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CHAPTER

HIV/AIDS - current issues

South Africa has one of the highest incidence and prevalence rates of HIV/AIDS in the world. The fact that these numbers have been increasing during the period when the national AIDS response was being mustered and implemented is of particular concern. This chapter looks at some of the reasons why efforts to stem the epidemic have not been as successful as hoped. The HIV/AIDS and STD Strategic Plan 2000 – 2005 is analysed, as are issues such as access to treatment, voluntary testing and counselling, confidentiality and notification, and the controversial debate around the link between HIV and AIDS. Recommendations are given regarding the way forward from here.

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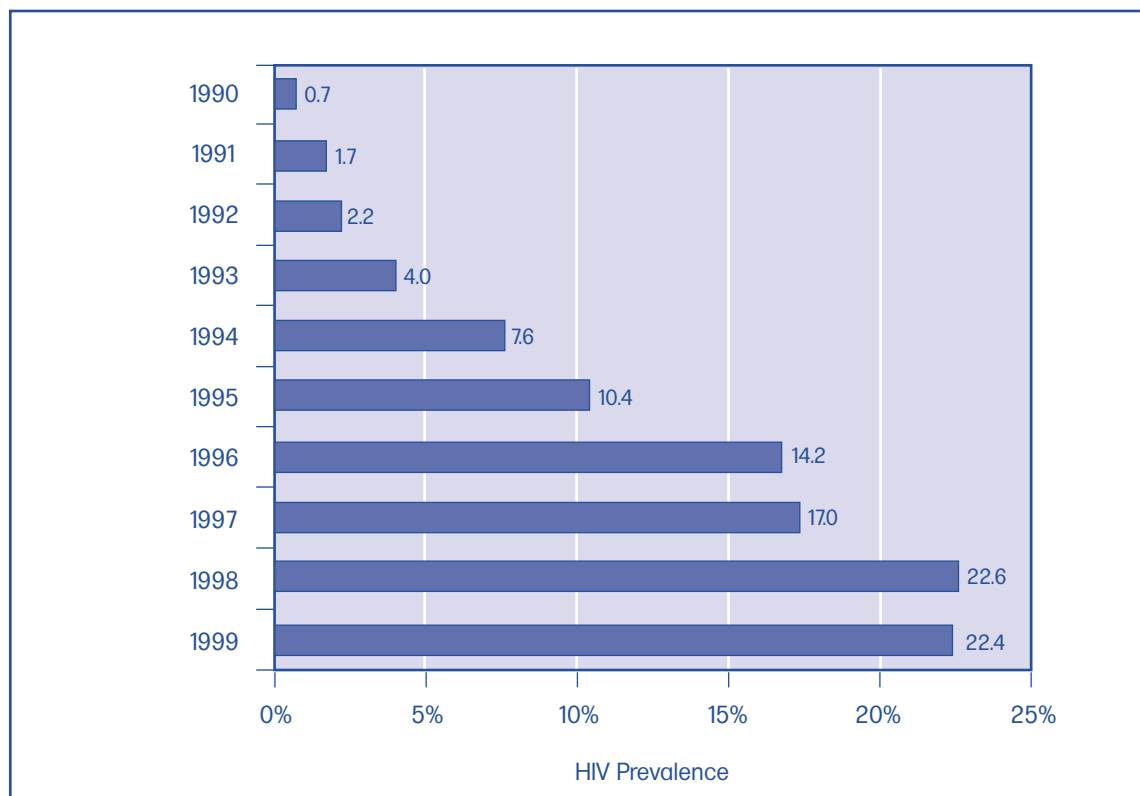
Introduction

Seventy-one percent of the estimated global total of people with HIV/AIDS live in sub-Saharan Africa.¹ In most sub-Saharan countries adults and children are acquiring HIV at a higher rate than ever before. There were 4.0 million new infections in the region during 1999.² South Africa has a high infection rate, and with a total of between 3.5 and 4.2 million infected people, has the largest number of people living with HIV in the world.³

