CDE debates

Why is South Africa struggling to get to grips with the AIDS crisis?

The Centre for Development and Enterprise held its 13th debate on 30 May 2000. The speakers were Dr Manto Tshabalala-Msimang, minister of health; Prof Jerry Coovadia, head of the department of paediatrics at the University of Natal; and Dr Anthony Kinghorn, senior manager of Abt Associates South Africa Inc. The debate was chaired by Barbara Masekela, former South African ambassador to France.

What the speakers had to say …

Dr Manto Tshabalala-Msimang opened the debate by saying that the government had an important responsibility in respect of the HIV/AIDS epidemic, but this was not and could never be the responsibility of government alone. Unless every citizen took responsibility for his or her sexual behaviour, the virus would continue to spread no matter what the government did. Ultimately, all citizens had to ask themselves what they were doing, as individuals and in the institutions in which they were active, to stem the epidemic.

To understand why this was so, the factors that contributed to this crisis had to be understood. Among these were unprotected sex, sex with multiple partners, transfusions with contaminated blood, intravenous drug administration, and the high prevalence in South Africa of sexually transmitted diseases (STDs). Others were socio-economic factors such as poverty, migrant labour, widespread commercial sex work, the low status of women, low literacy levels, a lack of formal education, and the stigmatisation of infected people.

She wanted to focus on a few of these factors; the first was sex. The problem was that sex was a highly personal issue which most people found difficult to discuss. People had to have enough information about the virus to allow them to decide whether and how they wanted to engage in sex, and the government believed it was responsible for providing that information. However, the government could not outlaw sexual contact.

The second was the low status of women. Men were often unwilling to discuss sexual matters, including family planning and contraception, with them. Also, many women were exposed to STDs by their partners. This was another factor that required a long-term and sustained effort to counter.

Another important factor was poverty. She was not saying that poverty caused AIDS; however, it did contribute enormously to the spread of the epidemic, and it was clear that South Africa's social environment was particularly conducive to this.

All governments, including South Africa's, were struggling to address the problem of HIV/AIDS. Nevertheless, the South African government was fully committed to doing so, and had made significant inroads.

It had established the South African National AIDS Council (SANAC), a collaborative partnership combining government and other sectors of society. It had formulated a five-year HIV strategy in terms of which past efforts were regularly reviewed and new goals and objectives formulated. It had developed guidelines for the treatment of infections, occupational exposure to HIV, infant feeding and HIV testing for mothers, and the ethical considerations surrounding HIV and AIDS.

It was sponsoring the Medical Research Council and the efforts of other scientists. Its quest was to find effective responses to the epidemic, but in particular to find a vaccine.

Recent survey results showed that, although much more needed to be done, the government was reaching people with information, and some of them were changing their behaviour. But HIV/AIDS was not just a government problem – it had to be owned by everyone.

Dr Anthony Kinghorn spoke about the socio-economic impacts of HIV and AIDS, and their policy implications.

Current evidence suggested that AIDS would not have the catastrophic effect on the macro-economy predicted earlier on; it now seemed that AIDS would reduce economic growth by 0,3 to 0,4 percentage points per annum over the next decade. Cumulatively, this would result in a substantially smaller economy, reducing the resources available for socio-economic development. But it made AIDS just one of the factors affecting growth and development rather than an overriding one.

Similarly, at the micro-economic level, AIDS certainly imposed significant costs on companies and employers in general, but it was unlikely to be a dominant factor for most businesses in determining whether they succeeded.

> **"I have never doubted that HIV causes AIDS"**
> Minister of health

Thus the true socio-economic impact of HIV and AIDS would be felt elsewhere, particularly at the household level. Affected households would face economic stresses because of the loss of breadwinners and the extra costs of caring for infected people. Infected people and those who cared for them would also be personally stressed.

A particular group needing attention was orphans. By the year 2005 there would be about 800 000 AIDS orphans in South Africa, rising to 2 million by the year 2010. These children would face enormous disadvantages that would have a long-term impact on the future of South African society.

