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### The Starfish Principle: Drawing Purpose From South Africa's AIDS Crisis

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Wandering towards the field hockey fields to meet my hosts and experience men's field hockey for the first time, I measured my expectations of South Africa against what I saw. Although my research had taught me not to expect lions or half-naked bush men to lurk in the bushes on the grounds of the Christian primary school, Trinity House, I saw no evidence of the poverty and misery that AIDS had supposedly inflicted on nearly six million of the country's roughly fifty-five million inhabitants.<sup>1</sup> What buildings and neighborhoods that did poke out above the high security walls of the campus betrayed the affluence on the other side. The plaid and polo combination so characteristic of private schools in the United States were echoed in the uniforms of the students I saw. The parents and students themselves were mostly white, friendly, and spoke with, what seemed to ignorant ears, a funny Australian-British hybrid accent, littered with charming phrases like "It's a pleasure," and "Yah-yah."

My hosts told me it was an uncharacteristically warm winter day, but I found it hard to believe there was such a thing as an African winter day. Perhaps I was just cranky and jet-lagged from the 10,000 mile journey to get to South Africa that had ended only very late the night before. So far my long plane ride seemed to bring me almost back to where I started, and when my host motioned for me to follow her to the car, I momentarily wondered if my trip would be the grand, life-changing adventure I had been picturing for months.

The drive to the orphanage was punctuated by the fast-paced and friendly chirping of my host who dutifully and thoughtfully briefed me about the background of Thandanani Orphanage. Leaving the gated and sheltered safety of the campus, I felt a

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<sup>1</sup> UNAIDS, "South Africa," [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007).

twinge of guilt and disgust with my initial disappointments. Within a few short minutes in the car, the impressive mansions and imposing high walls melted away. Trash littered the roads; and informal tents lined the streets full of various used, found, or stolen merchandise.

With one more right turn, the car bumped and jerked slowly along a pothole-ridden dirt road. My heart sank to my stomach, and every fact I had read in every book I had found came rushing back, nearly overwhelming me. To my right I saw tin and wooden shacks stretching out all along the road as far as I could see. It was a squatter camp or, in its more polite term, an informal settlement. This patch of earth constituted perhaps thousands of

people's last resort.

With no money, no jobs, and no where to go, the poorest of the poor huddle together in communities forged of nothing but scrap metal, trash,



and desperation. Not surprisingly, these informal settlements are huge breeding grounds for the spread of AIDS.<sup>2</sup> Education, opportunity, and stable families are nearly nonexistent as these settlements signify the overwhelming and seemingly hopeless situation faced by the government and anyone else wanting to affect change.

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<sup>2</sup> Karen Cosh, interviewed by author, Johannesburg, South Africa, May 19, 2007.

Then, I turned to my left. Literally on the other side of the road stood a modest, but proud two story home surrounded by a tall wire fence. This was the Thandanani Orphanage. Like perhaps hundreds of the children on the right side of the road, the children living in Thandanani have no living parent. Although the social workers are prohibited by law from disclosing which children were orphaned as the result of AIDS due to the still prevalent stigma surrounding the label, I was given the impression that most of the children live at Thandanani because of the epidemic. Thus, the background stories of the children on both sides of the road reflect one another. Yet, by the very nature of the side of the road that the Thandanani orphans live on, they have been provided an opportunity to beat the odds and succeed where most in their position never



get the chance. Through donations and volunteerism, the orphans are sent to various schools according to their age and availability of space. They are fed, clothed, and sheltered in what is considered to be above-level housing with well-qualified social workers.<sup>3</sup>

Before even entering the building, I took one more look at the squatter camp across the street and then gazed at the symbol of hope that stood before me. I had come to South Africa in

search of a group, organization, or person whose story I could bring back home and use to forge a connection between Americans and the seemingly incomprehensible, hopeless, and overwhelming situation faced by the people of South Africa from the AIDS

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<sup>3</sup> Kholi. interviewed by author, Johannesburg, South Africa, May 19, 2007.

epidemic. The epidemic in South Africa is among the worst in the world as more people live with AIDS there than in any other country.<sup>4</sup> No magic pill or amount of foreign aid will quickly and neatly shore up decades of social, political, economic, and psychological underpinnings that have paved the way for the epidemic's hold on the country. Yet, here stood a building and people working to affect change in the lives of nineteen orphaned children, part of the future generation of the nation. Small steps, enduring acts of generosity and kindness, relentless hope, these are the things that can save South Africa. I smiled to myself as I walked through the entry way and shook hands with the social workers. On my very first day, I had found my starfish.

One day a man was walking along the beach when he noticed a figure in the distance. As he got closer, he realized the figure was that of a little boy picking something up and gently throwing it into the ocean. Approaching the boy, he asked, "What are you doing?" The boy replied, "I'm saving the starfish. The sun is up and the tide is going out. If I don't throw them back, they'll die." "Son," the man said, "don't you realize there are miles and miles of beach and hundreds of thousands of starfish? There are too many. You can't possibly make a difference!" After listening politely, the boy bent down, picked up another starfish and threw it into the surf. Then, smiling at the man, he said, "I just made a difference for that one."<sup>5</sup>

Prior to my trip, I had always been struck by the gulf that seems to separate developed, first world countries like the United States from the issues and struggles faced by less developed nations. One can hardly turn on the news without seeing images of crying babies, bombed out villages, and useless carnage. Yet, because an ocean separates us from the devastation, we have the luxury of saying, "Gosh, that's really terrible," switching the channel, and eating our dinner without so much as a guilty conscience.

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<sup>4</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century: Disease and Globalization*, (New York: Palgrave MacMillan, 2006), 10.

<sup>5</sup> Loren Eiseley, "The Star Thrower," New York: Time Books, 1979, quoted in Center for Special Studies: New York Presbyterian Hospital, "The Starfish Project," <http://www.thestarfishproject.org> (accessed January 28, 2008).

Because we cannot relate to the plight of the people whose images we see nearly every day, we have a tendency to dismiss it. I think this comes from a failure to connect with the fact that real living, breathing, people are behind those images; people that, I have found, are not so different in a lot of striking ways.

Another problem is the sheer magnitude of the issue. AIDS afflicts far more people in Sub-Saharan Africa than anywhere else in the world. Nearly six-times as many people are infected in South Africa than in the United States, although it has roughly one-sixth the population.<sup>6</sup> Major social, historical, economic, and psychological obstacles stand in the way of eradicating the far-reaching and encompassing nature of the disease. At once, the problem can seem almost too big to tackle, too much to take.

Yet, the size of the issue should not translate into an excuse for indifference. The story of AIDS and South Africa is more than just a story of how six million people currently live with a fatal disease that has no cure. It is nearly fifty-five million stories of fifty-five million individuals who are profoundly affected by the epidemic every day. True, a group or community cannot realistically hope to significantly affect the lives of fifty-five million people, but they certainly can improve the chance for success for nineteen mostly AIDS orphans at Thandanani orphanage.

The story of AIDS and South Africa will not draw to a close for the foreseeable future, but by taking that walk down the beach when everyone else is content sunning themselves on their towels, we at least have a chance of making a difference to a few very special starfish.

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<sup>6</sup> UNAIDS, "South Africa," [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007); UNAIDS, "United States," [http://www.unaids.org/en/CountryResponses/Countries/united\\_states.asp](http://www.unaids.org/en/CountryResponses/Countries/united_states.asp) (accessed December 9, 2007).