HIV prevalence figures in South Africa are based on the results of annual, clinical, anonymous antenatal surveys undertaken at sentinel clinical sites. This surveillance, usually done each October, has been measuring HIV infection rates since 1990.⁴ South Africa has been described as having one of the fastest growing epidemics in the world. From 1990 up to 1998 there had been a 32 fold increase with a slight flattening for 1999.⁵ In 1990, South Africa had an infection rate of less than 1%. By 1999, an average infection rate of over 22.4% was estimated for antenatal attendees, as compared to Thailand that has remained at levels recorded in the early 1990's.⁵

HIV prevalence rose dramatically during the period when the national AIDS response was being mustered and implemented. Projections show that the country is likely to be in the throes of the AIDS epidemic by 2004.⁴

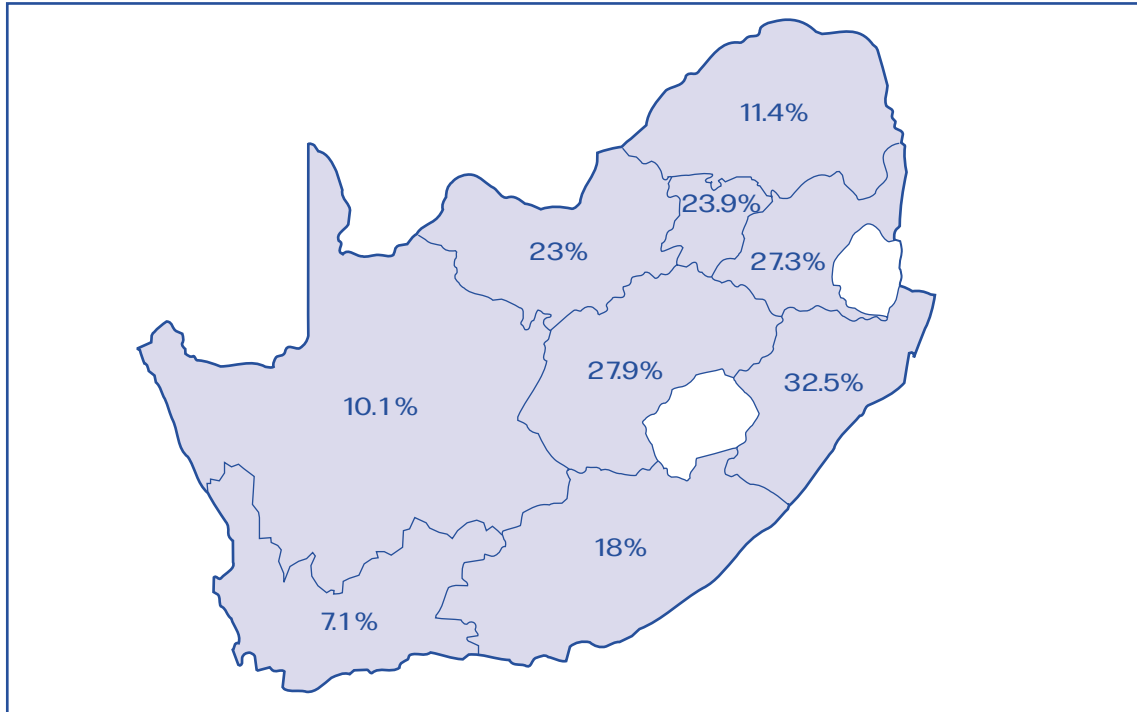
Figure 1: HIV sero-prevalence in women attending publicly funded antenatal clinics, South Africa, 1990 – 1999



Source: Southern Africa Journal of HIV medicine, launch issue July 2000.

Increase in prevalence has been measured in all provinces, though the rate of spread and level of infection are uneven across the country. In 1998, infection rates rose in seven of the nine provinces and seemed to level off in the other two (the Western and Northern Cape). The prevalence ranges from approximately 7% in the Western Cape to 33% in KwaZulu-Natal.¹

Figure 2: Provincial Rates, South Africa 1999



Source: The Impending Catastrophe, loveLife 2000.

