CHAPTER-III

HIV/AIDS POLICIES AND PROGRAMMES OF SOUTH AFRICA
3.1 The Development of HIV/AIDS Policies and Programmes

The South African government is well aware of the crisis that the AIDS epidemic has created in their country and is working hard to help battle the disease. In 2003, the South African government committed 1.7 billion dollars to fight HIV/AIDS during the next three years. The government also passed the Comprehensive National Plan on HIV and AIDS Care, Management and Treatment act, which aims to provide 1.5 million South Africans with antiretroviral treatment by 2008. However, South Africa lacks the resources and infrastructure to allow for sufficient access to treatment and education for all citizens.

One of the reasons is that South Africa is made up of large overcrowded cities and sparsely populated rural areas. The rural areas are underdeveloped and isolated, which makes it difficult to provide treatment and educational resources within the purview and reach of all the citizens. It also makes it hard to get an estimate of how grave the situation really is, because many people are never even tested for the HIV virus.

Medical treatment for PLWHAs (People Living with HIV/AIDS) has become more available as a result of the Treatment Action Campaign of 1998. This campaign was created in response to the government’s unwillingness or inability to provide antiretroviral treatment to those who are in need of the treatment such as Azidothymidine (AZT) drugs. In 2003, the South African government ordered the health department to develop a plan to more effectively provide drugs to those that need them. However, antiretroviral drugs are still not widely available to all PLWHAs, something that the government is attempting to change.¹ South Africa has the largest number of HIV/AIDS cases in the world. In fact, 13 per cent of all infections worldwide occur in South Africa.

---

The severity of HIV/AIDS epidemic in South Africa is illustrated statistically, see figure 3.1.²

Figure 3.1: Statistics of HIV/AIDS severity in South Africa by the end of 2002

- 21.5% HIV/AIDS prevalence among adult
- 27.9% HIV infection rate among pregnant women
- 5,300,000 adults and childrens are living with AIDS
- 5,100,000 adults are living with AIDS
- 3,700,000 deaths cause by AIDS in 2003

Source: UNAIDS

The diagrammatic representation in the figure 3.1 shows that in South Africa, the HIV prevalence rate among adult in the age group of 14-49 was 21.5 per cent, but this figure is not static, it tremendously varies from place to place. Likewise the number of adults living with HIV/AIDS was 5.1 million, adults and children living with HIV were 5.3 million. The deaths cause by HIV/AIDS including opportunistic diseases was 3,700,000;

national infection rate of pregnant women attending antenatal services was 27.9 per cent. All the above figures are from the UNAIDS report 2003.3

3.1.1 National HIV/AIDS Policies and Programmes

HIV/AIDS policies and programmes in South Africa were taken more seriously after the launch of the National AIDS Coordinating Committee of South Africa (NACOSA) in 1992.4

NACOSA was formally shaped in 1994 with an un-fatigable mandate to develop a national strategy on HIV/AIDS prevention and control. The main aims and objective of launching NACOSA was primarily to prevent further transmission of HIV/AIDS, minimize the personal and social impact of HIV infection, and to mobilise and unify, the provincial, local and international resources in the battle against HIV/AIDS.

The policies, programmes and plans highlighted under NACOSA is an integrative approach to South Africa’s health problems, NACOSA primarily deals with the HIV/AIDS, but TB and STDs are always included under the umbrella of NACOSA, because South Africa is equally suffering from chronic TB and an unavoidable STDs. NACOSA’s strategy and plans covers whole of South Africa as well as it serves as a platform to address HIV/AIDS issues in the regional perspective, especially among the South African Development Community (SADC) countries.5

3.1.1.1 The NACOSA (1992-1994)

National AIDS Coordinating Committee of South Africa (NACOSA), a nodal HIV/AIDS agency of South Africa has endorsed a beautifully crafted mandate to develop national strategies on HIV/AIDS prevention and control. The goal was set to prevent the further transmission of HIV/AIDS, reduce the personal and social impact of HIV infection, and to mobilise and unify the provincial, international and local resource in the battle against AIDS. In 1997, the South African National STD/HIV/AIDS review was conducted in respect of the goals outlined in the NACOSA plan of 1992. The review

3 Ibid.
5 Ibid.
indicated the strength in South Africa’s response to the epidemic, and soon in 1999, South African government has extensively prepared a comprehensible national strategic plan.⁶

The motive of the plan was to guide the country’s response as a whole to HIV/AIDS, since than the documents has become the basis for all governments, NGO’s and local institutions for developing their own strategic and operational plan, which in the process gets harmonised in maximising the efficiency and efficacy of the South African governments initiatives on HIV/AIDS. Besides, the responses by the South African government and the local or global NGOs on HIV/AIDS, there are also various international funding agencies, which have been quite appreciable in South Africa.⁷

The government has always been unequivocal about the fact that its AIDS policy stems from a belief that HIV causes AIDS. A recent cabinet statement announcing a substantial increase in state spending on HIV/AIDS emphasised that, government’s starting point is based on the premise that HIV causes AIDS, the statement concludes that as government focuses its efforts and resources on public health and the challenges pose by HIV/AIDS, it will therefore draw whatever it can from science and technology to fight out the HIV/AIDS epidemic. As in all areas of science, research and debate will continue, but government is not a protagonist in those debates.⁸

The strategic plans of NACOSA is an important document to South Africa’s health problems, because it not only serves to address the HIV/AIDS issues, but also other equally important diseases like TB and STDs. NACOSA is therefore designed to direct South Africa’s response as a whole to the various epidemic, importantly the HIV/AIDS. It is not simply a policy for the health sector alone, but a statement of programmes, policies, plans and strategies for the whole of South Africa. It is programmed to affect both within and outside the government.

No single Ministry, departments or organisation is by itself responsible for addressing the problems of HIV epidemic. The various programmes and policies on

---

⁶ Ibid.
⁷ Ibid.
HIV/AIDS, highlighted under the NACOSA documents are the guiding principles to be initiated and use by all the government departments, institutions, organisations and stakeholders, as well as it is been used as the very basis and the mandate to build their own strategy and operational programmes.9

3.1.1.2 National HIV/AIDS and Strategic Plan 1999

The government of South Africa has massively increased the budget for its HIV/AIDS and Sexually Transmitted diseases which is forcefully govern by the National HIV/AIDS strategic plan which was launch in 1999 for the term period 2000-2005, this five year plan is in line with the international governing bodies that are involved in fighting the disease, and are lauded as among the best strategies in the world.10

The plan has four priority areas: preventing further HIV infection; providing treatment, care and support for those infected and affected by HIV; researching on AIDS vaccine and conducting other research and monitoring; asserting the human and legal rights for the people living with HIV/AIDS as well as people by the disease.11

A total of 350 million Rand were budgeted by the Departments of Health, Social Development and Education for the financial year 2001-2002, this budget therefore saw an increase of 1 billion Rand, simultaneously the South African government targets to increase 1.8 billion Rand for the financial year 2004-2005.12

Since 1998, the then Deputy President Thabo Mbeki launched the Partnership against AIDS, the government has adopted a broad based, multi-sectoral approach towards fighting the disease. Given that HIV/AIDS affects all the sections and sectors of South African society, therefore all the initiatives such as awareness campaigns, care for the people affected by HIV/AIDS and research were strengthened with a partnership approach.

9 Ibid.
11 Ibid.
12 South Africa at a glance (2003), n.8.
In January 2000 the Partnership against AIDS was formalised by the formation of the South African National AIDS Council under Deputy President Jacob Zuma. The government is strengthening its own contribution to the partnership with the establishment of a Presidential Task Team on AIDS, consisting of cabinet minister which is headed by Deputy President.

Given that there is no cure for AIDS, the government’s strategy focuses on prevention by promoting public awareness and delivering life skills and HIV/AIDS education. The various AIDS awareness campaigns run by the government as well as NGOs such as LoveLife and Soul City are now bearing fruit. There is now a high level of awareness among youth regarding HIV/AIDS, the awareness level is appreciably above 90 per cent, but the pressing challenge is to ensure that this awareness translates into behavioural change. Educational programmes on HIV/AIDS are now fast becoming a school curriculum which is made compulsory and are fully implemented in South Africa beginning from 2003. Likewise many other selective areas of focus are considered in South Africa under the National HIV/AIDS and strategic plan 1999.

3.1.1.2.1 Treatment of Sexually Transmitted Diseases (STDs)

Government of South Africa’s primary health care initiatives includes the treatment and care of Sexually Transmitted Diseases (STDs), because STDs significantly increases the risk and chance of HIV transmission, this mode of governing the health care are extended to almost all the governments’ health centre and are also notified to the private health care institute. About 80 per cent of all the public health clinics are filled by HIV personnels and workers who are well trained in this field.

Because of such well monitored health care initiatives, both the cases and incidences of syphilis among pregnant women, who attends public health clinics has dramatically went down in South Africa.  