Africa had a long history of supporting terminally ill people and orphans, which had the potential of mitigating the impacts of HIV and AIDS. However, particularly in communities where levels of HIV were higher than the average, there would be thresholds beyond which such traditional mechanisms would break down, and the socio-economic impacts would become far more severe.

WHAT ARE THE CDE DEBATES?

CDE debates are intended to explore important issues, and identify challenges facing policy-makers and citizens. In this way, CDE hopes to inform public opinion. This publication is widely distributed and publicised as CDE's contribution to stimulating debate on the issue in question.

HIV and AIDS would significantly increase poverty. Many poor households would become much poorer, and many middle-income, upper-income and upwardly mobile households would be pushed back into poverty.

Apart from the impoverishment of many households, HIV and AIDS would have important implications for equity in South African society. It would impact on certain communities and even certain provinces far more severely than others. Also, disadvantaged communities were more vulnerable to HIV and AIDS impacts, because they were more susceptible to infection and had fewer resources to cope with the impacts of HIV/AIDS at the household and community level.

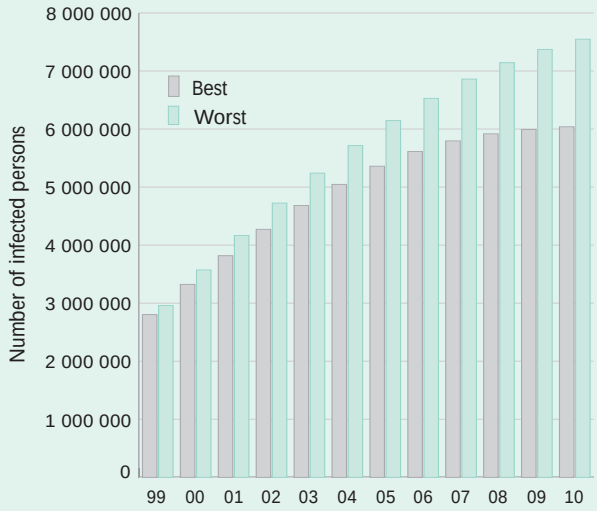
One of the key areas of impact was education. Many children would be disadvantaged by HIV and AIDS, and therefore less likely to benefit from education. Also, educators would be heavily affected. Therefore, common assumptions about South Africa's ability to build people's capacity to improve their socio-economic status would be undermined.

Another was that of health care. Estimates suggested that real public health care spending would have to increase by about R16 billion by the year 2010 to provide current good-practice levels of care for people with HIV/AIDS. Total public sector health care expenditure was currently around R25 billion, and available finances were not projected to increase in real terms in the foreseeable future. If antiretroviral drugs were provided, costs would be even higher, even with substantial price discounts. So there were clearly very difficult policy choices and questions to be dealt with in this respect.

The implications for the welfare system were also far-reaching. Some of South Africa's welfare grants would probably become unaffordable in terms of the current financing envelope; this created key policy issues, among them how to make welfare responses to orphans in particular, but people affected by HIV and AIDS in general, more affordable and effective.

As regards the policy implications of the socio-economic impacts of HIV and AIDS, South Africa needed to develop a coherent overall strategy based on a thorough understanding of them. It

Projected numbers of HIV-infected individuals: best- and worst-case scenarios



Source: *The impending catastrophe*, Abt Associates / loveLife, 2000.

had a long way to go towards developing a strategy that did not approach the many AIDS impacts in a fragmented, unco-ordinated way. This became particularly important when one realised that AIDS and its impacts would last for decades to come. Longer-term strategies rather than knee-jerk policy responses were required.

In the past, responses to the epidemic had been specific to HIV and AIDS. However, particularly as South Africa entered the AIDS epidemic proper, the challenge was to develop a more coherent and broader development approach to policy on HIV and AIDS. This was important in two respects:

- many of the socio-economic impacts of HIV and AIDS needed to be addressed in terms of a sound developmental approach; and
- fundamental determinants of South African society's susceptibility to HIV and AIDS lay in development issues: poverty, poor education, and poor prospects that put people at risk of HIV. Preventing new infections would remain a key issue. Despite the potential for the epidemic curve to reach a plateau, projections of new infection rates remained very high for at least the next decade. Unless socio-economic conditions were addressed, high levels of new infections would continue for the foreseeable future.

