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Global Health

The Forgotten Crisis

Health Policy in South Africa and Dealing with HIV

Michaela Braun

HIV is one of the most devastating pandemics of our time. South Africa – the country with one fifth of the world's HIV cases – has made some progress. However, that could change, if not as many HIV-positive South Africans as possible are taking antiretroviral medication regularly or if risky behaviour increases and awareness of the problem decreases. First signs for this can be found right now already.

Worldwide, there are 36.9 million people with the Human Immunodeficiency Virus (HIV), and 35.4 million have died of illnesses related to HIV and AIDS.[1] This poses a great challenge to global development policy. HIV/AIDS not only has disastrous consequences for sufferers and affected communities, but also threatens the country's security, development, and political and economic stability.[2] HIV damages the body's own defences by destroying immune cells. If left untreated, HIV becomes Acquired Immunodeficiency Syndrome (AIDS): The body loses its ability to fight off invading bacteria (such as tuberculosis pathogens), fungi, or viruses. The virus is transmitted via various bodily fluids. Unprotected sexual intercourse and blood-to-blood contact (such as infected needles used for drug injections) can transmit the disease, and it may be passed on from mother to child (pregnancy, birth, breastfeeding). HIV is incurable, but it has been treatable since the spread of antiretroviral medications (ARVs). These medications reduce the concentration of the virus in the blood as well as the risk of an HIV infection developing into AIDS. ARVs greatly extend the life expectancy of HIV-positive patients, but may have severe side effects and must be taken for the rest of the patient's life.[3]

The first cases of HIV/AIDS were reported in the early 1980s in the US, Europe and in African countries. By the mid-1980s, the disease had spread to all five continents, whereby eastern and southern Africa had become the epicentre by the late 1990s. Targeted education campaigns and early distribution of condoms and antiretroviral medications among the population achieved a drop in the number of AIDS deaths and new infections in some emerging countries such as Botswana, Namibia, and Brazil between the mid-1990s and the mid-2000s.[4] In the 2016 Sustainable Development Goals, the international community set the goal of completely containing the spread of the pandemic by 2030.[5] This is an ambitious goal because the prevention and treatment of HIV remains a challenge for nations worldwide. The greatest burden is borne by sub-Saharan Africa, where 25.7 million people are HIV-positive.[6] In South Africa alone, which has the highest HIV rate, 20.6 per cent of people between 15 and 49 have contracted HIV. A total of 7.9 million people in South Africa are infected.[7] Around one third of them still have no access to antiretroviral medications, and the number of new infections each year is around 275,000. Each year, between 89,000 and 110,000 people in South Africa die of secondary diseases resulting from HIV and AIDS – secondary tuberculosis (TB) is one of the leading causes of death.[8]

South Africa is among the countries with the highest level of development and per-capita income in Africa and has one of the most advanced health care systems on the continent. So why are infectious diseases, HIV and TB, so widespread there of all places? The article addresses this question by first tracing how HIV spread in South Africa in the past and identifying several factors that played a role. It then turns to the current situation and identifies factors that continue to impede sustainable, comprehensive containment of HIV in South Africa.

Finally, it attempts to provide an outlook on the opportunities and risks associated with combatting HIV/AIDS in South Africa and draws lessons for global efforts at containing HIV.

Handling HIV/AIDS in South Africa in the Past

The Beginnings of the Epidemic

At the beginning of the HIV/AIDS crisis in the 1980s, South Africa was atypical: Although it recorded its first cases of HIV in 1982 and the height of the epidemic reached the country later than in neighbouring countries, the apartheid government, and later the first democratically elected African National Congress (ANC) government after the 1994 elections, took no effective preventative measures until the mid-2000s. This enabled the disease to spread unimpeded.[9] While only 0.73 per cent of the population was infected with HIV in 1990, the rate had risen to 7.57 per cent by 1994.[10] In 2005, the rate was 10.2 per cent and hence affected 4.78 million people.[11]

Several reasons for the early spread of HIV can be attributed to South Africa's difficult initial conditions caused by its history, as shaped by the racially motivated policies of the apartheid system – policies which discriminated against non-white population groups, especially as regards issues pertaining to education and health. South Africa was (and is) also strongly influenced by labour migration.[12] These factors made South Africa especially susceptible to the spread of an infectious disease like HIV. Given that the spread of the epidemic advanced at the same time as the democratic transformation, the South Africa government was fighting a war on two fronts. The first democratically elected government under Nelson Mandela was unable to face the challenge of implementing regulations that might have prevented the outbreak of the epidemic. This was partly because it was dealing with the urgent task of establishing a new, politically stable, non-racist society. The government therefore focused on radical changes to the unjust apartheid system in favour of democracy, which had to be combined with comprehensive administrative and systemic structural changes.