Of the 4.2 million adults and children infected with HIV/AIDS as of the end of 1999 it is estimated that there are 2.3 million infected adult women (15 – 49 years) and 95 000 children (0 – 14 years).² The cumulative number of orphans^a is estimated to be 420 000 and the estimated total number of deaths for 2000 is expected to reach 90 000.¹

With more than 1 700 people infected daily with HIV, approximately 550 000 new infections are expected to have occurred over the last 12 months in South Africa. By the year 2005 the total number estimated to be positive in South Africa would be 6 million.^{3,4}

At the present rates of AIDS or late stage HIV infection, estimates of death due to AIDS stand at 120 000 per year, with this figure climbing to 250 000 by 2002, and reaching one million per year by 2008. Current indicators are that we are running ahead of expected figures, and our total estimates are now 2 years ahead i.e. in 2000 we are in line with the projections for 2002.⁵

a. Children less than 15 years who have lost a mother to HIV

The fact that there has been an exponential increase during a time of extensive HIV/AIDS prevention messages and a growing awareness of AIDS is of great concern, especially considering:

- ◆ South Africa now has one of the largest number of people living with HIV in any country in the world²
- ◆ The high rates of infection in women and men of reproductive and economically active age
- ◆ The projection that women of 20 – 30 years have the highest rates of all age groups and sexes, with prevalence rates of approximately 26%^{3,4}
- ◆ The increasing mortality over the last 5 years across all ages including infants and especially amongst women⁶
- ◆ The decreasing life expectancy with 15 year old youth having a 70% lifetime risk of AIDS death²
- ◆ The impact of the epidemic on young black and economically poor women is more severe than in any other group.⁵

The reasons why the epidemic has spread so rapidly in South Africa, despite the experience of the USA, Europe and other African countries are many and complex. Factors including poverty, migration, the position of women, socio-economic conditions, unemployment, the challenge of development, illiteracy and poor education were all detailed in the introduction to the 1994 National AIDS Plan. These same factors continue to fuel the ongoing epidemic. The epidemic, in turn, exacerbates these factors, creating a cycle of infection and vulnerability, and leading to more poverty.

Increased susceptibility to infection is due to numerous environmental, cultural, class, racial and socio-economic factors. Being a newly democratic society in transition, with a developing economy, our vulnerability to its' impact is potentially immense.⁵ In addition, through historical neglect, there are high rates of sexually transmitted diseases³ amongst the population, a generally early age of sexual debut;⁷ a high number of concurrent sexual partners; low levels of condom usage;⁸ poor rates of successful STD treatment; high mobility of the society; high rates of poverty; low levels of literacy⁹ and political manipulation.

In addition, it appears from meagre data at hand that South Africa has one of the highest rates of sexual assault in the world, but this crime is notoriously under-reported for many social reasons.⁷

There is no certainty at which level and when the epidemic will plateau.^{2,5} It is possible to predict an exponential increase in deaths across all ages, with a wave of deaths occurring over the next few years, and increasing numbers becoming evident with time.^{5,9} South Africa currently ranks 103 out of 174 on the UNDP human development index rating, which places the country in the medium human development category. However, like her northerly neighbours, South Africa is seeing a reversal of its human development index because of a decrease in life expectancy, largely due to HIV/AIDS.

South Africa has one of the highest incidence rates per capita of TB in the world. HIV will continue to keep these levels high, if not push them higher, as more of the population becomes immune compromised and thus more susceptible to TB. This is also the case in children where it is estimated that between 30% and 50% of HIV infected children will present with TB during their life.¹⁰ Many patients cured of TB will rapidly become re-infected and it is

not uncommon for patients with HIV to present with TB 2 – 3 times in a life-time, placing a huge cost on their health, as well as the system. TB results in increased morbidity and mortality of those dually infected.

The impact of HIV/AIDS programmes is hard to measure and takes time to manifest, but what is alarming are the rates of increase in areas where the overall prevalence rates are relatively low, e.g. the Western Cape which had a 36.5% increase from 1998 to 1999.⁴ As South Africa had the experience of the rest of Africa to learn from, so the Western Cape could take lessons from the failed campaigns in the rest of the country. The Western Cape has the opportunity to introduce integrated multi-strategic and multi-sectoral programmes, which in turn could be copied by the rest of the country. The province did make the decision to move ahead on the introduction of AZT and Nevirapine to reduce Mother to Child Transmission (MTCT), but even this has been somewhat cautious.