HIV and AIDS needed to be seen as an intersectoral issue. A key challenge was for everyone, whether in business or in government departments that did not traditionally deal with health issues, to start seeing HIV and AIDS as their core business; as something that would affect them all in a broader social sense as well as in their immediate social circle and workplaces.

Prof Jerry Coovadia said there were three major reasons why South Africa was struggling to get to grips with the AIDS crisis.

- The virus was very difficult to deal with. There had never been an epidemic like it in human history. The black plague wiped out one third of European society, but it came and went. HIV and AIDS were eroding the lives of Africa's people, and eating away at their societies.

  The virus itself was also very complex. Medical scientists understood it to a degree, but could not control it because it mutated so rapidly. Moreover, people were asked to perform a monumental behavioural change. How did one get people to change their sexual behaviour?
- The epidemic had arrived when South Africa was undergoing a complex transition, and South African society was not stable enough to deal with it. This had had an important bearing on the first four years, which were absolutely critical. Inter alia, the AIDS strategy was supposed to be implemented via the provinces, when these had not yet begun to function, and health districts had not yet been set up.
- The government had made a number of mistakes in dealing with HIV/AIDS. Most recently, it had made a major error in contributing to a climate which raised the possibility that HIV did not cause AIDS, and that certain antiretrovirals were toxic.

This would have been tolerable if the disease wasn't so complex, if there was a cure, and if people did not need constant reassurance and encouragement – especially in communities like those in South Africa, which were in the throes of poverty and violence, including violence against women.

In such a society, if the government said something that created any doubts, one was asking for problems. Ultimately, the man in the street said, why should I wear a condom, and why shouldn't I sleep with more than one woman?

The credibility of South Africa's AIDS programme had been affected by scandals such as Sarafina 2, the Virodene issue, the question of notification, the dissolution of the AIDS Advisory Council, the composition of SANAC, the doubts cast on whether HIV caused AIDS, and claims about the toxicity of antiretrovirals.

What one had now was a politicisation of medicine, and of a dreadfully dangerous disease. He was not saying that government should not make policy. But when one questioned whether HIV caused AIDS, contradicting 20 years of scientific work, and then asked two groups of scientists to debate this, this was a misunderstanding of how science worked. One could not have science by consensus.

So was government culpable? The answer was yes. But so was business, and the community as well – in fact, in one way or another everyone was culpable.

CDE debates

Points raised during open discussion …

- Why had President Thabo Mbeki cast doubt on whether HIV caused AIDS?
- What was the government's stance on the use of antiretrovirals, particularly AZT?
- Why had foreign scientists representing an unorthodox view on AIDS been included in the government's panel of experts?
- Did the minister herself have any doubt that HIV caused AIDS?

Dr Tshabalala-Msimang said the president had never said HIV did not cause AIDS. What he had said was that the government had developed a strategy along lines suggested by international agencies, and committed a lot or resources to it, but was not seeing satisfactory returns. He was now asking what elements were missing, and what could be done next.

She herself had never doubted that HIV caused AIDS. However, that did not mean she should not read alternative studies, or try to understand what other scientists were saying. This was precisely because, as Professor Coovadia had pointed out, these were complex and difficult issues. As such, the government would continue to seek new ways to respond to them.

> **"The government has made a number of mistakes in dealing with HIV/AIDS. A major error was to contribute to a climate that raises the possibility that HIV does not cause AIDS"**
>
> Head, department of paediatrics, University of Natal

On the panel of experts, she said the scientific community was not divided, as had been claimed. All the government had said was that it wanted to tap into broader knowledge in areas where additional research was needed; therefore, it was important for South Africa to have invited those scientists. Also, the panel included three South African scientists.

On AZT, she said pharmaceutical companies had only said they were prepared to supply these drugs at a reduced price, but did not say by how much, or how much it cost to produce them.