## Apartheid Era Policies from 1982-1994

The AIDS epidemic in South Africa is profoundly shaped by the historical context of the country, most specifically the legacy of apartheid. Without an understanding of the influence of apartheid on not only the progression of the disease specifically, but also its impact on social, political, cultural, and economic realities broadly, one cannot fully grasp the nature of an epidemic that infects approximately 1700 people every day, or the obstacles that remain to combating AIDS in the future.<sup>7</sup>

Like most African countries, the region that eventually became South Africa was colonized by the English and the Dutch during the seventeenth century.<sup>8</sup> The English came to dominate the Dutch colonists, who eventually established the new republics of Orange Free State and Transvaal.<sup>9</sup> In the 1880s, diamonds were discovered and the English invaded the Dutch colonies, sparking the Boer War.<sup>10</sup> Following the end of the war and independence from Britain, both groups shared power until the 1940s, when the Afrikaner National Party merged with the HNP and became the National Party. They gained a strong enough majority that they officially took power as the majority party in government.<sup>11</sup>

In 1948, with the National Party as the ruling majority, the first enactment of apartheid laws institutionalized racial discrimination. Apartheid laws were an extreme version of the segregation laws of the United States at this time. Whites and non-Whites were not allowed to marry with the Prohibition of Mixed Marriages Act of 1948, and

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<sup>7</sup> Helen Epstein, *The Invisible Cure: Africa, the West, and the Fight Against AIDS* (New York: Farrar, Straus, and Giroux, 2007), 106.

<sup>8</sup> Leonard Thompson, *A History of South Africa* (New Haven: Yale University Press, 2001), 33.

<sup>9</sup> Thompson, *A History of South Africa*, 102.

<sup>10</sup> Thompson, *A History of South Africa*, 144.

<sup>11</sup> Thompson, *A History of South Africa*, 187.

many jobs were available by law only to white people. Citizens were classified as white, black, or colored (mixed descent),<sup>12</sup> and black people were required to carry “pass-books” with fingerprints, photo identification, and personal information to travel to non-black areas of the country.<sup>13</sup>

Some of the most significant legislation affecting the course of the AIDS epidemic involved the relocation of over three million blacks and the establishment of Homelands. By the 1960s, ‘Grand Apartheid’ had evolved from its basic foundations and culminated in the Bantu Homelands Citizens Act of 1970, which designated territories called Homelands supposedly based on race or tribe where various African “nations” were in some cases forcibly moved. The government claimed that in its Homeland an African “nation” would “...develop along its own lines’ while all its rights were denied in the rest of the country.”<sup>14</sup>

The government tried to force as many Africans as possible into the designated territories. This was done along ethnic lines, which had not strongly dictated the social structure of the black people since colonization. Thus, entire groups of people left behind their homes to live in Homelands they had never seen, with people to whom they had no strong ties. The government packed black Africans into the territories so tightly that, by 1980 in the Sotho Homeland QwaQwa, 157,620 Africans survived on a paltry 239 square miles.<sup>15</sup> So poorly managed and grossly underdeveloped due to a prohibition on white

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<sup>12</sup> Thompson, *A History of South Africa*, 190-191.

<sup>13</sup> United Nations, “Human Rights: Historical Images of Apartheid in South Africa,” <http://www.un.org/av/photo/subjects/apartheid.htm> (accessed November 28, 2007)

<sup>14</sup> Thompson, *A History of South Africa*, 191.

<sup>15</sup> Thompson, *A History of South Africa*, 193-194.

investment by the government, the Homelands "...remained economic backwaters" while the rest of the South African economy flourished during the 1950's and 1960's.<sup>16</sup>

During the height of apartheid, other representative bodies of black people, such as the African National Congress (ANC) and Pan Africanist Congress (PAC), were outlawed as the country declared itself a republic no longer subject to the British Commonwealth. At this time, Nelson Mandela and other ANC and PAC leaders were imprisoned for speaking against the government. The apartheid government also took various steps to prevent black people from achieving any real economic success through such laws as Natives Laws Amendment Act of 1952, which narrowed the definition in which black people could have a guaranteed residence in a town or city. Thus, just before the outbreak of AIDS in 1980, the distribution of wealth in South Africa was such that the top ten percent of the population had fifty-eight percent of the wealth, while the lowest forty percent controlled only six percent.<sup>17</sup>

Perhaps the most openly racist law of all, the Bantu Education Act, Act No 47 of 1953, provided for a specific black-tailored education program that was designed to keep blacks from aspiring to positions in society and government that they would never hold.<sup>18</sup> At the same time, the government consistently spent ten times as much per capita on white school children as on Africans, and African classes were often more than twice as large as white ones. Thus, although black children outnumbered white children five to one in South Africa, only 12,014 black students passed their matriculation exam (similar

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<sup>16</sup> Thompson, *A History of South Africa*, 191.

<sup>17</sup> Stanford University, "The History of Apartheid in South Africa," <http://www-cs-students.stanford.edu/~cale/cs201/apartheid.hist.html> (accessed November 12, 2007).

<sup>18</sup> The New York Times Company, "Apartheid Legislation in South Africa," <http://africanhistory.about.com/library/bl/blsalaws.htm> (accessed November 14, 2007).

to an exit exam for high school) in 1978, while over three times as many white children did.<sup>19</sup>

Finally, in the 1970's and 1980's the foundations of apartheid began to weaken. Increasing international pressure in the form of sanctions and isolation combined with economic woes forced the government to make some concessions. Moreover, for the first time there was significant migration of whites out of South Africa due to falling GDP, (which was exacerbated by the much faster increase of the black population compared to the white population). This in turn caused a corresponding slump in much-needed professional sectors.<sup>20</sup> Meanwhile, the client rulers of the Homelands were such poor managers of the areas that they needed continual support and funding from the central government. Finally, the postwar African world was no longer controlled by Europeans, but native blacks, thus making South Africa a continental anomaly.<sup>21</sup>

The UN Security Council imposed a mandatory embargo on the supply of arms to the country, and the U.S. Congress passed the Comprehensive Anti-Apartheid Act, thus illustrating the international pressure on South Africa to end apartheid.<sup>22</sup> A tri-cameral parliament was created in 1983, and the Pass Laws requiring identification for blacks to enter white-only areas was abolished in 1986.<sup>23</sup> In 1984, a new constitution gave Asians and Coloreds, but not blacks, limited participation in the central government. The divided Afrikaners thought that making some calculated concessions to blacks would bring them back into the world fold and reduce the country's isolation from its European

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<sup>19</sup> Thompson, *A History of South Africa*, 196.

<sup>20</sup> Thompson, *A History of South Africa*, 242.

<sup>21</sup> Thompson, *A History of South Africa*, 222.

<sup>22</sup> South Africa To, "Apartheid South Africa," <http://www.southafrica.to/history/Apartheid/apartheid.htm>.

