mental health. Studies of children's reactions to date suggest that children show internalising rather than externalising

symptoms: depression, anxiety and withdrawal in contrast to aggression and other forms of antisocial behaviour.

Children who grow up without the love and care of adults devoted to their well being are prone to psychological problems in relating to others. As a result these children lack empathy, which arises from their deprivation as recipients of empathic care. They may develop antisocial behaviours which, on the scale or orphanhood predicted to result from the AIDS epidemic in South Africa, could cause social problems on an unprecedented scale. It is imperative that systems of care in response to the epidemic are supported and developed to ensure that the basic emotional needs of small children are met, as this is essential for later psychological integrity and the capacity to relate to other people in compassionate ways (see Children First 2001: 31-33).

3.2.5 COPING WITH GRIEF

Grief is the process and work of adjusting to the irrevocable loss of persons, objects, relationships, and dreams. The grieving period often begins before death (anticipatory grieving) but may appropriately extend for two years of more after death depending upon the nature of the relationship. Grief is a normal response to loss and includes such symptoms as sadness, crying, withdrawal from other friends and family, loss of drive or ability to concentrate, and fears of "losing ones mind" or experiencing physical symptoms similar those of the person who died. The grieving person requires significant support such as brief visits, phone calls, or invitations to simple social events. Many community hospice programs can provide this type of support. One role of the palliative care team is to assure that care is given to those left behind, the bereaved. Because of the concentration of activity near the time of death, the bereaved may not feel the full impact of the death for at least two weeks after the actual event. Contact at this time is helpful as is remembering the person on important anniversaries such as one month after the death, holidays, and days particular to the individual who died such as a birthday or wedding anniversary.

The first and tenth year anniversaries of the rituals related to the date of death which continue to comfort those surviving. Coping strategies that have been useful throughout the disease can also be applied after the death of a loved one.

Guidelines for After the Death

Mallinson has outlined guidelines for addressing grief which might be useful in working with those who are surviving loss from HIV disease. Simply rehearsing words or phrases ahead of time make it easier for the health care team to interact with survivors during a time which many find awkward.

- Acknowledge the death: "I understand that your (partner; spouse) died last week. How is this going for you?"
- Validate the importance to the survivor: "You knew her for a long time, and the two of you were very close. What was she like?"
- Speak of the deceased when appropriate: "I remember when Tommy was first born. This would have been his second-birthday this week. How are you feeling?"
- Note the existence of multiple losses: "Since you have been coming to clinic, you have lost your partner, your best friend, and now, your daughter. I can't imagine what it is like. How do you handle the grief?"
- Learn about grief and loss: Take courses, attend workshops, read research and acquire therapeutic communication skills (see Anderson 2000: 369 - 371 and see Seligson 1992: 112-115).

Euthanasia

Most people with AIDS thinks about euthanasia or suicide at one point or another. Particularly with the newly diagnosed, euthanasia is a much-repeated topic of discussion in the groups. Each person's viewpoint about his or her quality of life and euthansia is strictly personal and demands respect. Thoughts about

euthanasia are nearly always based upon fear. Fear of physical or mental suffering, pain, dementia, blindness, and paralysis is common. Fear of becoming a burden and dependent upon others is great. However, the greatest fear of all is that of dying alone. In Holland, although euthansia is illegal, under some special circumstances the physician may not be prosecuted for administering it. Euthanasia may be defined as willingly and actively terminating the life of a person at his or her explicit request. The use of pain medication, by increasing the dose and thus speeding death, it not considered euthanasia. Nor is stopping certain medical physician must adhere to are the following: the patient must have enough information to make an informed decision; the patient must agree to each step of medical treatment; the physician must previously consult with at least one colleague who interviews the patient; the physician must keep a medical journal, where the various consultations with the patient and second physician, as well as the process of the euthanasia, are recorded. Euthanasia may only be performed by a physician; the patient must be suffering physically and/or mentally without any hope of improvement through any medical treatment; the patient must state in writing that his or her request for euthansia is a voluntary, well-informed, and durable decision. The euthanasia request may not be a sudden decision or one made under duress by anyone other than the patient. The death certificate must state the cause of death as "unnatural." If the above-mentioned requirements are met, the physician will probably not be prosecuted in court, although police and court investigations will be made (see Ahmed 1992: 183 & 184).

From a Christian perspective the Bible does not have a chapter on Euthanasia. John 5:21 "For as the Father raises the dead and gives life to them, even so the Son gives life to whom He will" explains that life is sacred to God, so we should do all we can to protect and preserve life and not take life.

3.3 CONCLUSION

The objective of this chapter was to unite men and women in their efforts to increase men's participation in the struggle against HIV/AIDS by confronting stereo types and dismantling institutionalised bias that helps to maintain the gender gap. Research confirms that HIV is pushing up mortality quite dramatically and seems to be pulling down fertility. It may soon swell the number of orphans beyond families' ability to absorb them. Good policy and planning is based on thorough analysis of the existing situation. In the case of HIV, this includes an analysis of changing patterns of fertility, mortality, household and population structure, and an appreciation of the burden of the disease. The better the social, economic and physical causes and effects of these changes are understood, the better policymakers can plan for them and, where necessary, attempt to alter their course. More understanding and more coherent action will follow when all those involved in tracking, projecting, and planning to minimise the epidemic work closely together and inform one another's work to meet common goals (see Whiteside 2000:128-129).

CHAPTER FOUR

SOCIAL RELATIONS AND HIV/AIDS

4.0 INTRODUCTION

This chapter is concerned with the broader impact of HIV/AIDS on the population at large. It is deeply distressing to imagine that, in the next decade, as many as 20 - 30% of South African children will watch fearfully as their parents get ill, mourn them in their passing on, and struggle to pick up the pieces of an unjustly harsh future. In a society where HIV infection prevalence rates exceed 20% in several parts of the country, many children are made vulnerable because of the stress on services caused by the epidemic, the loss of skilled individuals from civic structures, and the distress of a nation both confused and grieved by widespread illness and death. It is true that on the extreme end of the continuum are children affected by HIV/AIDS in particular identifiable ways. This extreme end includes: children who are HIV - positive and who are sick and/or dying from AIDS - related illnesses; children orphaned by the death of HIV - infected parents; and children whose families and households are affected by HIV/AIDS in a variety of ways (see Children First- A journal on issues affecting children and their careers: 30 & 31).

HIV/AIDS is not only an increasingly cause of death among adults, infants, and young children, it is also slowly impoverishing and destroying families, leaving growing numbers of orphans in its wake. At all stages of the epidemic, families bear most of the social and economic consequences of HIV/AIDS depends on the state of the household's resources before, during and after the disease affects them. Material relief and moral support finished by neighbours are more viable alternatives during extreme crises. However, the impact of such relief assistance at the household level is not sustainable in and of itself. Over the long run, the household must continue with its internal resources. In addition, a resilient safety net requires community members who are willing and able to volunteer their time and resources.

If too many families slide into destitution, the community safety net will be overwhelmed. Fewer people will be available to share their resources within the community. This must be taken on board when offering help. It must be realistic, sustainable and may have to be long term (see Snidle 2001:52).

4.1 THE IMPACT OF HIV/AIDS ON THOSE WHO ARE INFECTED OR AFFECTED BY THE EPIDEMIC

Death and dying are issues that confront an individual who has been diagnosed with AIDS. For many patients, fear of debilitation and death is the most critical, open emotional crisis following diagnosis and is raised immediately in counselling. Other persons choose not to discuss death and, instead, maintain their usual routine to the greatest degree possible until late stages of their illness. There is no doubt that most therapists and helping professionals are uncomfortable with discussions about death. However, patients can be assisted in dealing with these issues so they can shift their focus, as much as possible, to living with AIDS rather than dying from AIDS. Persons with AIDS differ in their social and environmental support needs. Some patients have close, supportive social networks and are care for by family members or relationship partners during times of illness. Others are homeless and have few supports and few resources. Access to psycho-social, economic, and social supports may differ across persons in the various current high-risk groups (see Siegel 1988:5). The stress of an AIDS diagnosis is exacerbated when friends, family members, or health providers are not supportive (see Kelly 1988: 135, 138 & 139).

The Impact of HIV and AIDS on Children

HIV/AIDS has become a defining feature of South Africa society. We have the highest infection rate in the world with between 4.2 and 4.8 million people currently infected. KwaZulu Natal has the highest rate of infection and 27% of the country's children live in this province. The lack of clear political leadership when it comes to

effective action and policies, disempowers and dissipates the fragmented, under-resourced efforts that are being made. How does this affect the children's lives? What can be done to limit the harm? What is the cost of our inaction? These are some of the questions we must all ask ourselves.

Statistics

Of 44 million people living in South Africa, 17 million are children under the age of 18. Of this 17 million, 13% are under the age of six. Kwa Zulu Natal has an estimated population of nine million, of which 23% are children. 60% of these children live in rural areas. Children (under the age of 15 years) account for 10% of people infected with HIV. These numbers would be higher if the accepted definition of people under the age of 18 years was used in statistics. Many more children will be as directly affected as biological parents, guardians and adult relatives become sick and die. It is impossible to adequately convey the enormity and complexity of this disaster. In 1998, without AIDS, people could expect to live to 65. By 2010 the life expectancy will have dropped to 48 years. If children are not infected with HIV/AIDS at birth, there is an increased chance that they will be infected through sexual abuse (see Children affected and Infected by HIV/AIDS. An HIV/AIDS Project newsletter from Lawyers for Human Rights - 2001:3).

4.1.1 ECONOMIC IMPACT

An increase in illness and death in a population will inevitably have economic and social consequences. For each individual and his or her family, an HIV diagnosis and its consequences are a disaster. What is not clear is the degree to which AIDS will impact on the community and nation at the macro level. What will the impact of AIDS be in South Africa? Since the late 1980s, the doom-and gloom merchants have been having a field day in predicting the dire consequences of the AIDS epidemic.

This was epitomised in a book, AIDS: Countdown to Doomsday, published

in 1988. The author (Broomberg) argued that AIDS was likely to lead to economic collapse and a shifting balance of global power. The reality is and will not come true (see Broomberg 1996:77). In Africa, the epidemic is of a different order of magnitude and the impacts will be commensurately greater. But it is not entirely clear what they will be, as is apparent from the discussion in the rest of this chapter. In South Africa, the effect is only just beginning to be felt. There are a number of reasons for this:

- South Africa is at the moment experiencing an HIV epidemic. The AIDS epidemic is still developing rapidly. While the HIV epidemic is projected to peak around 2010 (it may even be sooner), AIDS cases will continue to grow for another 5 to 10 years.
- Except at the micro or household level where the effect of AIDS is immediate, the economic impact will only slowly manifest itself as the number of individual illnesses and deaths accumulate over time. It may take even longer to show up in the official figures.
- Ultimately, the economic impact will depend on how many people are infected and who they are. Economics does not value all lives equally. However, everyone is a consumer even if they are not produces.
- Social impacts arise because people interact in ways other than economic.

South Africa is at the beginning of the AIDS epidemic. The impact of illness and death is being felt by families, the public health service, and some private-sector firms. However, it will take time to work through into society at large. To find examples of impact, we have therefore to look to countries where the epidemic is further advanced. However, two caveats must be noted:

- Even in the developing countries where the epidemic is most advanced, the impact is still evolving and is largely unknown.
- South Africa is different to these countries. It is a more modern, skills-dependent and technologically advanced economy. Its citizens expect, and

get, more from the state than is the case in most other African countries.

Despite these reservations, we can be sure of three things. The impact will be:

- long-term
- complex
- surprising

In South Africa, a study was done on the impact of AIDS on the national economy in 1991. The study suggested that the major initial impact would be on the public health service. In the longer term, the epidemic was expected to pose a threat to ongoing economic growth, with some sectors being more seriously affected that others. The general conclusion was that while 'the overall effect of the AIDS epidemic would be a sustainable one for the South African economy for the next 15 years, the problem is still a desperately serious one for our society'.

As South Africa enters the new century, it is clear that, in macro-economic terms, the epidemic is not yet having a measurable impact. However, the impact of AIDS is gradual, subtle and incremental (see Broomberg 1996:52). It may well be that we will only know the true impact on government and the private sector when we look back from 2010 at what actually happened. Even then, it will be necessary to isolate its effect from all the other factors that influence the economy, e.g. government economic policy, export markets, interest rates, etc.

Recently, South Africa was finally predicted to be at the threshold of renewed economic growth. In 2000 the economy was expected to grow by 3,5 per cent, and the growth rate was to remain over three per cent in the foreseeable future. Will the increase in death and illness due to AIDS affect the prospects for economic growth in South Africa? The 2000 South African Budget Review produced by the Department of Finance includes a 'box' on population projections HIV/AIDS. This notes that the effects of HIV/AIDS on future population growth and labour force participation are difficult to predict, as is the economic and social impact.

However, it suggests that population growth may slow down to close to zero

per cent by 2010, with the growth of the working age population declining from over two per cent in 2000 to under 0,5 per cent by 2008. The review paints a stark future in adding the following statement. 'The economic and social impact of HIV/AIDS is also hard to predict. Household structure and behaviour will change as the size, composition and productivity of the labour force are affected. HIV/AIDS is more prevalent among the economically active part of the population, thus affecting economic activity through a loss of skills and experience. Labour productivity will decrease owing to absenteeism and illness of workers, and unit labour costs will increase as firms pay more for medical aid and group life or disability coverage. Initial evidence suggests that AIDS mainly affects lower income or skills groups (e.g. migrant or mobile labourers) but the future patter is still unclear.

One study predicts an HIV prevalence in 2003 of 12 per cent among highly skilled workers, 20 per cent among skilled workers and 27,2 per cent among low-skilled workers. Declining life expectancy and job losses in families will also affect the dependency ratio - the ratio of non-working age population to the working population. More orphaned children and child-headed households, combined with fewer economically active people, will burden family support systems, with implications for the future development of South Africa's social security systems. The Department of Finance is therefore beginning to take the threat of AIDS seriously. Over the next few years, we can expect a great deal more on this subject from them. More recently ING Barings produced a report 'Economic Impact of AIDS in South Africa: A Dark Cloud on the Horizon'. This combines earlier demographic modelling with macro-economic models. They noted that, although data were imperfect, the AIDS epidemic was expected to have an adverse impact on te South African economy. The 'nonalarmist' scenario suggested that annual GDP growth would be between 0,3 and 0,4 percentage points lower than the no-AIDS baseline over the next 15 years. The key areas identified by the report include:

- South Africa is already battling with a skills shortage. AIDS will exacerbate this and raise remuneration and replacement costs for companies.

- There will be a smaller labour force with lower productivity and income at the same time as demand grows for services such as health and welfare. Lower tax revenues combined with higher health spending will put pressure on the government's budget deficit. However, demand for housing as well as durable and non-durable goods could be negatively affected.
- A rise in the inflation rate together with a smaller savings pool could well put pressure on interest rates.
- Domestic savings may be squeezed to a point where foreign investment is vital to plug the gap. However, AIDS and the perception that it creates may deter such investment.

Meanwhile, the World Bank's paper 'Intensifying Action against HIV/AIDS: Responding to the Development Crisis' warns that prevalence rate above five per cent not only makes the disease more expensive and difficult to contain; it also starts seriously reducing economic growth. We are double that threshold right now (see Whiteside 2000: 82-89).

The Economic Impact

The other major impact of AIDS orphanhood on children stressed by participants in the collapse in their material fortunes. In most countries, urban rates of HIV infection are currently higher than those in rural areas. Conjugal breakdown is also more common in the towns and ties with kin and extended family weaker, a survey conducted among AIDS counsellors in Zambia found that 30 per cent of AIDS - affected families were already headed by single parents before the parent's death. As HIV-related illness takes hold of a breadwinner, household income is bound to decline. By the time death comes, the family's scant resources may have been absorbed in medical care of the patient.

In rural areas, the family farming plot may have been sold to pay for treatment. Alternatively, customary laws or determined relatives may deprive widows and their children of their rights to the inheritance of property. Moses

Ddombo of the Rakai World Vision Orphans Project in Uganda reported that in 40 per cent of the families looking after orphans in Rakai, the children were admitted into their guardians' homes with no resources of any kind. The laws of inheritance vary from country to country in the degree of protection they give to widows and orphans. All participants recognized this as an area either for legal change, or legal enforcement. Esnath Kalyati of Malawi described efforts being made by the national women's association to alert Malawian women to their modern inheritance rights, of which many in rural areas are completely ignorant.

There is bound to be economic stress on the extended family taking in orphans, a stress which may be passed on to the children themselves. Sometimes sibling groups are split up to spread the burden, depriving them of each other's emotional support. Among the under-five age group, health and nutritional status is an extra risk, in old age-groups loss of schooling through lack of means for fees, books and uniforms is the major concern. Where orphaned children are sent to live with aunties or uncles, they may receive less care than the natural children in the family. Liz Mataka reported that some urban children sent home to rural grandparents were treated as unpaid labour. Many of the group underlined the huge importance attached to loss of schooling and consequent loss of prospects.

Last, but not least, affected are the children forced to become heads of household at a very young age. This happens especially where a family is not living in their traditional rural homeland because persecution or disaster of one kind or another forced them to migrate and settle elsewhere. In Rakai district, a World Vision sociological survey found over four per cent of households headed by children between 12 and 16 years of age. Like some of the children of dying parents, many have to resort to begging for food, or to work in the fields or run errands - water or fuel collection - to earn the wherewithal to buy provisions. Some of these children, obliged to be adults prematurely and provide for their little ones, are truly remarkable in the way they manage to surmount daunting odds in their effort to run the household and maintain the unity of family life (see Black 1991: 12,13).

4.1.2 MIGRATION

Migration has been identified as the primary family and community coping mechanism in the face of the AIDS epidemic. It became established as a family and household coping mechanism in the face of migrant labour demands and the hardships occasioned by apartheid laws. Migration associated with AIDS occurs for several different reasons, both within rural and urban areas as well as between them. Some identified forms of migration include 'going-home-to-die', rural widows ging to town to seek worker or the help of relatives, and potential caregivers and dependants moving between household to achieve the best care arrangements under the circumstances (see Gilgen 2000:129).

Children are frequently relocated. Adolescents are particularly likely to migrate, as girls are sent to help out in other households, or older children are encouraged to try and fend for themselves by working or by becoming street children (see Children First - 2001: 32). Oscillatory migration is part of the reality of millions of South African men and women. A community - based study conducted in Hlabisa demonstrated that a woman's risk of HIV is substantially increased if her partner is a migrant worker. Current research in Hlabisa demonstrates that 80 per cent of all households have more than one male who is migrant while 33 percent of households had a female migrant (see Friedman 1998:20).

