# HIV/AIDS IN SOUTH AFRICA

How did the apartheid regime shape the volatile foundation that fuelled the HIV/AIDS prevalence among the black African population in South Africa?

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# Apartheid in South Africa

The original inhabitants of South Africa were the Bantu speaking Africans who lived there long before the Europeans colonized their land, and violently exploited the African continent. In 1652 the Dutch imperialists occupied South Africa, and in 1806 the British Empire captured the colony from the Dutch. South Africa is extremely rich in natural recourses, like gold and diamonds. When these key recourses were discovered, the suppression of the indigenous people was intensified. (Nigel, 2013)

From 1948 to 1994 there was a ruthless apartheid regime in South Africa. This racist system of racial segregation was legally implemented by the Afrikaner National Party (ANP). The main objective of the apartheid system was to separate races; whites from non-whites, and internal separation within the black African population. In addition, it also included the segregation of ''coloured' people who were working as migrants or lived there since the British Empire brought them there; India was a British colony. This has resulted in deep-rooted inequalities within the state. (Apartheid, Encyclopedia, 2015)

In 1994, South Africa became a democracy in which the African National Congress (ANC) won the elections and Nelson Mandela, who had been innocently imprisoned for 27 years, became the first black president of South Africa. Mandela formed a multiracial government and promoted racial unity and cooperation in order to overcome the dark past and work towards a bright future. (Boseley, 2013)

Approximately 1.5 million Africans, who were divided into nine Bantu groups, were coercively removed from their hometowns and forced to live in rural underdeveloped areas. In these overpopulated townships the living circumstances are very bad and there is a lack of basic living necessities like clean water and electricity, let alone a good healthcare-infrastructure and a solid education system which can educate the young generation and give them the right instruments to improve their living standards. This volatile foundation has created a **negative reinforcing vicious circle**: a fertile source for poverty, criminality, violence, gender-inequality, drug-abuse and widespread prevalence of HIV/AIDS and tuberculosis. (Catherine, 2011)

Not coincidentally, South Africa has the highest HIV epidemic in the world with 6.3 million people living with HIV in 2013. (Avert, HIV and AIDS in South Africa, 2015)

The main objective of this research is to determine to which degree the apartheid regime affected and shaped the key determinants for HIV prevalence such as, poverty, insecurity, criminality, unemployment, and lack of education and healthcare institutions in South Africa.

The analyses of the incidence and prevalence will focus on three key indicators: the political resistance of the ANC and Nelson Mandela, the education and employment in the Townships, and the gender inequality which embodies the subordinate position of women in society. The lack of economic development and healthcare infrastructure will also be considered as a significant contributor to the HIV epidemic, since it counteracts against the essential basics of a stable and fertile society. (Boehm, 2000)

**Research Question:** How did the apartheid regime shape the volatile foundation which fuelled the HIV/AIDS prevalence among the black African population in South Africa?

# Incidence & Prevalence of HIV/AIDS in South Africa

Not coincidentally, South Africa has the highest HIV epidemic in the world with 6.3 million people living with HIV in 2013; moreover, 19.1 % of the adult population is infected and there are 340.000 new HIV cases each year. The HIV epidemic causes 200.000 Aids-related deaths each year, and over 42 % of the adults are receiving antiretroviral treatment. (Avert, HIV and AIDS in South Africa, 2015)

In addition, South Africa has also the world's third largest tuberculosis prevalence. This is substantially caused by the extremely high HIV prevalence which significantly fuels the risk of developing tuberculosis. (Avert, HIV and AIDS in South Africa, 2015) In 2013 there were approximately 450.000 cases of active Tuberculosis in South Africa. (WHO, Tuberculosis, 2015)

Three main provinces in South Africa represent approximately 65 % of HIV prevalence out of the 9 provinces. These epicentres of the HIV epidemic are: Kwazulu-Natal, Gauteng, and Eastern Cape.