---

13 Ibid.
14 Ibid.
3.1.1.2.2 Reproductive Health Research

A joint project initiated between the department of obstetrics and gynecology, government of South Africa, university of Witwatersrand, Chris Hani Baragwanath hospital and the city of Johannesburg conducts research into sexual and reproductive health, including effective treatment of sexually transmitted diseases. They develop both clinical and non-clinical interventions for the prevention and treatment of STDs and HIV, which are then delivered to the communities and masses across South Africa who are vulnerable STDs and HIV/AIDS.15

To prevent the acquisition, transmission or progression of HIV and other STDs, the research team focuses on evaluating the effectiveness of new or innovative strategies by employing new approaches and treatments using the same methods of treatments. The research projects undertaken at present are: development of microbicides; treatment for genital herpes; and the arrangement of necessary infrastructure to increase the access and use of services by high-risk groups. These activities are supported by a strong social medicine programme focusing on the social life and context of participants, as well as the communities where these participants are from. The team consists of over 90 people, working from clinical trial sites in Soweto, Orange Farm, Yeoville and Johannesburg city, who are involved in the implementation of 8 community-based randomised controlled trials.16

3.1.1.2.3 Prevention of Mother to Child Transmission (MCT)

Prevention of Mother to Child Transmission programme in South Africa is run from some 18 research sites, more than 38,000 child bearing women have been brought under the purview of MCT programme. Pregnant women are offered voluntary HIV testing. Those who are HIV positive were administered Nevirapine, others were provided vitamins and given milk formula if they decide not to breastfeed their babies. Babies are also given multivitamins and prophylaxis for opportunistic infections. The availability of

---


Nevirapine antiretroviral drugs to all the HIV positive pregnant women has been ensured by the South African government, the plans were implemented from 2003. There has been a constitutional ruling in South Africa, which say that all the public health institutions must ensure the availability of Nevirapine drugs to pregnant women, who are infected by HIV.\textsuperscript{17}

Government of South Africa has been hesitant to do so given that there is still uncertainty around the drug’s toxicity. However, the guidelines on how to administer drug and provide backup services required were issued to all the hospitals in South Africa. Special task teams were setup by the ministry of health, government of South Africa. To facilitate the purpose of special task team, the health ministers from all the nine provinces of South Africa supports and assist the central health minister.\textsuperscript{18}

\subsection*{3.1.1.2.4 Treatment and Dealing of Rape Cases}

The incidence of rape, violence against women and demand for virginity in South Africa are high and rising; this on the other hand contributes to the spread of HIV/AIDS. Hence, government of South Africa has toughed the law and services by endeavouring to provide antiretroviral to the survivors of sexual assault and those who were injured by needle stick, as well as counselling, testing, care and support for HIV, STDs and pregnancy.\textsuperscript{19}

\subsection*{3.1.1.2.5 Treatment of People Living With HIV/AIDS (PLWHS)}

Beginning from the year 2000, the government of South Africa has set up a programme, which provides voluntary HIV testing and counselling to both the HIV positive patients and HIV negative people. There are around 495 sites identified in the various provinces of South Africa, treatment for opportunistic infections are regularly given in these sites.\textsuperscript{20}

\begin{thebibliography}{99}
\bibitem{17} South Africa at a glance (2003), n.8.
\bibitem{18} Ibid.
\end{thebibliography}
The government of South Africa has been pestering the pharmaceutical companies’ time and again to lower the costs of drugs, several rounds of agreement took place between the government of South Africa and pharmaceutical companies regarding the availability and pricing of drugs. A renowned company Pfizer has finally agreed to provide Fluconazole (Diflucan) to public hospitals and clinics for two years. Funding was provided for the training of healthcare workers in diagnosing and managing oral thrush and cryptococcal meningitis. Although antiretroviral drugs are still scarcely available in the public health centres in South Africa, however, the government of South Africa is committed in ensuring a healthy life to its citizens; the government recognises that they can improve the quality of life of people living with HIV/AIDS, if available drugs are administered correctly in line with international guidelines, also if these life promoting drugs were made available within the reach of every citizens of South Africa. Hence South Africa has been grossly intensifying its campaign to make sure that people infected by HIV, TB, and other diseases must follow the correct treatment advice.21

The South African government continues to lobby drug companies to lower the cost of antiretroviral and investigate the production of generic equivalents. Because such initiatives will make those costly drugs within the reach of poor masses, which in turn alleviates the poverty as well as vulnerability to HIV/AIDS? The government support and encourages the research and development for an alternative treatments and medicine, particularly those that boost the body’s immune system.22

3.1.1.2.6 Care, Support and Treatment to the Families Affected by HIV/AIDS

The care and support needed by the people living with HIV/AIDS and their families cannot just be supported by the hospitals alone, hence governmental support and encouragement is essentials in this aspect. The South African government have initiated a number of schemes and along with home-based care, support and treatment for the people living with HIV/AIDS and their families, such initiatives by the government gives hope, emotional support and loving care to the people living with HIV/AIDS. South African government extents help to the families affected by HIV/AIDS in the form of food

21 Ibid.
22 Ibid.
parcels, assistance to households headed by children, foster care grants and many other governmental interventions.

The budget were also appreciably increase by the South African government to meet the needs of home and community based care for the people suffering from HIV/AIDS. The allocated budget was 94.5 million Rand during the fiscal year 2002-2003, which was increase substantially to about 136 million Rand in the fiscal year 2004-2005. Various NGOS, either supported by the government of South Africa or funded by the international agencies, have set up home and community based care projects to extend help to the people living with HIV/AIDS and the families affected by the epidemic. Some of the popular NGOs, such as: Treatment Action Campaign (TAC); Hospice Association of South Africa; and Palliative Medicine Institute are actively engaged towards this noble cause.\(^{23}\)

3.1.1.3 Establishment of National AIDS Council (NAC)

The goals of South Africa’s HIV/AIDS policies are structured according to the following four areas and its components.\(^{24}\)

3.1.1.3.1 Prevention

The HIV/AIDS prevention efforts of South Africa primarily include: promotion of safe and healthy sexual behaviours; improvement in the management and control of STD; reduction of Mother to Child HIV Transmission (MCT); as well as the issues relating to blood transfusion, post exposure services and an improvement of accessibility to voluntary testing and counselling channels.\(^{25}\)

3.1.1.3.2 Treatment, Care and Support

South Africa follows the following key features in the treatment, care and support for the people living with HIV/AIDS and their families, these are: facilitation of treatment; care and support services; availability of treatment, care and support in the


\(^{24}\) Government of South Africa (2001), n.10.

\(^{25}\) Ibid.
communities; development as well as expansion of provisions of health care to all the children and orphans.\textsuperscript{26}

3. 1. 1. 3. 3 Research, Monitoring and Surveillance

The features which are ensured for research, monitoring and surveillance to tame the HIV/AIDS in South Africa are: to ensure and encourage the AIDS vaccine development initiatives; to investigate the treatment and care options; and to conduct regular surveillance's.\textsuperscript{27}

3. 1. 1. 3. 4 Human Rights

To take up the speedy plan on HIV/AIDS, the human right issues have been time and again made the central elements of HIV/AIDS policies in South Africa. The key features of these goals are: creation of an appropriate social environment; development of suitable legal and policy environment; and the establishment of grievances cells on human right abuse.\textsuperscript{28}

3. 1. 1. 4 Establishment of HIV/AIDS and STD Directorate

HIV/AIDS issues are brought to the attention of all the concern bodies in South Africa by the department of health’s HIV/AIDS and STD directorate. The directorate prepares effective briefing documents for all the national committees and it further conducts various meetings, which provides valuable information and reports on HIV/AIDS to all the concern bodies and committees.\textsuperscript{29}

The national policies and programmes on HIV/AIDS in South Africa have evolved from many plans and project over a long period of time, more prominently since 1990s. Some of the important development of 1990s are: launch of NACOSA in 1992; establishment of National AIDS plan in 1994-1995; the 1997 department of health’s white paper for the transformation of the health system in South Africa; Durban International AIDS conference of 2000; and various other national and regional

\textsuperscript{26} Ibid.
\textsuperscript{27} South Africa at a glance (2003), n.8.
\textsuperscript{28} Ibid.
\textsuperscript{29} Government of South Africa (2001), n.10.
conferences have led to an evolvement of a well documented policies on HIV/AIDS in South Africa.\textsuperscript{30}

The HIV/AIDS policy initiatives in South Africa primarily rest on three important pillars, viz; Prevention, Treatment and Care. The guiding principles on HIV/AIDS policies therefore are base on these three pillars, which involves the following features:\textsuperscript{31}

Involvement of HIV/AIDS people in all the prevention, intervention and care strategies; Prevention of any form of discrimination against HIV/AIDS people, their associates, families, partners and friends; Empowerment of women to participate without fear in the HIV/AIDS activities; Maintaining confidentiality of an individual’s, regarding the status and result of their HIV testing; Availability of government’s health services to all the women, children and youth; Education, counselling and health care elements must be initiated as per local reality and set ups; The policies must be sensitive to culture, language and social circumstances of all the people at all times; Government has the sole responsibility with regard to the provision of education care and welfare of all the people in South Africa; Cooperation and full participation of community in the prevention and care must be time and again developed and fostered; All the plans, intervention and care strategies must be evaluated and assessed before implementation; Both government and civil society must be actively engage to fight the HIV/AIDS menace; Capacity building must be emphasised to accelerate the HIV/AIDS prevention and control measures; HIV/AIDS and STD prevention and control should remain central elements in the response and policy formulation on HIV/AIDS.\textsuperscript{32}