4.1.3 CHANGES IN CAREGIVERS & FAMILY COMPOSITION

The diagnosis also affects lovers, friends, family members, and the health care providers who care for AIDS patients while they live and as they die.

Effects on Spouses and Lovers

Spouses, spouse-equivalents, and lovers are simultaneously confronted with the terminal diagnosis of a loved one and inevitable worries about whether they, too, will

become ill. With most other terminal diagnoses, relationship partners respond by drawing nearer to the diagnosed individual. Following an AIDS diagnosis, supportive and compassionate responses may be more strained since the lover is confronted with both the partner's deteriorating health and his or her own vulnerability. If the AIDS patient is a gay man with a male lover, there may be less recognition of the partner's needs and distress than if the patient were heterosexual and married. Partners, too, are often in need of mental health services as they attempt to cope with the future loss of their loved one and their own uncertainty about whether they may face the same illness.

Families

Families of AIDS patients face multiple stress. In addition to coping with the eventual death of the AIDS patient, family members often must come to terms with their feelings about the patient's lifestyle, with stigma because a member of their family has AIDS, and with their own fears concerning the illness (see Cadwell et al 2000:159). Developing mental health resources to better assist these families not only will benefit the AIDS patient and the family members but also has broader social implications. Expanding available services to family members can be justified as cost-effective health care. The increasing numbers of AIDS -affected persons threaten to overwhelm our health care system, and growing numbers of patient beds are required for persons with AIDS. Inpatient care is also expensive and may have to be prolonged if a family feels unable or unwilling to assist in the home care of a patient too ill to resume independent living. Family interventions can enable the family to provide home care and support benefiting the patient and reducing the need for extended hospitalization or residential care.

Caregivers

Those who care for AIDS patients are affected by the stress of the health crisis. AIDS is a merciless killer and most patients die within 2 years of their AIDS

diagnoses. Caregivers accustomed to curing their patients become taxed by their inability to provide substantive remedies to patients in the late stages of their disease. Often the tools of caregivers consist a little beyond reassurance, emotional support, and compassion. As a result, providers become frustrated by their inability to restore health to their AIDS patients. For those who have chosen to become involved primarily in working with AIDS patients, the toll of watching young people in the prime of life waste away takes a heavy emotional toll.(See Mann 1992:789) Caregivers may also be ostracized by professional peers who are uncomfortable with the disease or with the life-style of AIDS patients. This can lead to the provider's becoming isolated from collegial contact and support.

Many health care providers fear contagion (see Kramer 1994:54), even though a growing body of research indicates that health care workers are at little risk, if standard body fluid precautions are followed. Reed, Wise, and Mann (1984) surveyed 267 nurses and found that 67% were anxious about catching AIDS from their patients. When over 1,000 health care workers were followed in a surveillance project after they had become exposed to HIV - infected blood through needle stick injuries and other accidental on-the-job exposures, only 0.5% subsequently sero converted (see Marcus et al., 1987). Furthermore, 40% of those accidental exposures would not have occurred if the staff had followed recommended body fluid procedures.

When blood samples from nurses caring for children with AIDS and ARC were examined for HIV antibodies, more were HIV-exposed, even though the nurses cared for these children daily - giving baths, feeding blood and urine specimens, having contact with blood a secretions, and touching and comforting the children. Similarly, when a sample of dentists and surgeons who care for HIV-affected patients were tested, none had antibodies to the HIV by Western blot analysis. In spite of this knowledge, there can be a gap between cognitive knowledge and personal attitudes. In a survey of general practice physicians and pediatricians in New York, 48% of the general medical and 30% of the pediatric physicians reported moderate to major anxiety about acquiring AIDS from their

patients and more than 25% of the physicians in the study believed a physician could ethically refuse to treat an AIDS - affected patient. A similar study conducted in California assessed health care workers' estimation of risk and anxiety from caring for persons with AIDS. Interestingly, significant differences were found between male and female medical house officers' estimation of risk; 84% of the men but only 48% of the women believed house officers were at risk if they care for AIDS patients. More than 20% of the physicians reported they were "very anxious" about contracting AIDS from their patients, and 97% acknowledged that they worried about contracting AIDS at least occasionally. Twenty percent reported having nightmares about AIDS, and 18% of the physicians reported detecting symptoms in themselves that they erroneously interpreted as possible symptoms of AIDS.

It is evident that health care providers are vulnerable to increased stress even as they meet their professional responsibilities to AIDS - affected patients. Clergy traditionally minister to families and patients facing serious illness and death. The roles of a pastor, priest, rabbi, or chaplain in ministering to persons with AIDS are important and are the same as ministering to persons with other illnesses. This may involve administering traditional rites and sacraments of faith; providing support and counselling for the patient as well as family, friends, and caregivers; and helping the patient reconcile unresolved spiritual issues. While some clergy and church denominations have long had ministries to the urban poor, homosexual, and nontraditional communities, ministering to persons with AIDS requires sensitivity to alternative lifestyles and relationships and an ability to set aside judgements concerning aspects of the patient's behaviour that may be in conflict with traditional church doctrine. Several resources are available to guide clergy who provide pastoral care to persons with AIDS (see Kelly 1988 : 130 - 133 & 140).

4.1.4 NEW RESPONSIBILITIES AND WORK FOR CHILDREN

Several studies have shown that responsibilities and work, both within and outside of the household, increase dramatically when parents are ill or have died, and that

new responsibilities are given to children as young as five years of age. Work in the household includes domestic chores, subsistence agriculture, and care-giving of young, old and sick members of the house-hold. Work outside of the home may involve a variety of formal and informal labour, including begging for food and supplies from nearby communities and taking the place of ill relatives in farm work (see Children First - A journal on issues affecting children and their careers - 2001:32).

4.1.5 EDUCATION

In households affected by AIDS, the school attendance of children drops off because their labour is required for subsistence, and the money earmarked for school expenses is needed for medication and health services. School begins to compete with the many other duties that affected children are required to take on. In addition, stigmatisation may prompt affected children to remain away from school rather than endure exclusion and/or ridicule at school.

A study in Zambia, for example, showed that 75% of non-orphaned children in urban areas were enrolled in school compared to 68% of orphaned children. At a national level, a World Bank study in Tanzania suggested that AIDS may reduce the number of primary school children by 22% and secondary school children by 14% as a result of increased child mortality, as well as lower attendance and dropping out (see Children First - A journal on issues affecting children and their careers - 2001: 32). Barely heard and hardly seen, hundreds of millions of children endure grave and multiple violations of their rights. Among these children are the millions who labour on farms and in factories, who are trapped in commercial sexual exploitation, child soldiers, the millions not registered at birth, those lacking access to clean water and education, those not immunized and the millions living on the streets. The plight of all these children demands far more than the muted response it has so far evoked from the global community.

Breathtaking numbers of children are lost every day around the globe. Far too many - 30,500 each day, 11 million each year - die from largely preventable

causes. But as heartbreaking and senseless as those deaths are, it is not about them that I write, I am speaking of the millions upon millions of children who are lost among the living. Made virtually invisible by the deepest poverty, not registered at birth - and thus denied official acknowledgement of their name and nationality and the protection of their rights - they endure in profound obscurity. The lost children are the most exploited, the poorest of the poor: child soldiers, girls in brothels, young bonded workers in the factories, sweatshops, fields and homes of our seemingly prosperous globe. They are robbed of their health, their growth, their education - and often even their lives. Of the estimated 250 million children between the ages of 5 and 14 who are economically active, some 50 million to 60 million between the ages of 5 and 11 are engaged in such intolerable forms of labour.

Many of the lost children are girls. Gender discrimination combines with poverty to crush girls' sense of autonomy and self, as well as their potential. In many poor families, for instance, when choices are made about whether to send a daughter or a son to school, it is gender that tips the scale against the girl. As a result, millions are shunted away from education onto the well-worn path of domestic work, labouring at home for their own families or outside their home for others. They are among the lest visible of all children exploited in this manner, because the domestic tasks performed by girls and women are often not even dignified with the label of 'work'. The obscurity and low status of their toil put girls at further risk: many are both physically and sexually abused. Then, in one of the most brutal extremes befalling these lost children, millions - primarily girls - are forced into the nether-world of commercial sexual trafficking and exploitation. The abuse these children endure has long-term, life -threatening consequences, including psychological trauma, the risk of early pregnancy and its attendant dangers, and HIV/AIDS and other sexually transmitted infections (see The Progress of Nations - 2000: 27).

Education

Education changes how people see themselves. It also affects a person's health. Often, more educated a mother is, the healthier she is because she knows how to take care of herself. The healthier a mother is, the healthier her child will be. The level of a person's education can help or hurt your efforts to counsel someone. For example, a person who is able to read may have read newspapers and billboards about AIDS. He may already know something about HIV. You could teach him using written materials. The ability to read and write may mean that a person feels comfortable learning n a school setting. A person who does not read or write relies on other sources of information, such as radio, television, and friends. She often thinks more in terms of real-life situations. In this case, telling stories about other people with AIDS may teach more than listing facts about the number of people in the country with HIV. Using visual aids such as posters, drawings, and videos can be especially helpful. People who cannot read often learn better from their own experience than from information given in a student-and-teacher-setting. When counselling such a person, it is also better to ask more concrete (exact) questions; for example, ask "When you last had sex, did you use a condom?" Rather than "Should condoms always be used for sex?". Written materials such as pamphlets can help with your counselling. People may have questions after you have spoken with them, and the written information can help answer these. It can also remind people of facts they have forgotten. They can share the pamphlet with others. People who have difficulty reading can still be given written materials; their friends or family can read the materials to them (see Granich 1999: 104, 105).

Education, the Key

"Education" said the late Julius Nyerere, a former school teacher and much loved first President of the united Republic of Tanzania, "is not a way of escaping the country's poverty. It is a way of fighting it" (see The progress of Nations - 2000: 29).

Another Face of AIDS : 860,000 Children without Teachers

An estimated 860,000 children in sub-Saharan Africa lost their teachers to AIDS in 1999. Children in Kenya, Nigeria and South Africa are most seriously affected by these losses. For reasons that are not entirely clear, HIV seroprevalence is very high among teachers and school administrators. Zambia, for example, recorded 1,300 teacher deaths in the first 10 months of 1998, more than twice the number of deaths in 1997 and two thirds the number of new teachers trained annually. In the Central African Republic, between 1996 and 1998 almost as many teachers died as retired.

Although HIV/AIDS affects all sectors, its most profound effects are concentrated in education. Now, all over sub-Saharian Africa, hard-won gains in school enrolment - and the returns on investments countries have made to improve education - are being eroded. Schooling is disrupted when teachers are absent from class due to illness, death or the need to care for ill family members, or when a decreasing number of teachers have to take on larger classes. HIV-positive teachers are leaving schools in remote areas that lack health care facilities and requesting postings in locations near hospitals. In a number of countries, public spending is being shifted away from education to cope with other aspects of the AIDS crisis, which means less funding is available to hire an train teachers to replace those who have died. Educational quality also suffers when fewer resources are available for classrooms and materials. Discriminatory attitudes and practices towards AIDS - affected individuals interfere with the learning process, and high rates of teacher turnover and fluctuating numbers of students constrain educational planning. However, education must be safe guarded in the face of the AIDS crisis, as schools are key to reducing the impact of the disease. Countries' efforts to develop school-based programmes to control HIV/AIDS have been dealt a mortal blow, and assistance from the international community is urgently needed (see The Progress 2000 of Nations - 2000: 8)

4.1.6 BEYOND THE SAFETY NET

A safety net for children affected by AIDS is created by extended families, across multiple generations and in multiple locations, and by communities with reciprocal obligations among members. The net tends to be better preserved in rural areas, although this may change. However, affected households and children need relief through material help, as well as assistance with labour, care-giving and emotional support. Children who slip though these safety nets become highly vulnerable and exposed, and include street and working children, as well as child-headed households. The number of orphan households headed by very elderly caregivers, households with orphans from two or more families, working and street children, and sibling dispersion may serve as indicators of the saturation of the extended family safety net. In these cases it has been suggested that alternatives need to be developed, including adoption and foster placements, children's villages and institutions.

However, only through universal efforts, such as effective implementation and distribution of the child, foster care, and old-age grants can the existing safety nets be supported. We are still a long way from this. In a press briefing on the 14 September 2000, the Minister of Social Development, Dr Zola Skweyiya, said that most children orphaned by AIDS (65%) were in family or community care, 35% were in foster care and a very small number were formally adopted or in institutional care. He also said that in 1999/2000, only 48 965 of the estimated 250 000 HIV/AIDS orphaned children eligible for the foster care grant (20%) were receiving it (see Children First 2001: 33 and Intensifying Action 2000:10).

4.2 VIOLENCE AGAINST WOMEN

There's no vocabulary for love within a family, love that's lived in but not looked at, love within the light of which all else is seen, the love within which all other love finds speech. This live is silent.

- T.S. Eliot

(see Santrock 1994:433).

Violence against women is present in most societies but it often goes unrecognized, accepted as part of the order of things. Information about the extent of this violence from scientifically sound studies is still relatively scant. However, domestic violence against women has been documented for all countries and socio-economic environments, and available evidence suggests that it is much more far-reaching than was previously believed. In different parts of the world, between 16% and 52% of women suffer physical violence from their male partners, and at least one in five women suffer rape or attempted rape in their lifetimes. It is also well-known that rape and sexual torture are systematically used as weapons of war. Violence negates women's autonomy and undermines their potential as individuals and members of society.

The need for more research on the connection between human rights, legal and economic issues, and the public health dimensions of violence is clear. A rapidly growing body of evidence shows that women's experience of violence has direct consequences not only for their own well-being, but also for that of their families and communities. In addition to broken bones, third degree burns and other bodily injuries, abuse can have long-term mental health consequences, including depression, suicide attempts and post traumatic stress disorder. Violence involving sexual assault may also cause sexually transmitted diseases, unwanted pregnancies and other sexual and reproductive health problems. For girls, the health consequences can carry on into their adult lives.

Violence against women can also have inter-generational repercussions. For example, boys who witness their mothers being beaten by their partners are more likely than other boys to use violence to solve disagreements in their own adult lives. Girls who witness the same sorts of violence are more likely than other girls to become involved in relationships in which their partners abuse them. Thus, violence tends to be carried over from one generation to the next.

Violence against women and girls is a major health and human rights issue. At least one in five of the world's female population has been physically or sexually abused by a man or men at some time in their life. Many, including pregnant

women and young girls, are subject to severe, sustained or repeated attacks. Worldwide, it has been estimated that violence against women is as serious a cause of death and incapacity among women of reproductive age as cancer, and a greater cause of ill-health than traffic accidents and malaria combined. The abuse of women is effectively condoned in almost every society of the world. Prosecution and conviction of men who beat or rape women or girls is rare when compared to number of assaults. Violence therefore operates as means to maintain and reinforce women's subordination.

United Nations Definition

The Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993, defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It encompasses, but is not limited to, "physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution, and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs"

Why are Definitions and Measurements Important?

Accurate and comparable data on violence are needed at the community, national and international levels to strengthen advocacy efforts, help policy makers understand the problem and guide the design of interventions. Measuring the true prevalence of violence, however, is a complex task. Statistics available through the police, women's centres, and other formal institutions often underestimate levels of

violence because of under-reporting.

Population-based research is more accurate, but the lack of consistent methods and definitions makes comparisons across studies difficult. Because definitions are subjective, survey questions often ask whether women experience specific acts of violence, during a fixed period of time. While some studies examine only physical abuse, others may consider physical, sexual and psychological abuse. In family violence research, some may include only those women currently in a relationship, while others report on women who have ever been married. The severity of violence recorded may also vary between studies. For example, one researcher may record all violence regardless of whether it results in bodily injury, whereas another researcher may record only incidents in which a physical injury occurred (see WHO 1997).

4.2.1 DEFINITION & SCOPE OF THE PROBLEM

What is known is that violence against women is so pervasive and tenacious that it cannot be explained as solely the product of individual psycho pathology or faulty communication. We also know that violence against women take many forms, including, but certainly not limited to, battering, sexual harassment, and rape. We also know that this violence has devastating consequences for the woman, the family, and society (see Peled 1995:97).

To understand violence against women, one must understand why men believe they are entitled to control women, and why they feel they may use intimidation, coercion, threats, and force to do so. We cannot expect either prevention or intervention efforts to be successful unless the gendered nature of violence is understood and directly addressed. Culture is the "all-encompassing" whole that includes the concepts, habits, skills, instruments, arts, morals, laws, customs, institutions, and any other capabilities acquired by human beings as members of a society . Cultural norms and expectations play critical roles in promoting and shaping male violence against women, minimizing or covering up its harmful effects, and preventing the development of effective policies and programs designed to prevent such violence.

Norms and expectations prescribe and proscribe the rights and

responsibilities (i.e., the roles) of all persons in a particular social status or social category, including those social roles assigned by gender. It is through gender-related roles that specific cultural norms related to gender and violence are patterned, learned, and transmitted from generation. Socio-cultural norms and role expectations that support female subordination and perpetuate male violence are transmitted in the home, at the workplace, and in the military. These norms and expectations pervade our legal system, our literary works, and our everyday discourse (see Koss 1994: 3-7).

Patriarchy

Women's status is affected by relations in the family, class status, and the ideology of the social group to which they belong. It is inherited through historical instructions and culture. The social relations of gender as well as class relations are part of a historical inheritance. Among the ideologies underlying our inheritance is that of patriarchy. This is a term in which inequality and hierarchy are implicit and is a concept and institution which is discussed in sociological and feminist literature in a variety of ways, as Sylvia Walby shows in her chapter in this volume.

Literally 'power' of the father' and indicating male supremacy, it is understood variously as 'a symbolic male principle' governing social and gender relations, an institutional structure of male domination, or an ideology based on the power of men. Zillah Eisentein (1979) suggests that patriarchy provides the sexual hierarchical ordering of society for political control. It is a feature of a large number of societies redating capitalism; a separate phenomenon and independent dynamic observed in connection with social relations between men and women as well as the organization and control of production. Thus it is a useful analytical tool with which to investigate both class and gender relations. Operating in some or all of these senses, patriarchy as an ideology is deeply embedded in several societies, cultures, and institutions as well as in the minds of men and women. From experience and a variety of studies we are able to conclude that women over whom such power and authority is exercised are socialized suitably to 'fit in'. Prejudices coloured by patriarchy are inherent in many traditions. Where tradition rules, institutions,

cultures, social mechanisms, norms, and practices tend to become resistant to change and hinder women's development (see Moghadam 1996: 113 & 114).