<sup>23</sup> "Apartheid," *Encyclopædia Britannica* 2008. *Encyclopædia Britannica Online*. 10 Feb. 2008 <http://www.britannica.com/eb/article-9007978>.

and North American brethren.<sup>24</sup> Yet, this was also the time of the greatest political violence in the nation's history as 250,000 miners went on strike in 1987 to protest the abhorrent conditions of the mines and migrant work in general. For nearly ten years, violent conflict erupted periodically between Zulu supporters of Inkatha and the ANC and KwaZulu and on the Witwaterand.<sup>25</sup>

While apartheid was beginning to crumble, however, its effects had already led to the decrease in intellectual growth among blacks, as well as fostered a psychology of inferiority-superiority among whites and blacks. The forced migration to diamond mines undermined the familial structure of black families and promoted prostitution, as fathers and husbands spent many months away from their wives. Family life was increasingly disorganized and undermined due to the migratory labor system. Essentially, the forced societal structure created by apartheid legislation provided a "...rich societal Petri dish in which HIV and AIDS could flourish..."<sup>26</sup>

Thus, when the first case of AIDS was recorded in 1981 and almost no definitive knowledge about the disease existed, the social cohesion that could have combated it did not exist within the society. Furthermore, the various biomedical, economic, societal, and political elements existing within the country during the onset of AIDS as a worldwide phenomenon provided the ideal environment for the spread of the epidemic. South Africa, then, is a society with historical and legal factors that have entrenched susceptibility into its populace.<sup>27</sup>

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<sup>24</sup> Thompson, *A History of South Africa*, 229.

<sup>25</sup> Thompson, *A History of South Africa*, 232.

<sup>26</sup> Pieter Fourie, *The Political Management of HIV and AIDS in South Africa: One Burden Too Many?* (New York: Palgrave MacMillan, 2006), 151.

<sup>27</sup> Liz Walker, Graeme Reid, and Morna Cornell, *Waiting to Happen: HIV/AIDS in South Africa [the bigger picture]*, (London: Lynne Rienner Publishers, 2004), 20.

From a biomedical standpoint, although the first AIDS death was due to homosexual transmission, early on the South African variety was identified as clade C, a heterosexually transmitted strand of HIV.<sup>28</sup> In addition, the prevalence of many other so-called opportunistic infections like tuberculosis, or STDs in South Africa during the 1980s (and today), provided an environment for the infection to spread more easily.<sup>29</sup>

Economically, the apartheid laws left millions of blacks poor and often undernourished (another avenue by which HIV can more easily be transmitted). The poor who have TB or an STD for example, also do not have the resources to seek treatment for their conditions; thus the biomedical risk factors cannot be mediated.<sup>30</sup> The unequal distribution of healthcare resources during apartheid already meant that a black baby was thirteen times more likely to die than a white baby and that, while whites enjoyed an equal life expectancy of North Americans and Europeans, blacks could expect to live no longer than any of their African counterparts.<sup>31</sup>

The patriarchal society of the country during this time combined with the migratory nature of work meant women were at a severe disadvantage in sexual relationships. The incidence of rape of women in South Africa continues to be among the highest in the world with one study showing an estimated 1,000 occur every day.<sup>32</sup> Women could not control their own sexual lives and had no power to prevent adultery by the male or refuse sex. Thus, when the males went off to the mines and lived in single-sex hostels, they often freely slept with prostitutes, another prime place for the spread of

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<sup>28</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 52.

<sup>29</sup> S. S. Abdool Karim and Q. Abdool Karim, *HIV/AIDS in South Africa*, 433.

<sup>30</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 53.

<sup>31</sup> Thompson, *A History of South Africa*, 203.

<sup>32</sup> Mark Cichocki, "HIV Around the World – South Africa," [http://aids.about.com/od/clinicaltrials/a/safrica\\_2.hm](http://aids.about.com/od/clinicaltrials/a/safrica_2.hm) (accessed January 12, 2008).

a sexually transmitted disease.<sup>33</sup>

The South Africa of the 1980's was continually on the brink of civil war and experienced intense violence throughout the decade as the government repeatedly attacked neighboring states and destabilizing the region. The movement of troops, refugees, and peace-keepers in and out of the region probably also increased the spread of the disease.<sup>34</sup>

The government's response during the 1980s can be characterized as almost indifferent. Initially, the government took the position that the disease was the result of unacceptable immoral behavior and those who contracted the disease essentially deserved what they got. They pointed to homosexuals, sex workers, and drug users as outcasts and deviants of society rather than examining their own role in the spread of the disease. Furthermore, the first fatalities in South Africa were gay, white men; thus, the black community did not see the disease as relevant to their culture. They were safe.<sup>35</sup>

By the late 1980s it became clear that the disease in the country had taken a distinctively heterosexual turn. Still clinging to the morality argument, much of society, especially white society, now characterized the disease in terms of the immorality, ignorance, and animal-like sexual promiscuity of blacks. The stigmatization of the disease and the subject of sex made openly discussing the disease, distributing information, or finding a way to curb or stop the spread of it almost impossible. Since the government still blamed the person for his or her HIV status, it did not feel the need to provide care for the person, but only to try to discourage the spread of infection by

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<sup>33</sup> Liz Walker, Graeme Reid, and Morna Cornell, *Waiting to Happen*, 26-29.

<sup>34</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 56.

<sup>35</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 58-59.

appealing to morality.<sup>36</sup> The government even passed legislation in 1987 allowing medical officers of health to instruct a suspected infected person that he or she had to submit to a medical exam and place the person in quarantine until “free of the infection.” This legislation was eventually amended in the early 1990’s.<sup>37</sup> If it had been allowed to continue as it was, it could have stimulated perhaps the most significant discrimination against a people group in the country, even outstripping racism.<sup>38</sup>

The black population itself was confronted with explaining the disease as it had been initially categorized as a “white, gay problem.” The generations of mistrust of whites often led blacks to conclude that the message of abstinence or reduced promiscuity was really a white ploy to reduce black birthrates. Condoms, if they were mentioned at all, were looked on scornfully and hesitantly as a vehicle for negating manhood.<sup>39</sup>

The mixed signals and insufficient information about HIV and AIDS given by the government during this time compounded the problem still further. For example, governmental personnel were using homophobic language to describe who contracts the disease as late as the mid 1980s, and the passage of the Human Tissue Act (1983) further cemented this stigma by excluding such people as homosexuals from donating blood.<sup>40</sup> The government was also very slow to commence antenatal clinic surveys to determine the infection rate, only first doing so in 1990, and eight years after the first case.<sup>41</sup> South African medical agencies also placed a very low priority on developing demographic

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<sup>36</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 61.

<sup>37</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 88.

<sup>38</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 95.

<sup>39</sup> Liz Walker, Graeme Reid, Morna Cornell, *Waiting to Happen*, 57.

<sup>40</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 88.

<sup>41</sup> Nicoli Nattrass, *The Moral Economy of AIDS in South Africa*, (Cambridge: Cambridge University Press, 2004), 41.



models of who would be affected by the ensuing epidemic. This attitude only shifted gradually as the apartheid government realized it was going to lose power and needed to address not just the higher-class white segment of the population, but also the long-ignored, poor, black population. Thus, there was eventually a shift to emphasis on primary health care which could aid poorer communities and quality information about what people could do to prevent the spread of the disease.<sup>42</sup>

### **Mandela Presidency: 1994-1999**

The decade of the 1990's saw the culmination of the end of the struggle against apartheid with the release of Nelson Mandela by President F.W. de Klerk after twenty-seven years in prison. F. W. de Klerk then helped repeal what remained of apartheid law.<sup>43</sup> An all-white referendum in 1992 even approved of the negotiation between ANC leaders and the government to form a new constitution.<sup>44</sup> October, 1993, saw de Klerk and Mandela sharing the Nobel Peace Prize for ending apartheid and bringing true democracy to South Africa. This was finally achieved in April of 1994 when the first truly free elections in the nation's history elected the African National Congress (ANC) to an overwhelming majority. Nelson Mandela became president, foreign nations lifted their sanctions, and South Africa rejoined the British Commonwealth.<sup>45</sup>

The story of racial tension and inequality did not end in April of 1994. The hope and optimism that all of the country's problems would quickly and simply be solved quickly gave way to disillusionment about democracy and freedom. The long-oppressed

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<sup>42</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 93-95.