Administering antiretrovirals in South Africa would cost R70 000 a patient a year, and perhaps R17 000 to R20 000 if the price was reduced. Given that the entire health budget was R2 billion, this meant the department would have to stop providing any other services. These were difficult choices to make.

Besides this, patients receiving AZT would need to be regularly tested and monitored. This would require infrastructure and personnel which did not exist. Moreover, the long-term effects were unknown. In the United States, for example, 50 per cent of HIV-positive people took antiretrovirals. Of those, 35 per cent were dropping off because they could not tolerate the side-effects.

At the World Health Assembly in Geneva, the government had also been advised not to embrace antiretrovirals. This did not mean the government was not exploring the possibility of administering these drugs, but the issue was far from straightforward.

- There was a lot of disillusionment among the unemployed. Some jobless people – some of them with AIDS – were saying, if they weren't working, why should they use condoms? What impact would the AIDS debate have on macro-economic strategy, and especially job creation?
- What was the role of the alleged lifestyle causes of AIDS, particularly poverty and malnutrition?

Prof Coovadia said he had no doubt that some of the problems surrounding HIV transmission had to do with the nature of communities such as those in South Africa, which were marked by violence. The root causes of violence, in turn, were a sense of frustration, humiliation and shame, arising from poverty and a lack of adequate resources. If those factors were addressed, this would undoubtedly have an impact on AIDS.

One of the primary preconditions for violence was not a lack of economic growth as such but a disparity between rich and poor. When this gap was as large as it was in South Africa, it was a prime pointer towards social dissatisfaction and upheaval.

It was not enough for the ministry of finance to deliver a 4 per cent economic growth rate. What was needed was investment in the liberation of women, land reform, education, health, and other social needs.

The minister said that unemployment and AIDS should not be linked too directly. She was not saying that poverty did not influence the spread of HIV and AIDS, but the issue was not as simple as that. The issue of poverty had to be approached in an integrated way. For now, though, prevention was the key.

SANAC had only met twice, and was still trying to find its feet; it was therefore too early to say what it had achieved. However, it was bringing together government, the private sector, CBOs, traditional healers, sport, hospitality industry, unionists, and so on, thus taking forward the multisectoral approach South Africa was trying to develop.

- Occurrences such as the Virodene and AZT controversies had caused a lot of confusion and disillusionment on the ground. Therefore,

there was an urgent need for the government to issue a statement explaining its stance and spelling out clearly what it intended to do.

- What could be done about AIDS orphans?

Dr Kinghorn said the issue of AIDS orphans was very complicated; multiple strategies had to be adopted. At the level of individual households, an environment had to be created where people could learn about their HIV status earlier and plan for the support of their children.

A broad menu of solutions was needed to support orphans and ensure that their life chances were adequate. Where community-based alternatives were lacking, children would require institutional care, and South Africa needed to build the capacity to provide this.

However, this would not be the first choice. What was needed for orphans as well as infected people was to build the capacity of the community to support those people.

The question was, what agencies such as the government, NGOs and others should do to support rather than break down or replace traditional coping mechanisms. There were also other means of support, such as fostering, that needed to be supported, politically as well as financially.

The adequacy of employee benefits should also be examined to ensure that the relatives of employees who died were provided for. Finally, South Africans needed to think hard about how they would respond as individuals to AIDS orphans.

Prof Coovadia said there were some positive factors: mother-to-child transmission had largely been resolved, and could be reduced with drug therapy. Also, the country could afford to treat at least some adults who were HIV-positive. However, the biggest hope was prevention, and his worry was that changing people's behaviour in the current social climate would take a long time.

No scientist would recommend that antiretrovirals be administered to all HIV-positive adults. If optimal antiretroviral therapy was given to all infected adults, this would more than double South Africa's current per capita expenditure on health. This was not possible.