The HIV/AIDS and STD Strategic Plan for South Africa 2000 - 2005¹¹

The precursor of the 2000-2005 Strategic Plan, the 1994 HIV/AIDS Plan was reviewed in 1997.¹² This was an extensive national review, which gave a very frank and critical assessment of the Plan. A series of findings from this review were presented to the Minister of Health.

The main strengths of the Plan were identified as follows:

- ◆ The general availability of treatments for the syndromic management of sexually transmitted diseases (STDs)
- ◆ An improved National TB programme
- ◆ Highly motivated community service organisations (CSOs) operating with limited resources.

The main constraints were identified as being:

- ◆ The delayed employment of personnel due to restructuring at national and provincial levels
- ◆ Limited human and financial resources at all levels
- ◆ Lack of adequate referral mechanisms and continuity of care, including hospital and home-based care
- ◆ Lack of integration of TB and the HIV/AIDS programmes
- ◆ Lack of multi-sectoral approach outside of Health.

On the 14th of January 2000, the National Department of Health launched the HIV/AIDS and STD: Strategic Plan for South Africa 2000 - 2005.

Essentially, this is a revised version of the 1994 AIDS Plan, which was only implemented in part. Although most provinces adopted policies that were based on the Plan, there was no united and co-ordinated effort to implement it. This may be because the implementation section of the plan was ambitious, costly and difficult to co-ordinate. Most government departments seem not to have used the plan as a working document.

Some important guiding principles of the 2000 - 2005 Strategic Plan, which were retained from the 1994 Plan, include:

- ◆ People with HIV and AIDS shall be involved in all prevention, intervention and care strategies
- ◆ People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination
- ◆ The vulnerable position of women in society shall be addressed
- ◆ Confidentiality and informed consent with regard to HIV testing and test results shall be protected.

The Strategic Plan has four Priority Areas:

- ◆ Prevention
- ◆ Treatment, care and support
- ◆ Research
- ◆ Human and legal rights.

Each priority area is detailed through:

- ◆ Objectives
- ◆ Selected strategies
- ◆ Lead agencies.

The Strategic Plan does attempt to create the mechanism for an integrated response, with other government departments, non-governmental organisations (NGOs) and community-based organisations (CBOs) that are detailed in the Plan, being responsible for delivery in certain areas.

While it can be argued that this 2000-2005 Strategic Plan is simpler than the 1994 Plan, it remains somewhat generalised in terms of what is to be done and how resources are to be prioritised. The Plan does not sufficiently reflect an understanding of where we are in dealing with the epidemic, and what has been learned in the past six years. Strategies to turn the principles into reality require clearer crafting and development with clear, obtainable and measurable indicators being identified, and concrete steps need to be outlined as to how the goals are to be achieved.

Although the principle of having people with HIV and AIDS involved at all levels forms part of the plan, their voice needs strengthening. Despite the principle of having concern for the particularly vulnerable position of women, women's issues need to be made more prominent. The greater vulnerability of younger women to HIV transmission needs to be acknowledged, and there is a need for an indication of the steps that will be taken to address this. Confidentiality is acknowledged as one of the principles that underlies the Strategic Plan, but the Plan needs to state what mechanisms are to be put in place so that client confidentiality can be guaranteed. Commitment in the Plan to the provision of anti-retroviral treatments, such as AZT and Nevirapine, is unclear.

In a country that seems to be lacking a sense of urgency, the 2000-2005 Strategic Plan should capture this sense of urgency and give vision, purpose, and leadership while calling for decisive action. Plans for dealing with the impact of the escalating epidemic over the next ten years or more should be outlined.

The Plan needs to deal with some of the important issues which will impact on South Africa. These include:

- ◆ Community devastation
- ◆ The skills shortage within all sectors, especially those of service delivery
- ◆ The burden of costly funerals on communities
- ◆ The loss of creativity and talent
- ◆ Erosion of parental authority.