In 2014, mostly females are infected with HIV. The following statistics show that HIV prevalence is most present among young African women, who have a vulnerable and submissive position in society, and therefore face much sexual intimidation and violence. The lack of solid (judicial)-institutions, fuels the ''rape-supportive attitude'' of the black men. (Charnelle & Philip, 2009)

| Age | % Male Positive HIV | % Female Positive HIV |
|---|---|---|
| 0-14 | 2 | 2.1 |
| 15-19 | 1 | 5 |
| 20-24 | 5 | **17** |
| 25-29 | 17 | **28** |
| 30-34 | 25 | **36** |
| 35-39 | 28 | 31 |
| 40-44 | 16 | **28** |
| 45-49 | 13 | 19 |
| 50-54 | **15** | 14.5 |
| 55-69 | 5 | 9 |
| 60+ | **4.5** | 2 |

Source: (Avert, HIV and AIDS in South Africa, 2013)

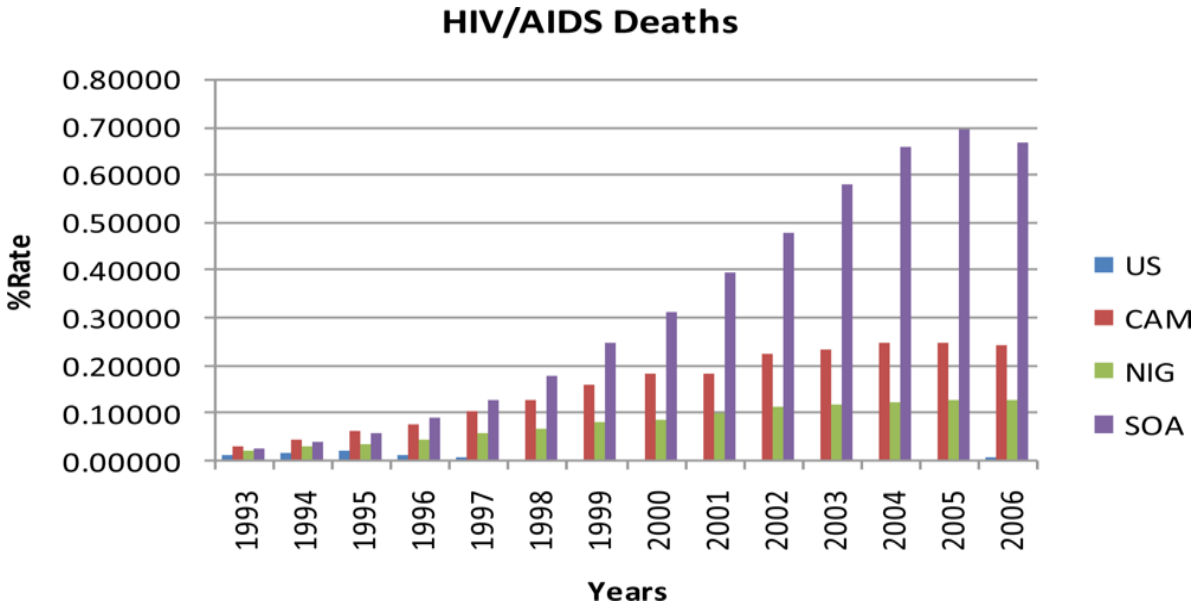
The table shows that women between 20 and 44 are mostly infected with HIV. The **bold red** numbers show the great contrast between the percentage of male and female prevalence. Furthermore, it is striking that man between 50 and 54, and 60 + are slightly more infected with HIV than females, but there is no clear explanation for this dissimilar prevalence. (SANAC, 2011)

The HIV incidence rate is determined by some essential factors. The largest affected and vulnerable group are low educated black African women who live in urban informal areas, especially the youth, aged between 15 and 29. The three main provinces, Kwazulu-Natal, Gauteng and Eastern Cape have also the highest incidence rate. In addition, those who are sexually active, but not married pose also a higher risk, as well as pregnant woman. People who have more than one sexual partner, sex workers and their clients, and men who have sex with men are also highly vulnerable to get infected. (SANAC, 2011)

HIV prevalence in South Africa is also highly determined by different racial groups. A study conducted in 2004 shows that 0.5 % of the whites were infected with HIV, and in contrast, 19.9 % of the black Africans. To put these statistics into context; 80.2 % of the population are black Africans; the coloured are 8.8 %; the whites are 8.4 %, and the Asian are 2.5% of the population. These statistics strongly indicate that there is a structural root cause of the HIV prevalence among the black African population. (CIA, 2015)

The population-based surveys that were conducted in 2004 demonstrate that the substantial contrast in HIV prevalence is mainly generated by risky sexual behaviour in general. Especially the number of sexual partners determines the wide gap of HIV prevalence between the white and the black population. (Kenyon, 2013)

The first case of HIV in South Africa occurred in 1982, and this was the start of an expansion of the HIV epidemic which was limited to the gays and blood-transfusion recipients. Until 1987, the HIV prevalence among the black African population remained significantly low. This was measured by the government who conducted surveys in community-based Townships and analysed voluntary blood donors from the Black population. (Karim, Karim, 2002)