4.2.2 VIOLENCE AGAINST WOMEN IN FAMILIES

Women and Violence

South Africa has a history of violence but nothing has wracked this country like the violence and intimidation that mark our transition to democracy in the closing years of this twentieth century. Women bear the brunt of this violence. Women and children are the victims of violence as often as men. Whole families are wiped out, women are left without male support, children are orphaned. No one is safe.

Domestic Violence

One tragic result is the domestic violence on the increase everywhere. There has never been more wife battering, more child abuse, more physical violence, more family murders, more ill-treatment of the elderly, or more mental torment that is reported today - ironically on the eve of the United Nations International Family Year in 1994. The Human Sciences Research Council brochure on family violence reports that South Africa has been subject to sweeping changes over the past century. Factors such as the rise of the mining industry, the technological revolution and increasing urbanisation have taken their toll not only in terms of their far-reaching effects on the family (in all the different population groups) but also in respect of increasing pressure on the family, consequently making it more susceptible to violence.

> *There has never been more wife*
> *Battering, more child abuse, more*
> *Physical violence, more family*
> *Murders, more ill-treatment of the*
> *Elderly, or more mental torment....*

This vulnerability is illustrated clearly the sharp rise in the divorce rate, illegitimate

births, child neglect and family violence, as well as by the search for alternatives to marriage and traditional family life.

Family violence manifests itself in various ways, for instance as child abuse, wife abuse, husband abuse, parent abuse, and family murder (see Lessing 1994: 259, 260). The most common form of violence against women is domestic violence, or violence against women in families. Research consistently demonstrates that a woman is more likely to be injured, raped or killed by a current or former partner than by any other person. Men may kick, bite, slap, punch or try to strangle their wives or partners; they may burn them or throw acid in their faces; they may beat or rape them, with body parts or sharp objects; and they may use deadly weapons to stab or shoot them. At times, women are seriously injured, and in some cases they are killed or die as a result of their injuries.

The nature of violence against women in families has prompted comparisons to torture. The assaults are intended to injure women's psychological health as well as physical violence. Also like torture, the assaults are unpredictable and bear little relation to women's own behaviour. Finally, the assaults may continue week after week, for many years (see WHO 1997).

4.2.3 RAPE AND SEXUAL ASSAULT

The State Response to Rape and Sexual Assault

I was raped in October 1994. I was in my boyfriend's apartment cooking. His roommate and I were alone. His roommate came from behind into the kitchen and attacked me. He dragged me to the bedroom. He raped me. I screamed and struggled. I scratched him until he had marks all over his face. There was blood everywhere. All the time, he was threatening to kill me. Then he picked up a knife and told me he would kill me if I told anyone.

I was so scared he was going to kill me, I threw myself out of the window. I fell three floors to the ground. My pelvis and

spine were broken. See these scars on my legs, they are from the broken glass of the window. I was hospitalized and then in a wheelchair for three months. Even now, I have to wear this medical corset to support my spine and I can't stand for long. I don't have a job any more because I cannot trave anywhere. I still get dreams about the rape. I have two children I have to support.

I reported the case to the police. I told them I know the man and that he had scratches on his face. But the police have done nothing. I even see him around here every once in a while. What's the use of going back?

Rape is defined in South Africa as an intentional, unlawful sexual intercourse with a woman without her consent. The essential elements are men's real (intent); unlawfulness; sexual intercourse with a woman; absence of consent. The law only applies between a man and woman and there must be penetration of the penis into the vagina. Acts of forced oral sex or sodomy, or penetration by foreign objects such as bottles or sticks, are not considered rape, but are criminalized under such as bottles or sticks, are not considered rape, but are criminalized under indecent assault. This narrow definition of rape has been criticized by South Africa women's organizations because the law does not recognize as rape any forced sexual act which does not include penetration by a penis; because only a woman or girly may be raped; and because consent, and not coercion, is the standard used. While the number of rapes reported is only a fraction of the total, the number of prosecutions is even smaller. Less than one third of reported rapes reach the courts. Of those cases prosecuted, only half - that is, less than 15 percent of the reported cases - result in convictions. By contrast, more than two thirds of prosecutions for aggravated assault are successful. On the 27,056 reported rape and attempted rape incidents in 1993, only 8,998 (33.3 percent, or 17.6 percent of the total) resulted in convictions. During the period July 1993 to June 1994 , a total of 8,553 rape cases were prosecuted, and 4,311 convictions were secured.

The South African legal system is rife with assumptions and biases against women who have been raped. Riana Taylor, a criminologist who works with the Advice Desk for Abused Women, noted that the role of the courts in rape cases is "absolutely frightful at the moment". She added: In order to prosecute for rape, a woman must deal with the district surgeon (i.e. a government doctor), the prosecutor and the judge. With all three, there are potential problems (see Manby 1995: 89-90). Large-scale studies of rape and sexual assault are scarce. Those that do exist, however, consistently report high prevalence rates. Research conducted in industrialized countries has shown that the likelihood of a woman being raped or having to fight off an attempted rape is high. In developing countries, research suggests tat rape is an ever-present threat and reality for millions of women.

Although rape and sexual assault may be perpetrated by strangers, evidence from many sources indicates that a high percentage of rapists are acquaintances, "friends", relatives, and those in positions of trust or power. Another consistent finding is the high percentage of young, and often very young, rape victim. Many sexual assaults are perpetrated by more that one attacker. "Gang rape", where two or more men subdue and penetrate their victims, is not uncommon. Women are also subjected to what has been termed "non-contact" sexual abuse in which, for example, men expose their penises or make obscene telephone calls. Where non-contact abuse has been studied, it has been discovered that a high percentage of women have experienced this type of abuse; in some cases up to 50% of all women questioned (see WHO 1997).

4.2.4 ARMED CONFLICT AND DISPLACEMENT

Women are not passive victims of situations of struggle and conflict. Women have taken leading roles, including as fighters, in armed conflict on numerous occasions, for example, in Nicaragua against the Contras, in Eritrea in the War for Independence from Ethiopia. Women refugees manage daily life in many refugee camps. Women workers in the export-oriented-industrial zones in Sri Lanka, the Philippines, Malaysia and elsewhere have been the first to protest at the exploitative practices of employers. Women, from Scotland to Hong Kong, have organised, often in the teeth of extreme opposition, to protect their jobs and their rights as

workers. Unarmed women are in the front line also in anti-apartheid struggles in South Africa and have shown themselves fearless in the face of all forms of aggression. Women have been, and are, in for peace, security and equitable gender relations - essential to the reduction of conflict at all levels and lasting respect for human rights (see 'O'Connell 1993:vi and Machel et al 2001:56). Armed conflict and uprootedness bring their own district forms of violence against women with them. These can include random acts of sexual assault by both enemy and "friendly" forces, or mass rape as a deliberate strategy of genocide.

4.2.4.1 SOME FORMS OF VIOLENCE RESULTING FROM CONFLICT/REFUGEE SITUATIONS

- Mass rape, military sexual slavery, forced prostitution, forced "marriages" and forced pregnancies.
- Multiple rapes and gang rape (with multiple perpetrators) and the rape of young girls.
- Sexual assault associated with violent physical assault.
- Resurgence of female genital mutilation, within the community under attack, as a way to reinforce cultural identity.
- Women forced to offer sex for survival, or in exchange for food, shelter, or "protection".

4.2.4.2 INCREASED VIOLENCE AGAINST WOMEN DURING CONFLICT

The general breakdown in law and order which occurs during conflict and displacement leads to an increase in all forms of violence. The tensions of conflict, and the frustration, powerlessness and loss of traditional male roles associated with displacement may be manifested in an increased incidence of domestic violence against women. Alcohol abuse may also become more common and exacerbate the situation. The underlying acceptance of violence against women which exists within many societies becomes more outwardly acceptable in conflict situations. It can, therefore, be seen as a continuum of the violence that women are subjected to in peacetime. The situation is compounded by the polarization of gender roles which frequently occurs during armed conflict. An image of masculinity is

sometimes formed which encourages aggressive and misogynist behaviour. On the other hand, women may be idealized as the bearers of a cultural identity and their bodies perceived as 'territory' to be conquered. Troops may also use rape and other forms of violence against women to increase men's subjugation and humiliation.

4.2.4.3 WHO IS THE MOST VULNERABLE?

Some groups of women and girls are particularly vulnerable in conflict and displacement situations. These include targeted ethnic groups, where there is an official or unofficial policy of using rape as a weapon of genocide. Unaccompanied women or children, children in foster care arrangements, and lone female heads of households are all frequent targets. Elderly women and those with physical or mental disabilities are also vulnerable, as are those women who are held in detention and in detention-like situations including concentration camps (see WHO 199).

4.2.5 THE GIRL CHILD

What are little boys made of?
Frogs and snails
And puppy dogs' tails.
What are little girls made of?
Sugar and spice
And all that's nice.

-J.O. Halliwell,
- Nursery Rymes of England, 1844 (see Santrock 1994: 376).

Denial to Girl Child Her Right to Live

The right to live had been denied to the girl child since long as the British discovery of female infanticide in India found it existing in 1789 among a clan of Rajputs in

eastern part of Uttar Pradesh. The reports of the British districts office observers were generally of direct female infanticide. Kolloor (1990) defines it as killing of an entirely dependent child under one year of age who is killed by mother, parents or others in whose care the child is entrusted. Mascarenhas (1990) calls it "postnatal abortion".

Institutionalized Violence Against Girl Child in Different Cultures

A majority of the cultures of the societies in the world are patriarchal, except for tiny pockets here and there, which are matriarchal or matrilinial. Consequently, it means that the male of the species of Homo Sapiens considers himself superior to the female in spite of the unique ability of the female to propagate and nurture the species with little co-operation from the male.

Sigmund Freud - the great patriarch of modern psychiatry (basing his experience on the treatment of mentally ill women and men) discovered the importance of the sexual life in human beings. But biassed as he was in favour of the males, he formulated the concept of 'Penis Envy' not acknowledging envy in the male towards the female, because of her function of reproduction. It is conjectured that the envy of the male originated when the cave man came back to his cave one day and found his mate with "cave children". Wonder struck though he might have been, the fact that his mate could reproduce, while he could not must have filled him with horror, discomfort and envy. His knowledge of the part he had played in reproduction was nil at that time.

Here was a being (woman) who not only bled periodically during menstruation and did not die-when normally people die of bleeding-but was even able to produce 'little cave people', could 'Womb Envy' have originated in him then? This is a question that needs to be probed deeply before the envy felt by girls for the freedom enjoyed by boys in patriarchal cultures is interpreted as 'Penis Envy'. The entire process of human reproduction from menstruation of girls to the birth of children by them as women, has been degraded by ideas of impurity, pollution and taboos. While man has sought freedom and even abused it, woman has not only been

restricted, confined and subordinated by means of powerful ideas, rituals, traditions and customs, but also by inflicting untold but unnecessary pain and suffering on her being, to bring her and keep her under control to suit men's whims and desires (see Kapur 1993: 11, 47 & 48).

Violence against the female is symptomatic of the low status of girls and women. Insofar as such violence is prevalent in both the developed and developing countries and in traditional as well as modern societies, it is safe to suggest tat it has more to do with 'gender' than with 'class', 'creed' or 'race' or the level of socio-economic development of people. The female child is encouraged to imbibe qualities of meekness and gentleness in her attitude as well as behaviour. Assertiveness among girls is equated to an aberration and among boys to independent-mindedness. The belief that the female is "of the home" and the male "of the outside" is carefully projected and perpetuated through child rearing practices. The notion that men are the principal earners and anchors of the household as well as the economy is fostered both within the family and in schools.

As is pointed out by a recent report on sexual violence against women in Europe, "Violence against women originates in a number of assumptions but the respect roles of men and women.... Behaviour patterns and prejudices associated sexual differences are acquired in early childhood. School offers tremendous opportunities for perpetuating or conversely transforming these stereotypes." Proceedings of a recent Inter-American Consultation on Women and Violence also point to the existing patriarchal system as being the fundamental cause of violence are: "domination and authoritarian relations; male power as the governing principle of social relations; economic factors; socialization norms employed in the education of children; aggressive behaviour for men; passive behaviour for women; and violence suffered by children in the family..." (WIN News, 1991: 38-39).

Violence against the female takes place both within the home and outside and is the most potent form as well as outcome of genderism. It affects the female from her birth, indeed in some cultures and contexts, from her conception. Violence against the female foetus and child occurs, as was pointed out in earlier chapters, in countries and cultures which have a distinct preference for sons over daughters.

As childhood passes, the veil or purda, takes over to isolate the girls from the boy, ad to begin the confinement of the female to the family. Adolescence and menarche cause further restrictions - behavioural, social and intellectual. Girls have to stay away from any kind of social intercourse to safeguard their bodies and virginity and uphold their family's name and honour.

The isolation and imprisonization of the young girl by hiding her behind the veil is only one of the ways in which traditional societies have sought to restrict the female's freedom to movement. More drastic measures have been adopted in other cultures. One of these is the custom of footbinding in China, and the other the practice of female infibulation or circumcision in African and Islamic countries. Yet another method is child marriage which is widely practised in India and other Asian countries and provides an effective way to limit and control the emerging risk of adolescent sexuality. As scholars have repeatedly noted, rather than introducing stringent restrictions and penalties on irresponsible male sexual behaviour, societies everywhere have found it easier and more acceptable to manipulate and coerce women into sexual and biologically stratified lifestyles.

4.2.5.1 VIOLENCE AND GIRLS

Evidently, the major and more devastating consequences of female gender related violence are borne by girls. After all it is they who have to forfeit their lives as foetuses or as infants and young children, whose chastity is first feared and tested; who are veiled, foot bound and circumcised to keep them from being footloose; who are married as childbrides; who are often widowed as children and forced to live a long bleak life in widowhood; who, even after marriage, face the humiliation of lack of acceptance by the husbands or their families often for reasons entirely outside their control, who are forced to give up their childhood in a hurry to act as surrogate mothers and caregivers; who are physically, sexually or psychologically abused as children; who are sexually harassed in the streets, schools in the workplace; who experience date rape and other forms of violence from young boys and men; who are sexually exploited and lured into marketing their bodies in prostitution and pornographic trades; and finally, who face the mst risks of sexual abuse from family

members and the community because of their age and innocence. According to recent studies in the United States, for instance, one out of three girls is molested before the age of 18 as compared to one out of ten boys'. A study of 450 adults in America who had been sexually abused in childhood further revealed that nearly 60 per cent had repressed their memories. The earlier the abuse, and the more violent it is, the more likely it is to be repressed in memory (see Sohoni 1994: 121 - 125).

The earliest years of a person's life are supposed to be a time of carefree exploration, growth and support. For millions of girls around the world the reality is quite different. Violence against the girl child includes physical, psychological and sexual abuse, commercial sexual exploitation in pornography and prostitution, and harmful practices such as son preference and female genital mutilation.

4.2.5.2 SEXUAL ABUSE OF CHILDREN

Child sexual abuse is an abuse of power that encompasses many forms of sexual activity between a child or adolescent (most often a girl) and a older person, most often a man or older boy known to the victim (see Seedat 2001:91). The activity may be physically forced, or accomplished though coercive tactics such as offers of money for school fees or threats of exposure. At times, it may take the form of breach of trust in which an individual, such as a religious leader, teacher or doctor, who has the confidence of the child, uses that trust to secure sexual favours.

Studies have shown that between 36% and 62% of all sexual assault victims are aged 15 or less. Incest, sexual abuse occurring within the family, although most often perpetrated by a father, stepfather, grandfather, uncle, brother or other male in a position of family trust, may also come from a female relative. As with sexual abuse, incest is accomplished by physical force or by coercion. Incest takes on the added psychological dimension of betrayal by a family member who is supposed to care for and protect the child.

A general unwillingness to acknowledge the extent of child sexual abuse exists in many societies. Attempts to downplay the prevalence and nature of child abuse often blame the victim or the victims' mother fo the violence. Accusations against the child include the idea that the child invites the abuse or that she

imagines it. The mother may be blamed for "causing" the abuse by refusing to have sex with the abuser, or for "colluding" by not realising or reporting what was going on. Attention is often focussed on commercialized paedophilia, which while important, distracts attention from the more widespread problem of incest and sexual abuse (see WHO 1997).

4.2.6 HEALTH CONSEQUENCES

4.2.6.1 OUT-OF-PHASE STRESS

It has often been said that one of the tragedies of HIV is the young age of those who are infected and die. Most often they are young adult men in their twenties and thirties, though the numbers of young women and children are increasing. The emotional pain of the death of one's offspring has been ranked one of the greatest stress in life. The pain results both from loss of the relationship as well as loss of the legacy parents hoped to leave behind. In addition, parents who are looking forward to retirement or living alone may have their dreams interrupted by the return of a son or daughter or even a grandchild who must be cared for.

One young, female drug abuser was infected by a long-time lover. After his death she moved in with her grandmother. Their life is now chaotic, because the young woman stays out all night, uses drugs, refuses to eat or sleep properly, and even misses her medication, causing her grandmother intense anxiety. Both are in therapy with a nurse who is trying to help each see the other's position (see Lego 1994: 61 & 62). Violence against women and girls increases their risk of poor health. A growing number of studies exploring violence and health consistently report negative effects. The true extent of the consequences is difficult to ascertain, however, because medical records usually lack vital details concerning any violent causes of injury or poor health.

4.2.6.2 PHYSICAL CONSEQUENCES

Homicide

Numerous studies report that most women who die of homicide are killed by their

partner or ex-partner. In cultures where the giving of a dowry is practised, the custom can be fatal for the woman whose parents are unable to meet demands for gifts or money. Violence that begins with threats may end in forced "suicide", death from injuries, or homicide.

Serious Injuries

The injuries sustained by women because of physical and sexual abuse may be extremely serious. Many assault incidents result in injuries, ranging from bruises and fractures to chronic disabilities. A high percentage of these require medical treatment. For example, in Papua New Guinea, 18% of all urban married women ad to seek hospital treatment following domestic violence.

Injuries During Pregnancy

Recent research has identified violence during pregnancy as a risk to the health of both mothers and their unborn foetus. Research in this area has shown increased levels of a variety of conditions. (see WHO 1997)

4.3 CONCLUSION

The objective of this chapter was to highlight the impact of HIV/AIDS on those who are infected or affected by the epidemic. Families are also silent about members suffering from HIV/AIDS because they fear isolation or ostracism from neighbours or in a few reported cases, violence. The silence is also made possible by long latency period of the disease.