It requires a timeline to be put in place, as well as mechanisms for monitoring and evaluating progress. A more concrete and measurable plan would enable various departments to identify a clear way forward, and sectors other than health to build on a solid base. Support for various departments and sectors, in terms of the development of their operational plans, needs further development.

There are several questions to be asked of the Strategic Plan, given that this is the response almost 20 years into the epidemic:

- ◆ Who takes the overall lead?
- ◆ Who takes the ultimate responsibility?
- ◆ What power does the South African National AIDS Council (SANAC) have?
- ◆ Who sets the national priorities?
- ◆ Who determines and allocates budgets?
- ◆ What are the time frames for the various strategies?
- ◆ With what authority can the Technical Task Teams^b make recommendations?

To be effective against HIV and to be able to mitigate the effects of AIDS, an integrated plan needs to be strategic and also to command sufficient resources. Financial resources need to be guaranteed, but there is ongoing and distressing evidence that the AIDS budget has been consistently under-spent, both nationally as well as provincially.^{13, 14} This in part may be a reflection of a lack of decisiveness and clarity in the Plans, and the failure to generate a united response. There are in effect 10 responses to HIV/AIDS in South Africa - the national plan and the nine provincial ones. On paper these are a united response, but in reality there are still tensions between the different spheres of government as to who is able to do what. It is not clear as to what authority provinces have in determining their own collective response.

Resources in the form of trained personnel support staff and counsellors should be committed to assist in implementing the Strategic Plan, and CBOs and NGOs should be involved so that available resources are used as effectively as possible. This has been slow in getting off the ground. NGOs and CBOs feel that they are able to do more. Their potential should be recognised and support funding should be easier to obtain.

The national response has to be viewed in the context of the size and growth of the epidemic. By world standards, we have so far not been successful in halting the spread of this disease in South Africa.

^b The task teams that give advice to the South African National AIDS Council

To succeed, the Strategic Plan requires:

- ◆ Commitment at all levels
- ◆ Understanding of the science of HIV and AIDS
- ◆ Understanding of the economic and political issues
- ◆ Action that is decisive and strategic
- ◆ Recognition of what did not work in the past and why
- ◆ Finding ways to understand what does work, and how such interventions can be strengthened and replicated.

Does HIV cause AIDS?

At the same time as the Strategic Plan was launched, an AIDS controversy was raging in the country. This was over the question, raised in debate by the President, about the causal links between HIV and AIDS. From the President's office came the question of whether HIV was sufficient to cause AIDS, and indeed whether there was any link between them.

The debate was raised in the light of views of AIDS dissidents. These dissidents, represented most forcefully by Peter Duesberg and David Rasnick, claim that there is no clear evidence that HIV causes AIDS, but rather that there is evidence to show that the so-called anti-AIDS drugs cause AIDS.^{15,16} The debate is over a decade old and has been roundly dismissed, but it was revived in South Africa. Coupled with this question was the question of what is it about AIDS in Africa that might make HIV/AIDS such a different epidemic as compared to the West, requiring different treatments, responses and interventions.^{6, 15, 17-19}

To answer these questions the President convened a specialist panel with members comprising AIDS dissidents and people who held the view that there is a proven, causal connection between HIV and AIDS.^{6,15} The debate was put forward as being between two competing and equal views - the so called orthodox view and the dissident view and, in a clear misunderstanding of how science works, it was hoped that a consensus view would be reached over two meetings, but this did not prevail. The report from the meetings and the subsequent cyber discussion is still awaited.

By the time of the Durban conference in July 2000 the debates were heated and led to the Durban Declaration²⁰ in which over 5 000 scientists worldwide re-affirmed their belief that HIV was the cause of AIDS.

The debate was accompanied by a disconcerting insistence upon accepting the official line and the net effect was that it created in the minds of many people yet another reason to doubt the existence of HIV/AIDS. It fed into the denial and the refusal to take seriously the behavioural connection between sex and HIV infection, and it is believed by many health workers that HIV/AIDS campaigns were seriously set back. Once broken, safer sex behaviour patterns might be impossible to revisit, and at this stage of the epidemic, such a reversal in understanding and behaviour would have grave consequences.