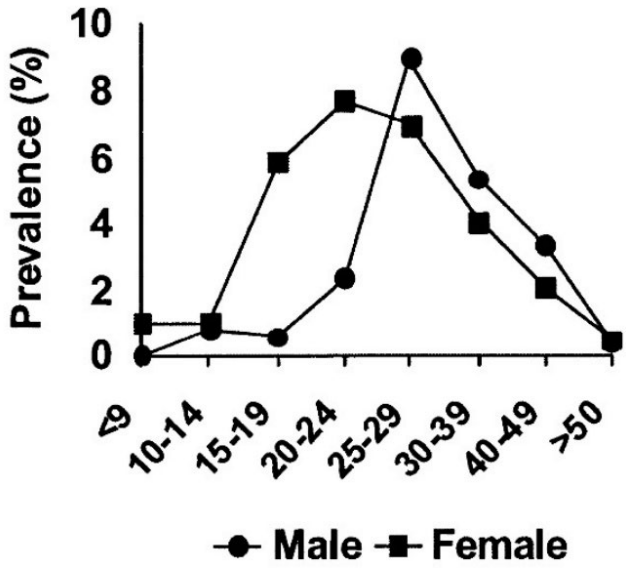



Source: International Journal of Environmental Research and Public Health, 2011

The table above shows that the HIV related casualties in South Africa explosively expanded since 1997. In contrast with the other countries, The USA, Cameroon and Nigeria, it becomes clear that the black population in South Africa is extremely suffering through this epidemic.

In 1990, the HIV prevalence was 0.76 %; in 1995 it had increased to 10.44 %, and in 2000 it had reached an incredible 22.4 %. The rise of HIV prevalence by a 21.6 % in 10 years embodies the explosive expansion, and especially, there is no sight at a ‘’saturation plateau’’. (Karim, Karim, 2002)

The graph below shows the age and gender differences in HIV infection in Kwazulu-Natal 1992, which is still the epicentre of the HIV epidemic in South Africa. The highest HIV prevalence is found in young women between 19 and 29, and in men who are approximately 10 years older. These statistics have remained almost entirely the same as the epidemic expanded. However, there has been a shift for the highest prevalence among women to the age between 30 and 44. (Avert, HIV and AIDS in South Africa, 2015)




Source: The evolving HIV epidemic in South Africa, International Journal of Epidemiology. (Karim, Karim, 2002)

Especially the prevalence of AIDS within the HIV epidemic constrains the limited healthcare service that exists in South African Townships. The number of available beds in inferior hospitals is occupied for 84 % by patients who have HIV/AIDS. Important to note is that most Townships have almost none, to limited healthcare, and the vast majority of the people can't afford an expensive treatment in a sophisticated hospital. (Cain, et al., 2013)

# Analyses of Incidence & Prevalence

In order to understand the evolution of the HIV epidemic in South Africa it is important to take the economic and social structures into account, as well as the fragmentizing and suppressing policies of the imperialists, which have intentionally implemented the ''divide and rule'' principle. (Karim, Karim, 2002)

The indigenous people of South Africa were segregated in 1652, when Cape of Good Hope was colonized by the Dutch. When the Dutch found gold and diamonds in 1666, they developed a strategy to convert the black African farmers into labourers, which one can classify as slaves.

This migrant-labour system, in which men resided in single-sex barracks, is a key element of the apartheid policy, and resulted in widespread prostitution. These malicious conditions devised a fertile foundation for the uncontrollable expansion of sexually transmitted diseases. (Karim, Karim, 2002)

The Apartheid regime didn't take significant action against the HIV epidemic, since it was a problem of the ''blacks and gays''. Furthermore, the regime targeted the black communities with their population control programmes. For this reason, the black community blamed the racist government for fuelling the expansion of the HIV epidemic. This deep distrust in the government fuelled the rise of the African National Congress, and initiated the wide supported battle against the apartheid regime. (Saul, 2004)

Only in 1994, when the ANC won the elections and Nelson Mandela became the first black president of South Africa, the government attempted to counteract the HIV epidemic, and attempted to implement policies which would substantially decrease the HIV prevalence.

In 2000, the South African government established the South African National Aids Council (SANAC). The main objective was to stimulate cooperation between the government, civil society and other stakeholders, in order to devise a National Strategic Plan against HIV, tuberculosis, and various other sexual transmitted infections. (SANAC, 2011).