3.1.1.5 Development of Provincial AIDS Coordinators

The expanded responses to HIV/AIDS in South Africa are managed by various structures in all levels. Each government ministry has a focal person and HIV personnel’s, whose responsibilities are planning, budgeting, implementation and monitoring the HIV/AIDS interventions. All other sectors including women, youth, religious organisations, non-governmental organisations, parastatals, corporate and

\textsuperscript{32} Ibid.
private sectors as well as international organisations has a dedicated HIV/AIDS focal person and experts. See figure 3.2 which represents the national and provincial structures governing the HIV/AIDS policies and programmes in South Africa.\textsuperscript{33}

For instance the Department of Economic Development of Western Cape province provides services relating to HIV/AIDS workplace policies and programmes, such as: Targeting the big corporate employers in the province; Mobilisation of existing and possible new partners; facilitating and driving the HIV/AIDS in the Workplace initiatives; Moreover it gives advice on development and implementation of HIV/AIDS
workplace policies and programmes; It also encourages research and development on HIV/AIDS.\textsuperscript{34}

Likewise, the Department of Economic Development of the government of South Africa also examines and identifies what initiatives were taken and what plans were implemented by the corporate sectors. If any sustainable and plausible practices were implemented, then the government advises them to share it with other organisations. Government encourages media coverage of such initiatives to raise awareness and provides assistance to small business firms to carry and implement the good planning and policies of large firms. Organisations such as Small, Medium and Micro Enterprises (SMMEs) can learn and follow the highlights and pitfalls as well as recognise the value of these initiatives of the successful firms.\textsuperscript{35}

Research and studies shows that many small business owners feel helpless to deal the HIV/AIDS problems in South Africa. They don't have proper knowledge and understanding about the prevalence of HIV/AIDS amongst their staff and workers. Many a time they either deliberately avoid it or don't know how to deal with an employee who is living with HIV/AIDS. Moreover, they even don't know how to initiate HIV/AIDS awareness and education into the workplace. Hence, the government of South Africa along with its agencies and NGOs has been encouraging companies to buy the comprehensive HIV/AIDS toolkit of international standards, which were produced by the South African Business Coalition on HIV/AIDS (SABCOHA). The significant and logic behind these toolkit is that it provides business sectors, especially SMMEs a means of implementing cost effective workplace programmes and policies.\textsuperscript{36}

The various structure and chambers both at the national and provincial levels as well as their specific role and functions relating to HIV/AIDS are briefly discuss in the following heads:

\textsuperscript{35} Ibid.
\textsuperscript{36} Ibid.
3.1.1.5.1 Cabinet

The cabinet, which comprises the president and the deputy president, is the highest political authority in South Africa. The cabinet meets weekly, but HIV/AIDS is not discussed at this levels. All the cabinet members, deputy members and the members of health department meet monthly in the inter-ministerial committee on AIDS.37

3.1.1.5.2 Inter-Ministerial Committee on AIDS (IMC)

The Inter-Ministerial Committee (IMC) on AIDS was the first high-level political body that was established to oversee the national response to HIV/AIDS in South Africa. This committee was established at the end of 1997 and was chaired by the then Deputy President, Mr Thabo Mbeki. All ministers and deputy ministers attended committee meetings. The main objectives of the committee were to provide leadership, political oversight and guidance to the HIV and AIDS programme.38

The South African Cabinet formed the IMC in 1997, it consists of all the ministers and deputy ministers and is chaired by the deputy president. This committee meets on a monthly basis to review South Africa’s response to AIDS epidemic. Issues of strategic importance are discussed and political guidance is given to the HIV/AIDS and STD directorate as well as Inter-Departmental Committee on AIDS (IDC).39

3.1.1.5.3 South African National AIDS Council (SANAC)

The national AIDS council of South Africa is the highest body that advises government on all the matters relating to HIV/AIDS. Its functions are: To advise government on HIV/AIDS and STD policy; To advocate an effective participation of all the sectors and organisations in implementing the HIV/AIDS policies and programmes; To monitor the implementation of HIV policies as well as to create and strengthen the partnership of an expanded national response to HIV/AIDS among all the sectors;

SANAC also mobilises the national resources for the speedy implementation of AIDS programme and recommend an appropriate research on HIV/AIDS in South Africa.\textsuperscript{40}

The basic objective of forming SANAC was to strengthen the strong political will and leadership as well as to ensure the inclusion of civil society in the overall response to HIV/AIDS in South Africa. The Council is composed of both government and civil society organisations.\textsuperscript{41}

SANAC is chaired by the deputy president and consist of 15 governments’ representatives and 16 civil society representatives, see figures 3.3a and 3.3b.

\textsuperscript{40} South African Government Information., n.38.
\textsuperscript{41} Ibid.
Figure 3.3a: the Government representatives in SANAC

Other than the governmental representatives in SANAC, there are representatives from civil society as shown diagrammatically in the following figure 3.3b.

Source: National AIDS Council, Government of South Africa
3.1.1.5.4 Technical Task Teams

The decision and the deliberations of national AIDS council of South Africa are assisted by the technical task teams, which comprises experts in the following five fields: Prevention, Care and support; Information, Education and Communication (IEC); Social
mobilisation; Research and Monitoring; Surveillance and Evaluation; and finally the Legal issues and Human Rights.42

3.1.1.5.5 Inter-Departmental Committee on AIDS

The IDC consist of representatives from all the government departments, that co-ordinate the HIV/AIDS activities and strategies. They meet every month to review the government’s programmes and answer the various questions from the IMC. The IDC’s goals are: Facilitation of HIV/AIDS workplace policies in all the government departments; Development of common minimum programme on HIV/AIDs for all the government departments; and Ensure that all the government departments’ does allocates financial resources for the implementation of HIV/AIDS programmes and policies.43

3.1.1.5.6 Ministry of Member of Executive Committee (MinMEC)

Min MEC consists of all the provincial health Members of Executive Committees (MECs) and the national minister of health. Min MEC meets every six weeks. It is this body that approves the national policies and guidelines. HIV/AIDS is the limelight of this body, where reports on national and provincial programmes are discussed and deliberated thoroughly.44

3.1.1.5.7 Provincial Health Restructuring Committee (PHRC)

The PHRC consists of all the provincial heads of the department of health in South Africa. PHRC meeting takes place every month, were they discuss about the strategic issues on HIV/AIDS, from the view points of national and provincial importance. HIV/AIDS is PHRC’s standing agenda, where reports from the IMC (Inter-Ministerial Committee on AIDS), national HIV/AIDS and STD directorate and provincial HIV/AIDS coordinators are discussed. Once the PHRC has discussed and approved the documentation, it is referred to the Min MEC for the political consent and approval.45

43 Ibid.
44 Ibid.
3.1.1.5.8 Director General’s Forum

The Director General’s Forum or DGs (DGF) consist of director generals from all the national government departments and meets on a regular basis. HIV/AIDS is DG forums standing agenda item, where reports’ from the IMC (Inter-Ministerial Committee on AIDS) are discussed at lengths.46

3.1.1.6 National HIV Policy 2005

The policies and programmes on HIV/AIDS in South Africa became more prominence after the launch of NACOSA and other strategic plans. But an abrupt initiations and development of HIV policies as such were championed by South Africa’s health Minister Dr. Manto Tsabalala Msimang in July 1999 under the aegis of President Mr. Thabo Mbeki, who has put forward a daunting challenge to all the sectors and sections of South African society, to become actively involved in the initiatives designed to address the HIV/AIDS epidemic.47

It all began with a meeting held in July 1999 to evaluate and measure the status of HIV/AIDS prevention, treatment and care efforts in South Africa. It was attended by almost all the sections of the society, with a representatives coming from People Living with HIV infection or AIDS (PWA), religious or faith base organisations, non-governmental organisation (NGOs), human rights organisations, academic institutions, the salvation army, the media, the civil military alliance, women’s organisations, youth organisations, organised labours, organised sports, organised businesses, insurance companies, health professionals and health consulting organisations, political parties, international donor organisations and relevant government departments and institutions.48

The outcomes of July 1999 meeting was an eye opener, it set an important pattern to be initiated in dealing the HIV/AIDS problems in South Africa, the meeting also catalyst into developing a five year National HIV/AIDS and strategic plan. The priority areas were identified as: Treatment, care and support; Legal and human rights; Monitoring and research as well as evaluation. This outcomes yielded more aims and

46 Ibid.
48 Ibid.
objectives, which were added to the nations HIV Policy. Besides; the South Africa’s health ministry had held a several rounds of meetings, conferences and seminars with faith based organisations, traditional leaders and corporate personnel’s, that has greatly helped in garnering their views and suggestion in making the policies more vibrant, enthusiastic, dynamic and acceptable to the public in the fight against HIV/AIDS in South Africa. In September 1999, the health ministry and the Member of Executive Committees (MEC) of all South Africa’s nine provinces met to evaluate and table the identified task and priority areas under the previous meetings and planning’s. 49

This was soon followed by a two day national meeting held in October 1999 as well as November 1999, which was attended by provincial AIDS coordinators, Departments of Health (DOH) HIV/AIDS/STD Directorate, representatives of the AIDS Training and Information Centre (ATICs) and the representatives of several other organisations and professionals. In this meeting the goals and objectives of NACOSA, reports and documents of previous meetings and the progress made in the five year HIV/AIDS and STD strategic plan were discussed at length. They reviewed the 1997 annual HIV/AIDS plan, the 1994 National AIDS plan for South Africa and the department of health’s white paper for the transformation of health systems as well as the reports of provincial members of Executive Committees and the National AIDS meetings. In November 1999, a draft document was presented to the Inter-Ministerial Committee on AIDS for its approval and endorsement, which was finally completed and submitted in January 2000. 50