The failure on the part of the Department of Health, and especially the Minister, to state early and categorically that HIV is the cause of AIDS, as well the refusal to give a direct answer to a direct question, was regrettable.¹⁷ Subsequent claims that the national intervention programme is being based on the premise that HIV does cause AIDS were confusing for many. The Director General and the Director of Maternal, Child and Women's

Health in the Department of Health did express their views that there is a causal link between HIV and AIDS; albeit somewhat belatedly. While it gave some security to people working in the field, it occurred late in the debate, and people could have been unaware of it.

The debates^c have had a positive spin off in that HIV/AIDS has been given a higher profile than ever before and in the ferment of discussion, denial and accusation, there is the sense of renewed commitment to new and successful campaigns.

Access to treatment

One aspect of the debate was the question of the provision of treatment. This was linked, in the first instance, to the government's refusal to sanction the use of AZT for pregnant women and rape survivors, questioning of the efficacy of AZT particularly for the "African" setting. The Treatment Action Campaign (TAC) was founded in 1999 to be a pressure, lobbying and advocacy group for improved access to treatment for all.

At the heart of the treatment question are three fundamental issues:

- ◆ First, the retention of patents by pharmaceutical companies with the link to the high cost of drugs
- ◆ Second, the restriction on imports of generic medicines
- ◆ Third, the ability of South Africa to administer and monitor the use of drugs and supply adequate nutritional and medical infrastructure to ensure the safety of people taking these drugs.

The South African government has been in a protracted dialogue with the pharmaceutical industry and there has been a great deal of debate about how drug companies appear to be profiteering from the illness of people with HIV and AIDS. A few major companies have announced free supply of certain drugs, or the provision of drugs at greatly reduced prices. However, in some cases these have been found to have restrictive conditions attached, raising the concerns of government and AIDS activists, and thus delaying access to these medications (see the chapter on Drug Pricing.) The important positive aspect is that negotiations continue and prices appear to be coming down.

The reasons for government's objections to the provision of the drugs, and to the acceptance of the free/reduced price offers remain unclear. Government has been cautious in accepting the results of the trials that show the significant cost effectiveness of Nevirapine and AZT on the rate of MTCT, and after much pressure, limited new trials are now being undertaken in provinces.²⁴ Quite apart from the human rights issues of not giving women access to a proven and effective drug, there is also the consideration of what the effect of such an intervention would be on the rate of the epidemic. There is clear evidence to show that access to the counselling and testing that would accompany a drug programme would have a significant impact on limiting the progression of the epidemic.^{23, 24}

c These debates/mixed messages and intellectual confusion around the origin and pathogenesis of HIV, the level of infectiousness of the virus as well as its detection are described in many texts.^{6, 15, 17} However, the scientific explanations for the link between HIV/AIDS are very clear. The virus has been isolated and photographed by electron microscopy, showing virus budding off an infected T-cell surface.^{21, 22} Contaminated bodily fluids transmit it and that includes sexual transmission. The Elisa tests and the other more recent rapid tests are very reliable and positive tests are always checked for confirmation and to rule out human error. Most people who are HIV positive will unfortunately progress to fully developed HIV infection and AIDS (although there are medications - anti-retrovirals - that can dramatically slow down this process).²⁵

The government has raised the question of cost of drugs, stating that in the current financial climate and with all the competing demands they would be unable to afford the treatments. The debate has centred on what is affordable and what is cost effective. It may be difficult for the government to afford the treatments now, but it would certainly be cost effective in terms of the cost of replacing the skills lost to AIDS deaths, and the costs of providing care for the dying.

Clearly this is a complex issue. There is no doubt that people on the complicated combination drugs would need skilled and careful medical attention, and there is also a need for physicians to develop those skills. The debate about drugs comes at a time when some provinces (for example Gauteng) appear to be reducing their dedicated HIV clinics, thereby reducing the level of specialised skills available.