However, the lack of unity, experience and the deep-rooted corruption within the government counteracted against these fixed goals. (Hyslop, 2005)

The racial and ethnic discrimination of the apartheid regime, as well as the exploitation of the country, significantly affected the political, economic and social live in the Townships. There is a solid lack of economic development and healthcare infrastructure, and the education and employment rates in the townships are significantly low. (Cain, et al., 2013)

These essential determinants devise a **negative reinforcing vicious circle** which creates a structural fertile foundation for poverty, criminality, rape, and the expansion of HIV/AIDS.

This fertile foundation can best be illustrated by analysing the incidence and prevalence rate in the epicentre of the HIV epidemic in South Africa: province Kwazulu-Natal. A study conducted between 2007 and 2010 affirms that the HIV incidence and prevalence is highest among sexually active women between 18 and 35 years old. The incidence is highest among the population who lives in rural areas, where they have no access to solid education and healthcare services. This lack of personal and intellectual development can most likely explain the **risky (sex) behaviour** of the black population. This risky behaviour is one of the key determinants of the high HIV prevalence among the blacks, in contrast with the low prevalence among the white population. (Nel., et al, 2012)

Furthermore, the gender inequality and gender norms among the black African population play a major role in the expansion of the HIV epidemic. A study conducted by the University Hospital Basel in Switzerland affirms that women have a submissive position within (family) relationships and society. This ''disempowerment'' in relationships with men makes the young women significantly vulnerable, and afraid to protest against unsafe (enforced) sex. (Fladseth, Gafos, Newell, McGrath, 2015)

Kwazulu-Natal largely contains all of the following key risk-groups: young women aged 18 to 35, young people who drop out of school, people from low socio-economic groups, uncircumcised men, people with disabilities, sex workers and their clients, people who abuse alcohol and drugs, transgender individuals, and men who have sex with men. (Sanac, 2014)

There is a significant high unemployment rate, and this results in criminality since people have to eat and pay for their basic necessities. In addition, it does not provide bright future-perspectives for the young vulnerable generation, which makes them hopeless and stressed. In addition, this lack of **equal opportunities** stimulates alcohol and drug abuse and forces many women into prostitution, which intensifies their vulnerable and submissive position within society. (Boehm, 2000)

Moreover, the decline in traditional industries like mining and manufacturing also increase the unemployment among the majority of the black Africans, which are not educated and did not have the opportunity to develop their skills and competencies. The apartheid regime devised the foundation for a ''racially differentiated and unequally distributed'' education and employment opportunities. (Boehm, 2000)

This embodies that the white people take the best jobs in South Africa, subsequently, the ''coloured'' people take the remaining jobs, and eventually, no proper jobs are left for the black African population, let alone in (rural) underdeveloped areas where 65 % of them reside. (Boehm, 2000)

Therefore, there is a fertile ground for the prevalence of poverty, criminality, alcohol & drug abuse, (gender)-violence, rape, and sexual transmitted diseases, which is shaped by deep-rooted structural determinants. Generally, the segregation and unequal position of black people in South Africa, which is initiated by the colonialists and intensified by the apartheid regime, in order to exploit the rich resources of the country, and to exclude and contain the inferior black population. (Karim, Karim, 2002)

# Conclusion

South Africa has the highest HIV prevalence in the world, of which almost entirely only the black African population suffers. This is shown by these striking statistics: 19.9 % of the adult population is infected, of which 19.5 % are black Africans, and only a tiny 0.5% are white people.

The highest HIV prevalence is found by young black women between 18 and 35 years old. In addition, the incidence rate is highest in rural underdeveloped areas, where there are no solid educational institutions, employment opportunities and healthcare facilities. This structural lack of equal opportunities, collective services, and intellectual development most likely results in risky (sex) behaviour among the black population, which may explain the enormous contrast in HIV prevalence between the white and black population.

Kwazulu-Natal is the epicentre of the HIV epidemic in South Africa, and not coincidentally, the key determinants which devise a negative reinforcing vicious circle, are majorly present in this underdeveloped province. Furthermore, gender-inequality is deep-rooted and prevalent in all layers of society and relationships. This, in combination with an insecure environment which lacks solid institutions and rule of law, intensifies the vulnerable and submissive position of women.

The apartheid regime has intentionally devised a volatile fragmented and segregated foundation in which the minority white population dominated and supressed the majority black population. The research strongly suggests that the apartheid regime deliberately implemented the ‘’divide and rule’’ principle, in order to exploit the natural resources, and more importantly, contain and control the inferior black African population. (Karim, Karim, 2002)

Actually, the colonialists initiated the segregation and inequal position of black people in South Africa, and subsequently the apartheid regime intensified en deepened this process.