During this course of policy developments, right from the birth of NACOSA and its subsequent reviews, have indicated that there needs a high level commitments from Ministry of Health (MOH) and Department of Health (DOH) at various levels. To ensure these commitments, the inter-departmental, inter-sectoral, non-governmental organisations (NGOs) and Community Based Organisation (CBO) must be highly motivated for their active role and participation. Moreover, adequate availability of drugs

49 Ibid.
50 Ibid.
and easy accessibility for STD management and treatment must be facilitated in all the clinics with an improvement in TB services.\textsuperscript{51}

However, many hurdles and constraints were noted. The re-structuring of national and provincial department delayed the appointment of HIV expert and personnel’s, both human and financial resources were found unplanned, district structures remained non-established, home based and terminal care for HIV/AIDS patient were negligible. The commitments of the policies were invisible outside the arena of department of health. Discriminations, human right abuse and ill-treatment of HIV infected people continued in South Africa, coupled with the lack of provincial policies and guidelines on HIV/AIDS. The comprehensive care, support and counselling tools as well as health promotional materials were not tune into the local needs and reality and were largely found to be client insensitive. These all factors have begun to shake South Africa’s ambitions AIDS policy.\textsuperscript{52}

The loopholes and setbacks in South Africa’s HIV/AIDS policies have made the responsible offices more active and clever. After much debates and meetings as well as consultation, various strategies and plans right from the year 1997 till 2000 were again reviewed and were vibrantly documented to initiate the policy machine running.

The highlights of the reviewed documents were:\textsuperscript{53} Each province to have co-coordinators on HIV/AIDS, which will support regular training and meetings to facilitate the implementation of HIV programme; Inter-ministerial committee on AIDS to be established, which consists of the ministers and deputy ministers and will meet on a monthly basis to discuss the HIV/AIDS and provide political direction and policy guidance to HIV/AIDS and STD directorate of department of health; Department of education to develop an HIV/AIDS policy for learners and educators, which will make the HIV/AIDS education a component and tool in all the secondary level schools in South Africa; National policies, that deals with the Post Exposure Prophylaxis (PEP) to HIV and the syndrome management of STDs will be developed, which are missing from the policy guidelines throughout the history of HIV/AIDS in South Africa; The South

\textsuperscript{52} Government of South Africa (2004), n.47.
\textsuperscript{53} Government of South Africa (2004), n.47.
African AIDS vaccine initiative, launched in 1998, have paved way for an easy availability of AIDS vaccine, which are both effective and cheap as well as within the reach of poor's. Hence the vaccine initiatives were kept encouraging; The National AIDS Council (NAC), to be kept motivating, as this body overseas the overall national response to the epidemic and initiates the policy implementation.

NAC facilitates collaboration between government and all other sectors including the international agencies and donor countries;\textsuperscript{54} The national inter-departmental HIV/AIDS committee to be established, which will work to develop HIV/AIDS workplace policies, which could yield the common minimum HIV/AIDS programmes for all the government departments; The strategic framework for South African AIDS youth programme needs to be initiated; The integrative and collaboration between HIV/AIDS, STDs and TB programme will be put forward in all the area of policy formulation and advocacy.

The above points of the reviewed documents have become the part and parcel of South Africa’s HIV/AIDS policy guidelines.\textsuperscript{55}

The battle and partnership against HIV/AIDS menace launch by the president of South Africa in 1999, which seeks to include the participation by all the sectors and sections of society was a powerful and potential platform, through which every South Africans can address their grievances without difficulties.\textsuperscript{56}

3.1.1.7 National Inter-Departmental HIV/AIDS Committee (IDC)

The Interdepartmental Committee on HIV/AIDS was established in 1997, it was initiated by Doctor N.C Dlamini Zuma, the then South African minister of health. The IDC was set up as a mechanism to facilitate and strengthen the response to HIV/AIDS by the government departments at all levels. The committee meets every month since 1998. The mandate is the same as described in the HIV/AIDS and STD strategic plan of South Africa, such as: To review government HIV/AIDS programmes; To facilitate the development of workplace policies on HIV/AIDS; To ensure that all government

\footnotesize{\textsuperscript{54} Government of South Africa (2005), n.51.} \\
\footnotesize{\textsuperscript{55} Ibid.} \\
\footnotesize{\textsuperscript{56} Ibid.}
departments allocate financial resources to HIV/AIDS programmes; and to develop at least a minimum programmes on HIV/AIDS for all the government departments. 57

IDC is comprises the members, who are also the HIV/AIDS coordinators of national government departments. To date most departments allocate this function to mid-level officials with expertise in the field of human resources or social services, IDC members tend to be practitioners, not managers. The IDC is led by two chairpersons who are elected amongst its members. South Africa’s health department provides the entire fund needed for IDC’s smooth operations. IDC sets its priorities during its annual planning workshop; chairpersons and secretariat jointly constitute the steering committee that reviews the progress made by the committee on a monthly basis and ensures that the IDC meets the needs of its members. The monthly IDC meetings form the heart of the IDC operations. Specific projects are referred to IDC task teams. It is during the IDC meetings that task teams are elected and held accountable, interdepartmental campaigns are planned and monitored, departmental HIV/AIDS programmes are presented for peer review, hence IDC meetings serves as a platform for the exchange of information and resources. 58

In accordance with the IDC operational plan, there are a range of follow-on activities and projects. These include: Identification of training needs and provision of training; Implementation of interdepartmental HIV/AIDS campaigns and interdepartmental advocacy; Monitoring and reporting on departmental HIV/AIDS programmes; Policy and programme research; Representation as well as support to the external stakeholders; Dedicated support initiatives tailored to suit the specific needs of a particular departments; Practical networking, resource sharing and joint projects between departments are the follow on activities being sort by the IDC. 59

Some of the IDC initiatives discerning from its operational Plan of 2003 and 2004 are: Development of capacity building programme; Public awareness campaigns

such as STI week, TB day, Candle Light Memorial and World AIDS Day. The Commitment Campaign is an IDC project that celebrates government’s role in the partnership against HIV/AIDS. IDCs promotion and marketing strategy includes: Improvement of stakeholder relations; Development of promotional and exhibition material. The Department of Public Service and Administration (DPSA) established a popular project called ‘Impact and Action Project’ in 2000. Impact and Action Project was one of the pioneering programmes to prepare the public service for managing the impact of HIV/AIDS at workplace.\(^{60}\)

IDC members are accountable to the departments they represent. Interdepartmental initiatives that are funded by the Department of Health require the approval of the health department. The IDC submits its reports twice in a year to the Social Cluster and once in a year to the Deputy President, who is also the chairperson of SANAC.\(^{61}\)

### 3.1.2 Planning and Implementation of HIV/AIDS Policies

To ensure the achievements of its objectives and goals, the HIV/AIDS policies and programmes of South Africa are extensively used in developing the national, provincial and district operational plans. Yearly operational plans are based on the realistic objectives, which are done by taking into consideration the existing financial and human resources, capacity building, political commitment and the participation of civil society. The goals are then implemented at provincial level, which gets duplicated at the district and community levels.\(^{62}\)

All the structures, such as: The national AIDS council; Inter-departmental committee on HIV/AIDS; Inter-ministerial committee are duplicated in each provinces. Appropriate structures and policies at district levels are launched and many are periodically launched by taking into consideration the dynamism and situations of

---

\(^{60}\) Ibid.

\(^{61}\) Ibid.

\(^{62}\) Government of South Africa (2001), n.10.
HIV/AIDS. District HIV/AIDS committees are also well established in South Africa, which includes the community based committees.63

The functions of community base committee are that they represent the major role-players within the community in the field of HIV/AIDS. These committees broadly include local government to ensure the integration of HIV/AIDS, STD and TB issues in their policy formulation and planning. Many a time due to non allotment and allocation of funds on time, the various developmental and planning initiatives are either delayed or roll backed. Since HIV/AIDS is one of the major issues and debate in South Africa, the South African government has made it an earnest to ensure that adequate funds are made available both at the national and provincial levels, within the health care environment so as to ensure its proper and timely delivery.