CHAPTER FIVE

WHAT CAN THE CHURCH DO ABOUT AIDS?

5.0 INTRODUCTION

Where the church is silent in the face of injustice in the lives of the people, it is not being faithful to God's mission. The time has come, then, for the church to examine and assess the extent of its complicity in upholding the social structures that perpetuate women's subordination. In some parts of the world, for instance, the churches have collaborated in the myth that the transmission of the AIDS virus is confined to commercial sex workers, homosexuals and drug users. This is untrue, damaging, and needs to be refuted (see Paterson 1996:11).

Women have stood in solidarity with Christ and with the church since the day Mary of Nazareth said "Yes" to God. "Behold, I am the handmaid of the Lord, "Mary said to God's messenger. "Let it be to me according to your word" (Luke 1:38). Salome and many others put their material wealth and spiritual resources at the disposal of the Jesus school. Lydia and Priscilla supported with all their resources the Jesus movement in its infancy. Through the centuries women have been ardent supporters, promoters and facilitators of community in their churches, as they are today (see Oduyoye 1999: 2).

AIDS - Not a Punishment from God

If people get AIDS through an immoral, promiscuous life style we cannot say it is a punishment from God. However, we can say that it is the inevitable result of sexual behaviour which is against God's law. The people themselves and not God are responsible for their actions and therefore for getting AIDS. We shouldn't blame God for allowing people to misuse their freedom and get AIDS as a result. So the problem is not God punishing people by AIDS, but people bringing the disease on themselves by not listening to God's word and keeping his law of love. According to St John "God is love" (1 John 4:8). He always has been and always will be a God

of love and mercy and compassion who can never stop loving us no matter how we fail Him or turn away from Him. Only He fully knows the human heart and is always more ready to forgive than we are to ask for forgiveness and He doesn't point the finger at anyone (see Slattery 2002:26).

The Church

This institution is faced with its own dilemma through this epidemic. Moral ethical and theological questions have to be faced in the light of AIDS. The church's main calling is to reach out to mankind with a message of hope through the gospel. Tragically this disease, because of its sexual orientation, has caused the church to stand at a distance and to retreat into a 'ghetto mentality' (see Cameron 1992: 5).

5.1 EDUCATION

An important aspect of religious counselling should be directed outwards towards the church or other religious organisations. Expressed hostility (or the more common forms of indifference) should be exposed and condemned as heartlessness and opposed on all terrains. One can counter such views by educating and involving religious leaders and the faithful in the AIDS fields. All religious institutions should also be encouraged to become involved in an organised way in HIV/AIDS care and counselling by, for example, financially and physically supporting existing hospices or (where necessary) by founding such caring facilities. Research has shown that it is much more desirable in the long term to involve local agencies and religious institutions than to depend on often undependable foreign support.

In such circumstances churches, synagogues, temples, mosques and other religious organisations cannot sit backK and remain unmoved by the tremendous suffering and dereliction of infected people. In the face of the HIV/AIDS pandemic, religious institutions will have to redefine their usual way of 'caring for the poor'. They will have to engage in prevention and education programmes and also pay attention to the spiritual and physical needs of people who are suffering from

illnesses or who experience desperate poverty because of the loss of breadwinners and parents to AIDS (in the case of the vast numbers of AIDS orphans).

5.1.1 COUNSELLING

A Counselling Model

A four-phased model is proposed with a view to counselling the AIDS patient (see Louw 190:46).

a) The impact stage. Because of the impact, a reaction of shock, denial, severe anxiety and helplessness could surface immediately. This is not the time for idle conversation. Rather, the pastor should concentrate on the person's basic needs: His/her need for acceptance, understanding, love and sustainment.

b) The regression stage. Forced to deal with the reality of the situation many patients retreat emotionally. They go into a psychological state of isolation, loneliness and mourning. During this stage caring roups and the quality of patients' support system, ie. family, could play a crucial role. Love and compassion are now vitally important.

c) The internalisation stage, which describes the period of coming to terms with the long-term consequences of the disease. It is a period of mourning and a process of acknowledgement and acceptance of the reality. It is now important that the patient should discover the presence and the faithfulness of God.

d) The reconstruction stage is directly connected with decision-making, future planning, target development and meaningful actions.

The process of self-actualisation through faith and confidence in God's promises, could help the patient to discover self-esteem and develop the courage to make new decisions. The message of the living Christ and the perspective of the resurrection could create vital energy for hope (see Louw 1994: 132 & 133).

Why Does God Cause/Allow AIDS?

One of the most difficult but nonetheless urgent and immediate questions of life is why God allows suffering to exist on earth. Would it not have been advisable for God to have excluded all suffering (such as illness, pain and death) from this earth? An associated question is: Is illness caused directly by sin or some kind of transgression? Although a person may accept that some agent (ie. a germ or virus) may be the direct cause of disease, such an explanation is not adequate within a religious framework. Ultimately the question still remains: Why did it happen to me? Why did this attack me - and not somebody else?

A Secular Frame of Reference

The above question can be answered quite easily form the perspective of a secular (non-religious) world view: there is no ultimate cause. The agent attacked a specific person either because he or she was accidentally exposed to it (and his or her immune system was vulnerable or unable to fight the organism) - or else certain behaviours (or behaviour patterns) caused the person to expose himself or herself to the organism.

A Judeo-Christian Framework

Within a Judeo-Christian framework one may extend the above questions (*eg. Why does God allow AIDS?)* To the following:

- Is HIV/AIDS God's punishment?
- Am I a bad person? Did I deserve to get ill because I sinned.

Four basic answers can be given to these two questions:

1. Sickness and death came into the world because of sin (Genesis 6:3). However, this does not mean that one can attribute specific illnesses to

specific sins.

2. The purpose of illness (or any suffering) is not to punish us for sins but to test our faith and so make us better people. Suffering sometimes enables us to purify ourselves and grow spiritually.
3. Because of our limited insight and knowledge as human beings, we cannot on the whole make any sense of suffering. Although we accept that suffering may not be intended as punishment, we might believe that it fits into God's plans in some mysterious way - although we often do not know exactly what God's purposes and intentions may be. It is therefore problematic for any religious person (including counsellors) to try and 'play God' by explaining the purpose of suffering or disease.
4. Even if the person thinks that he or she has sinned (which is in any case true of all human beings), the spiritual HIV/AIDS counsellor should rather emphasise forgiveness and reconciliation to God and other believers. The Old and New Testaments abound with examples of people who sinned and who were subsequently forgiven by God. These include great heroes of faith like Abraham, Moses and King David. Within a Christian framework the examples of the prostitute (John 8) and the robber whom Jesus pardoned on the cross (Luke 23:43) can be used as helpful examples of God's infinite desire for forgiveness (rather than for punishment and retribution) (see Van Dyk 2001:311-314).

5.1.2 CARE

Our attitude and our behaviours towards people living with AIDS is a great test of our Christian faith, it is a great challenge to our society. Very many south Africans especially in rural areas who are dying of AIDS are doing so in great poverty and with little care and are often rejected by their own flesh an blood. In these areas with very high unemployment most people struggle to survive from day to day, often on the old age pension of a parent or grandparent.

In such circumstances how can the family alone look after someone in the

final stages of the disease who needs special care and support? As the number of patients keeps on growing and the number of people and families affected by AIDS keeps on increasing, government health services in many areas can no longer cope. There are not enough beds to accept all HIV/AIDS patients. Social workers cannot handle the ever increasing number of affected families and vulnerable children and orphans. This is not a normal situation but a very serious crisis with about 5 million people who are HIV positive or who have full blown AIDS in our country (see Slattery 2002: 35).

5.1.3 COMMUNITY

The magnitude of the loss of lives through HIV/AIDS represents only one aspect of the tragic impact of the epidemic. The epidemic has the potential to undermine permanently the social and economic fabric of affected communities. For many people HIV/AIDS has acted as a spotlight exposing and revealing the many iniquitous conditions, such as poverty and injustice, in our communities' lives which we have neglected to confront. As Christians we are challenged to examine the underlying realities in our churches and communities which encourage the spread of HIV/AIDS and to work to address those realties in a way which can help build or restore healthy, safe communities.

The church by its very nature as the body of Christ is called to become a healing community. This community must be a safe space of openness and acceptance: healing spaces, for sharing and telling life and death experiences. Christ's community of care should be an environment of trust and commitment, in which risks can be taken and where all members acknowledge their mutual vulnerability. The presence of HIV/AIDS in our community, particularly but not exclusively in the church community, requires us to reflect on who we are and how we are responding to the urgent need to act for inclusiveness and justice. We are not simply called upon to offer charity to those whose physical bodies have the virus. We are challenged by our belonging to this community to acknowledge that the virus has come into our own body. (see World Council of Churches Study

Document 1997).

Most people with HIV are adults from 20 to 40 years of age. This means people are dying at an age when they are vital members of their communities. Illness and death at these ages affect the strength and productivity of a community. In most places, women and men between the ages of 20 and 40 take care of their own children and sometimes even their parents, grandparents, or grandchildren. When these men and women die, children and the elderly are often left without support. It is predicted that by the year 2000, there will be 5 million orphans worldwide because of AIDS. In most countries there are not enough orphanages to support all of the children whose parents die from AIDS. This is just one way AIDS changes families and communities. The spread of HIV has also changed health care. More hospital beds are needed for people who are sick with AIDS. Because hospitals and clinics are so busy, less attention can be given to everyone who is sick. In one African country, three top officials of th ministry of health died of AIDS in one year. There was no one in the country who could replace them. This affected the health of the entire country (see Granish 1999: 23).

5.1.4 PRAYER

HIV/AIDS and Pastoral and Spiritual Care

Pope John Paul II
November 1989
Vatican AIDS Conference

"I invite all the faithful to offer their prayer to the Lord of Life to help humanity to gain something also from this new, threatening calamity. May God wish to enlighten believers as to the true and ultimate reason for existence in such a way that always and everywhere they might be messengers of undying hope... And still today, facing the impending plague of AIDS, while searching for effective remedies, we trust that, with the help of God, life will triumph over death and joy over suffering."

Bishops of Uganda

1989

AIDS: A Challenge to Church and Society

"The AIDS epidemic should be looked at by us Christians, as a phenomenon which constitutes a special time in salvation history, a moment of grace paradoxical as this might seem. It is a time, when once again, we hear the call to conversion, to turn to faithfulness to God's law, regarding sex and marriage; and to rediscover the value of chastity. We do not believe that the disease, or any other one for that matter, should be looked at, as a punishment from God. Rather than looking with any feeling of condemnation at those who have contracted it, we should reach out to them in love, understanding and compassion. To you who have received the Sacrament of Matrimony, we stress and remind you that the most common mode of transmission of the AIDS virus is through normal heterosexual contact, and that the greatest risk factor is having multiple sexual partners. A stable and continued faithful marital relationship between husband and wife is the most effective protective weapon against catching AIDS. We encourage you to seek God's grace and guidance in prayer, for "a family that prays together stays together"(see MacLaren 1996: 9,10-14).

5.1.5 AIDS AND SEXUALITY

The AIDS epidemic is especially difficult because AIDS is not only a disease. AIDS is a sexually transmitted disease! People may not even know that they have AIDS until they are in the late stages. During this entire period they can continue to infect many others if their sexual practices involve different partners in different places. In some cultures the genital area is supposed to be covered at all times. Although it is considered cute and funny to observe a baby when he or she discovers toes and fingers, the discovery of penis or clitons may be ignored or treated as an abnormality. When innocent childhood questions are asked about pregnancy and the origin of babies, the subject is quickly changed or the child is told that it will be

discussed later. Later never comes. Children learn about sex from other children and often the information which they receive is inaccurate and may reflect sexual standards of which the parents do not approve.

5.1.5.1 SEXUALITY AND THE BIBLE

This hang-up about sexuality does not come from the Bible! The Bible clearly states that God created people as male and female. Our femaleness and maleness is even God-like. We are created in the image of God and that is good. So God created humankind in his image, in the image of God he created them; male and female he created them. God blessed them and God said to them, "Be fruitful and multiply, and fill the earth and subdue it;"... (Genesis 1:27-28). The sin of Adam and Eve was not their sexuality; it was their disobedience. They ate fruit from the tree which God had told them not to eat "And He said, who told you that you were naked? Have eaten of the tree of which I commanded you that you should not eat?" (Genesis 3:11).

5.1.5.2 SEXUALITY IN THE OLD TESTAMENT

Sexuality in the Old Testament period was a natural part of life. The writers of the Bible seemed to view the physical world as basically good. Ruth, following the advice of her mother-in-law Naomi, took the initiative in an intimate marriage proposal to Boaz (Ruth 3:1-18). Certainly romantic passion is acknowledged and affirmed in the Song of Solomon 1:2-4 and 7:6-7:

Let him kiss me with the kisses of his mouth!
For your love is better than wine,
Your anointing oils are fragrant,
Your name is perfume poured out;
Therefore the maidens love you.
How faire and pleasant you are, O loved one,
Delectable maiden!

You are stately as a palm tree,
And your breasts are like its clusters.

Life was very fragile for the early Hebrews. They were a small tribal group trying to survive alongside much more powerful Egyptian and Babylonian neighbours. They needed all the manpower they could get in order to defend themselves. This may have been a reason for the punishment of Onan as noted in Genesis 38:9-10. By spilling his semen on the ground when he slept with his brother's wife, Onan would have wasted the seed which might have produced another warrior. Homosexuality and masturbation, sometimes referred to as onanism, were condemned for the same reason, the sanctity of the semen.

5.1.5.3 FREE SEXUAL EXPRESSION IN OLD TESTAMENT TIMES

Free sexual expression seems to have been the privilege of men in Old Testament times. Women were valued because they produced children for their husbands, but they were seen as the property of their fathers and later of their husbands. They could be inherited, taken in war, bought and sold as concubines and slaves (II Samuel 3:7, 1 Kings 2:21-22 and Deuteronomy 21:10-14). According to Hebrew culture, if a man was not satisfied he could easily dispose of his wife by divorce (Deuteronomy 24:1-4). He could take another wife and/or visit a prostitute.

A double standard was also present in the story of Tamar and Judah (Genesis 38:1-26). However, there was a small colony of Jews, living in Africa, where the status of women was more liberal. Letters and marriage contracts have been found from Elephantine in Egypt, four hundred miles south of Cairo on the Nile River, which indicate that women even then could divorce their husbands and could receive and exchange property. This was about 500 years before Christ at the time of the prophets Ezra and Nehemiah.

5.1.5.4 THE APOSTLE PAUL AND SEXUALITY

The Apostle Paul condemned adultery and prostitution. He clearly encouraged

mutuality and equality in sexual relationships: The husband should give to his wife her conjugal rights, and likewise the wife to her husband. For the wife does not have authority over her own body, but the husband does; likewise the husband does not have authority over his own body, but the wife does. Do not deprive one another except perhaps by agreement for a set time, to devote yourselves to prayer, and then come together again, so that Satan may not tempt you because of your lack of self-control (1 Corinthians 7:3-5). This passage from 1 Corinthians has been used by Christian men to condone demands to have sex with their wives at anytime and as often as they like even against the wishes of their wives.

- How do you understand this passage?
- How does it compare with your own cultural and family experiences?

5.1.5.5 HOMOSEXUALITY

Aids is not a homosexual disease. The fact is that lesbians or female homosexuals are less likely to get AIDS than are heterosexuals. It is true, however, that AIDS was first identified in the male homosexual communities in the United States and that many male homosexuals have died of AIDS. Because of this Christians have been forced to look more closely at the biblical material on sexuality, especially homosexuality.

According to the Holiness Code in the Old Testament, sexual sins such as adultery, incest and homosexuality were punishable by death, as was child sacrifice and the cursing of father or mother (Leviticus 20). When the men of Sodom demanded to know or have sex with the male visitors of Lot, the Sodomites were offered Lot's virgin daughters instead, to do with them as they pleased (Genesis 19:8). The Levite's concubine was gang raped and abused all night until she died, in order to save the Levite from the same treatment (Judges 19:25-26). The term sodomy, as used today, refers to male homosexual activity. It is considered extremely derogatory by those who are homosexuals. And yet the sin of Sodom was not a faithful loving sexual relationship between two males as does sometimes exist. If the sin of Sodom was their sexual practices, it had more similarity to gang rape than to homosexuality. In fact, according to other biblical passages, the sin of

Sodom was quite different.

This was the guilt of your sister Sodom: she and her daughters had pride, excess of food, and prosperous ease, but did not aid the poor and needy. They were haughty, and did abominable things before me; therefore I removed them when I saw it (Ezekiel 14:49-50). But whenever you enter a town and they do not welcome you, go out into its streets and say, "Even the dust of your town that clings to our feet, we wipe off in protest against you. Yet know this: the kingdom of God has come near. I tell you, on that day it will be more tolerable for Sodom than for that town (Luke 10:10-12).

During the biblical period there were idolatrous cults in which temple worship involved sexual relationships with male and /or female prostitutes. The Bible is clear in its condemnation of anything that has to do with worship of the body or the creature more than the Creator. The familiar passage in Romans 1:18-2:16 may refer to this kind of worship. Verses 18-23 describe ungodliness and wickedness, including idolatry. By using words like Therefore... in verse 24, For this reason... in verse 26 and since they did not see fit to acknowledge God... in verse 28 it seems that Paul was linking these sections to the idolatrous worship as noted in verse 25. Because of their idolatrous worship God gave them up to ..... a long list of sins as diverse as lusts of the heart, unnatural intercourse, a debased mind, murder and gossip, foolishness and rebelliousness towards parents. In chapter 2 verse 1 the main point of his argument seems to come out clearly: Therefore you have no excuse, whoever you are, when you judge others; for in passing judgment on another you condemn yourself, because you, the judge, are doing the very same things (Romans 2:1).

In his letters to the Corinthians and to Timothy Paul consistently linked sexual sins with the common sins of everyone. He placed fomication, adultery, male prostitution and homosexuality along with the greedy, drunkards, revilers and robbers in 1 Corinthians 6:9-10. In his letter to Timothy, murderers, slave traders, liars and perjurers were included in a similar list (1 Timothy 1:8-11). Jesus spoke of an adultery of the heart and the sin of judging others. He said that his disciples were forgiven as they forgave others (Matthew 6:14-15 and 7:1-5). In the parable

of the Pharisee and the tax collector, the repentant tax collector went home justified, whereas the proud Pharisee did not, in spite of his claim not to be a thief, a rogue or an adulterer (Luke 18:9-14).