Party politics has also entered the fray, detracting from the central issues which impact on the whole country. The toxicity of anti-retrovirals has been stated as a reason for not providing greater access to them. However this argument is undermined by the fact that members of Parliament can access these drugs through their medical aid scheme.

The Medicines Control Council (MCC) has been cautious in getting the registration process completed for the broader use of anti-AIDS drugs such as Nevirapine and has also been restrictive in how they have granted licenses for use.

No one doubts the effects that HIV infection and AIDS illness will have on the country, that many of the possible development gains will be eroded, and that the country will face unprecedented levels of suffering, as well as a threat to social, political and economic security. It must be asked whether, in the light of this and the overwhelming epidemic that is being faced, the most constitutional and effective decision would be to provide comprehensive treatment and care.

There is little doubt that an effective HIV vaccine would be a major factor in dealing with HIV. However, it is also the case that there is unlikely to be an HIV vaccine before 2008, and by then many thousands of South Africans will have been infected and died.²⁵⁻²⁷

South African National AIDS Council

The South African National AIDS Council (SANAC) is supported by technical task teams, made up of 5 expert groupings whose function it is to assist and advise the SANAC and which to some extent mirror the strategies of the Strategic Plan 2000 - 2005:

- ◆ Prevention
- ◆ Care and Support
- ◆ IEC and Social Mobilisation
- ◆ Research, Monitoring, Surveillance and Evaluation
- ◆ Legal Issues and Human Rights

Other key support committees to the Strategic Plan are The Inter-Ministerial Committee on AIDS (IMC); The Interdepartmental Committee on AIDS (IDC); MinMec;^d the provincial health restructuring committee;^e the Director-General forum and the HIV/AIDS

d MinMec is comprised of all provincial MECs for Health and the national Minister of Health. This committee meets every six weeks. They approve national policies and guidelines.

e This committee is made up of all provincial Heads of Health, and meets monthly.

and STD Directorate in the national Department of Health. The Directorate facilitates the workings of the Technical Task Teams.

SANAC has to be more vocal about the debates of the last year. This Council is the highest body that advises government on all matters relating to HIV/AIDS. It is chaired by the Deputy President and made up of 15 government representatives and 16 civil society representatives. This body is in a position to advise the government on the effect of the HIV/AIDS debates as well as on the appropriate way in which to deal with the subsequent controversies. To be more effective, SANAC has to be clearer about where it stands and what it supports.

In response to the perceived shortcomings in the make-up and functioning of SANAC, a shadow national AIDS council has been established. This body attempts to highlight the kinds of questions which the SANAC should be debating.

Voluntary testing and counselling

Part of the government's strategy is to encourage the development of voluntary counselling and testing (VCT) sites at district level. It is hoped that this will have a number of benefits:

- ◆ More people will come forward for counselling and testing and ongoing support
- ◆ Having an HIV/AIDS test will be normalised
- ◆ More people will feel secure in disclosing their HIV status to partners, families and associates.

Establishing such a programme relies on a body of well-trained counsellors and on the facilities to provide testing free of charge in a supportive and enabling environment. Despite having a programme to develop minimum standards for counselling for close on five years, this has not yet been established and not enough counsellors have been trained to make VCT available nationally at the primary level. But there is some evidence from Zimbabwe to show that VCT programmes do not always have the desired effect.²⁸ People who have been tested tend to have increased morbidity and mortality, believing their status to be some form of punishment. Women tested in antenatal clinics may suffer from increased postnatal depression, especially where there is little perceived benefit offered to patients.²⁹ VCT requires a full support network for a continuum of care from the test through to illness and possible death.³⁰ There needs to be an established network of home-based care, home visitors and extensive support structures. For VTC to be effective, there has to be a continuum of care.

Dealing with HIV/AIDS is not only a case of making the present more manageable, but of transforming the conditions under which people live and how they deal with the illness and death of themselves, close family and friends.

It is believed that VCT will help to reduce the stigma which still surrounds HIV and AIDS and that people will be able to disclose their status in an environment of security and trust. It is also believed that VCT will improve the health services for People Living with AIDS (PWAs) in that nurses will gain greater experience and that clients will get early diagnosis and support. However, in the absence of treatment, disclosure may not be what people wish to do. VCT can only work where there is some support and treatment following diagnosis.