In order to do away with such hurdles and constraints, the policy makers have adopted several practical methods, which have greatly helped in the planning and allocation of financial resources directly to the provinces. Currently about 10 Rand per person per year has been allocated, which totals up to around 400 for the whole of South Africa.64 However, for the overall success and development, it is arguably the capacity rather than funding, hence, proper delivery of human resource is an utmost important tool of HIV/AIDS policy. Currently the standard in South Africa is one dedicated HIV expert or employee per 1,00,000 population.65

The various policies and programmes of HIV/AIDS in South Africa are reviewed every year at the national and provincial levels as well as quarterly reports, which are submitted to the provincial and national HIV/AIDS authority.66

The national department of health has the overall responsibility for the proper implementation of the programmes and plans within the provincial structures. Specific measurable targets are developed for each objective and goals, which are reported during the yearly operational plans. The policies and programmes on HIV/AIDS are monitored by their objectives which are then supplemented with additional monitoring; including

63 Ibid.
64 Government of South Africa (2005), n.51.
65 Ibid.
66 Ibid.
national, provincial and local behavioural surveys. These surveys measures the changes in the HIV related risk behaviours, including condom use, delay sexual initiation among youths, HIV incidence and the number of sexual partners. Another important step taken by the programmers is the establishment of a mechanism, where a constant and consistent feedbacks and reporting by provincial to national structure and vice versa.\textsuperscript{67}

South Africa’s HIV/AIDS policies provides a broad framework to the governmental organisations, non-governmental organisations, businesses, labours, women and all sectors of society. Each sector has developed a specific plan based on their role, activities and specific strengths in the society. Many sectors have established AIDS committees, which are responsible for advocating, managing and coordination in the implementation of HIV/AIDS activities within that sector. The sectoral AIDS committees are responsible for liaison with other sectors and the department of health’s HIV/AIDS and STD directorate. The role of the sectors in South Africa are:\textsuperscript{68} Identification of the spread of HIV/AIDS and STDs specific to the sector; Identification of strengths and weaknesses with respect to HIV/AIDS and STD; Identification of obstacles to the response within the sector; Integration of HIV/AIDS and STDs activities in their yearly plans; Formulation of specific HIV/AIDS sectoral plans and budget for their implementation; Mobilisation of resources for the interventions; Documentation of the best practice within the sector and share the information; Preparation and submission of quarterly reports on HIV/AIDS and STDs to the national AIDS council as well as all the ministries, including the ministry of home, submit the quarterly reports to the national AIDS council on their HIV/AIDS activities.\textsuperscript{69}

The effective implementation of the HIV/AIDS policies and the national strategic plan on HIV/AIDS in South Africa largely depends on the availability of human, financial and institutional resources, for which the monitoring and evaluation tools are established. The monitoring and evaluation ensures that the policies are properly implemented according to the guiding principles of the HIV/AIDS policies and plans, and that each implementing agencies and their partners contribute to the accomplishment of

\textsuperscript{67} Government of South Africa (2004)., n.47.  
\textsuperscript{68} Ibid.  
\textsuperscript{69} Ibid.
policy aims and goals. Effective monitoring and evaluation tools are developed and customised for each intervention. These tools identify the strengths and weaknesses in the HIV/AIDS programmes and policies as well as it also identifies those areas that need the redirection of resources.\textsuperscript{70}

Thus the policies and programmes on HIV/AIDS in South Africa are vibrant and well structured; the national HIV/AIDS and STD strategic plan which is the basis of South Africa’s HIV policy is a living document and will be time and again subjected to regular critical reviews.

\section*{3. 1. 3 Regional Cooperation}

\subsection*{3. 1. 3. 1 Southern African Development Community (SADC)}

A regional response and initiatives is an important step in the international collaboration, especially when HIV/AIDS is in the question, this has been exemplified, when the countries of Southern African Development Community (SADC) came forward to agree upon a common platform to address and tackle the HIV Epidemic.\textsuperscript{71}

\subsection*{3. 1. 3. 1. 1 SADC’s HIV/AIDS Policy}

SADC is composed of 14 Southern African countries viz: Angola; Botswana; Democratic Republic of Congo; Lesotho Malawi; Mauritius; Mozambique; Namibia; Seychelles; South Africa; Swaziland; Tanzania; Zambia and Zimbabwe.\textsuperscript{72} These all countries suffer from common problems of HIV/AIDS. Hence, under the championship of South Africa, the SADC nations have come together to pull their resources and fight the common battle against the common enemy.

\subsection*{3. 1. 3. 1. 2 Establishment of HIV/AIDS Task Force}

SADC has established a task force and prepared a common policy on HIV/AIDS in 1999, which shows encouraging results in these countries. The exchange of

\textsuperscript{70} Governments of South Africa (2001), n.10.
\textsuperscript{71} Ibid.
\textsuperscript{72} Ibid.
information, medicine and experts on HIV/AIDS is a significant element among the SADC countries. The three main goals of SADC’s HIV/AIDS Policy are: Better co-ordination and harmonisation of responses to the HIV/AIDS and STD among the member states; Multi-sectoral response to HIV/AIDS; Improved quality and coverage of the responses on HIV/AIDS both at the national and regional level.

These initiatives has been vital in ensuring South Africa and its regional partners to have a more coordinated and collective response to HIV/AIDS epidemic. SADC thus forms an important and significant link in the mechanisms and structures available to South Africa.

3.1.4 Corporate AIDS Policies

A survey of more than one thousand firms in South Africa found that 43 per cent of firms envisaged significant adverse impact within 5 years due to HIV/AIDS, 30 per cent of them reported higher labour turnover, and 24 per cent increased costs of recruitment and training. As per SABCOHA (South Africa Business Coalition on AIDS), businesses have to be proactive and learn from the experiences of their counterparts in Sub-Saharan Africa, who say that the best time to respond is when the prevalence is low. The problem is that the infection may go unnoticed for years, as generally there are no exclusive symptoms. That is why it is often called a silent killer. Manifestation of the problem in terms of identification of illnesses and deaths takes years.

At a conference organised by the Global Business Coalition (CBC) on HIV/AIDS, Dr. Brian Brink, Medical Director for South African mining conglomerate ‘Anglo American’ issued a timely warning to business leaders across the world: Don’t make the same mistake we made in South Africa - we saw this coming but the first reaction of the business

---

73 Government of South Africa (2005), n.51.
75 Ibid.
was that it wasn’t our problem, it wasn’t threatening us now, we’d let the government sort it out. 78

Global gem-miner De Beers was honoured for its workplace response to HIV/AIDS counselling and testing by the Global Business Coalition (GBC) at its annual awards for Business Excellence. GBC is the pre-eminent organisation harnessing the power of the international business community in responding to the challenges of the epidemic. Instituted in 1998, GBC’s awards for Business Excellence identify and honor private industry HIV/AIDS programs that have far reaching effects on the workplace and the community. At the 2004 GBC awards for Business Excellence, De Beers was commended for its effort to manage the affliction caused by the HIV/AIDS epidemic through various workplace programs, which it does in partnership with the South African National Union of Mineworkers. 79

De Beers is honored to be recognized for our efforts in fighting the spread of the HIV/AIDS epidemic in sub-Saharan Africa, where nearly half of the world’s people infected with the virus live. 80

The HIV testing program is an integral component of a comprehensive workplace response, De Beers said. Voluntary Counselling and Testing (VCT) services are made available in Southern Africa to all the De Beers employees, their spouses and contractors. Whenever situation demanded, De Beers has always committed itself in extending similar services to the community members as well. De Beers also has a peer educator program which uses employees who volunteer their skills to engage their colleagues and encourage testing through conveying the benefits of knowing one’s status and de-stigmatising the disease. In 2004, the focus on VCT within De Beers has resulted in a rise in testing of employees and spouses. In some campaigns, as much as 80 per cent to 90 per cent of the permanent workforce were tested. This has also seen a marked increase in the registration on the company’s treatment program. 81

78 Ibid.
80 Jonathan Oppenheimer, the Managing Director of De Beers Consolidated Mines Limited in South Africa, regarding their company’s HIV/AIDS initiatives in Southern African region.
81 Ibid.
Bayerische Motoren Werki (BMW), the German automobile giant has made a profound and important commitment in establishing a workplace programme among its associates to deal with the HIV/AIDS. Their main objectives are: To stretch and ventures a high profile education and awareness campaigns far beyond the BMW associates; To minimize the social, economic and developmental consequences to staff and the company; To provide resources and leadership to implement the HIV/AIDS and STD program; To improve counselling services to BMW associates; To observe clinical protocols in the treatment of people living with HIV/AIDS; To encourage associates to volunteer for testing of their HIV status through medical schemes.82

Despite the international attention and huge spending on alleviating AIDS, it is still a pandemic that is out of control, particularly in sub-Saharan Africa. UNAIDS figures for 2007 estimates that 68 per cent of the global total of about 33.2 million people living with HIV/AIDS is in sub-Saharan Africa. Meanwhile, there have been 2.5 million new infections every year in the world. South Africa has the largest number of HIV positive people in the world, although prevalence rates vary considerably between provinces. South Africa’s economic, political and social climate poses unique challenges in alleviating the spread of HIV/AIDS compared to other parts of Africa. UNAIDS has estimated that around 16 per cent of the South African population are infected by HIV/AIDS,83 a level of prevalence similar to other countries in the region, such as Zimbabwe and Zambia. What differentiates South Africa is the parallel rise of HIV prevalence’s along with its high Gross Domestic Product (GDP) growth during the past decade. The GDP growth rate was around 4.8 per cent per annum in 2005, one of the reason attributed to this parallelism is said to be the transition from apartheid to a democratic government and the eruption of a strong multinational business in South Africa. Yet the country also suffers from high levels of unemployment, extreme social inequity, and a president who, for too long, refused to acknowledge the link between HIV and AIDS. The high levels of HIV prevalence in South Africa present a risk to companies operating in the country. Failure to take action to contain the spread of the virus can

impact on a multinational’s bottom line, through illness, absenteeism and possible death among employees, as well as directly impacting on recruitment and retention. Consequently, a high percentage of Multinational Corporations (MNCs) operating in South Africa have comprehensive HIV policies in the workplace, covering education and prevention, provision for testing and, in many cases, treatment for employees and their spouses. But business’s operation extends beyond its workplace and is often reliant on the services and skills of suppliers and contractors (the supply chain) and on recruiting local talent. As the epidemic has spread within South Africa, so too has its impact on companies, particularly those which have operations in high prevalence areas. This has led to some MNCs in South Africa addressing AIDS on a broader scale - to extend programmes beyond the workplace and introduce innovative programmes in communities and the supply chain.84