The woman who was caught in the act of adultery, while advised to sin no more, received no greater condemnation that did her accusers, the religious ones with the stones (John 8:1-11). The good news of the Gospels and in the Letters of Paul is that God loves and forgives, even those of us who judge others! (see Transkei Council of Churches, 1994:13-18). AIDS, wrote an American journalist, is 'two epidemic diseases - the disease which actually disrupts the health (and thus affects the body) and a psychological illness' (Time 23rd September, 1985, cited by Schmidt 1985). The general social association with AIDS infers the psychological illness which must be designated as a collective neurosis. Victims of both diseases are primarily homosexual men:

- they comprise over three quarters of the AIDS and HIV - infected patients,
- they are predominantly the targets of the collective hypochondria generated by AIDS and its associated prejudices, moralistic judgements and social criticisms (see Jager 1988: 66 and Corless 1988:38).

5.2 THE CHALLENGES OF AIDS

5.2.1 CHALLENGES FROM THE BIBLE

The Greatest Commandment:

When the Pharisees heard that he had silenced the Sadducees, they gathered together, and one of them, a lawyer, asked him a question to test him. "Teacher, which commandment in the law is the greatest?" He said to him, "You shall love the Lord your God with all your hear, and with all your soul, and with all your mind. This is the greatest and first commandment. And a second is like it: 'You shall love your neighbour as yourself.' On these two commandments hang all the law and the prophets." (Matthew 22:34-40).

The New Commandment:

Jesus said, ... "I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know tat you are my disciples, if you have love for one another."(John 13:34-35). "Love is patient; love is kind; love is not envious or boastful or arrogant or rude. It does not insist on its own way; it is not irritable or resentful; it does not rejoice in wrongdoing, but rejoices in the truth. It bears all things, believes all things, hopes all things, endures all things." (1 Corinthians 13:4-8)

LOVE NEVER ENDS

5.2.2 CHALLENGES FROM THE PRESENT

AIDS is a global disease. People of all ages, of all racial groups and nationalities are at risk of getting AIDS. Rich people, poor people, good people and evil people can get AIDS. With AIDS there is no superiority or inferiority. We are all affected in some way by AIDS. In Africa AIDS is primarily a heterosexual disease. This is not because Africans are more promiscuous or have lower moral standards. The primary reason has to do with the social and economic situations in most African countries. When there is illiteracy, people cannot read about AIDS. When millions of people are homeless and barely able to survive on the streets or in extremely crowded conditions there may be lack of motivation to do what one knows is best. When there is unemployment there is no money to buy condoms or to go to the hospital for diagnosis or treatment.

In South Africa there is the additional legacy of the apartheid system. Family life is disrupted. Men who live in crowded single sex hostels far from their families are easily tempted to support the prostitution business and may engage in homosexual activities. It is estimated that at least 1000 women are raped every day in South Africa. In spite of the availability of contraceptives, the number of teenage pregnancies continues to increase. Churches are still an important part of the life of the community, but priests, pastors and church elders are almost exclusively men. Women have very little representation on the decision-making bodies of our

communities, our government or our churches. We may feel depressed and helpless in the face of so many problems. But we are not alone. We can work together. We can learn from one another. We can help each other because we are one body. "If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it. Now you are the body of Christ and individually members of it" (1 Corinthians 12;26-27).

Part of the problem is that the issue at stake is very uncomfortable yes, HIV/AIDS is putting the church in a very uncomfortable predicament. Throughout history the church have had specific views on sexual behaviour and sexual morality. What must now be said about sexual behaviour and sexual morality in the light of the threat of AIDS has been part of the moral stance of the church through all the years. But it seems as if the message of the church has not had the effect the church thought it had. The church now has to answer for its own ineffectiveness and limited impact on the lives of people. Because of HIV/AIDS the church is now forced to take a very hard look at itself, its message, the consequences of its message, what happens in the lives of people and the effectiveness of its communication.

AIDS creates a spiritual crisis. As Christians we are confronted with questions that reach down to the foundation of our humanity, our relationship with God and each other. The church will have to provide guidance to and care for people who live and die with HIV/AIDS as well as work actively to inhibit or even stop the spread of the HIV virus. In order to do so, we need to get clarity on a great variety of issues because there is a wide spectrum of theological questions (some often ambiguous) arising out of the present situation which must be answered. Actually, AIDS raises no new theological problems. We have always agreed on the importance to respond to the suffering of people in society. Even the theological questions ae not new. But there is a difference. The difference lies in the force with which HIV/AIDS is challenging the church to give understandable and adequate answers and to respond to societal issues in a bold and acceptable way. The problems may not be new but the answers must be. To generate new answers, we may have to change our paradigm of thinking. At the same time, we must face the

fact that our responses in the past may not have been contextually and culturally relevant to the plurality of the South African situation.

Challenged by the situation we face, we have to answer penetrating questions about the identity and function of the church. The church does not only care for people with AIDs. The church has AIDS. We may not make people just objects to help, because that very often contributes to a judgmental attitude. We will even have to move beyond a "interventionist ethic" advocated by some towards a participatory perspective and existence in the AIDS situation. In the real church "they" are part of the church, "they" become "we" and we are the church. It is a different way of thinking in which we move away from an "us and them paradigm" to a "we paradigm" so that we can say "we have AIDS". Much of what we know about AIDS comes from first world countries. If we change our thinking towards a more subjective perspective then we must also be willing to identify with the "Africanness" of our context. The African culture and identity must then also become part of our thinking about our problem. This is important because every country affected has its own epidemic which is shaped by the local circumstances. The patterns of transmission are influenced by situations unique to the country and it's culture. South Africa is our context (see Cameron 1992: 104-106).

5.2.3 CHALLENGES TO SAY "NO"

Fathers and mothers can teach their children about sexuality and how to say NO. Parents can demonstrate and teach love and mutual supportiveness for each other within a closed sexual relationship. Children learn the most from what they observe, and the way in which they are treated. If mother is beaten when she refuses to have sex with a drunken husband, what is her daughter learning abut sex and marriage? What is the son learning about Christian manhood? What kind of husband and father will he become?

Young people can dare to be different. Not everyone is, in fact, jumping in and out of bed with every other person of the opposite sex, as the American soaps would have us believe. There are husbands and wives who are faithful to each

other. There actually are young people who do not have sex before marriage. No one ever died from not having sex. One does not go made from not having sex. It is possible to wait until marriage before having sex. Girls say No to their boy friends, older male teachers, employers and sugar daddies. If the social pressure from peers or the economic pressure from poverty seem too great, it is important to remember that giving in or saying yes can be a death sentence. Talking with friends about these common temptations and sharing knowledge about ways to say no can give us courage. There is strength in numbers. We can support and encourage each other. Life is worth the effort!

Boys can say NO to the sexual advances of girls. A young man may feel an urgent need to follow a seductive young woman to her bedroom, but he can resist. He is not at the mercy of his sexual drives. His body is also sacred. He has only one body! Women can courageously say NO to the unprotected sexual demands of their husbands when they suspect infidelity. This represents one of the most difficult choices that a woman may have to make. On the one side are her marriage, economic security and social acceptance. On the other side are her own life and the lives of her children, those already born and those yet to be born. A supportive family, committed friends and/or fellow believers can help her to choose life. Not every woman has the luxury of such a supportive community.

Men can say NO to the position of privilege that their sex has had for generations. Men can follow the upside-down standard which Jesus taught, ... "whoever wishes to be great among you must be your servant, and whoever wishes to be first among you must be your slave;...." (Matthew 20:26-27). Husbands can love their wives as Christ loved the Church. A husband can give himself up for his wife and treat her with as much love as he has for his own body (Ephesians 5:25-33).

Church leaders can exercise their power as Christ did. We are responsible for the spiritual lives of the people in our congregations and parishes. Many people look to us for help and guidance. What can be done to save our children, our youth, our families from AIDS? Women's associations and groups can help our members to exercise their gifts and the building up of the Body of Christ. Women may not be

the head, but without a heart there would be no head. Without the hands there would be no reaching out. Without the feet there would be no forward movement. Without the ovaries and eggs there would be no new life (see Transkei Council of Churches 1994: 29-32). Some churchgoers contracted HIV before they became Christians. It can surface after they have begun new lives and are happily married, infecting their wives and possibly their children as well.

Others who regularly attend church lead double lives: a person can pretend to be one thing for an hour or two a week, and probably at work too, while beneath the respectable veneer he has a drug problem or is sleeping around with men or women. The result may be AIDS.

5.2.3.1 FAITH - THE ULTIMATE WEAPON AGAINST HIV?

Whether we try to prevent HIV with condom distribution, or by encouraging testing, celibacy and monogamy, we are faced with a problem. We know education encouraging these things will have a limited effect. The reason is that most people do not want to change. Therefore the only secular motivation we can possibly provide is fear.

I have often heard AIDS educators say you must not give a negative message based on fear because it will be counter-productive (incidentally, the statement it itself a similar negative). However, the fact is that all successful health promotion works by creating anxiety about what could happen if you ignore the message. The faith motivation is totally different and ultimately much more powerful, as social psychologists are beginning to recognise. Faith creates hope, new expectations about behaviour and gives people purpose, self-worth and meaning. Christians also believe that faith in Jesus Christ releases God's power in our lives, enabling us to change.

Before the communist regime fell in Hungary, secret approaches were made by the communist leaders to a friend of mine who was heading up an evangelical organisation based in the UK. His work was to smuggle Bibles and other items for persecuted Christians behind the iron curtain. The authorities asked to meet him because they needed help in dealing with a rapidly worsening drug problem. They

knew that those finding faith often came off drugs rapidly and permanently. A wonderful, low-cost, 'infectious' weapon against drugs was too good to turn down. Instead of threatening him with arrest as before, they unofficially invited him to bring others in. The gospel was proclaimed and programmes set up. They too had seen the power of faith.

As Christians we can have confidence in who we are and what we stand for. We have an answer which we feel is the prevention, based on medical facts. We can also seek to influence behaviour through the rapid spread of faith in the world today. An important part of the answer to AIDS is for the church, as the most powerful organisation in the world, to combine efforts with governments and communities to help save people from themselves.

5.2.3.2 WHERE IS THE BODY OF CHRIST?

So who is the voice of Jesus today? Who are his hands and feet? No single person has the capacity to represent the heart and mind of God. We are told that together as believers we are his body. That is why Jesus prayed so much that those who believed in him would be one. Together we show his love, together we seek to express his voice, together we seek to present his challenge to the world and together we seek to reconcile the world to God. That is why I am so encouraged to see God's people joining together across the nations, with barriers breaking down, whether as millions of people praying for our world as in March for Jesus, or whether it is at the sharp end of providing unconditional care to those with AIDS who are dying.

5.2.3.3 DARING TO BE DIFFERENT

We are called to fight discrimination, stigma, prejudice, bigotry, intolerance, oppression, injustice and cruelty. We are to encourage love, care, consideration, compassion, understanding, responsibility, commitment, faithfulness, truth and righteousness. Jesus promised we would be identified, targeted, challenged, mocked, misunderstood and persecuted. The trouble with the church is that so

often we have deserved a rapping on the knuckles for strident moralism based only on an empty call to stand as light, without being prepared for the loving sacrifice of being salt. The more fully we represent Jesus, the more we may find that some people love what we do, but sometimes hate what we are (see Dixon 1994: 344,345, 363, 364).

5.2.3.4 CHALLENGES TO EACH OF US

AIDS is still synonymous with sin, either explicitly or by implication. The link between wrong-doing and AIDS is what underlies, for instance a moralizing discourse which speaks of punishment coming from God and divine retribution. This keeps persons living with AIDS in a state of latent guilt which is both cruel and unjustified. AIDS is a disease, not a punishment sent from God, and certainly not a sin. Understandably enough, there may seem to be a justifiable level of responsibility with regard to this 'evil' for some persons who are paying the price for a life of debauchery or immoral conduct (and that would be the case for sexual perversions and drug delinquency). Very often, the accusation and blame heard within the family remind sick persons how guilty they really are. This merely increases the burden of guilt which sick persons already have placed upon themselves and cannot but aggravate their sense of isolation and tendency to be depressed (see Simard 1997: 125).

5.3 THE STORIES FROM WOMEN IN SOUTH AFRICA LIVING WITH HIV/AIDS

To get HIV/AIDS onto the public agenda, it is important for persons living with HIV/AIDS to speak out publicly. But, as Gugu Dlamini's death revealed all too starkly, the climate of stigma and discrimination surrounding HIV/AIDS in South African can make public affirmation of one's HIV serostatus difficult and dangerous, especially for members of vulnerable population.

5.3.1 WILL THE KILLING OF GUGU DLAMINI BRING ABOUT CHANGE IN SOUTH AFRICA

AIDS activists in South Africa are hopeful that the tragic killing of Gugu Dlamini will

be a potential catalyst for change. But they realize that real change comes slowly in South Africa, a country with the world's fastest - growing HIVAIDS epidemic. In the meantime, Gugu's death - and the recent "coming out" of Justice Edwin Cameron - have focussed attention on the need to keep HIV/AIDS on the national agenda, as well as on the risks faced by persons living with HIV/AIDS who decide to go public.

5.3.1.1 THE KILLING

Gugu Dlamini, a volunteer field worker for the National Association of People Living with HIV/AIDS (NAPWA), died on December 22, 1998. Three weeks earlier, on World AIDS Day, Gugu had gone public, speaking about her HIV infection on Zulu-language radio and on television. Her neighbours accused her of bringing shame on their community by revealing that she was HIV positive. Gugu was repeatedly threatened. The day before she died, Gugu was punched and slapped by a man who told her she should have kept quiet about her illness, like most other people in her situation. She called the police, but they did nothing. That night, a mob attacked her house and stoned her, kicked her and beat her with sticks. She later died from the injuries.

5.3.1.2 THE RESPONSE

Very little has been done by either the government or the police to address the killing of Gugu Dlamini. After the initial flurry of articles, the media has largely ignored her story. However, two South African newspapers have started columns written by persons living with HIV/AIDS. And additional work with the media is planned for the coming year to promote more responsible journalism. Gugu Dlamini's death has galvanised the small AIDS activist community in South Africa. Partially in response to her killing, NAPWA launched a Treatment Action Campaign in partnership with the AIDS Law Project, the AIDS Consortium and the National Coalition for Gay and Lesbian Equality.

As part of the Treatment Action Campaign, the objective of which is to

improve access to treatments for persons living with HIV/AIDS, fasts and rallies were organized in four large cities on March 21, 1999, Human Rights Day in South Africa. The rallies attracted over 1,000 people and received substantial media coverage. Organizers expressed hope that these rallies would someday be seen as the beginnings of a genuine movement of persons living with HIV/AIDS in South Africa to assert their rights. A few days later, organizers of the campaign met with Dr Nkosazana Zuma, the Minister of Health. Dr Zuma pledged her support for the organizers' take-to-the-streets campaign and agreed to meet the organizers again to discuss their demands. As well, the Treatment Action Campaign was endorsed by the South African Council of Churches and a range of trade unions.

5.3.1.3 UNDERLYING ISSUES

People infected with and affected by HIV/AIDS in South Africa are becoming increasingly concerned about access to treatment. However, many people are more preoccupied by broader social and economic issues - such as the link between HIV/AIDS and poverty, unemployment and crime - and by how to get people in South Africa to talk more openly about the reality of HIV/AIDS, about the problems caused by HIV/AIDS, and about potential solutions.

To get HIV/AIDS onto the public agenda, it is important for persons living with HIV/AIDS to speak out publicly. But, as Gugu Dlamini's death revealed all too starkly, the climate of stigma and discrimination surrounding HIV/AIDS in South Africa can make public affirmation of one's HIV serostatus difficult and dangerous, especially for members of vulnerable populations. In April 1999, Justice Edwin Cameron, of the High Court of South Africa, decided to publicly reveal that he is HIV positive. Justice Cameron is a candidate for an appointment to the Constitutional Court. He chose to speak out because there had been talk in the legal community about his health condition. Justice Cameron said that he was able to disclose his status because

".... I have a job position that is secure;
because I am surrounded by loved ones;

friends and colleagues who support me; and because I have access to medical care and treatment has ensured that I remain strong, healthy and productive."

For millions of South Africans living with HIV or AIDS, these conditions do not exist. They have no jobs, or their jobs would be at risk if they spoke about their HIV. They not only lack community support, but face grave personal danger if they do so. And, most importantly, they do not have access to proper medical care and treatment. For them, in a still hostile climate, the choices are strictly limited. Their right to invoke confidentiality remains of critical importance to them. It is only by creating conditions in which people can speak out without fear that we can begin to end the silence surrounding South Africans living with AIDS ad HIV. Activists hope that the courage of Gugu Dlamini and Justice Edwin Cameron, and other like them who have been public about their HIV status, will help create the conditions that will enable more people to speak out without fear about HIV/AIDS in South Africa.

5.3.1.4 LESSONS LEARNED

- A tragic incident - such as the killing of Gugu Dlamini - can be used to mobilize people to address HIV/AIDS issues.
- Persons living with HIV/AIDS must carefully consider whether or not to disclose their status publicly, especially in communities that are ill-prepared and not properly educated to deal with the situation.
- NGO's need to develop strategies to help persons living with HIV/AIDS feel comfortable about disclosing their status.
- Change can sometimes happen very slowly, particularly in situations where people are afraid to speak out about HIV/AIDS (see Heywood 1999:19 & 20).

5.3.2 "I DIDN'T KNOW I WAS HIV POSITIVE UNTIL MY SON DIED." - BONGI'S STORY

"My life changed when I lost my son a couple of months ago. He was only 6 months old when I found out he was infected with AIDS. I didn't know I was HIV positive until my son died. I didn't know what to do. I didn't have a job. I didn't know anyone who could possibly help me. My life turned upside down. It was bad and I didn't know who to talk to. A councillor told me to go to Mc Cord Hospital. He said there was a clinic there, a centre for people who are living with AIDS, a centre with people who can help me. I went there, and at Mc Cord Hospital, they taught me that I can help myself by doing something that can help me make money. I am a mother of two, and with that money I can help myself and my family.

Now I accept everything that I am. I am OK. I know I am HIV positive, I can live with it. I know I can do something with it. I can help other people and other people can help me, by encouraging me. They can open arms for me, they can give me hope. People should welcome every person who reveals his or her HIV status, so we can feel happy and accepted. If they chase us away, we feel down. So they can rather encourage us, welcome us, as we can help them too. We must not be pitied, cast away or looked down upon. We are all the same. So please welcome us with open arms, accept our condition, smile at us. Please don't cast us away because we are HIV positive. We live with hope, every day. So please encourage us.