Until as late as 2002, South African politicians denied the link between HIV and AIDS. There was no targeted combatting of the virus.

Government Failures in HIV Policy Under Thabo Mbeki

When the second president after the democratic transition, Thabo Mbeki, took office, the HIV epidemic reached alarming levels owing to a disastrously misguided health policy. Mbeki and his health minister denied that AIDS was caused by HIV and, until 2002, refused to make antiretroviral medications available through the public health sector or to accept international aid funds for that purpose. During this period, there were virtually no scientifically substantiated measures supported by the government for prevention and education in the fight against HIV. The treatments recommended by the government were beetroot, vitamins, and traditional medicine.[13] As a result, between 2000 and 2005, 35,000 newborns were infected by their HIV-positive mothers, 330,000 people died from the consequences of AIDS, millions of children became orphans,[14] and the number of new HIV infections each year rose to 550,000.[15] The high rates of infection and death mean that the epidemic still has a negative impact not only on the individual lives of millions of South Africans, but also on all areas of society. The large number of patients overstrain an already fragile health sector, and the economy has suffered greatly from a shortage of qualified workers.[16]

HIV stigma: Civil society organisations call for a free access to medicine and launch awareness campaigns to combat prejudice. Source: © Finbarr O'Reilly, Reuters.

Initial Successes

The revolution in HIV policy was primarily the result of civil society actors putting pressure on the government. No later than 1998 people knew that giving antiretroviral medications to HIV patients greatly reduced the danger of infection during birth and the breastfeeding of newborns, increased the life expectancy of those infected, and reduced the risk of infection from sexual intercourse. Even though this in itself theoretically provided treatment methods, medications were accessible only via private purchase, and thus unaffordable for the majority of the South African population. Civil society organisations such as the Treatment Action Campaign (TAC) called for free-of-charge access to ARVs via the public health sector, mobilised the public, took legal action against pharmaceutical companies, and obtained a price drop and access to generic ARVs. A lawsuit against the South African government in the Constitutional Court succeeded in making ARVs free-of-charge as of 2002 via the government health sector for especially severe cases, at least at selected locations.[17] Other players who contributed to changing the ANC government's position were the South African media, which denounced government policy, and private companies such as Anglo American, BMW, and Volkswagen, as well as ESKOM, South Africa's public electricity utility, which provided their workers with HIV programmes and antiretroviral medications.[18]

With Mbeki's resignation in 2007, and especially since the first term of the former Minister of Health, Aaron Motsoaledi,[19] South Africa has achieved HIV policy successes since 2009. Today, the country has the world's largest ARV treatment programme that is financed by a public health system. The programme is designed to provide therapy for all those infected with HIV immediately after a positive test result. The government aligns prevention and treatment measures with national five-year plans developed by the South African National AIDS Council (SANAC). The latter consists of representatives from government, the scientific community, NGOs, unions, churches, and the private sector. Over the past ten years, funds provided by the state for HIV programmes have tripled,[20] amounting to a total of 22.1 billion rand in 2016/2017 (about 1.38 billion euros).[21] Yet, these efforts do not suffice when it comes to meeting the complex challenges of the HIV epidemic. To date, there have been no effective strategies for implementing the programme. Systemic political errors, corruption, and inefficient use of funds stymie complete containment and sustainable behavioural changes among the population.

Despite falling rates of new infections, it is likely that South Africa will only achieve the first of the UNAIDS "90-90-90 targets" by 2020.

Current Challenges

South Africa still struggles to reach all HIV-positive individuals and provide them with long-term treatment. Since 2004, the number of HIV- and AIDS-related deaths has fallen by more than half and the number of annual new infections by one third.[22] Nevertheless, South Africa is likely to achieve only the first of the UNAIDS "90-90-90 targets" by 2020.[23] Currently, about 4.4 million people are receiving ARV therapy.[24] However, this only corresponds to some 56 per cent of HIV-positive people in the country. The virus has been suppressed for only about 43 per cent of HIV-positive people.[25] This means that the danger still looms large: The number of people infected with HIV is steadily increasing, and this trend can be traced back to the extended life expectancy provided by ARVs. The risk that these people infect others is contained only if they consistently remain in treatment. However, the treatments of both TB and HIV require a great deal of individual responsibility and discipline on the part of the patient. Many patients fail to demonstrate this. Following an HIV

diagnosis, they do not return for lifelong therapy or fail to take their medication regularly. In turn, TB cases often remain undetected because diagnosis is difficult, and the disease requires treatment lasting from six to 24 months.[26]

People in South Africa still continue to test HIV positive, amounting to 750 a day, and the number of tuberculosis (TB) deaths remains high.[27] The HIV infection rate in certain population groups is especially worrisome: One third of new infections are women between the ages of 15 and 24. Other groups with high rates of HIV include sex workers and non-heterosexuals. Migrants and illegal immigrants, children (especially orphans), and people in informal settlements are considered particularly vulnerable.[28] But what are the reasons for the new infections and gaps in treatment in South Africa?