The case for business involvement in AIDS in South Africa has become clearer in the past five years, as the pandemic has spread more broadly within society. Few businesses are able to flourish in an environment of uncertainty. The business risk posed by AIDS in South Africa has been exacerbated by President Mbeki’s former position of denials, which set back the implementation of HIV policy. It has also been affected by resource constraints in the health service on prevention of HIV and treatment of AIDS, both in terms of lack of capacity and Anti-Retroviral (ARV) roll-out. An effective company AIDS policy seeks to mitigate and manage this operational risk. A study conducted by the South Africa Business Coalition on HIV/AIDS (SABCOHA) and the Bureau for Economic Research (BER), of more than a thousand companies across various sectors, found that between 60-80 per cent of the mining, manufacturing, financial services and transport companies had workplace programmes.85

The companies HIV/AIDS programmes and policies have helped in reducing absenteeism and death among employees as well as it has greatly helped in reducing new infections. It has been estimated that a company will have an average return of about 3

US dollar for every 1 dollar invested on employees’ health, due to reduced absenteeism, better productivity and reduction in employee turnover. The business case has been bolstered by the falling costs of ARV treatment over the past five years. This has provided a greater incentive for business to provide treatment for employees, rather than relying on the public health system, particularly where it fails to deliver. In some of the research carried out in South Africa, it has been found that many business respondents repeatedly referred to a sense of duty to help alleviate the epidemic by extending programmes beyond the workplace, because of the increasing negative impact of HIV within society. It should be noted that employee’s lives are connected to the wider community, so it is inevitable that workplace programmes alone will have only limited impact when trying to reduce rates of sexually transmitted infections. It can therefore be argued that companies have a responsibility to help the communities that lay within a company’s sphere of influence, means the communities who are close to the company’s operations. However, some companies express concern that community health programmes will lead to an increased expectation and burden of responsibility on businesses. The emergence of corporate responsibility as well as the international pressure on corporations to contribute positively to society has made the business operators more careful about their liabilities. Therefore, an MNC’s failure to address the problems of HIV/AIDS when operating in countries of high prevalence may impact negatively on its reputation and, consequently it will impact its operation. Conversely, high profile AIDS programmes involving local communities can have a positive impact on a company’s brand. MNCs are also under pressure to ensure that their supply chain meets standards of ‘responsibility’, which may include implementing effective AIDS policies.86

The involvement of business in responding to the AIDS epidemic touches on broader issues of public responsibility. Some argue that the private sector has no role in providing health services when the public sector can provide them. Therefore, they argue that MNCs should contribute to publicly financed services through taxation mechanisms. This position is countered by those who argue that increased taxes may deter business investment and operations as well as job creation. This is a key concern given high levels

86 Ibid.
of unemployment in South Africa. To date, country successes in reducing rates of new infections have been based on multi-sectoral interventions rather than public health sector interventions. Experience in countries as diverse as Thailand and the UK suggests that an effective national response requires support from the media, politicians, police and private sector, not just the public sector. In light of this, possibilities need to be considered that incentivise, rather than discourage, business involvement. A range of civil society organisations and AIDS networks, as well as some business leaders, encourage a minimum standard of AIDS policy and practice across businesses. Introducing regulation to impose such standards could ensure that every employee has access to a certain level of AIDS education and prevention. However, the corporate responsibility trend indicates a preference among business for voluntary standards rather than legal obligations to drive social initiatives.87

The limited scope and scale of corporate action on HIV/AIDS suggests that enthusiasm within the United Nations system, bilateral and multilateral development organisations, and international NGOs, for the voluntary role that business is playing and can play in the fight against HIV/AIDS needs to be tempered with an awareness of the current lack of wholesale and comprehensive engagement on this matter by even the largest companies, and even in the most affected areas, such as South Africa.88

3.1.5 NGOs/CBOs HIV/AIDS Policies and Programmes

There are several NGOs working on HIV/AIDS issues in South Africa, the largest among them is known as LoveLife which was launched in 1999. NGOs accomplishes their objectives by implementing wide-scale media campaigns, service and support programs such as national help hotlines, as well as closely evaluating the program’s effect throughout the country. A survey conducted in March 2004 found that South Africans spend more time at funerals than they do getting their haircut, shopping, or going to barbeques.

87 Ibid. 
A wide range of NGOs have responded to the HIV/AIDS crisis in South Africa. They engage through various parameters such as raising awareness, research, training, advocacy, education, welfare and health service provision, materials production, orphan care, counselling and other activities. It is NGOs, who have driven the campaign for access to treatment, lower drug prices, improved care and more effective policy on HIV/AIDS. NGOs relationships with the government of South Africa has a peculiar instances, on one hand the National Association of People Living with AIDS has received government funding, on the other NGOs like Treatment Action Campaign has been attacked by government for its protests and litigation over the response to the epidemic. Huge sums have been channelled to NGOs by donors but it has often been difficult for smaller organisations to access funds and some donors have tended to push for particular responses, such as orphanages or high-profile prevention campaigns, instead of responding to local needs or priorities. Services have tended to be fragmented but in recent years, NGOs have come together in coalitions to promote a more coherent response, directories of AIDS service organisations have been developed and information on funding for HIV/AIDS work has been collated. Bodies such as the Joint Civil Society Monitoring Forum have brought together NGOs, business, government, donors and health professionals to work together in the fight against HIV/AIDS epidemic. There have also been more efforts to identify the good practices. 89

Households, CBOs and Faith Based Organisations (FBOs) have long been shouldering the human tragedy of HIV/AIDS in South Africa. It is at community level that people living with HIV/AIDS find comfort and support instead of suffering rejection and discrimination. It is at this level that awareness is spread or ignorance reinforced. It is through people’s daily interactions with one another that a climate of compassion and solidarity or of fear and neglect is created. The support and services invested in community responses to HIV/AIDS, and the acknowledgement of those responses, will determine for how long and how effectively they can continue. Many households in South Africa barely survive, through casual work, subsistence gardening or trading, old age pensions or mutual borrowing and assistance. The impact of AIDS has stretched

these survival strategies to breaking point in many cases. There is a limit to how many
times a person can queue all day at a clinic with a sick relative, how many loved ones a
family can bury, how well a grandmother can care for another orphaned grandchild, how
many funerals a neighbour can attend or help pay for. The experience of AFSA (AIDS
Foundation of South Africa) and other grant makers has shown that even small amounts
of funding targeted at community organisations providing small-scale day-to-day services
to those in need can make the difference between resilience and breakdown. Among the
kinds of support needed are initiatives to ensure people can access the documents they
need to apply for grants, the services to which they are entitled, assistance with providing
home-based care, information and counselling and training.90

3.1.6 International HIV/AIDS policies

Before the Emergency Plan for AIDS Relief, only 50,000 people of the more than 4
million people in sub-Saharan Africa needing immediate AIDS treatment were getting
medicine—think about that, only 50,000 people. After two years of sustained effort,
approximately 400,000 sub-Saharan Africans are receiving the treatment they need.91

The international response to the HIV/AIDS crisis revolves around the action of inter­
governmental organisations, governments, donors, civil society, and the private sector.
However, it seems that parliament does not figure prominently in the response, and that
the legislature could do more as a central locus of decision-making, monitoring, and
guidance. There is a need for parliaments and their members to be more involved and
better equipped to response the HIV/AIDS epidemic, especially in the developing
countries were HIV is more vulnerable and visible. Global strategies by the donor
community should be better targeted to the parliament in each country in order to
optimise the available resources and obtain more sustainable results. To help achieve this,
international communities have come forward to mobilise parliaments by exchanging
experiences, sharing information, and providing mutual support.92

90 Ibid.
92 Enhancing the parliamentary response to the HIV/AIDS Crisis, Accessed 21 August 2007, URL:

166
The year 2001 has seen a remarkable convergence of political, scientific and economic forces, creating major new opportunities for a more intensive global response to the AIDS pandemic. In the political sphere, there has been more concerted and higher level action than there was any before. In 2001, Nigerian president Obasanjo has mobilised in hosting a special summit of the organisation of African Unity in Nigeria to focus African leadership on the response to HIV/AIDS. It resulted in the Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases, AIDS situation was declared a ‘state of emergency’ facing the continent. African governments vowed to commit at least 15 per cent of their national budgets to the health sector to assist in the fight against HIV/AIDS, tuberculosis and other related infectious diseases.93

In other regions of the world as well, the political action against HIV/AIDS epidemic was intensified after 2001. Important events include: The launch of a Pan-Caribbean Partnership against HIV/AIDS by CARICOM (Caribbean Community); A major discussion on AIDS at the Economic and Social Commission of Asia and the Pacific; and attentions were singularly given to AIDS in the declaration and plan of action adopted at the summit of the Americas in Quebec in 2001.94