<sup>43</sup> Thompson, *A History of South Africa*, 242-244.

<sup>44</sup> Stanford University, "The History of Apartheid in South Africa," <http://www-cs-students.stanford.edu/~cale/cs201/apartheid.hist.html> (accessed November 12, 2007).

<sup>45</sup> "Apartheid," Encyclopædia Britannica 2008. Encyclopædia Britannica Online. 10 Feb. 2008 <http://www.britannica.com/eb/article-9007978>.

blacks learned that economic inequalities could not be wiped out over night, and the immense education gap that the apartheid laws created made in extremely difficult for the government to find qualified black citizens for an integrated governmental bureaucracy. The government simply promised more than it could realistically give with its limited budget and sometimes overwhelming internal problems.<sup>46</sup>

For example, in 1994 the government had to contend with annual murder rate of ninety-eight murders per one-hundred-thousand people, which was over six times higher than the next closest Western country, the Netherlands, and nearly ten times as high as the United States.<sup>47</sup> The abysmal educational facilities for black students at all levels of schooling also posed a problem for the new government as it tried to raise school attendance, promote increased graduation rates and skilled employment for blacks.<sup>48</sup> In addition, the government proclaimed the return of land to more than one million displaced individuals, but by 1999, only 231 people had received their grants.<sup>49</sup> Clearly, the Mandela Administration had several imposing obstacles to overcome when the apartheid era officially ended without the overwhelming issues posed by AIDS.

While the public was disillusioned with the progress of the new government in general, many scholars today believe that the inability of the Mandela government to adequately and directly address the growing problem of AIDS in South Africa during the early and mid 1990s probably contributed to the soaring rates today.<sup>50</sup> Of course the new government had many other issues facing it besides AIDS, and in a country where much ignorance and stigma still surrounds the disease, Mandela would have had a difficult time

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<sup>46</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 106.

<sup>47</sup> Thompson, *A History of South Africa*, 267.

<sup>48</sup> Thompson, *A History of South Africa*, 279.

<sup>49</sup> Thompson, *A History of South Africa*, 283.

<sup>50</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 137.

addressing the issue and still getting any of his other measures accomplished. While many scientists were warning the government at that time that the rates of infection were about to skyrocket, it simply did not have the resources or political capital to tackle the problem. In fact, today Mandela credits his reluctance to address the growing AIDS epidemic as one of his biggest regrets while in office and does more to spread information and contribute to combating the disease than he ever did while president.

His first policy initiative related to AIDS was the National AIDS Plan (NAP) of 1994. By now there had been a shift away from emphasizing the epidemic as a health policy problem to a need to embrace a more human rights-centered outlook.<sup>51</sup> Unfortunately, by the time Mandela left office in 1999, the NAP had failed horribly in attaining any of its goals. It did not achieve its primary goal of reducing infection rates or AIDS-related morbidity and mortality. In fact, HIV prevalence among women at antenatal clinic more than tripled from 7.6 percent in 1994 to 24.5 percent in 2000.<sup>52</sup>

What, then, was wrong with the NAP? On paper the initiative contained everything recommended by the World Health Organization and other NGOs related to AIDS. It was also exceedingly politically correct and socially appropriate and included provisions for education and prevention, counseling, health care, human rights and law reform, welfare, and research. The failure of the NAP was really a failure of logistics. The new government did not have the infrastructure, level of qualified personnel, or resources to implement what the policy initiative called for. The NAP was just not realistic for the condition of the country.<sup>53</sup>

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<sup>51</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 107.

<sup>52</sup> S. S. Abdool Karim, and Q. Abdool Karim, eds., *HIV/AIDS in South Africa* (Cambridge: Cambridge University Press, 2005)

<sup>53</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 111.

As the harsh realities of running a new democracy set in for the ANC and Mandela, the issue of AIDS took a backseat to other policy issues for the president and it was basically handed over to the Department of Health. The issue was no longer as important or as powerful since the president himself was not directly addressing it. This further undermined the goals of the NAP and eventually drove a wedge between the government, which still insisted on focusing on prevention, and public groups who demanded treatment options. Most ironically, despite the obvious failings of the NAP, it was never officially amended or replaced by another program.<sup>54</sup>

By 1996 Mandela's government needed a new platform for addressing AIDS. From this necessity came perhaps the greatest gaff in Mandela's entire presidency, the distribution of the movie *Sarafina II*. Modeled on the original anti-apartheid play of the 1980s, it was used to inform young people about the risks and danger of HIV and AIDS.<sup>55</sup> Unfortunately, at a cost of one-fifth of the national budget, it seemed to illustrate a national government and AIDS policy that was extremely out of touch with its audience.<sup>56</sup> It drained the national budget, and its contents fell well short of appealing to young people in the first place. Public advocacy groups erupted at what they perceived to be governmental waste on such projects when the money could go towards treatment or more effective prevention programs. Not surprisingly, the controversy left a significant mark on the new democracy.<sup>57</sup>

The Virodene scandal struck another blow to public perception of the government's commitment to tackling the AIDS crisis. The drug, marketed as a miracle

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<sup>54</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 145.

<sup>55</sup> S. S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 278.

<sup>56</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 123

<sup>57</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 317.

AIDS cure and developed by three scientists from Pretoria, was supported by many senior politicians before definitive testing could confirm the drug's effectiveness. The international scientific community, as well as many fellow South African researchers, soon questioned the legitimacy of the new drug. Tests found that it contained toxic levels of an industrial solvent, dimethylformamide, which could cause serious liver damage and cancer, hardly a viable AIDS treatment.<sup>58</sup> Worse still, it was uncovered that the supporting politicians were given or bought shares of Virodene stock. The government's action in bypassing standard medical research to find quick fix miracle solutions further eroded public and civil confidence in the government's ability to handle the problem, especially since the Deputy President, Thabo Mbeki, had been one of the loudest proponents of the drug initially.<sup>59</sup>

A third misstep by the Mandela administration occurred in 1998 when it was announced that the government would not provide Azidothymidine (AZT) to HIV-positive pregnant women. This was a profoundly significant announcement as AZT had been proven effective in reducing mother-to-child transmission in many clinical trials.<sup>60</sup> Thus, the decision was counter to the spirit of the National AIDS Plan and directly contradicted established scientific data. While the government claimed that the distribution of the drugs was not cost-effective, economists demonstrated that it was more than doable within the budgetary constraints of the government and could save the government millions of dollars as less infections would mean less medical bills and long-

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<sup>58</sup> Miriam Mannak, "South Africa: A National Health Controversy Takes on Regional Dimensions," Inter Press News Service Agency, September 27, 2007.

<sup>59</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 139.