For several years, the country has seemed to be falling into "HIV fatigue". The media are spreading the message that the danger is almost over.

Factors Sustaining the HIV Epidemic in South Africa

Awareness of the Problem is Fading in the Media and Society

Serious gaps in knowledge about AIDS and the measures taken for protecting oneself against it continue to persist in South Africa. Even among those who are thought to be informed on these matters, perceptions of personal risk seem to have declined. Risky sexual behaviour is becoming increasingly common and is confirmed by the prevalence of unprotected sexual intercourse and the number of teen pregnancies.[29] A sort of "HIV fatigue" appears to have crept in, which has has been reflected in changes to media reporting ever since the government gave in to the pressure exerted from civil society groups. Reports now primarily focus on the successes achieved in containing HIV and the side effects of ARVs, and less on the continued grave danger the epidemic presents, which in turn would further raise awareness among the population.[30]

Social Forces Serve to Drive the Spread of HIV

Another challenge in the fight against HIV is that the problem is not merely a medical one; socioeconomic and cultural factors must be taken into consideration, too. Effecting a change in behaviour is therefore proving to be difficult. The spread of HIV varies greatly depending on age, gender, place of residence, socioeconomic status, level of education, and personal convictions.[31] Studies show that there is a connection between the spread of the epidemic and socioeconomic factors such as poverty and inequality. South Africa has one of the highest levels of inequality worldwide. Forty five per cent of the population live on two dollars per day or less.[32] The effects of this inequality manifest themselves above all in the area of health. Hence, poor and black population groups have especially high rates of infectious diseases such as TB and HIV. The HIV infection rate is highest among the black population (16.6 per cent compared to 5.3 per cent for Coloureds, 0.8 per cent for Indians/Asians, and 1.1 per cent for whites).[33]

Further structural factors and social norms facilitate the spread of HIV, especially in urban townships and rural areas where structures are weak. These factors include abuse of alcohol and drugs, high unemployment, defective family structures, patriarchal role models, and violence. South Africa belongs to the countries with the highest rates of rapes and sexual violence against women. Sexually risky behaviours such as promiscuity and polygamy are also widespread, with former President Jacob Zuma considered to have been an embodiment of this.[34] Sexual relationships involving a great age difference, asymmetrical power relationships, and financial dependency are also common. Thus, young girls are often infected by older men who do not want to use condoms, but upon whose financial support they rely.[35]

Myths about HIV and AIDS Cause Confusion and Impede Education

Like other African countries, South Africa is partially conservative and religious, and belief in traditional medicine is common in remote areas. Numerous myths surround HIV treatment and prevention. Some misperceptions are that sex with virgins can cure AIDS, certain blood types are immune to the virus, and showering after sex can provide protection from HIV (a claim made by former South African President Zuma himself).[36] Those infected continue to be stigmatised. At the same time, some South Africans remain sceptical of antiretroviral medications.[37] The disastrous, contradictory HIV propaganda by government representatives in the past contributed greatly to distrust and confusion and impedes the success of education measures to this day.

The State Health System is Overstrained

The HIV and TB programmes drawn up in the national plan are coordinated by the health agencies in the provinces and predominantly implemented in government facilities at the municipal level and in community centres by non-governmental organisations. They are available to the population free-of-charge. The responsible health personnel largely consist of nurses and community assistants.[38] This means that public facilities provide the backbone for infectious disease containment. But these facilities, like the entire health sector, have for years been the subject of criticism and suffer greatly from the lack of qualified personnel, medications, and technical equipment.[39] Waiting times for patients can be long, and ARVs and contraceptives are often out of stock for months. Both the quality and number of facilities and health personnel varies greatly from one geographical location to another.[40] Studies in South Africa show that some patients are insufficiently educated and sometimes feel that they are mistreated by health personnel.[41] The weaknesses of the state health system impair the success of the programmes aimed at containing infectious diseases as they result in HIV-positive or TB patients dropping out of treatment.[42]

Poor Governance and Inadequate Implementation of Planned Measures Impair HIV Programmes