Meanwhile, in many of the wealthy countries, efforts in the global response to AIDS were accelerated and became more concerted. The European Union adopted a programme for action against HIV/AIDS, malaria and tuberculosis in the context of poverty reduction. The US and most other donor countries significantly increased their budgets to support AIDS control activities in the developing world. The Group of Eight (G8) at its meeting in Genoa in Switzerland has reasserted the commitment it had made in the previous meeting held at Okinawa in Japan to increase funding for HIV/AIDS.95

These events culminated into the special session on HIV/AIDS held by the United Nations General Assembly at the end of June 2001; this was one of the most concerted, high levels and comprehensive gathering of nations ever held to discuss AIDS. ‘The

---

95 Ibid.
Declaration of Commitment\textsuperscript{96} unanimously adopted at that session included commitments to: national planning; prevention targets, including 25 per cent reductions in prevalence among young people; urgent provision of the highest attainable standard of treatment for HIV/AIDS; enacting or strengthening human rights protection for people living with HIV/AIDS; reducing vulnerability to HIV infection; national strategies to support children orphaned by AIDS; dealing with the economic and social impact of AIDS; increasing investment in HIV related research, including work on vaccines and microbicides; incorporating HIV programmes in emergency responses; and, by 2005, the annual expenditure on HIV/AIDS is targeted at 7-10 billion US dollar in low and middle-income countries.\textsuperscript{97}

3.2 The Framework of HIV/AIDS Programmes

3.2.1 The 1998 AIDS Vaccine Initiatives

Government of South Africa has allocated a substantial funds and other support towards the research and development of HIV vaccine, vaccine trials were conducted in South Africa by the South African AIDS Vaccine Initiative (SAAVI), part of the International AIDS Vaccine Initiative (IAVI). However, a vaccine, if developed, will be of no help to those already infected with the virus and will also only be available several years after its creation, but at least it is a great leap forward in eradicating HIV/AIDS.\textsuperscript{98}

Furthermore, a vaccination for HIV poses many challenges: because the HIV virus incorporates its own genetic material into the host’s immune system, it is difficult to destroy the virus without destroying the immune system too. It also mutates very fast, with sub-types that vary from one geographical region to the next, from person to person and even in the same person.

\textsuperscript{97} Ibid.
\textsuperscript{98} South Africa at a glance (2003), n.8.
3.2.2 Administration of Post Exposure Prophylaxis (PEP)

The most effective methods for preventing HIV infection are those that protect against exposure to HIV. Antiretroviral therapy cannot replace behaviours that help avoid HIV exposure such as sexual abstinence, sex only in a mutually monogamous relationship with a non-infected partner, consistent and correct use of condom, abstinence from syringe-drug use, and consistent use of sterile equipment by those unable to cease injection while using drugs.

Medical treatment after sexual, syringe-drug use or other non-occupational HIV exposure\(^9^9\) is less effective than preventing HIV infection by avoiding exposure.\(^1^0^0\) PEP service has been made available to the public throughout South African since 2002.

In one year between April 2002 and March 2003, nearly 53,000 rapes and attempted rapes were reported in South Africa, although the actual rate may be up to 9 times greater.\(^1^0^1\)

With 14 per cent to 28 per cent of rapists in South Africa estimated to be HIV infected, their victims face considerable infection risks. Providing all rape victims with PEP may be substantially less costly than treating them later after becoming infected. In South Africa, the difference could be as great as 2,000 US dollar per person. In the modelling exercise, researchers made several assumptions. First, they assumed that the use of PEP after rape would be at least 80 per cent effective. This reflects results from a retrospective case-control study indicating that the odds of HIV infection were reduced by about 81 per cent among health care workers who took PEP after exposure to HIV via needle stick injuries.\(^1^0^2\)

---

\(^9^9\) A non-occupational exposure is any direct mucosal, percutaneous, or intravenous contact with potentially infectious body fluids that occurs outside prenatal or occupational situations (e.g., healthcare, sanitation, public safety, or laboratory employment). Potentially infectious body fluids are blood, semen, vaginal secretions, rectal secretions, breast milk or other body fluid that is contaminated with visible blood.


\(^1^0^1\) Nicola Christofides, a senior scientist with the Medical Research Council of South Africa, regarding increasing incidence of rape cases in South Africa.

A substantial body of other research also supports the effectiveness of PEP after occupational exposures to HIV in health care settings. PEP has become the standard of care in such settings. The United States even has national guidelines for occupational PEP. Nevertheless, the efficacy of occupational PEP has not been proven, and failure of PEP to prevent HIV infection has been reported.\textsuperscript{103}

Nevertheless, the question of how to determine whether the risks of HIV infection justify the use of PEP remains to be seen. Most exposures to HIV will not result in infection. In the case of sexual assault, considerations include the infectiousness of the rapist (e.g., viral loads are higher in recently sero-converted individuals) and the risk of infection based on the victim’s age. For biological reasons, younger women are more susceptible. (Notably, the South African researchers estimated that women under age 18 years had twice the risk of infection than did adult women), also to be considered is the degree of vaginal trauma and abrasions caused by rape. Risk of HIV infection after unforced vaginal intercourse with an infected man has been estimated to be 0.1 per cent to 0.2 per cent,\textsuperscript{104} but traumatic and forced sex could quadruple that risk.\textsuperscript{105}

3.2.3 Safe Blood Transfusion and Compulsory Screening

Blood transfusions in South Africa remain safe despite the country’s high incidence of HIV and hepatitis B infection. Providing safe blood is an ever increasing responsibility for the Western Province Blood Transfusion Service (WPBTS) and the organisation sustains its safety record through stringent donor selection, the maintenance of a dedicated panel of healthy, voluntary donors and utilising the latest available technology. South Africa is currently the only country in the world that tests every donor’s contribution at each donation for HIV, syphilis and hepatitis B and C, using the


latest Nucleic Acid Testing (NAT) technology and maintains an accurate record of all donors and test results.

The WPBTS utilises NAT testing which uses DNA technology that effectively narrows the detection period of HIV infection to between 5-11 days. This ensures that South African transfusion services, (Western Province Blood Transfusion and its counterpart, the South African National Blood Service) are in line with the highest standards of international blood transfusion practice. Many developing countries, including several countries in Africa, still use unscreened blood and blood products.

A shortage of safe donors, lack of funds and a high prevalence of HIV and hepatitis B combined with a lack of scientific technology makes the provision of safe blood supply in Africa, except in South Africa, erratic and risky, specifically in sub-Saharan Africa.106

The Haemovigilance Report of South Africa stated that, until the year 2000 there were no confirmed cases of HIV/AIDS transmission through blood transfusion in South Africa.107

There were no confirmed cases of disease transmission during 2000 when 8,81,613 blood units were issued. This is quite remarkable because the theoretical risk of contracting HIV/AIDS during blood transfusion is about 1 to 100,000.108

The window period for HIV/AIDS, which could be up to three months, makes it impossible for the SANBS to detect the early stages of infection in the blood. There will therefore always be a small number of patients that will be infected by these agents during the blood transfusion. However, it seems that the strict criteria for blood donors, limited this possibility to even less than the theoretical risk of 1 in 1,00,000.

The perception amongst the public is that the transmission of infectious diseases, particularly HIV, is the most common and dangerous complication of a blood transfusion.

Which is in fact not true but the greatest danger of a transfusion is linked to human error. A total of 50 serious transfusion reactions, including 3 deaths, were reported out of more

---

108 Dr Teresa Nel, medical director of South Africa National Blood Service (SANBS), on the prevalence of safe bloods in South Africa.
than 8,00,000 cases, 30 per cent of the 50 cases were as a result of human error, 24 out of the 50 were immune reactions, where patients reacted to incompatible blood, 15 of these were a result of an administrative error, were as 12 of these have occurred at the bedside in hospital and 3 technical errors were made at the blood bank. 109

One of the more serious reactions resulted from the blood being incorrectly heated. Hospitals have special devices with which they warm up the blood, but sometimes people panic and they heat it in the microwave or in boiling water. South Africa’s blood safety profile compared favourably to other developing countries, the risk of transfusion must be seen through the perspective that many lives of patients depend on the availability of blood, without blood products the management of patients with leukaemia and cancer will simply not be possible.110

3.2.4 WHO’s 3 by 5 Initiatives

“3 by 5” is the global target set by the World Health Organisation (WHO) and the United Nations AIDS committee (UNAIDS) on World AIDS day 2003, to get 3 million people living with HIV/AIDS in developing and middle income countries on Anti-Retroviral Treatment (ART) by 2005. It is a step towards the goal of providing universal access to treatment for all who need it as a human right, because the constitution of WHO says - The highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social conditions.111

Undoubtedly, the most significant recent development in the HIV/AIDS struggle in South Africa was the decision taken by South African government in 2003, to provide Anti-Retroviral (ARV) therapy in the public health sector as part of the operational plan for the comprehensive HIV/AIDS care, Management and Treatment for South Africa. Which can be said a timely effect of the initiatives of WHO and UNAIDS. The decision taken by the South African government gives new hope to thousands of people who require this treatment to reduce morbidity levels and defer premature death. However,

109 Ibid.
110 Ibid.
this decision brings with it a new set of challenges, these include: Overcoming capacity constraints within the public health sector and issues of treatment; Literacy for patients to ensure treatment compliance and the avoidance of drug resistance strains of the virus.112

The success of HIV/AIDS programmes largely depends upon the patient’s adherence in taking their course of medication; patients are required to take three types of tablets twice a day at the same time each day for the rest of their lives. Treatment preparedness and support for patients commencing ARV therapy is therefore imperative, as ARV therapy is a life time commitment, it is therefore, vital that the patients in their earlier stages of HIV be educated on proper management, as well as encouraged them to keep themselves healthy for as long as possible, so that their CD4113 counts remain high, thereby deferring the need to commence ARV therapy. The ARV rollout is happening at different rates, on different scales and with different degrees of commitment and success from district to district and province to province. The office of the national manager for ARV programme released the national patient numbers by province and site for the first time in January 2005 in South Africa. The statistics showed that about 29,000 people were on ARV treatment at more than 113 public sector facilities in 2005. The figure for KwaZulu-Natal was 8,467, Gauteng 10,000, Northern Cape 515, North West nearly 2,800, Mpumalanga 1,000, Free State 945, Limpopo just 729 and the Western Cape nearly 6,200 patients on ARVs by the end of the year 2005.