<sup>60</sup> S. S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 471.

term care for those infected by the disease.<sup>61</sup> The Health Department then claimed the drugs were potentially toxic, a curious departure from their willingness to accept Virodene without much scientific proof of its safeness for patients.<sup>62</sup>

By October of 1998, just months before the end of his presidency, Mandela arranged for Thabo Mbeki to speak about a new initiative, the Government AIDS Action Plan, before the entire nation. His wooden performance was a public relations disaster, and the fact that Mandela did not attend perpetuated the administration's image as not placing AIDS very high up on the government's priority list. Public advocacy groups emerged as the opponent of the central government, a fact that was cemented in April of 1999 when the government announced it was going to make HIV and AIDS notifiable medical conditions.<sup>63</sup>

### **Mbeki Presidency 1999-present**

When Thabo Mbeki came to power in 1999, the ANC had increased its share of the electorate from 62 percent to 66 percent, and the AIDS problem had truly become an epidemic.<sup>64</sup> In 2001 360,000 AIDS-related deaths occurred, and by 2002, 4.5 million people were living with the disease in South Africa.<sup>65</sup> The civic and international grumbling that the South African government had not done more to confront the crisis grew to a deafening roar. Mbeki also inherited the low confidence in the central government as the result of the embarrassing events of the Virodene scandal and *Sarafina II* debacle.

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<sup>61</sup> Nicoli Nattrass, *The Moral Economy of AIDS in South Africa*, 47-48.

<sup>62</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 151.

<sup>63</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 131.

<sup>64</sup> HIVAN Center for HIV/AIDS Networking, *Annual Review 2003*.

<sup>65</sup> Nompumelelo Zungu-Dirwayi, Olive Shisana, Eric Udjo, Thabang Mosala, and John Seager, eds. *An Audit of HIV/AIDS Policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland, and Zimbabwe*, (Cape Town: HSRC Publishers, 2004), 10.

Under such a context, the new administration developed the HIV and AIDS/STD Strategic Plan for South Africa months after Mbeki took office. This new plan did not altogether abandon the original ideas of the NAP, but altered them to fit with the new AIDS policy obstacles faced by the new administration. Drafted in 2000, it called for all governmental departments, organizations, and stakeholders to base all of their initiatives on the document. This would help maximize effectiveness by integrating programs. Furthermore, the draft called for the creation of a South African National AIDS Council (SANAC), the Interdepartmental Committee on AIDS (IDC), the Provincial Health Restructuring Committee (PHRC), and Provincial AIDS Councils (PACs).<sup>66</sup>

Unfortunately, while the Strategic Plan was universally praised for its comprehensive and far-reaching approach, the difficulties of implementing the programs' initiatives again prevented real progress. The newly created SANAC's "...invisibility... for most of 2001 prevented [the devising of implementation strategies] from taking place."<sup>67</sup> Critics of the initiative saw the unclear lines of communication between the different provincial governments and inadequate resources for the provinces as major roadblocks to implementing any of its policies. The continued resistance of the state to decriminalize commercial sex work or distribute Antiretroviral (ARV) therapies and Mother to Child Transmission prevention programs also illustrated the gap between what the Strategic Plan called for and what the government seemed willing or able to do.<sup>68</sup>

The SANAC, created to essentially to coordinate, monitor, and implement the Strategic Plan for all sectors of society, was supposed to have a 34-member body made up of governmental officials and members of civil society with the Deputy President as

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<sup>66</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 112.

<sup>67</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 115.

<sup>68</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 399.

the chair of the committee. Although this body appeared to mend the rift created by the Virodene scandal and *Sarafina II* embarrassment, it soon proved another governmental gaff as all members were swiftly and unilaterally appointed by the government and basically excluded scientists and anyone from the AIDS Consortium (a network of AIDS NGOs). Essentially composed of governmental officials out of step with medical information and civic desires, the SANAC became an ineffective and unrepresentative symbol of bureaucratic waste.<sup>69</sup> Rather than behaving like a comprehensive and representative body of all AIDS interests in South Africa, it simply legitimized Department of Health policies already at best questionable in their soundness and prospect for success.

During the end of the Mandela Administration and into the Mbeki Administration, the issue of providing essential drugs to people with AIDS flooded the international agenda as a dispute erupted over US-based pharmaceutical companies' unwillingness to allow South Africa to manufacture AIDS medicine under generic names for a fraction of the price. Eventually, the South African government won the case before the World Trade Organization, but Minister of Health Dr. Manto Tshabalala-Msimang announced just weeks later that the drugs were still going to be too expensive to parallel import or manufacture locally.<sup>70</sup> Opponents of the minister were later up in arms when the AIDS directorate in the Ministry of Health failed to spend forty percent of its funds during the fiscal year 1999-2000,<sup>71</sup> and the strange about-face of the government further deepened the gulf between the state and public groups as the latter viewed the financial constraint argument as nothing more than a suspicious excuse. Despite the government's

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<sup>69</sup> Nompumelelo Zungu-Dirwayi, eds., *An Audit of HIV/AIDS Policy*, 28-30.

<sup>70</sup> Nicoli Nattrass, *The Moral Economy of AIDS in South Africa*,

<sup>71</sup> Helen Epstein, *The Invisible Cure*, 110.



unwillingness to utilize its victory on the world stage, the one positive from the WTO's decision was to cement the new human rights-based approach to the AIDS epidemic on the rest of the world, particularly the developing world.<sup>72</sup>

At the close of 2001, some important legislation was passed that represented important steps for ensuring the rights of South Africans with AIDS. Firstly, Chapter II of the Employment Equity Act came into effect. This law made it illegal for employers to discriminate based on the HIV status of an employee or potential employee.<sup>73</sup> Its provisions were upheld in two court cases involving applicants for work on South African Airways, *Hoffman v. SAA* and *'A' v. SAA*. Also, the government backed off of its stand to require AIDS to be a notifiable medical condition.<sup>74</sup> This victory for public advocacy groups meant the lessening of stigma for infected individuals. The government cited this as a reason for abandoning the policy as well as limited resources for enforcing it.

Perhaps one of the most important and startling aspects of the Mbeki Administration's handling of the AIDS epidemic in South Africa has been the confusing, contradictory, and controversial leadership of the president himself.<sup>75</sup> First illustrated with Mbeki's endorsement of Virodene in 1997, his unsettling willingness to go against established scientific literature and mainstream research indicated a potentially debilitating effect on the government's ability to combat the growing crisis. Here he accused the Medical Control Council, which had the power to approve certain drugs as safe, of being racist for not allowing the drug to be sold on the market. Apparently, the

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<sup>72</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 124.

<sup>73</sup> Isaac Moledi, "HIV-AIDS Rights at Work," *The Sowetan* (Durban) November 11, 2003.

<sup>74</sup> Helen Epstein, *The Invisible Cure*, 116.