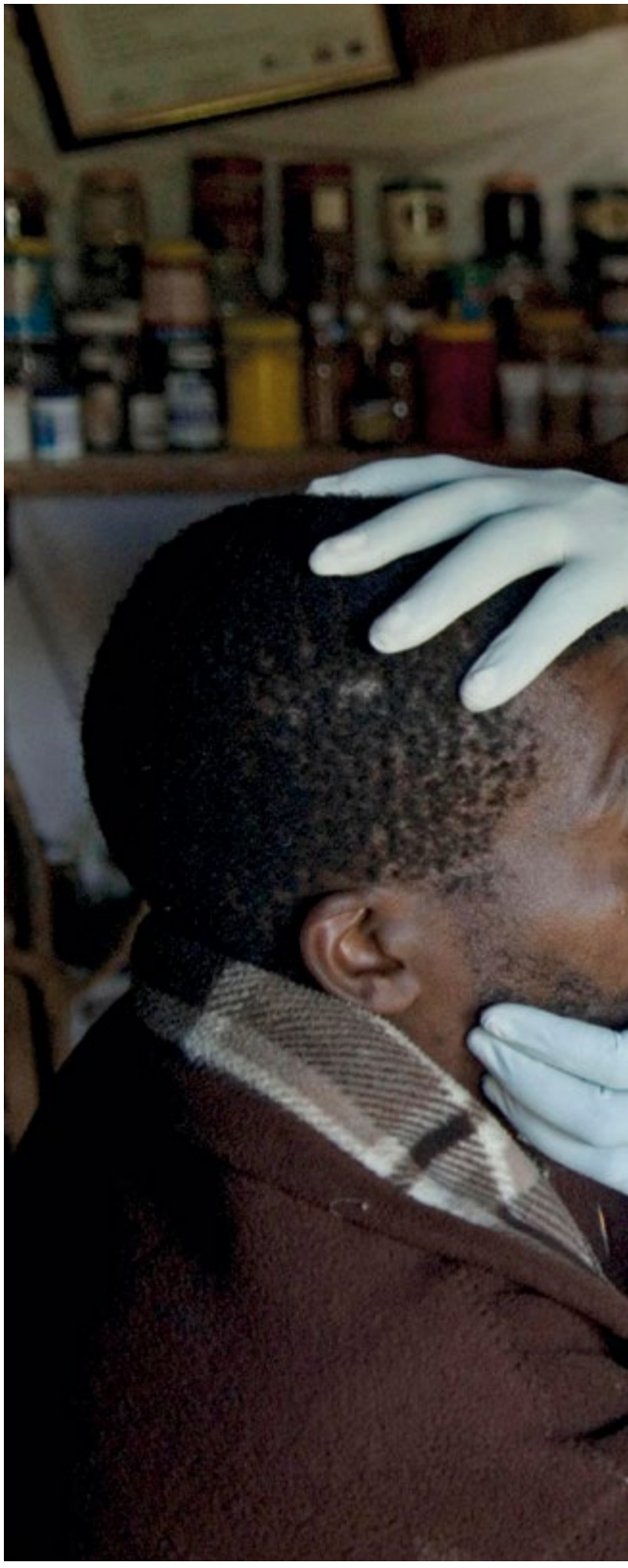
One of the reasons why the HIV epidemic in South Africa has reached this level – and there continue to be gaps in treatment along with a high rate of new infections – is the poor governance by the ANC. While the party has – after consistent AIDS denialism of some government representatives and HIV policy failures – in cooperation with civil society developed good measures and laws for combatting HIV, these measures have not been efficiently implemented to date.[43] The government still fails to strengthen the public health system as the basis for effective HIV programme implementation through sufficient budgets, personnel, and infrastructure.[44]

One reason for this is poor budgeting and financial planning: The government earmarks 12.19 per cent of its budget for health,[45] and per capita expenses in the area of health are above WHO targets for emerging countries.[46] Nevertheless, the government health sector exhibits major shortcomings; there has so far been no effective reform, and the budget is not sufficient to employ enough qualified personnel or ensure adequate equipment. To achieve better results, the government ought to invest existing funds more efficiently. This brings us to a second factor that limits ANC government successes: The years under President Zuma in particular witnessed cases of corruption and political patronage within the governing party that reached record levels. Tax revenues earmarked for such items as HIV programmes were instead used for the personal gain of party leaders and allied businesses. This nepotism infiltrated the health sector as well: The public health system was systematically undermined and this, in turn, had a direct impact on the success of HIV and TB programmes.[47] Ongoing inadequate planning and coordination among national, provincial, and municipal governments and among ministries and agencies, along with inconsistent implementation of guidelines and procedures, contributed towards the failure to achieve the targets under

the national strategic plan.[48] Thus, systemic obstacles in the form of inefficiency, corruption, and mismanagement that are present in several areas of South African politics continue to hamper sustainable, significant developmental progress.