Confidentiality and notification

Believing that the secrecy that surrounds the diagnosis of HIV was contributing to the stigma and prejudice surrounding HIV and AIDS, the government, in 1999, announced its intention to make AIDS a notifiable disease. This they believed would help to normalise AIDS and encourage greater openness. This decision was challenged on a number of grounds. It was believed that:

- ◆ It would drive the epidemic underground
- ◆ Having information on the number of AIDS cases would have no bearing on the number of HIV cases and thus not be of any use in planning for the future impact of the epidemic
- ◆ The parameters of “close family” in the legislation was too broad
- ◆ In the absence of legislation to protect people with HIV and AIDS, greater hostility to people with HIV and AIDS was likely, as this was the tone of these regulations.

There was a call that, since government was asking people to disclose their status, the leadership for this initiative should come from government itself and that prominent people living with HIV and AIDS should declare their status to make the path of disclosure easier for other people. To date this has not happened and the debacle surrounding the death of the Presidential Spokesman Parks Mankahlana highlighted what happens when there are rumours about HIV and AIDS in a society that looks to sensationalise rather than to normalise an illness.³¹

Conclusions and recommendations

The UNAIDS report on the global HIV/AIDS epidemic of June 2000 summarises the common features of effective national responses that have brought about a decrease in the incidence of HIV, or at least stabilised the epidemic.²

These are:

- ◆ Political will and leadership
- ◆ Societal openness and determination to fight against stigma
- ◆ A strategic response
- ◆ Multi-sectoral and multi-level action
- ◆ Community-based responses
- ◆ Social policy reform to reduce vulnerability
- ◆ Long-term national/global response
- ◆ Learning from experience
- ◆ Adequate resources

It is possible to see, in general terms, that the South African response in the Strategic Plan does address these factors. But these UNAIDS factors are also generalised and lacking in specific detail of how such a programme is implemented effectively.

For South Africa to survive this catastrophe we need strategic leadership, especially at the political level, as well as from our community, religious, private and academic sectors. We need a clear, focused and incremental approach to education and service delivery on all aspects of HIV/TB/STD's, from prevention through to care and support.

Linked to education are comprehensive communication strategies. Information needs to get out and reach the entire population. For this to work requires an integrated multi-sectoral response at the district level, with national support and the appropriate legal framework. Clear milestones have to be laid, achievable goals with timelines have to be set, and this requires effective management at every level.

Women and positive people have to feel part of the plan and we all have to own it. Hope has to be given; without it we will be a destroyed nation. All of the above came out in the 1997 review¹² and yet, three years down the line, how much closer to these goals are we?

Despite more than a decade of policies and programmes to manage the HIV/AIDS epidemic, South Africa has not yet made any significant impact on the rate of the epidemic; although there are some signs that this is beginning to change.

We do now have a Strategic Plan which is “not a plan for the health sector specifically, but a statement of intent for the country as a whole, both within and outside of government. No single sector, ministry, department or organisation is by itself responsible for addressing the HIV epidemic.”¹¹ However implementation of the goals of this Plan is still awaited.

It is essential that we cease to see prevention and care as separate entities. By offering and providing a comprehensive and holistic programme with hope and care and with the aim of achieving positive outcomes, more people will feel part of the national response.

To quote Dr Jonathan Mann “...separation and fragmentation dominate... Few if any, can tell us, clearly and coherently, what our global strategy is today. Instead of a strategy, we have a series of tactical approaches. We have learned that traditional, individually-focused, HIV risk reduction efforts, while necessary and useful, are clearly not sufficient to control the pandemic... public health must deal directly with the societal conditions which create and enhance vulnerability to HIV.” Although this is meant in a global context, it does also have a national relevance to South Africa. He goes on to say “... true healing requires connecting with others; the creative, religious, and artistic life of every culture celebrates this fundamental reality. To be connected is to choose life.”³²

Our response must be based on a calm sense of urgency and solidarity, and carried out with a sense of connectedness, not panic. Only together can we turn the tide.