- Given the proven link between STDs and HIV and AIDS, was enough being done to combat STDs generally?
- Had any other countries, particularly developing countries, successfully tackled AIDS in a way that South Africa could learn from?
- Was anything being done to try to control the booming commercial sex industry?
- Why was it now thought that HIV/AIDS would not have a major impact on the macro economy?
- None of the speakers had talked about the fact that South Africa had no role models – prominent members of society who were prepared to declare publicly that they had HIV or AIDS. What leadership had the ANC given to infected people to make this more public and therefore less stigmatised?

Dr Kinghorn said there were notable successes, of which Thailand was the most undisputed. However, applying lessons from Thailand to South Africa would be very difficult. Elements of that programme – including a very committed multisectoral leadership – could be applied here. Thailand had a highly systematised and legalised sex work industry, and managed to contain infection levels in that sector. However, beyond it HIV was still spreading because people were still not using condoms in more stable partnerships.

Uganda was also held up as an example of a successful programme. Again, key elements seem to be a highly committed leadership manifesting itself early on and across all sectors of the economy and society. Workplace and community programmes also showed definite results in restricting infection rates.

One of the issues raised by the success in Thailand was how to deal with commercial sex work. Legalising commercial sex work would have to be seriously considered. The industry would not disappear; in fact, the HIV/AIDS epidemic would reinforce pressures on women to become commercial sex workers. Thus a subtle but bold response was needed.

> **"The experience of Uganda and Thailand shows that strong leadership and a simple clear message about preventive measures can deliver results"**

Regarding the macro-economic impact of HIV and AIDS, he said the people most susceptible to infection were in lower-skilled and poorer groups who played a less important role in driving economy growth. Therefore, despite its magnitude, the epidemic would have less of an impact on growth than might initially be expected. Also, despite the toll taken by the disease, enough people of working age would be available to maintain growth, albeit at lower rates.

The underlying message was that using economic growth to measure the seriousness of the epidemic was grossly inadequate; despite the relatively low impact on growth, the epidemic's social impact would be enormous.

Prof Coovadia said the issue of role models was very important; if more people in positions of leadership and respect came forward and said they were HIV-positive, they would give others the confidence and security to say so themselves, and reduce the stigma surrounding the disease.

CDE debates

Concluding remarks by Ann Bernstein, executive director, CDE

This debate has helped to clarify crucial issues surrounding HIV/AIDS. The first is the primacy of prevention. It is clear that, whatever can and must be done to ameliorate the effects of the disease, reducing the infection rate must be the first priority.

While some work has been done to change sexual conduct, these efforts are still far from adequate. If the infection rate continues to rise, the disease will burden our society exponentially to the point of simply overwhelming our social resources.

One of the most important points made in this debate is that any sign of irresolution on the part of government confuses and demoralises people on the ground. The government should learn from the mistakes that have been made and do its utmost from now on to develop a clear policy position and provide firm and unequivocal leadership. The experience of Uganda and Thailand shows that strong leadership and a simple clear message about preventive measures can deliver results.

Government must lead with a simple message that everyone can grasp, even if its strategic planning and policy responses are necessarily more complex.

The government's credibility with respect to its AIDS prevention programme is in serious question. It seems to lurch from one mistake to another – Sarafina 2, the Virodene issue, and now the doubts cast on whether HIV causes AIDS.

Government has to base its prevention programme on the best available medical advice. The world's leading scientists and South Africa's leading medical opinion is clear – HIV causes AIDS. The responsibility of political leaders is to communicate clearly and simply what people must do to prevent the spread of AIDS – wear condoms, change their sexual lifestyles, understand how this disease spreads. Government must campaign vigorously against the myth that sleeping with a virgin (a critical factor promoting rape) will cure AIDS. South African leaders must look at other developing countries where these preventive measures coupled with effective leadership at the very highest level have worked, and learn from these experiences.

It is not appropriate for political leaders to indulge publicly in amateur medical science.

If there are concerns about the nature of AIDS in Africa and its possible difference from the disease elsewhere – questions which are the stuff of scientific debate, clinical tests and peer review – then research into these questions should be discussed and encouraged (in the appropriate fora) with the South African and international scientific community.

When the country is in the grip of a killer epidemic it is highly inappropriate for political leaders to cast public doubt on the best available, tried and tested preventive measures.

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