Outlook for South Africa

The future of HIV containment in South Africa depends on good governance and clear action to counter corruption. In this area, health policy is a good proxy for the generally deficient ANC governance. It is not enough for the government to ensure that funds for HIV programmes are used for the originally intended purpose. Coordination among individual government and administration levels and consistent implementation of monitoring and theoretically good policy measures are also necessary. However, capacity for such improvement is insufficient, especially at the province and district level. SANAC, the multi-sector national institution tasked with designing HIV programmes, could cooperate efficiently if structures in the provinces were improved.[49] International development cooperation could contribute to enhancing local governments and administration, planning, and budgeting. Active involvement by civil society and the media will remain necessary to hold government officials to account for mismanagement and to ensure that HIV remains high on the agenda. Opportunities are afforded by measures such as promoting greater exchange between the public and private health sectors and reforming the health system.[50] Challenges will include continuing fast-paced urbanisation and the many migrants and illegal immigrants, who can participate free-of-charge in South African treatment programmes, and hence



HIV myths: The belief in traditional medicine in South Africa is widespread. Myths continue to surround HIV treatment and prevention, for instance that sex with virgins could cure AIDS. Source: © Rogan Ward, Reuters.

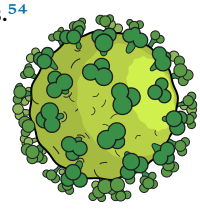
place an additional strain on health facilities, particularly in metropolitan areas.[51] To further reduce dependency on international aid funding in the future, South Africa will need to find other ways of increasingly funding its programmes from domestic sources and spending the money more efficiently.

Lessons from South Africa for the Global Fight Against HIV

To halt the spread of HIV, as many HIV-positive people as possible must receive a diagnosis and undergo permanent treatment. There must also be comprehensive education on the issue. The South African example can provide lessons for combatting HIV that may be useful in the global development policy context.

Containment of HIV Is a Responsibility that all of Society Must Bear

The delayed establishment of medical treatment for HIV sufferers is one of the main failures of South African AIDS policy. However, especially in the last ten years, South Africa has initiated promising projects. Among them are participatory development of national strategic plans by the government and a panel of experts based on insights from international scientific research. The approach of engaging civil organisations and HIV sufferers as assistants and involving local communities directly in the implementation of HIV programmes also has potential. It should result in contact with previously unreached individuals, and follow-up aims to ensure continued treatment and ultimately to eliminate taboos.[52] To achieve permanent gains, such plans need to be coupled with concrete implementation strategies and assignment of responsibility at all levels of government and agencies.[53] There must be sufficient financing for all government facilities to be supplied with antiretroviral medications, means of prevention, technical equipment, and trained personnel, as well as sufficient capacity to document, follow up, and monitor HIV cases.[54]



HIV Programmes Suited to the Target Group, Along with Supporting Measures, Promote Changed Behaviour

Permanent containment and changed behaviour requires a combination of measures that address the socioeconomic context in which the disease spreads. Macroeconomic, health, and social policy strategies must target poverty, access to health care, and education about what constitutes a healthy lifestyle. They must also include interventions combatting violence, deconstructing patriarchal ideals of masculinity, and tackling discrimination against infected individuals. One important task for international efforts is to address those who have not yet been reached, along with populations and groups considered to be particularly vulnerable. It is also necessary to change behavioural patterns that make the spread of HIV in societies more likely.[55]

Prevention campaigns are most effective when they successfully communicate to these individuals how an infection with HIV will affect their own lives and make preventative measures such as male and female condoms and Pre-Exposure Prophylaxis (PreP) and microbicides (such as preventative antiretroviral vaginal gel), accessible free-of-charge in as many areas as possible. Voluntary, medically correct male circumcisions, which significantly reduce the risk of HIV transmission during sexual intercourse for both men and women, should be offered free-of-charge by the government health system. Every person must be able to obtain information about HIV at little cost or effort. Programmes must be appropriately directed to target groups, and education needs to use suitable communication channels.

Test, advice, and treatment offers will reach more people if they are integrated into everyday locations; these include the workplace, local health centres, and recreation facilities, as well as automated medication dispensing, telephone, online-based advice centres and apps. The linking of various programmes (HIV programme and mother-child preventative care as part of standard preventative examinations, co-diagnoses of

TB and HIV, sex education and socialisation with respect to gender roles at schools), may lead to a higher usage rate and more efficient resource deployment.[56]

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