<sup>75</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 316.

governing body's decision not to endorse the drug constituted some underlying white plot to allow millions of HIV-infected blacks to die.<sup>76</sup>

On the heels of the Virodene scandal, Mbeki also publicly questioned the value of AZT, a drug that has universally received high marks from scientists around the world, as effective in combating HIV in the central nervous system. Most startling was that Mbeki gleaned his arguments from internet searches of dissident groups who claimed, among other things, that HIV is not even a real disease, that HIV does not cause AIDS, or that the virus itself was created by pharmaceutical companies to make money. The public support of such blatantly incorrect dissident groups by one of the highest officials in government served to foster suspicion and disgust of the administration by public advocacy groups in South Africa and around the world.<sup>77</sup>

By early 2000, the Presidential AIDS Panel officially referred to the link between HIV and AIDS as a "thesis," and Mbeki himself garnered a censure from the South African Medical Association for questioning the now standard method of investigating the causes and origins of the AIDS virus itself. Furthermore, the President released a letter to most of the top political leaders around the world calling AIDS dissidents modern Galileos. This letter was thought so bizarre and shocking by President Clinton that at first he thought it must have been a fake.<sup>78</sup>

Later that year, Mbeki restated his belief that the life-saving ARV medications were not safe or effective and that the world was grossly overestimating the incidence of AIDS in South Africa. He also called the theory that the disease originated in Africa a huge insult and perpetrated by racist, white, European scientists. In Durban during the

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<sup>76</sup> Helen Epstein, *The Invisible Cure*, 119.

<sup>77</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 544.

<sup>78</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 122.

Thirteenth International AIDS Conference, he not only repeated his doubts of proven scientific research, but also called poverty and not HIV the main contributor to the AIDS epidemic.<sup>79</sup> By September the South African Communist Party (SACP) and Congress for South African Trade Unions (COSATU) pleaded with the President to stop openly criticizing the medical research concerning the causes of AIDS in public. He did, while maintaining behind closed doors that the CIA and American drug companies had allied in a conspiracy to discredit his findings.<sup>80</sup>

In 2001, President Mbeki defended his decision not to declare the AIDS epidemic a national emergency and publicly refused to concede that HIV causes AIDS. He also contested the idea that AIDS was the main killer of adults in South Africa, citing seven-year-old statistics which seemed to show that it was only the twelfth-leading cause of death, with crime the largest killer in the country.<sup>81</sup> The fact that the statistics were grossly out of date was eventually leaked, and the credibility of the administration questioned. By the end of the year the administration was taken to court by the Treatment Action Campaign (TAC), which demanded the distribution of ARVs to rape survivors and to prevent mother-to-child-transmission. In early 2002 the Constitutional Court ruled in favor of the TAC.<sup>82</sup> Minister of Health Tshabalala-Msimang later stated before the Barcelona AIDS Conference that she must, "give her people poison."<sup>83</sup>

The year 2002 opened with public pleas from numerous high profile public figures, such as Nelson Mandela and Archbishop Desmond Tutu, for the government to

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<sup>79</sup> Mothuphi Modiba, "Address by the RSA Deputy President and ANC NWC Member Phumzile Mlambo-Ngcuka at the National General Council of the South African Students\* Congress (SASCO)," (speech presented in Johannesburg, South Africa, August 21, 2005).

<sup>80</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 136.

<sup>81</sup> "Thabo Mbeki and AIDS" *Washington Post* (national), October 2005.

<sup>82</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 139.

<sup>83</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 541.

begin distributing ARV medication as soon as possible. In March a dissident pamphlet was distributed to Parliament calling mainstream AIDS research Eurocentric science and insisting South Africa must reject the finding that HIV and AIDS are a self-inflicted disease. The government spent much of the rest of the year delaying any plans or negotiations for distributing ARV medicine and disobeying court orders.<sup>84</sup>

The following year, Mbeki's address to the opening of Parliament devoted only two sentences in a 21-page speech to the AIDS epidemic. The Health Minister's recommendation that HIV-infected South Africans eat garlic, beet root, and olive oil to boost their immune systems rather than take ARV medication caused an uproar among most of the South African scientific community and further tarnished the country's international standing and respect.<sup>85</sup> The President restated numerous times to the BBC and Washington Post that AIDS was not a large problem in South Africa and that he did not know anyone personally who had been infected or died of AIDS.<sup>86</sup>

The President reinforced his alignment with AIDS dissidents by retaining his controversial Health Minister in 2004. Since her reappointment, Mbeki consistently stood behind Tshabalala-Msimang, despite growing criticism from most national and international public advocacy organizations.<sup>87</sup> In February of 2005 the government reported a 57 percent rise in deaths from 1997 to 2002. Most took this as an indication of the growing effects of the AIDS epidemic on the country, but the Mbeki administration was still accused of underplaying and underestimating the disease's impact.<sup>88</sup>

Leading scientists in 2006 called for the use of circumcision to curb the infection

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<sup>84</sup> Helen Epstein, *The Invisible Cure*, 122.

<sup>85</sup> S. S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 542.

<sup>86</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 143.

<sup>87</sup> Thompson, *A History of South Africa*, 293.

<sup>88</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 175.

rate in South Africa, but the government was hesitant to endorse the initiative despite evidence that it could reduce rates in men by as much as 60 percent. Later that year the President began phasing in the Deputy Minister of Health, Ms. Madlala-Routledge, into the main role of coordinating the government's AIDS policy from the department. Most speculate that this was largely due to the growing criticism of the outside community on the Minister of Health's support of dissident research, but the government claims that it was because of the Minister being placed on the liver transplant list for health reasons. Interestingly, Madlala-Routledge was dismissed shortly after taking over for the ailing Minister. Critics argue her stark divergence from Tshabalala-Msimang's policy positions and push for ARV distribution programs prompted the dismissal.<sup>89</sup>

The placement of the Minister of Health onto the liver transplant list became a source of scandal in 2007 as reports were published claiming she needed the liver because of an excessive drinking problem. The report also claimed that she was fired from a hospital in the 1970s for stealing a watch from a patient while he was under anesthesia. The President's response to the newspaper's story was only that no investigation would occur unless credible evidence was presented. Either way, the already tarnished and questionable reputation of the Minister was further blackened.<sup>90</sup>

Clearly, the political response to the AIDS crisis by the South African government has been characterized by a checkered and suspicious history of controversy and misunderstanding. While the government has supported spurious AIDS "cures" like an industrial solvent, a coal-derivative, and a nutritional cocktail of garlic and vegetables,

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<sup>89</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 186.

<sup>90</sup> Nasreen Seria, "Minister Hit By Scandal" *Business Daily* (Durban) July 29, 2004.

there has been a corresponding lack, until obligated, of government support for ARVs for rape victims, prevention of mother to child transmission, or treatment of AIDS.<sup>91</sup>

Many observers have tried to explain the disturbing conduct of President Mbeki with regards to the handling of the AIDS crisis. Perhaps his long exile during the apartheid years has instilled within him an enduring hatred and mistrust of white people and the west that could foster paranoia of conspiracy. The President often accuses critics of being racist themselves (if they are white) or being bound by the racial oppression that has characterized most of the nation's history.<sup>92</sup> Other times, he claims that any opposition to his public statements by outside actors is really just a unified conspiracy to get him out of office.<sup>93</sup> The contention that pharmaceutical companies have bribed AIDS public advocacy groups into endorsing the accepted scientific research illustrates these points.

Perhaps, the heart of the bizarre behavior of the President lies in his refusal to concede that the dreams for a post-apartheid South Africa have a long way to go. Mbeki cannot allow himself to believe that something as taboo and undignified as unprotected sex and a debilitating and shameful disease like AIDS could be destroying his new African hope for democracy and real prosperity. Thus, he has grasped on to any quick-fix propositions such as Virodene and minimized the severity of the epidemic. Calling AIDS the result of poverty indirectly puts the blame of the epidemic on the oppressive conditions of apartheid and history.<sup>94</sup> Though apartheid was and continues to be largely

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<sup>91</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 538.

<sup>92</sup> Helen Epstein, *The Invisible Cure*, 124-125.