SINIKITHEMBA AT Mc Cord Hospital has given me, and many other people living with AIDS, hope to live. Sinikithemba has supported me a lot. I now feel wonderful, more than ever. I now appreciate everything - life, myself, the people I am living with every day, and anything that happens to me is a gift. My message to the HIV positive people out there is to stand up and be positive. Just because you are HIV positive does not mean you are going to die or you have to wait for Judgement Day. You can do anything - feel the sunshine, walk in the rain, breathe the cool, fresh air in the morning or even eat your favourite sandwich. Come, talk to someone here at Sinikithemba. I have been made proud of myself again of who I am. The people at Sinikithemba have made me realise that I can live, give my love

and most of all, give my love to God and my precious family and kids. Sinikithemba allows me to support my children, buy the medicine I need, everything is OK for me now. "Thanks to God"(see Who's Who in Health in KZN 2000:17).

5.4 NATIONAL HIV SERO - PREVALENCE SURVEY OF WOMEN ATTENDING PUBLIC ANTENATAL CLINICS IN SOUTH AFRICA: 1990-2001

The primary objectives of the 2001 survey were:

To estimate HIV prevalence in South Africa in 2001 and present trends in HIV prevalence from 1990 to 2001 among pregnant women. To describe HIV trends in 2001 by age group and province and present age and province specific trends from 1990 to 2001. To make estimates (on the basis of the DOH model) of the number of men, women and infants in the general population who were infected with HIV by the end of 2001 (see Summary Report - National HIV and Syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa 2001:1).

The Epidemiology of HIV Infection and AIDS in South Africa

The Global HIV Epidemic

According to recent estimates from the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), 34.7 million adults and 1 million children were living with HIV worldwide at the end of 2000. In addition, the epidemic has crated a cumulative total of 13.2 million AIS orphans.

In 2000, an estimated 600 000 children aged 14 or younger became infected with HIV. Over 90% of these were babies born to HIV-positive women, who acquired the virus before or at birth, or through their mother's breast milk. Almost nine-tenths of these new infections occurred in sub-Saharan Africa. The overwhelming majority of HIV infections, around 95% of the global total, live in the developing world. This is a proportion that is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems, and limited resources for effective prevention and care fuel the spread of the virus. Sub-

Saharan Africa is the worst affected region, having around 70% of the global total of HIV-positive people. Most of these infected populations will die in the next 10 years, joining the 13.7 million Africans already claimed by the epidemic.

South African HIV/AIDS Data

Most data on the South African HIV/AIDS epidemic is obtained from the anonymous, annual survey of pregnant women attending public sector antenatal clinics. Although imperfect, these data are sufficient to estimate the current and future size and impact of the epidemic by using projection models, such as the Doyle simulation model used here, to extrapolate from antenatal clinic attendees to the rest of the population.

Using projection models allows us to estimate the level of HIV infection in the general population. However, some groups and geographical areas will be much more or less affected than the average, and we need to consider this when assessing these models. Community surveys have confirmed the high level of infection among young women. For example, one study in a high-risk community surrounding a mine in Gauteng showed that HIV prevalence among men peaked at 30% at age, 35, and among women at 50% at age 25. Also, information from death certificates confirms an alarming increase in deaths among the 20 to 40 year age group (see Impending Catastrophe Revisited - an update on the HIV/AIDS epidemic in South Africa - Love Life 2001:4&5).

HIV/AIDS: The Global Situation

In 2001, approximately 36 million individuals were living with HIV/AIDS. Assuming that each HIV/AIDS case directly influences the lives of our other individuals, a total of more than 150 million people are being affected by the disease. Sub-Saharan Africa is the region most affected by HIV/AIDS - now that area's leading cause of adult morbidity and mortality. Most, if not all, of the 25 million people in sub-Saharan Africa who are living with HIV/AIDS will have died by the year 2020, in addition to the 13.7 million Africans already claimed by the epidemic. HIV/AIDS is

also spreading dramatically in Asia. India leads the region in absolute numbers of HIV infections, estimated at 3-5 million. China, too, has a growing HIV/AIDS problem, with approximately 0.5 million AIDS cases and, according to private estimates by Chinese specialists, up to 10 million HIV infections. Asia will overtake sub-Saharan Africa in absolute numbers before 2010; by 1010 Asia will be the HIV/AIDS epicentre (see Barnett 2002:9).

5.4.1 SURVEY RESULTS

People are Dying

Abantu Abaafa! - People are Dying!

This survey was conducted concurrently across all nine provinces from the 1st to 31st October 2001. The study was an anonymous, unlinked, cross-sectional survey. The study population included pregnant women who attend antenatal clinics in the public health sector of South Africa. A national workshop of provincial co-ordinators was held to review the protocol, review study methods, plan field logistics review standard operating procedures, and review field logistics, (e.g. Provision on 5 ml Vacutainers with SST gel and clot activator, paired bar-code labels, and data capture sheets). It also prepared the team for data analysis and processing procedures.

Participating laboratories and courier services were prepared to ensure that appropriate testing procedures would be adhered to and blood specimens safely and timely transported from each antenatal clinic to testing laboratories. The national departments co-ordinating office ensured the overall co-ordination of the survey including support visits to the nine provinces, conducting the procedural audit of the survey countrywide, re-processing provincial estimates, processing of the national data set, modelling further HIV estimates and compiling a singular national report. The procedural audit included investigation into preparation of sentinel sites, logistics and adherence to the study protocol in general.

HIV Testing

The HIV testing methodology employed is the World Health Organisation (WHO) recommended procedure for antenatal surveys. As required by that protocol blood specimens were tested with one ELISA (Abbot Axysm System for HIV-1/HIV-2) in all provinces except the Western Cape where two tests were performed. According to the WHO protocol low HIV prevalence as in the Western Cape province (less than 10%), requires that two ELISA tests be used. Sera found to be reactive on the first assay were retested with the second ELISA test, whereas those shown to be non-reactive on the first test were considered HIV antibody negative and therefore not retested. All positive HIV sera were stored for the pilot HIV incidence testing.

Results

A total number of about 16 743 pregnant women participated in the survey (HIV results were not recorded for 13 specimens and therefore not included in the analysis, whilst 42 were excluded for RPR). Thus 16 730 specimen were tested for HIV and 16 701 were tested for syphilis (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001: 6,8,9).

5.4.2 NATIONAL HIV PREVALENCE

Based on the 16 730 blood samples tested for HIV during the survey, it is estimated that nationally, 24.8% of pregnant women were infected with HIV by the end of 2001. This is in comparison with a prevalence rate of 24.5% in were not recorded for 2000. Whilst this rate of infection is high and a significant public health problem the findings indicate that there is not a statistically significant growth in the epidemic from the previous year. Figure 1 shows that the national prevalence rate of increase has slowed in its increase since 1998. This is referred to as a levelling off, plateau or stabilisation in growth.

Figure1: National HIV prevalence trends among antenatal clinic attendees in South Africa:1990-2001.

Figure 1

1990	-	0.7	%
1991	-	1.7	%
1992	-	2.2	%
1993	-	4	%
1994	-	7.6	%
1995	-	10.4	%
1996	-	14.2	%
1997	-	17	%
1998	-	22.8	%
1999	-	22.4	%
2000	-	24.5	%
2001	-	24.8	%

(see National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001: 9).

It is estimated that around 4 million South Africans are currently HIV infected. This number is expected to continue to rise over the next 10 years - unless major behaviour change occurs that could significantly alter the course of the epidemic. There could be around 5.3-6.1 million infected individuals by 2005, and 6 to 7.5 million by 2010. These estimates from the Doyle model are lower than estimates from other sources, which put the number of currently infected people in South Africa at 4.5 to 5 million people (see Impending Catastrophe Revisited - an update on the HIV/AIDS epidemic in South Africa - Love Life 2001: 5).

5.4.3 HIV POINT PREVALENCE ESTIMATES BY AGE GROUP

There were different trends between young and older women. HIV prevalence among teenagers was estimated at 15.4%. This represents a decline in HIV prevalence between 2000 and 2001. However it is not statistically significant. HIV

prevalence in the 20 to 29 year age group has not shown an increase from the previous year whilst there is a significant increase in HIV prevalence amongst women in the 30 to 39 year age category (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001 :11).

Approximately 15% of all South African adults aged 20 to 64 are currently infected and these levels could rise to 20 to 23% by 2005 and 22 to 27% by 2010. HIV is a disease that mostly affects younger people with around half of all adults who acquire HIV becoming infected before they turn 25. Over 50% of these young people will die of AIDS before their 35th birthday. Gender differences are also pronounced, with women at highest risk between the ages of 15 and 20, while men achieve their highest incidence some years later. Infection levels among teenagers are the first to reflect reduction in high-risk behaviour. In South Africa, where 53% of the population are under 25 years old, teenage infection levels are still increasing at an alarming rate (see Impending Catastrophe Revisited - an update on the HIV/AIDS epidemic in South Africa - Love Life 2001: 6).

5.4.4 PROVINCIAL HIV RATES

Provincial prevalence rates show the geographic variations in the HIV epidemic. Table 1 show the HIV rates over the last three years (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001 :9).

KwaZulu-Natal is situated on the east coast along the Indian Ocean. With a population of 8.4 million KZN is South Arica's largest province, containing one-fifth of the country's population. The population is about 45 percent urban and includes Durban, the largest port and third largest city in the country. About 25 percent of the country's black population resides in the province. Africans, primarily Zulu-speaking, make up about 76 percent of the population. Indians comprise 14 percent of the population, 7 percent are White, and 3 percent are Coloured. During the mid 1980s and again in the early 1990s thee was substantial political unrest and violence in

KwaZulu-Natal and, as a result, the first democratic local elections were not held until 1996, a year later than the rest of the country. While KwaZulu-Natal should not be considered a typical or representative province, many of the underlying social and economic conditions are similar to those found in other provinces in which a substantial proportion of the population resides in the former homeland areas.

KZN has the highest level of HIV infection in the country. HIV prevalence among antenatal clinic attendees was an estimated 33 percent in 1998 (South Africa Department of Health 1999). The high prevalence and rapid rise in its level have been attributed to widespread migrant labour in the province and its association with multiple partners; lack of condom use mainly because of the device's association with distrust between partners and a lack of cleanliness; high value placed on multiple partnerships by men; high level of poverty in the province; and poor health care services (see Rutenburg et al 2001:5 &6).

5.4.5 HIV BY POPULATION GROUP

From the study of the data for 1999 it was not possible to obtain reliable data on HIV prevalence in the different population groups because women attending public health clinics are predominatly African. The sample size of Indian, Coloured and White women were too small for any reliable conclusions to be drawn on HIV in those population groups.

5.4.6 EXTRAPOLATION TO THE GENERAL POPULATION

The Department of Health uses a model, which it developed to generate estimates of HIV infection in the general South African population. On the basis of this model, it is estimated that in 2001 2.65 million women between the ages of 15 to 49 were infected with HIV and 2,09 million men between 15 and 49 were infected with HIV. It is estimated that 83 581 babies became infected with HIV through the mother-to child transmission route. It is estimated that by 2001 approximately 4.74 million people in South Africa had become infected with the HIV virus. This is in comparison with 4.70 million who were infected by 2000 (see Summary Report -

National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001:12).

The epidemic will impact on population directly through deaths of infected people. In addition, birth rates are expected to decline due to deaths among people in relatively high fertility age groups as well as reduced fertility of HIV-infected women. Without HIV/AIDS, the South African population would have been expected to grow from 43.7 million in 1999 to 51.3 million in 2010, with a growth rate of around 1.7% in 1999, falling to around 1.5% by 2010. As a result of the HIV/ADIS epidemic, and excluding migration, the population is now expected to reach only 47 million in 2010 under a best-case scenario. Under the worst scenario, the population will peak at 46.7 million in 2008, and have slightly negative growth thereafter (see Impending Catastrophe Revisited - an update on the HIV/AIDS epidemic in South Africa - Love Life 2001:8).

5.4.7 NATIONAL PREVALENCE TRENDS

The sampling design for the national HIV prevalence study is made to enable reliable estimates of HIV at provincial level. As expected, the provinces are at different stages of the HIV epidemic and the epidemiological pattern on HIV is not the same for all provinces. To illustrate these differences, the observation is made that KwaZulu-Natal which had reported the fasted growing epidemic and which still has the highest provincial prevalence rate is not stabilising at 33.5%. As these studies yield prevalence and not incidence estimates, the reasons for this decrease may be numerous. The Western Cape on the other hand, has the lowest HIV prevalence rate in the country, but its HIV rate may also be stabilising at this relatively low HIV level (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001:15).

5.4.8 TEN YEAR TRENDS

The findings of the 2001 antenatal survey show that HIV/ADIS is a significant health

problem in South Africa. It is estimated that 4.74 million individuals are now infected with the HIV virus despite the intensive HIV prevention programmes that are in place. These high prevalence rates have significant implications on the future burden of HIV associated disease and the ability of the health system to cope with provision of adequate care and support facilities.

The most striking observations that can be made on HIV prevalence estimates however is that the prevalence of HIV though still high, has not increased between 2000 and 2001. These findings confirm the observation that the rapid growth of the South African epidemic may be slowing down. Whilst HIV prevalence trends have their limitations as a marker of overall reduction in new HIV infections, the slowing down factor is supported by what is emerging from syphilis trends and HIV trends in teenagers. The second set of data, which provides information supportive of the argument that the HIV epidemic in South Africa is stabilizing relates to HIV prevalence rates in women/girls under 20 yrs. HIV trends in teenagers are considered a good indicator of behavioural change aimed to reduce HIV infection such as a delay in sexual debut and condom use. As demonstrated in this report the early decline and stabilization are very encouraging (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001: 14 & 15).

5.4.9 POPULATION PREVALENCE TRENDS

It is worth noting however that HIV prevalence decreased but not statistically significantly in KwaZulu-Natal between 2000 and 2001. HIV prevalence rates did not change significantly (statistically) in Mpumalanga, Gauteng and Western Cape provinces between 2000 and 2001. Provinces which had marginal increases (also not statistically significant) include Limpopo, Free State and the Eastern Cape provinces. There were however large increases in the Northern Cape and North West Provinces; the increase in the Northern Cape was marginally significant statistically (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001:10).

5.4.10 GENERAL

Up until 1998 South Africa was described as having one of the fastest growing epidemics in the world. The 2001 survey confirms that the trend seen since the 1998 survey indicates that this is no longer the case. The findings of this survey are however an important pointer to the magnitude of the HIV/AIDS problem that South Africa confronts, where an estimated 4. 74 million individuals are infected with HIV. The full participation of all sectors of society and the strengthened intersectoral involvement in implementing the HIV/AIDS and ST1 strategic initiatives will be critical to an effective national programme and maintaining the gains that South Africa is beginning to observe. The epidemiological trends in HIV prevalence should at this stage be a source of encouragement and leave no room for complacency as the numbers of individuals who are acquiring HIV infections each day is still high and the health care implications of the current infections are enormous.

This HIV survey and the expanded surveillance programme which places emphasis on high risk behaviour monitoring and monitoring HIV incidence will continue to be important in underpinning areas to strengthen the national response to HIV/AIDS (see Summary Report - National HIV and Syphilis Sero-Prevalence Survey of Women attending public antenatal clinics in South Arica - 2001:16).

5.5 WORKSHOPS TO EMPOWER WOMEN

5.5.1 DIFFERENT COMMUNICATION TECHNIQUES INCLUDING PRESENTATIONS BY LEADING RESEARCHERS

"Be doers of the word, and not hearers only, deceiving yourselves. For if anyone is a hearer of the word and not a doer, he is like a man observing his natural face in a mirror; for he observes himself, goes away, and immediately forgets what kind of man he was. But he who looks into the perfect law of liberty and continues in it, and is not a forgetful hearer but a doer of the word, this one will be blessed in what he does" (James 1:22-25).

The Church of Jesus Christ only possesses the answers to the crises of misplaced sexual behaviour and the resulting HIV and AIDS diseases in our communities. God is calling the Church to rise up, take the lead and get involved in rescuing a whole generation in Africa, from premature death.

1. **Role Models**

The local church can disciple Christian role models who can demonstrate to the non-Christian community that it is possible to:

- ✞ Live sexually pure lives.
- ✞ Resist sexual temptation.
- ✞ Raise morally pure children.
- ✞ Not be afraid of the HIV and AIDS -infection.
- ✞ To love and care for HIV and AIDS-infected.

Sadly, the non-Christian community is seeing very little positive role modelling in government, on television and radio, and in the community. The church can be living examples of 'right' living without being judgemental.

2. ***Train All Church Leadership in the following:***

These topics should be taught and reinforced in the local church on a yearly basis:

- ✞ Sexuality God's way, moral teaching
- ✞ Life-Skill management at all ages/levels
- ✞ HIV/AIDS Awareness
- ✞ Truth about condoms, testing
- ✞ STDs, sexual abuse
- ✞ How HIV/AIDS affects me and my family
- ✞ Ways of church involvement in social issues relating to the community

Note : Where possible utilise other good Christian resources available to you. Examples are:

- ✞ Christian Videos
- ✞ Christian Tapes

3. ***Constantly Reinforce the Biblical Teaching of God-given Self-Empowerment Over One's Own Body and Sexual Urges as follows:***

Men and/or women can help themselves from being promiscuous. Women do have a choice over their own sexuality and body. Men/Women do not have the right to sleep around and then take HIV home to kill their spouse and children. Mothers have a responsibility to get tested before getting pregnant. HIV-infected mothers must be taught alternate methods of feeding baby besides breastfeeding. Here the Church can help reduce infant mortality of infected babies by providing instruction in non-breasting feeding procedures and nutritious milk formula procedures (see Tisdalle 1999:178).

5.5.2 CAPACITY-BUILDING WORKSHOPS AND DISCUSSION

1. ***Biblical Principles in Relation to HIV/AIDS***

The Bible does not speak directly about AIDS. AIDS is a relatively new disease in terms of when it was discovered. Yet, AIDS is not a new disease in the eyes of God. He knew about the onslaught of AIDS from the beginning. However, the principles of practical living, given in the bible, speak to the problem of AIDS and related issues that affect out families, our churches, and our communities.