The black African slaves, who were part of the migrant-labour system in which they resided in malicious living circumstances, unintentionally have initiated the explosive expansion of the HIV epidemic, since they were commonly visited by prostitutes who have intensified the expansion.

Widespread poverty, criminality, violence, gender-inequality, drug and alcohol abuse, lack of solid (educational) institutions and equal employment opportunities, and the lack of rule of law, are the key determinants which are part of an interconnected **negative reinforcing vicious circle.** In the course of time this has resulted in the deepening and intensification of the fertile source which fuels the HIV epidemic among the black African population.

In fact, the HIV/AIDS epidemic has become major in South Africa, because the apartheid regime has never conducted a solid inclusive action plan against the explosive expansion of the HIV prevalence, in order to contain the disease, and prevent further deepening and expansion among the black population.

This may indicate that the apartheid regime deliberately used the HIV epidemic as an instrument to contain, control and damage the black African population.

# Recommendations

To bring the explosive HIV epidemic under control, a solid and inclusive combination of measures is required. First of all, the government should provide solid leadership for the African people, in order to unite all forces in society and stimulate education and development. Since there was a lack of strong united leadership in the past, all efforts to fight against the epidemic remained fragmented, and therefore highly ineffective. Corruption must also be countered, legal institutions must be strengthened and rule of law must be respected.

Subsequently, the government should centralize all its recourses and target the key fuelling determinants of the HIV epidemic, in order to contain the HIV epidemic. South Africa has the most enormous antiretroviral treatment programme in the world, which it has mostly financed from its own natural resources. However, due the structural rooted determinants this repressive treatment has no substantial success, because the fertile foundation for the epidemic is not targeted sufficiently.

These general measures must ensure that the government will be a loyal and cooperative financer and partner for projects and action-plans against the HIV epidemic. Furthermore, structural modifications must be implemented in the South African Townships, such as stimulating education, creating employment through micro-loans and assuring security and stability for the inhabitants of these cities.

A specified **three-point action plan** has to be devised, with the main objective to strengthen the vulnerable position of black women in society, and provide the young generation with a combination of preventive and repressive instruments to contain and counter the HIV epidemic.

The objective of the first **short-term** measure is to contain the already existing HIV prevalence and prevent further (explosive) expansion among the young generation, aged 15 to 35. Free condoms must be provided by the government to everyone who is sexually active in South Africa. This collective measure must be accompanied by a national campaign which informs, stimulates, and convinces the people to structurally change their risky (sex) behaviour. The campaign must be conducted through television, radio and social media. However, there must be ‘’road-shows’’ which travel throughout the country, and especially target the rural underdeveloped areas, where the poorest (uneducated) people reside. The main objective of this intervention is to break through the Stigma of HIV, and convince people that their destiny is in their own hands.

The second **medium-term** measure is to establish solid community centres throughout the country, especially in rural (underdeveloped) areas. These community centres must be an enriching and informative melting point for the young generation, where they can gather and exchange information an experiences. The collective centres must be equipped with collective computers, televisions, libraries and other instruments and games to stimulate relaxation and development of skills and competencies of the young generation.

In addition, these centres must also be equipped with the most needed healthcare-equipment and medicines, and accompanied with well-informed advisors and (medical)-students who can inform and convince the people to change their risky habits. Consultations with doctors could be arranged when possible, and lectures could be given my role models of society. In a nutshell, these community centres have both a preventive, as well as a repressive role in countering the HIV epidemic.

Finally, the **third long-term** measure is to provide micro-loans to the young black generation, especially the woman who have a submissive and vulnerable position in society and are frequently victims of intimidation, and sexual violence. This will result in a strong young generation, who can significantly improve its living standards, and make especially the woman, less dependent.

This measure can be perceived as a snowball, because it starts with little unconnected steps, but eventually it will devise a fertile foundation for progress, development and more employment, and that is exactly what the black African population needs in order to counter the HIV epidemic.

This combination of measures could be illustrated as a reinforcing vicious circle which needs fundamental elements to be effective in the long-term. In the long term this combination of preventive measures that targets the structural roots of the epidemic, will result in a substantial decrease of the HIV epidemic, and therefore make it more controllable. Eventually the young black generation can shape a fertile and bright society, but they need the right instruments and competencies to accomplish this complex task. Change requires perseverance and patience.

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