<sup>93</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 177.

<sup>94</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 179.

responsible for the economic state of South Africa, Mbeki's argument ignores very real facts about the culture and society of the country.

His adamant rejection of mainstream research on HIV and AIDS has all but severed ties between South African AIDS public advocacy organizations and the government. Thus, the issue cannot be adequately addressed and has even had a hard time staying at the forefront of the public agenda. The continued delay of beginning the distribution of life-preserving medicine has greatly increased the number of AIDS-related deaths and new infections to the point that the TAC has officially accused Minister of Health Tshabalala-Msimang of genocide. Without effective governmental action, South Africa's AIDS crisis has begun to take the lives of roughly 1,000 people every day.<sup>95</sup> An additional 600,000 new infections occur each year,<sup>96</sup> and the overwhelming scale of the epidemic has proven an almost insurmountable task for a new democracy whose leaders cannot even agree on its causes, let alone the best strategy for combating its effects.

### **Challenges for Combating AIDS:**

Apartheid and the political actions of the South African government from the end of the apartheid era through the Mbeki presidency have obviously had a huge impact on the course and progression of the AIDS epidemic in South Africa. Their effects are echoed today in the cultural, economic, and political challenges faced by the government and the people in implementing any successful AIDS strategy.

#### ***Cultural Challenges:***

The South African AIDS epidemic has undeniable and unmistakable ties to its long history of gender inequality. Though the very earliest beginnings of the disease

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<sup>95</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 173.

<sup>96</sup> UNAIDS, "South Africa," [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007).

have their roots in homosexual activity, today the disease has taken a decidedly heterosexual turn with women, especially young women, making up a disproportionate number of those infected.<sup>97</sup> This fact has its foundations in early adolescent relationships where the boys have the power to tell the girls what to do, and the girls are taught that their place is to do as their boyfriend tells them and not to assert any independence. Older men who have money and influence in society often exploit the conditions of the numerous poor young women in South Africa. In return for sex and submission, the girls are given money, clothes, or jewelry, which they sometimes spend themselves, but often give to their poor families.<sup>98</sup>

Furthermore, throughout much of South African culture, it is more than acceptable for a man to have more than one girlfriend, but not for a girl to have multiple boyfriends. Women are also almost powerless in most situations to negotiate condom use, a well-known effective barrier method of prevention. Most do not believe they even have the right to refuse sex to their boyfriends or husbands anyway. If a woman asks her boyfriend to wear a condom it is seen as a sign of mistrust. Even if the man is known to have other sexual partners, the woman is expected to have confidence that her partner is being safe with the other women.<sup>99</sup>

South Africa's gender inequality can be most easily illustrated in its disturbingly high incidence of rape and domestic violence compared to most other countries in the world. Approximately 13 percent of women report being beaten by a partner, and there is widespread agreement among men that for a boyfriend or husband there is no such thing

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<sup>97</sup> Liz Walker, Graeme Reid, and Morna Cornell, *Waiting to Happen*, 22.

<sup>98</sup> Nompumelelo Zungu-Dirwayi, Olive Shisana, Eric Udjo, Thabang Mosala, and John Seager eds., *An Audit of HIV/AIDS Policies*, 13.

<sup>99</sup> Liz Walker, Graeme Reid, and Morna Cornell, *Waiting to Happen*, 35.



as rape of his girlfriend or wife by him.<sup>100</sup> The misinformation that a man can be cured of HIV by having sex with a virgin has also made young women targets of rape. The promotion of virginity testing by local traditional medicine doctors has helped desperate sexual predators identify their prey.<sup>101</sup>

Often then, there is an age gap between the genders in a relationship, with men being older by at least a couple of years. Not surprisingly, the peak rate of infection for women is between 14 and 24 years of age, but more like 24 to 35 for men. The more efficient transmission of the disease in women further exacerbates the inequality created by traditional societal pressures. In 1992 just before the severity of the epidemic took off in South Africa, the infection rate for 20-24 year old women was 6.9 percent. By 2001 it was an inconceivable 50.8 percent.<sup>102</sup>

The challenges in terms of unemployment, wage gaps, literacy levels, and occupational segregation are greatest for poor, black women who consequently make up the largest demographic of those infected with HIV. Too often in South African society women are faced with the realities of their immediate situation, a reality that cannot consider the dangers of AIDS years down the road, but only the present needs for food, clothing, and a relatively safe place to sleep. Thus, women who may even know the risks of AIDS are forced to sell their bodies.<sup>103</sup> Throughout their lifetimes, these women may have children with multiple fathers and are forced to depend on their financial "generosity" to sustain themselves and their children.<sup>104</sup>

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<sup>100</sup>Thompson, *A History of South Africa*, 241.

<sup>101</sup>Bongani Mthethwa and Sibongile Khumalo, "Uproar as State Moves to Ban Virginity Testing," *Sunday Times* (Durban), July 10, 2005.

<sup>102</sup>S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 288.

<sup>103</sup>"Sex for Cell Phones," *The Independent On Saturday*, September 13, 2003.

<sup>104</sup>AfroAIDS e-Newsletter June 13, 2007 Discrimination Against Women Fuels HIV/AIDS in Southern Africa.

The cultural emphasis on procreation and continuing one's bloodline is so strong that many men are unlikely to approve of barrier methods such as condoms or abstinence. For poor men, their economic conditions are often such that they may be forced to migrate for work, which often then leads to more sexual relationships as they are away from home for long periods of time.<sup>105</sup> The lower status of women in relationships means that the likelihood that men may be unfaithful will be fairly high. They then come home to their wives and transmit the disease to them. These women then often transmit the disease to their unborn children at birth. Thus, today more married women are infected with HIV than unmarried.<sup>106</sup>

The transmission of HIV or AIDS to an unborn child has become an increasingly serious problem in South Africa specifically, and within the entire continent. Africa bears 90 percent of all cases of HIV-infected children in the world.<sup>107</sup> Mortality rates are 55 percent for two year olds, 90 percent for three year olds, and 98 percent by five years of age. Between 25 and 45 percent of children whose mothers have HIV will be infected; this is much higher than the 10 to 30 percent infection rate of babies in industrialized countries. The hope is that AZT injections which can greatly reduce the transmission rate would also reduce the growing number of orphans, which has reached an estimated 1.2 million in 2007 and may be as high as 2.3 million by 2015.<sup>108</sup> The alarming trend of mother to child transmission coupled with the maturity of the epidemic in the adult population has meant that by 2010, experts estimate the average life expectancy of South

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<sup>105</sup> Nompumelelo Zungu-Dirwayi, Olive Shisana, Eric Udjo, Thabang Mosala, and John Seager eds., *Audit of AIDS Policies*, 12.

<sup>106</sup> "AIDS Experts in Despair Over Male Sex Views," *The Mercury*, September 26, 2003.

<sup>107</sup> UNAIDS, "South Africa," [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007)

<sup>108</sup> Anokhi Parikh and Alan Whiteside, "Twenty-Five Years of HIV/AIDS: South Africa's Policy Challenges," *The Fletcher Forum of World Affairs*, winter 2007.