The wide differences reflect the numbers needing treatment and the capacity of provinces to deliver. NGOs emphasise the benefits of having access to such data in order to monitor and support the operational plan. Most treatment is still hospital based and most of the patients are adults. There is an urgent need to support the initiatives to decentralise or devolve the management of ARV treatment at the level of local clinic and


113 It stands for Cluster of Differentiation 4, it is a Glycoprotein expressed on the surface of T helper cells, regulatory T cells, monocytes, macrophages, and dendritic cells. It was discovered in the late 1970s and was originally known as leu-3 and T4 (after the OKT4 monoclonal antibody that reacted with it) before being named CD4 in 1984. [Online: web] Accessed 19 December 2007, URL: http://en.wikipedia.org/wiki/CD4.
ensure that children have access to treatment and care. It is also critical to improve access to generics, to bring down the price of drugs and the cost of diagnostic testing.\textsuperscript{114}

3.3 Social Mobilisation Programmes

HIV and AIDS raise many communication challenges as they touch on all aspects of life. Issues range from personal identity and sexuality, to how one can possibly understand morality and disease at the same time as well as the social problems of stigma and discrimination. The pandemic has seen courageous and creative responses from people living with HIV/AIDS, and those living with the social impact of it. The communication approaches that have been developed to tackle HIV/AIDS in South Africa hold lessons for other countries also.\textsuperscript{115}

The successes of the HIV/AIDS care and treatment plan not only in South Africa were facilitated by a well defined social mobilisation and communications strategy in almost all the countries. This strategy includes external Information, Education and Communication (IEC) strategy which are closely linked to social mobilisation component that together articulate the implementation goals. Research has shown that susceptibility to HIV infection is related to a wide range of factors, such as poverty, culture, gender relations, and lack of education. Raising awareness is but one aspect of HIV prevention. Prevention also requires strategies and interventions that support behaviour change, particularly access to services, a supportive environment, and positive social norms. Increasingly in South Africa, HIV/AIDS communication campaigns are focusing on care as well as risk reduction as an area of intervention. This reflects the progression of the HIV/AIDS epidemic to the point that a significant proportion of the population is directly affected. HIV/AIDS intervention campaigns are therefore about developing a range of strategies and interventions that will support behaviour change. Successful implementation of the various elements of HIV operational plan requires communication strategy, which involves a wide range of governmental sectors and non-governmental organisations at the national, provincial and local levels. The specific aims of the

\textsuperscript{114} Ibid.
communication plan are to ensure that all relevant government programmes, health care providers, PLWHA, their families, care-givers and stakeholders are fully knowledgeable about all of the key provisions and requirements of the plan, as well as their respective roles and responsibilities.116

A comprehensive communication strategy provides basic HIV/AIDS information, and promotes available services and advocacy efforts. Basic informational activities include mass media messaging; distribution of small media (such as leaflets and posters); and social mobilisation activities. Promotion of services focuses on interventions such as condom use, voluntary HIV counselling and testing, an AIDS Helpline, the use of ARVs and treatment of opportunistic infections, and sexually transmitted infections. The communication strategy serve as a vehicle for supporting the following HIV prevention and education priorities such as: Healthy lifestyle choices, and how they can help prevent HIV infection; The importance of testing to learn one’s HIV status; The reduction of stigma at a societal level, to ensure that all those HIV positive individuals who desires should be gladly associated in the prevention and care programme.117

Social mobilisation modalities are central to the implementation of a comprehensive HIV/AIDS care and treatment plan. The implementation of the plan should expand on the existing sector advocacy activities, such as national, provincial, and district AIDS councils, faith-based organisations, women’s organisations, men’s groupings, and celebrities, to reach a broad range of South African society. Social mobilisation is a critical component of any media campaign aimed at mobilising people and communities to action. It provides visible on-the-ground presence for the campaign and its messages. The overarching goals of social mobilisation efforts are to ensure that PLWHA have access to care and treatment programmes and an adequate support structures in their local communities, and that stigma and discrimination experienced by PLWHA are eliminated or reduced, thereby reducing social isolation and increasing the likelihood of their adherence in the system. These goals are achieved through community

117 Ibid., p.175.
networks that address these issues, with emphasis on providing supportive networks to those on ARV treatment and their families. 118

To achieve its objectives, the communicational plan pursues a combination of strategies that include augmentation of the existing communication and social mobilisation capacity at the national and provincial departments of Health. Particular attentions are given on ensuring that communication strategies are integrated into existing efforts and lead to an overall systems improvement. The current government campaigns have achieved a number of successes in both the development and implementation of their objectives, such as: Implementations of intensive public campaign that has increased and maintain the uptake around VCT; and the rollout of a comprehensive treatment programme, the ARV communication campaigns are therefore build on these achievements. The scope of work for the treatment campaigns are organised in three components: public awareness (mass communication); Small media material and social mobilisation. Mass communication campaign aims to raise the awareness’s and provide a backdrop for complementary communications and small media as well as interpersonal activities such as, the AIDS Helpline and VCT services.

A major thrust of the campaign is the use of traditional broadcast media, with the bulk of spending on radio and outdoor advertising, because small media material is a crucial determinant in the rollout of the ARV programme. It includes the development of posters, leaflets, guidelines and strategic documents and is made available in at least 5 out of the 11 official languages in South Africa. These materials are intended to support the interactive activities such as, health care, workers training and patient counselling, and can also be used at clinics and events. The provision of appropriate small media products allows for dialogue to be supported by objective information, and also empowers many individuals and organisations to offer accurate information in relation to ARVs. 119 Because HIV/AIDS care and treatment are community based, involvement of the existing community structures is critical to the success of HIV/AIDS programmes. Essential elements needed in social mobilisation includes: Utilisation of existing structures, such as AIDS Councils and the expansion of an existing mechanisms and

118 Ibid., pp.177-178.
119 Ibid., pp.176-177.
structures that relate to HIV/AIDS; The creation of subcommittee in the provincial AIDS council on community mobilisation are necessary for the commencement of treatment, this subgroup could include representatives of the provincial departments of Health and Social Development as well as relevant NGOs, faith-based organisations, celebrities and PLWHAs, representatives of traditional leadership and traditional health practitioners. Prior to the initiation of comprehensive care and treatment, it is essential to raise community awareness not only about access to the treatment programme, but also about HIV and AIDS in the broader sense.

There are many misconceptions remains, which are the potential source of deterring people from seeking care and treatment services in South Africa. The pre-implementation phase for social mobilisation must include identification and evaluation of existing community mobilisation programmes, such as the involvement of traditional health practitioners, trade unions, local community leaders and the business sector as partners. This should include establishment of regular meetings of these entities to set up a community support system that effectively coordinates and refer people about the care and support mechanisms. Dissemination of information related to the existence of the programme can be achieved with the help of these community groups. They should also make use of the mass media campaign, including radio, TV, and print media in locally relevant languages to increase understanding about HIV transmission as well as how it causes disease, how to prevent it and were to access the treatment, care and support facilities. Care must be exercised to ensure that communications are reflective of local sensitivities. Essential implementation of ARV treatment programmes will need to be linked to community services, many of which are outside of the traditional health care system. A system of referrals from community centres to the health care system, and back from the health care system to community centres, such practices will allow clinic service coordinators to assist patients and their families in accessing community services. The above systems of referral must be established as a part of the continuum of care at the district and local level. Treatment literacy curricula were developed interestingly in South Africa, which includes teaching the HIV/AIDS people about the importance of good nutrition, healthy lifestyles, preventing infection and re-infection. Additional teaching and education about side effects is an important goal, as knowledge of early signs of side
effects has proven effective in tackling the health problem. Patients who are knowledgeable about side effects are more likely to seek medical attention earlier, when lower cost solutions are still possible.\textsuperscript{120}

Besides the above core features of social mobilisation, Media programming's such as: Television; Radio; Movies; Newspapers; Journals and magazines; Seminars, discussion and debates; Posters and placards; Brochure and pamphlets; Concerts and shows; Celebrity appeal and message; and, Religious appeal and messages needs to be well knitted and incorporated into the social mobilisation programmes on HIV/AIDS.

\textsuperscript{120} \textit{Ibid.}, pp.178-179.