2. ***The Biblical Teaching on Suffering and Sickness***

Because of sin, suffering and sickness have entered this world. God did not bring suffering and sickness, to teach people lessons. Rather, sin entering the world in the first place, and the sinful nature of each individual at birth,

lends to choice in life that brings suffering and sickness on an individual basis. Suffering and sickness may be used by God to display His power and glory, to produce righteousness in the believer's life, to bring about repentance and in purifying the life of the believer.

3. *The Biblical Teaching on Healing*

Healing in the crisis of HIV and AIDS is the believer's privilege. Here, the Church of Jesus Christ can raise up an army of praying believers that will intercede for those hurting from the effect of AIDS. We can pray; we should pray; we must pray! Are all those for whom we pray (infected by HIV/AIDS and other illness) going to be healed? The Biblical principle that all were not healed also follows with HIV and AIDS. Experience shows us that some who are prayed for healing from HIV and AIDS will be healed. Others will not be healed, sometimes for reasons that we cannot understand. Yet, we should not stop praying for them.

4. *Condemnation as a Response*

Sadly, many Christians have felt in their hearts the following attitude towards those infected with HIV and AIDS: "They are getting what they deserve! They should have been more mindful of their behaviour!" In honesty, while many Christians will have never openly said those words, in their hearts they have held those kinds of attitudes. We have seen that the Biblical response to AIDS is that of love and compassion summarised by "there but by the grace of God, go I". Therefore, we must examine our hearts before God and be willing to confess wrongfully judging those with HIV and AIDS, and also demonstrating our bias by non-involvement in the AIDS crises in our communities. We also must examine the issue of AIDS and God's judgement. There is no doubt that God does not bring AIDS to anybody. We also believe that AIDS is not a judgement of God as such. We also know that God's heart is yearning for every single person to come into right relationship with Him. The Christian church's task is to be the "light" in the darkness of

AIDS. To be the "Salt" in a world where generally there is a taste for unrighteousness (Matthew 5:13,14). There is no other answer to the AIDS problem than the message of Jesus Christ, relayed through the church of Jesus Christ! (see Tisdalle 1999:187-196).

5.5.3 THE DISCUSSION AND ANALYSIS ARE:

5.5.3.1 PREVENTION

Awaken Awareness

Each local church needs to begin to awaken the conscience of people (Christians first then community) that involvement in the HIV/AIDS crises is their God-given responsibility! For too long the church has felt it was the world's problem because we are all saints! AIDS is in the church (see Tisdalle 1999:172 and also see Jackson 1988:49).

5.5.3.2 SUPPORT AND CARE

The Bible Encourages strong family and community involvement in the care of the sick and needy. Jesus is our example of this as we read in the Bible that He cared for and healed the sick and afflicted. Jesus reached out to sick people; so should we.

"God anointed Jesus of Nazareth with the Holy Spirit and with power, who went about doing good and healing all who were oppressed by the devil, for God was with him" (Acts 10:38).

Christian are encouraged to cheerfully help those who are in need, which definitely includes people living with AIDS (see Aggleton 1994:29). "Be joyful in hope, patient in affliction, faithful in prayer. Share with God's people who are in need. Practise hospitality" (Romans 12:12-13). How sad it is to see people with AIDS suffer alone, be rejected, and not have anyone to help them with the process of dying.(see Mok 1995:253) Often families quarrel, war, and divide because the pain of having a loved on sick with AIDS was too much to bear. Each one of us makes plans for marriage,

raising children, building the future, employment, etc. How strange it is for most of us to have to look death in the face and deal with it by relating it to our lives. Yet, death is part of living (see Tisdalle 1999:102 and Meursing 1997:23).

5.5.3.3 TREATMENT

People who are infected with HIV require treatment. Prior to treatment is 'positive living' where people are encouraged to eat healthy balanced diets, avoid stress, give up harmful substances such as drugs and alcohol and lead more balanced lives. When their immune systems begin to fail they contract opportunistic infections such as TB, diarrhoea and thrush. Most of these can be treated or in some cases prevented by the judicious use of drugs which cost only a few dollars per patient per year. As the immune system deteriorates, patients can be provided with anti-retroviral therapy. Since 1996, in the US, Western Europe and Brazil, highly active anti-retroviral therapy (HAART) has dramatically reduced death rates from AIDS and Hospital admissions for AIDS complications.

South African government was taken to court by a group of 39 pharmaceutical companies led by Merck and GlaxoSmithKline. These companies argued that for countries such as South Africa to obtain drugs cheaper that the major pharmaceutical companies were willing to sell them was to threaten profitability and ability to continue research and development. This evidence showed that profitability and levels of research and development were not as intimately related as the companies had claimed. The companies subsequently withdrew from the action, and this turn meant that generic forms of patent-expired drugs could now, in principle, be freely purchased (see Barnett 2002:338,340)

5.5.3.4 LEGAL, ETHICAL AND PUBLIC POLICY

The ethical principles that are particularly applicable to the concerns and needs of people with AIDS are those involving individual rights to liberty, informed consent, confidentiality, and distributive justice. The numbers of women with AIDS is increasing, and some of these women are and will become pregnant. Therefore,

ethical questions with this population include abortion, postponement of pregnancy, and sterilization. Should a women at high risk for HIV infection and AIDS have a baby? What role should the state and health professionals play? Can we ethically justify suicide? In these instances by thinking of such an action as rational suicide? Would it be ethical to give patients requested information regarding methods of suicide? For example, should a patient be told the drug dosage necessary to kill an individual?

Many problems in decision making arise when people become incompetent to make their own health care decisions prior to making their wishes known and prior to the appointment of a surrogate decision maker. In the event that a patient does not legally appoint a surrogate decision maker prior to incapacity, the patient's next of kin would become, by law, the decision maker, even though this might prevent the patient's expressed wishes from being implemented (see Ahmed1992:20,28-30). Public Policy is the means of defining in a rational and authoritative manner the distribution of goods and services according to benefits and costs in society (see Pike 1997: 73) However, the denial, misinformation, and stigma associated with HIV/AIDS, unparalleled in recent America history in connection with any disease, continue to contribute to a political culture in which effective public policy formation in the areas of prevention, research, and treatment remains inadequate. This is evidenced most acutely in the area of prevention and the continuing surge in HIV infection. Significant public policy questions related to children, adolescents, and families with HIV/AIDS remain to be addressed in the areas of resource allocation, access to comprehensive and clinical drug trails, behavioural research and prevention initiatives, access to zidovudine therapy for pregnant women with HIV, and the continued development of effective psychosocial and psychotherapeutic interventions that are culturally sensitive and competent. With no vaccine or cure currently available for HIV/AIDS, the provision of mental health and prevention services is the only means of preventing the further spread of the virus and should be a high-priority public policy concern (see Boyd-Franklin1995:311,322-323 and Cameron 1992:93-99).

5.5.3.5 CONCERNS RELATING TO WOMEN

We are just now beginning to confront the bleak realities of women dying of AIDS- the multitude of worries they may have about their fate; the children they may feel toward a sexual partners and friends; the anger they may feel toward a sexual partners and friends; the shock and frustration of being pregnant while being gravely ill; the grief at perhaps ending a pregnancy they might have otherwise wanted. Although every death from AIDS is a particularly sad death, women's death from AIDS have tragic qualitites on their own. Women with AIDS are, in many ways, a spin-off effect of the larger epidemic which has affected predominantly men (93%). Women with AIDS present a new social and ethical dilemma at the intersection of issues regarding sex, fertility, reproductive, rights, and economics.

We cannot hope to improve the situations of women with AIDS without openly addressing these issues and thereby formulating policy which will improve the conditions of women in general, and in particular poor women and women of colour (see Coreless 1988:77).

What can the church do about HIV/AIDS? The church can do the following:

- Educate religious leaders and workers about HIV/AIDS prevention and care.
- Educate all sectors of the community served about HIV/AIDS, especially children and youth (promotion of abstinence, adolescent reproductive health, training peer educators).
- Provide HIV/AIDS counselling (appropriate to religious teaching).
- Promote openness in discuss about HIV/AIDS, sexuality and relationship issues and other sexuality issues within the religious community - use all opportunities to discuss HIV/AIDS. For example:
  a) Pre-marriage, counselling sessions
  b) Youth groups, confirmation classes etc.
  c) Religious radio programmes
  d) Education at religious health facilities.
- Help to maintain family and social cohesion, crucial in the reduction of susceptibility to infection and the mitigation of impact (including among

religious leaders and workers).

- Restructure work conditions and responsibilities to reduce susceptibility to HIV infection.
- Ensure protection for widows/widowers and orphans.
- Integrate HIV/AIDS education and training into the curricula of theological/religious training institutions.
- Provide models of responses to HIV/AIDS to increase involvement and responsibility in HIV/AIDS throughout the community.
- Use religious leadership to advocate for the rights and needs of people infected and affected by HIV/AIDS - "peer-to-peer" influence has been shown to be highly effective in mobilising the religious sector.
- Co-ordinate activities with other bodies and organisations in the HIV/AIDS field - there are many effective programmes already in existence which can be readily shared and modified according to local needs, thus saving resources and time taken to re-develop interventions and programmes. Study visits to existing programmes can be highly motivating and empowering.
- To combat stress and burnout:
  a) Develop internal support systems for those involved in HIV/AIDS work within your religious group
  b) Provide training in stress management
  c) Offer opportunities for open discussion and support
  d) Provide opportunities for respite, reflection and retreat
- To address ethical issues:
  a) Develop and uphold religious standards for your religion

  b) Provide guidance to those needing it (for example, appoint a key theologian to fulfil this role)
- To address morbidity and mortality among religious leaders and workers:
  a) Provide information on reducing personal susceptibility
  b) Provide adequate benefits to religious personnel (sick leave, pension

cover, etc)

- To provide for material needs and legal protection:
  a) Educate religious workers and community members on human and legal rights
  b) Train religious and lay workers in advocacy and paralegal skills to ensure that rights are not being infringed
  c) Develop self-help and income generating activities within the community
  d) Encourage the reduction of funeral costs to ensure that maximum resources are left for the family.

5.6 CONCLUSION

This chapter reflects that the AIDS epidemic has shown us that an existential crisis is occuring within society and the human being which calls for a renewed spiritual and moral commitment. HIV infection and AIDS have served to indicate what little interest our society takes in those who question what it considers obvious, who don't fit into the social mainstream or disrupt the existing health and social services establishments. HIV and AIDS require a life response based on a greater measure of humanity and love. They also require a word of hope for those who need help to go on living and find meaning in their suffering. Even more than speeches and words, it is through human acts shared with those who are looking for proof of it, that an ethical and spiritual will take place (see Simard 1997:243).

CHAPTER SIX

CONCLUSION

The objective of this research is to provide a comprehensive overview of the research development focusing on the concepts of "Women and HIV/AIDS: The Churches' Response".

6.0 INTRODUCTION

(Topic/ Brief Overview of the whole research project)

HIV/AIDS is the greatest challenge facing the world today. There is no longer any person in South Africa who does not know someone or of someone who has died of AIDS or is living with HIV. Immediate action is needed to be taken to enhance the status of women and children. The men need to behave more responsibly. The Church has a vital role to play as it is a powerful "Voice" in society. Religious leaders are in close and regular contact with all age groups in society and their voice is highly respected. Family and community support mechanisms is greatly needed to show love and support to those needing care. To educate religious leaders, caregivers and workers in the communities on HIV/AIDS Prevention and care is essential and especially children and youth (promotion of abstinence, adolescent reproductive health and poor educators). There is also a need to promote openness in discussion about HIV/AIDS, Sexuality issues within the religious community. The HIV/AIDS Challenge is enormous but people must not feel powerless. It is all about action on many different fronts. There are many women who have been through trauma and adversity and are seeking answers and are trying desperately to find purpose in the pains they have endured. They are haunted by unanswered questions, and in their heart they are still asking, Why? They have survived, but that is not enough. They are seeking to go beyond survival to healing. Faith is more than a fact faith is an action. Together, as a nation we can silence HIV/AIDS.

6.1 SUMMARY OF EACH CHAPTER/FINDING OF EACH STEP IN THE RESEARCH PROCESS

Chapter One deals with the Research Design; Autobiography, Topic and Rationale, Aims and Objectives, Relevance of research, Key Critical Questions, Approach/Methods and Conclusion.

Chapter Two is the longest chapter in this dissertation because it introduces the HIV/AIDS pandemic, highlights the transmission of this disease and looks at the fact that the lack of success of prevention means that South Africa has to deal with the impact flowing from the illness and death of large numbers of people. One of the main problems around the epidemic is having people conceive of the size of the problem and sadly its inevitability. Those who will fall ill and die during the course of the next few years are already infected. Thus, the future of South Africa will to a large extent be determined by how quickly the penny drops that the impact of AIDS has to be dealt with. This explains what HIV/AIDS is and why it should be considered as a unique disease. The effect of an infection is felt first and most immediately by the person who falls ill and their family. It then spreads like a ripple out through the household, community and then through the country as a whole. The principle of successful prevention is ensuring that people are not exposed to the disease, or if they are that they are not susceptible to infection. This Chapter acknowledges that sex is the main mode of transmission and it is here that winning prevention strategies are needed.

AIDS will initially be felt by the health sector as the number of people needing care begins to rise. Already a significant percentage of South Africa's public sector hospital beds are occupied by those with HIV-related illnesses. This proportion is set to rise in the years ahead. The private sector provides health care for a sizeable percentage of South Africans, most of whom are covered through medical aid schemes. The total covered at the end of 1999 was estimated at around 7,5 million, including family dependants. However, the schemes have ceilings on the amount of care they will fund, and sometimes only provide cover for people while they are

in employment. Those people whose medical aid cover lapses when they are too ill to work will be forced to seek care in the public sector. This will add to an already stretched situation.

This chapter also looks at the fact that good HIV prevention and care is an essential part of safe motherhood. HIV can also pass from mother to child during pregnancy, labour and delivery or through breastfeeding. A growing amount of research has been conducted into the cause and possible prevention of mother-to-child transmission (MTCT), with a number of important results. A child can be infected with HIV prenatally, at the time of delivery or postnatally through breast-feeding. Infection at delivery is the most common, leading to the practice of caesarean section as a method of reducing the risk of HIV infection. A number of factors influence the risk of transmission, particularly the viral load of the mother at birth - the higher the load, the higher the risk. Another factor affecting the risk of mother-to-child transmission is the type of the mother's virus: rapid/high virus isolates are associated with transmission and slow/low virus isolates are associated with non transmission. A low CD4 count is also associated with increased risk. Antiretroviral drugs may decrease the viral load and inhibit viral reproduction in the infant, thus decreasing the risk of mother-to-child transmission. To test this hypothesis, the AIDS Clinical Trial Group conducted a study at a number of sites in the US. The study involved administering AZT to HIV-positive pregnant women in 100 mg dosages five times a day from 14-34 weeks (with a median of 26 weeks) of pregnancy until delivery. An additional oral dose of AZT was given to the infant. All women in the trial had CD4 counts above 200, were symptom-free and had not taken AZT before. The results of the trial showed a 67,5 percent reduction in transmission. The high cost of the course (R10 500 per mother-child pair) and the complexity of adhering to it have meant that only the richer nations are using this intervention at the moment.

The search for cheaper and simpler alternatives has led to a number of trials of short-course antiretroviral drugs. The greater risk of transmission in the later stages of pregnancy and during delivery means that a shorter treatment period produces only a small reduction in efficiency. In addition, it lessens the risk of non-

compliance associated with long-term courses. The Centres for Disease Control sponsored a trial of short-course AZT in Thailand, involving the administering of AZT for the last four weeks of pregnancy. The results showed a 50 percent reduction in transmission. Similarly, the PETRA (Perinatal Transmission) study undertaken in five urban settings in South Africa, Uganda and Tanzania showed transmission reductions of between 37 and 50 percent, depending on whether children were breast-fed or not. In Uganda, trials involving short-course dosages of nevirapine also produced a 50 percent reduction in mother-to-child transmission.

The cost of providing long course antiretroviral treatment is prohibitively expensive for the poorer nations. The long course of AZT would cost R1 562 per mother-child pair, the short course with AZT R562 and the short course with nevirapine R35. However, the avoidance of expensive hospitalisation charges could mean that a short course of either AZT or nevirapine may save on costs in a South African setting. Nevirapine is still under consideration by the Medicines Control Council in South Africa. Although reports say that the council has approved the drug, the body is still reviewing data from Uganda where the drug has been tested. The Department of Health said that a decision on whether the government would buy the drug for use in its hospitals and clinics would be made only when all the relevant test information from local drug trials was available. It is not known exactly what proportion of babies born to HIV-positive mothers will be infected themselves, but without any kind of intervention, it is estimated that between 15 and 45 out of every 100 would be infected. The prospects for infected children are not good.

Chapter Three pays close attention to gender and HIV/AIDS. It also investigates whether or not the fundamental cause of women's vulnerability is oppression and inequality and mens personal behaviour and circumstances is profoundly influenced and conditioned by society, which is patriarchal. The patriarchal perception that women are inferior to men and have to be obedient to their husbands, combined with the societal pressure to procreate, have significant implications for African women as far as sex is concerned. They feel compelled to have intercourse with their husbands. More important, husbands feel that their wives are compelled to

have intercourse with them. It is the prerogative of the husband to have sex with his wife when he wants to. The wife has no right to refuse. Traditional African Society known no such thing as marital rape. It also noted that African women are particularly vulnerable to HIV because of their inferior standing in traditional society, which is still a very patriarchal one and further an understanding of the various socio-economic and socio-cultural factors ought to inform our response as it is only with knowledge of such factors that appropriate solutions for the epidemic can be sought.

Children feature strongly in this chapter. I speak for those children and adolescents who tremendous potential to influence society has not been fully harnessed, with tragic result. If recognised, this potential can turn the tide against the relentless death march of HIV/AIDS. The disease has infected more than 36 million people in the world to date, about a third of whom are youth between 15 and 24 years old. Every minute, six young person below the age of 25 becomes infected with HIV. I believe that to overcome the crisis of AIDS everybody must be involved, particularly the youth. Youth engage in risky behaviour in part because of a knowledge gap. Many, particularly those from poor backgrounds, lack ways to get accurate information about AIDS. Parents, who are often uneducated and uninformed themselves, cannot help. Cultural obstacles are another factor. It is still taboo in many families to discuss sex or sexually transmitted infections. Girls in particular are often reluctant or unable to enquire about sex for fear of being considered morally 'loose'. The result is that too many children - especially the most marginalized - are ignorant about how the disease spreads.

The lack of accurate information from a parent or another close family member is a tragedy. We can, however, turn this into an opportunity. Because young people can and do speak honestly to one another about their concerns when they have the information and the confidence to impart it. Peer education is one of the most powerful but underused tools we have to confront HIV/AIDS. Just knowing about HIV/AIDS is not sufficient to change the way we behave. There is another factor: power. AIDS preys most on those who lack power, and girls are the most vulnerable. They are often pressured or forced into having sex, or are denied

information they need to help them make informed decisions. Girls frequently lack the skills to negotiate with boys or men and the confidence to challenge them; girls fear that being too assertive will make them unpopular. Even when a girl makes an informed decision to have sex, she may be unable to negotiate safe sex. So it is not enough just to teach skills.

For a young person, challenging cultural and sexual stereo-types is a tall task. The community must stand behind young people as they assert themselves. Young people, especially adolescent girls, have been reassured to see that they are not alone in tackling this frightening disease. AIDS is challenging us to find new solutions to our problems. Together, we really can save the world. Gender discrimination, also plays a major role in this chapter. The idea that people living with HIV/AIDS are 'immoral' - as well as unwarranted fears of casual infection (for example, through sharing eating utensils) - leads to stigmatization and discrimination directed at both infected women and men. Women, however, are more often blamed for spreading HIV/AIDS than men. For example, men are warned to stay away from sex workers because they may be infected, but little is said about the women protecting themselves against infection. Moreover, it has been observed in various African countries that men increasingly seek younger women for sex because they believe that younger girls will be free from infection. The immaturity of the genital system of young girls puts them at higher risk of contracting HIV than other women and men (19). Also, the sexual history of these men is likely to be longer and they may already be infected themselves.

In many parts of Africa polygamy is still common, although the practice has declined considerably in the last decades. Demographic and health surveys in 17 African countries show that about one-third of married women are co-wives (20). For example, in Tanzania 28% of women are in a polygamous union, in Uganda 34%, in Kenya 23% and in Zambia 18%. In most West African countries, more than one-third of women are co-wives. In Togo this is as high as 52%. There is no evidence that polygamy in itself is a risk factor for HIV infection. However, the system of polygamy may influence societal norms about sexual relationships. Also, to support multiple wives, men need to marry at a considerably older age than

women; this results in a prolonged period during which premarital sexual activities are predominant. AIDS makes Africa's future seem bleak. Life for many Africans is already poor, unhealthy and short; AIDS is making it tougher still. Over the next 20 to 30 years, the virus will make life poorer, sicker and shorter. No knows what the psychological impact of the epidemic will be when almost every family has lost someone to the disease. Survivors will not be able to shake off the effects like a dog coming out of water. All around them teachers, nurses, business folk, civil servants and relatives will be growing ill and dying. Life will be full of delays, cancellations and funerals.

Adversity can make people strong, but it will be an unusual AIDS orphan who gains anything from the epidemic. The damage from growing up along will be deep and, in some cases, permanent. AIDS will hurt children in a number of ways. Child mortality will increase, as will levels of malnutrition, illiteracy and child abuse. The number of children living on the street, fighting in wars, committing violent crime, joining gangs and abusing drugs and alcohol will rise. More children will die, if not in their early years from HIV, then perhaps from neglect after their mothers' deaths. Because many people believe that all children born to HIV-positive mothers will inevitably be infected too, many babies will be abandoned. Relatives sometimes wrongly assume that an orphan is going to die and so don't spend money on medicines for treatable childhood illnesses. A motherless child often has no one to ensure that she receives her inoculations. Street children are more likely to die young. AIDS sets off a vicious spiral. As adults die, families grow poorer. As families grow poorer, children go hungry. When children are hungry, they grow weak and vulnerable to infectious diseases. If they have inherited HIV from their mothers, this leaves them more vulnerable still. Many grow up with stunted bodies and minds. More children will drop out of school to care for dying parents, earn a living, do household chores or raise younger siblings. Missing out on school will make them less employable. It may also leave them ignorant about sex, AIDS and condoms.

More children will be abused, because they lack shelter and protection or because selling sex is their only means of survival. Abused children are more likely

to take greater sexual risks or find themselves in abusive relationships in adulthood. The trauma of rape can destroy people's self-esteem. Orphaned girls are particularly vulnerable to sexual abuse because they've assumed adult responsibilities, such as caring for dying parents or raising siblings, without the maturity to understand quite what has happened to them. Crime will escalate as more children steal to survive and join gangs in search of a surrogate family. More will abuse drugs and alcohol to numb their pain. Some will suffer permanent brain damage from sniffing glue or other intoxicants. Increased instability and the risk of riots by hungry, unemployed young people will make investors nervous. Already, firms are looking at the impact of AIDS on productivity when considering, for instance, whether to sink money into Southern African mines. If the environment becomes too risky - too many employees dying, too many expatriate engineers killed or too much machinery stolen - they'll pull out or stay away. Unemployment, already widespread in most African countries, will get worse.

The US Central Intelligence Agency (CIA) is worried that the 'lost orphaned generation' may be exploited by political groups for their own ends, for instance, as child soldiers. Children are already deployed by guerrilla factions in northern Uganda, Liberia, the Democratic Republic of Congo, Sierra Leone and several other countries. To break the morally restraining ties of community and tradition, warlords sometimes force child soldiers to take drugs or to kill their own parents. Orphans, with no such ties to break, could be even simpler to mould into adolescent killing machines. There are even some who speculate that the current violence in Zimbabwe and Congo may have been sparked by the feeling of hopelessness afflicting a generation who know they do not have long to live. Assuming, in line with national statistics, that about a quarter of the followers of Zimbabwean President Robert Mugabe are HIV-positive may help explain the violence that erupted in the Zimbabwean countryside in 2000. If you expect to die within a decade, you have little to lose from trying violently to seize the property of those richer than you.

Africa after AIDS will be an unpredictable place. What will happen to the minds of a generation that grows up alone, poor and ashamed by the stigma of the disease that killed their parents? Some will suffer depression. Others may lash out.

A whole generation is carrying a millstone of sadness from their childhood into their adult years. Those who bottle up their grief will probably be the most susceptible to depression. Girls, especially, may turn their distress in on themselves. This will make them vulnerable to exploitation. Desperate to be loved and accepted, they may be less assertive in negotiating wages, choosing friends or insisting that boyfriends use condoms. Look into the eyes of a typical orphan, and you can see a child begging for approval. A few orphans will overcome all obstacles. They'll win scholarships and find good jobs. Many, especially female orphans, aspire to enter caring professions such as social work or medicine. A few, more often boys, aim to win back respect from relatives who have snubbed them by becoming rich and powerful. But the stars will be the exceptions. The poor often take a fatalistic view of life. In Africa, where AIDS is drastically shortening life spans, such fatalism may grow more widespread.

As street children witness their friends die, as well as their parents, they may become more blasé about life and death. Abandoned and unloved, they may take more risks with their own lives, and, in some cases, with other people's. Watching AIDS cut short lives all around them, some young Africans may decide that they might as well live fast, spend what money they have and pack lots of sex and children into the 30 or 40 years they can now expect to survive. Having children is extremely important in Africa. With or without the threat of AIDS, most Africans will continue to have lots of them. The fear of dying young and leaving children orphaned will not be much of a deterrent. But the birth rate will fall for other reasons: HIV makes women 20% less fertile, HIV-positive women will often die before their potential child-bearing years are over and some children will contract HIV from their mothers. Few of these children will survive past infancy. Despite this catalogue of anticipated horrors, the orphan generation is unlikely to reduce Africa to anarchy. A child-headed household suffers behind its closed front door. Street children are more often beaten by the police and other adults than vice versa. Unhappy and hungry orphans will probably raise crime levels in the countries where they are the most numerous, but slowly, not suddenly or dramatically. What can be done? The most useful thing would be to slow the spread of HIV. Although there

is no cure for AIDS, and unlikely to be a vaccine for several years, we do now know how to avoid contracting the virus: abstain from sex, be faithful to your partner or use condoms.

Chapter Four deals with Social Relations and HIV/AIDS with special emphasis on the impact of HIV/AIDS on those who are infected or affected by the epidemic. It looks at both immediate and underlying factors that are contributing to HIV transmission in South Africa. Immediate determinants of the HIV/AIDS epidemic include behavioural factors such as the frequency of unprotected sexual intercourse and multiple sexual partners. Underlying determinants include socio-economic factors as poverty, the migrant labour system, the practise of commercial sex, the low status of women, illiteracy, lack of formal education, stigmatisation and discrimination. This chapter presents a global overview of violence against women, particularly as it pertained to the health of women and girls. This chapter also looks at how HIV/AIDS impacts on the economy. The fact that South Africa has a more developed economy may magnify the impact. There will be two mechanisms at work. Firstly, South Africa is more dependent on skilled labour than other countries in the region, and the skills base is extremely small. Losses of skilled and professional staff could hamper business and government operations, and possibly slow economic growth. The second mechanism is that South Africans have more interaction with and expectation of service from their government than is the case in the rest of Africa. Examples are:

- Pensions - there is only one other country where the elderly can expect to be paid a pension and that is Botswana which has a pension of P117 or R154. In South Africa a pensioner can expect to receive R540 per month.
- Health care - all South Africans are entitled to health care and, in the case of pregnant mothers and children under the age of six, this is free.
- Provision of housing and basic utilities such as water and electricity is a national priority and delivery of these is being achieved, albeit more slowly than originally envisaged.

- There is a grant for foster children. This is paid following a successful application to the court by a non-related person to have a child placed in his or her care. The payment is R460 per month. In practice the grant has been paid to family members, particularly to grandparents.
- There is a child support grant for children under the age of 7 years. The payment is R140 per month.

This means that the expectations of assistance and health care as the epidemic develops will be greater. Concurrently, the human resources that are expected to provide these services will, in turn, be depleted by the epidemic. Just as the government and other principal role players are trying to construct a civil society, the country will be waging an uncivil war against an invisible enemy more ruthless than any human adversary. It poses an enormous challenge.

It is generally argued that the epidemic is likely to have devastating consequences for overall economic development in South Africa as the demographic impact of the disease begins to have an effect. Two major mechanisms are postulated to have a negative impact on economic growth. The first is the impact of HIV/AIDS on the labour market. Here the argument is that disability and deaths from AIDS will result in serious shortages of skilled, semi-skilled and perhaps even unskilled labour. This in turn is predicted to drive up wages, as labour shortages and the premium on skills take effect. These developments are then argued to result in higher cost structures in the economy, an increasing mechanisation drive, and the possibility of serious losses in the productive and competitive capacity of the economy.

The second mechanism is the shrinking of both domestic and international markets for consumption of South African goods. It is suggested that the negative demographic impact in South Africa will have a dramatic effect on local markets. It is also argued that the potential collapse of the economies of several African countries will have a detrimental impact on the demand for South African exports. Similarly, the speculation that the economies of several African countries which import goods from South Africa will collapse is not substantiated. Unemployment

is high in all these countries; it is also not clear how seriously the relatively small formal economies that account for imports of South African goods will be affected by HIV/AIDS, and there has not been any attempt to assess the potential of international economic aid to assist in the maintenance of these economies, and thus of their capacity to import.

This is not argue that these overall economic effects will not be felt in South Africa. It is clear that HIV/AIDS will have an impact on economic development, and that the mechanisms suggested here are those likely to mediate the effects of the epidemic. However, in the absence of detailed analysis and quantification of the labour market and demand effects of the disease, speculation about the size and nature of overall economic impact is unhelpful. The links between poverty and health are increasingly recognised and understood. It is not clear that AIDS is simply a disease of poverty, although poverty undoubtedly helps drive the epidemic. In the early stages AIDS appears to infect the relatively well off: they have the disposable incomes that allow them to travel and, in the case of men, purchase sex. Of course more poor people are infected - because there are more poor - but it is likely that, as the epidemic evolves, they may be proportionately worse affected. What is clear is that AIDS increases poverty. There has been one in-depth study of a rural village in Tanzania. This study shows that AIDS-affected households are generally pushed into poverty and the situation faced by many can only be described as desperate.

In South Africa the poorest 40 percent of households receive only 11 percent of total income, while the richest 10 percent receive 40 percent. The poor (classified as the poorest 40 percent of households) are defined as those earning less than R355 per adult per month. The ultra poor (the poorest 20 percent of households) are those earning below R194 per adult per month. About 50 percent of the population (21 million) live in the poorest 40 percent of households and are therefore classified as poor. About 27 percent of the population (11 million) live in the poorest 20 percent of households and make up the ultra poor. For these households an AIDS case will decrease income and increase the demands on existing sparse resources. In effect, AIDS has the potential to push households

even deeper into poverty. AIDS may also increase inequality. Part of the survival strategy will be to sell assets, but when richer households purchase assets from AIDS-stricken poorer households, the long-term impact may be to accentuate existing inequalities in the distribution of incomes and assets. The cost of the disease is also being shifted onto households in various ways:

- Where workers who are too ill to work are retrenched or medically boarded, they lose most of their benefits. Ultimately, they have to rely on the state or their families.
- State hospitals recognise that they are neither the appropriate location nor can they provide care for people with AIDS. These patients are discharged to be cared for at home which places an extra financial burden on the households.
- People living in urban areas may return to their rural homes when they fall ill, but they can no longer access health services there.

Chapter Five poses a question- What can the church do about HIV/AIDS? There is a call to respond. Only a response which takes into account the medical aspects of illness as well as the human, cultural, ethnical and religious dimensions of life can offer complete solidarity to its victims and raise the hope that the epidemic can be controlled and turned back. This chapter seeks to provide guidance to religious leaders and community workers facing the multiple dilemmas and challenges which the AIDS epidemic presents to communities throughout the world.

As a result of the growth in HIV prevalence, and the failure to control the spread of HIV, South Africa faces a major AIDS epidemic. Instead of being able to focus purely, or even largely, on prevention activities, the country is about to have to deal with the consequences of large-scale conversion from HIV to AIDS. These will be far-reaching. In terms of impact, there is a great deal that is unknown, nowhere in the world has the epidemic run its course, and it will be many years before it does. AIDS is a disaster, but: 'Disasters do not happen, they unfold'. The implication is that, in theory, it should be possible to take the model of the future

course of the epidemic, plan for its impact, and consider it in national and regional policy. It is important to note that the effect will be serious and will probably be more so than in most other countries. There are a number of reasons for this.

Most obviously, the scale of the epidemic in South Africa is considerable. The 1999 data show that 22,4% of antenatal clinic attenders are infected. Although this percentage is a shade below the previous year's, it could well rise further before the epidemic is brought under control. As the epidemic progresses, the sheer number of illnesses, deaths and orphans will be greater in South Africa than in other countries. The 2001 data show that 24,8% of antenatal clinic attenders are infected. Since the beginning of human existence people have tried to understand the reasons for disease and suffering. Sometimes they could see that a certain kind of behaviour caused one sickness or another. They observed that some diseases were spread from person to person by touching. It was easy to believe that a misfortune or illness was directly related to an individual's sinful acts. Jesus proclaimed that all are sinners. Suffering was not assigned to people on the basis of the seriousness of their sins (Luke 13:1-5). When Jesus was promoting the new commandment of loving one's enemies and praying for those who persecute us, he added that God makes the sun shine on both the evil and the good people and sends rain on both the righteous and the unrighteous (Matthew 5:44-45).

The church is called to educate, equip and empower.

1. To know and understand the basic facts of HIV/AIDS

2. To understand the needs of the infected and affected B-L-E-S-S acrostic.

B - body needs - caring for the person and helping out around the house.

L - legal needs - get them to write a will, they should not lose their job because of HIV

E - emotional needs - fear, depression, denial etc.

S - social - help them to feel accepted and not stigmatized

S - spiritual - GIVE HOPE, share Christ because He is our hope

3. Equip the care-givers with skills for infection Control.

DEVELOP A STRATEGY

1. Know your community - what particular areas are unique to your community, how can you get involved, find a small that you can do, also find out who else is doing something. Don't duplicate and be competitive, but be complimentary.
2. Find leadership - people who have the compassion and want to do something.
3. Define the HIV-related needs - how can we help to meet those needs?
4. Develop a plan of action - have specific objectives, be plan oriented. Remember if you FAIL to PLAN, you PLAN to FAIL. Start small - SUCCESS BREEDS SUCCESS.
5. Solicit church members participation - get them to catch the vision.
6. Network with other organizations - learn from others strengths and weaknesses (see A Handbook for Christian Leaders: 37,38).

Chapter Six gives an overview of the whole research project with summaries of each chapter, a conclusion and issues identified for further research.

6.2 CONCLUSION

HIV/AIDS is the most important threat to the structure and development of South Africa. Although AIDS cannot be cured, it can be prevented. Current infection rates should never have reached such catastrophic levels. Now that they have leaders at all levels and in all countries, both industrialized and developing, must immediately commit the resources, time and energy to prevent further such tragedies. Failing to educate people about the disease is like signing their death sentences. Political leaders, Religious leaders, Artists, Performers and Teachers therefore need to seize every opportunity to educate people about how to protect themselves from HIV infection. We must speak about the high risks our mothers and sisters face of contracting this disease; their risks are higher than men's and boys'. Girls and women are extremely vulnerable. Physiologically, they become infected more easily

than men, and social pressures, cultural practices, violence, repression and prevailing values and behaviours make it difficult or even impossible for them to protect themselves. We cannot, with clear consciences, keep quiet about this. We must help women understand their rights and risks, and we need to support them when they exercise their right to take control of their sexuality and their bodies. As individuals, we must speak of the need to change behaviour. It is suicidal to have numerous sexual partners. The message must be repeated again and again in as many ways as necessary that the surest protection against HIV infection is either abstinence or practising safe sex and limiting one's sexual exposure. Equally, we must dispel the negative myths surrounding life with AIDS. Those living with AIDS can be helped to live full and secure lives and inturn help others avoid the disease.

Until there is a cure, let us raise our voices against HIV/AIDS in a song heard around the world. It is a song of defiance and struggle. But most of all, it is a song of hope- the hope that when we sing forcefully together, the silence and stigma that nourish this epidemic can be broken, and life can triumph over death.

I would like to further my research on HIV/AIDS, the issues identified for further research is the Youth and HIV/AIDS. South Africa's population is young : 54% are below 25 years of age and 12% are below 25 years of age. Changes in population structure where young to middle-aged adults are lost will result in large numbers of Orphans. The Youth are in large numbers of orphans. The Youth are regarded as our future generation. In a decade's time every fourth South African will be aged between 15 and 24. Will HIV/AIDS wipe out our youth, our future leaders?

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