Africans to fall to just above 45 years of age.<sup>109</sup> Perhaps the most troubling aspect of this news is that the country until very recently enjoyed the highest life expectancy of any African country, and one that was comparable to some developed countries.<sup>110</sup>

Further reinforcing the gender inequalities in South Africa are societal institutions like schools, work places, communities, and even health systems. Men are cast as aggressive and dominant, with the most desirable characteristics being virility and courage. In contrast, women are portrayed as subordinate, dependent, and passive. Their most desirable qualities are supposedly their virginity and obedience. Women are also, most importantly, supposed to be passive and ignorant of sex.<sup>111</sup> Not surprisingly then, surveys consistently find that men have more knowledge of HIV and AIDS than women.

Research has found an undeniable link between socioeconomic status and HIV prevalence. Black women are most often on the low end of the socioeconomic scale in South Africa, though black men are also. Because these people have few expectations for success and economic and social fulfillment in their society, they are often more willing to take risks, thus increasing the chances of infection.<sup>112</sup> The unique racial history of South Africa further exacerbates the situation as the politically correct government does not want to confirm racial stereotypes. The conservative attitude of the culture towards discussing sex has been a difficult obstacle in addressing the issue of AIDS at all. Still somewhat of a taboo subject despite its increasingly enormous effects on society, AIDS

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<sup>109</sup> UNAIDS, "South Africa," [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007).

<sup>110</sup> Thompson, *A History of South Africa*, 235.

<sup>111</sup> Liz Walker, Graeme Reid, and Morna Cornell, *Waiting to Happen*, 48.

<sup>112</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 456.

and its causes are still not something the society as a whole feels comfortable talking about, though this attitude has finally begun to change.<sup>113</sup>

A disturbing cultural challenge that has emerged within not just South Africa, but much of the most AIDS-afflicted areas of Africa in general, has been the continued suspicion of the disease as a white plot to exterminate blacks by many prominent leaders and much of the poor and uneducated populace. For example, in 2004, Wangari Maathai, a recent Nobel laureate for her efforts to promote environmental issues in her native Kenya, stated that she believed, "evil Western scientists created AIDS as a biological weapon to wipe out blacks." Though she admitted she had no real proof, she questioned the reliability of condoms by saying, "If a doctor operating on HIV/AIDS infected patients put on three pairs of gloves when operating, how is just one condom expected to prevent the disease?" As the first African woman named a Nobel laureate and someone with a doctorate in biological sciences, her views have carried increasing weight.<sup>114</sup> The history between the West and Africa has been characterized by oppression, conquest, and exploitation on the part of white conquerors and that history has apparently not yet receded from the African consciousness. Thus, it is difficult for well-meaning Western scientists and NGOs to contribute to the AIDS effort, and like the policies of President Mbeki, the open suspicion of prominent African leaders fosters confusion and fear among the general population.

Clearly the cultural obstacles to successfully battle the AIDS epidemic in South Africa are formidable ones. The entire society's concept of gender relationships must change for the rate of infection of women to slow down. As women disproportionately

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<sup>113</sup> Nicoli Nattrass, *The Moral Economy of AIDS*, 121.

<sup>114</sup> Darren Taylor, "Another Shade of Green," *Mail and Guardian* (Durban), October 15-21, 2004.

carry the burden of the disease, they must also be the basis for attacking AIDS at its heart. South African society must also alter its attitude towards sex, relationships, and the very concept of men and women. Without a greater appreciation for the magnitude of sexual relationships and marriage, partners will continue to be unfaithful and the disease will continue to spread.

***Political/Economic Challenges:***

The economic obstacles to combating the AIDS epidemic in South Africa can be divided into two main categories: those pertaining to the government and those pertaining to individual people. Here the legacy of apartheid is most evident as its effects continue to echo in the challenges faced by the country's current generation.

The government's so called crisis of implementation for the otherwise universally approved Strategic Plan has hindered any hope for governmental impact on the progression of the disease.<sup>115</sup> The post-apartheid government promised the people of South Africa much more than its relatively modest economic status could support. As previously stated, the Mandela Administration had many other issues to address besides the growing concern of AIDS; and the new government had to be organized, staffed, and coordinated. The cost of medication was also initially extremely expensive. However, the victory of South Africa against U.S. drug companies for the ability to buy and make generic brand drugs negated that problem. For the past several years the Mbeki Administration and most specifically his infamous Minister of Health have maintained

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<sup>115</sup> "Assessing the Implications for the Planning Process," Town and Regional Planning Commission Report: The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal, 2000, 35-37.

that the distribution of antiretroviral medication and AZT to pregnant women is not a cost-effective method for dealing with the crisis.<sup>116</sup>

Government officials have also claimed that the expensive ARVs only delay the inevitable death of the infected, and the AZT medicine, while roughly 25 percent effective, still amounts to an eventually dead mother and thus an either HIV positive or negative orphan. Yet, economists point out that with sustained ARV medication HIV infected individuals could maintain a productive place in the economy for many more years than they would without the medicine. Rather than burden the state with mounting medical ailments, these people can contribute to society. In the end, the cost of the medicine would actually be far less than their inevitable medical bills. Similarly, the great success of the AZT injection in preventing mother to child transmission means the child will be less of a burden on the state as an HIV positive individual and at least has the chance to grow up and contribute to society.<sup>117</sup>

Although the actual cost of ARV and AZT medicine would amount to less than the future medical bills of HIV-infected people, the continued impact of apartheid era policies have made distributing the medicine difficult and coordinating the erratic health care system a formidable task. The apartheid system left millions of blacks poor and uneducated. The regions with the highest infection rates are also the most rural and most poor; consequently they are also the regions where the effects of the apartheid government's policies are still the most evident. As the result of the administrative initiatives of the old government, South Africa has a comparatively good infrastructure compared to the rest of the continent. However, the rural areas remain a difficult region

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<sup>116</sup> Nicoli Nattrass, *The Moral Economy of AIDS*, 116.

<sup>117</sup> Nicoli Nattrass, *The Moral Economy of AIDS*, 119-121.

to travel within. Thus, getting the appropriate medicine to the regions that need it the most has proved an enormous challenge.<sup>118</sup>

The administrative structures of the central and provincial governments have difficulty coordinating and communicating between each other. As a result, the large amounts of funds appropriated to various initiatives do not end up getting spent. For example, in 2001 only 35.5 percent of the national AIDS budget was spent. However, by 2004, about 85 percent of the budget was spent. With more monitoring of provincial governments' spending of the money this figure could improve even more.<sup>119</sup> The administrative delays on processing applications for governmental assistance with everything from educational programs, to orphanages, to treatment facilities are so severe that many groups have turned to international nonprofit organizations and the UNAIDS program for assistance. This practice has become an embarrassment to a government already tarnished by its sometimes controversial and bizarre AIDS policy.

The health care system in South Africa has also made the success of combating the epidemic difficult. Some quality health care exists in the country, but it is really only available to the wealthy who can afford it. Demand for quality care in rural areas has been the highest, but this is also the region with the least amount of adequate health care. The cumbersome and unorganized system itself does not effectively handle the increasing burden more and more sick AIDS patients have placed on it.<sup>120</sup>

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<sup>118</sup> Vicki Robinson, "AIDS 'Third Wave' Hits Economies," *Mail and Guardian* (Durban), March 10, 2003.

<sup>119</sup> Fourie, *The Political Management of HIV/AIDS in South Africa*, 168.

<sup>120</sup> Thompson, *A History of South Africa*, 238.

UNAIDS estimates approximately 34 percent of South Africans live on less than two dollars a day.<sup>121</sup> Thus, for individual people, the economic burden an HIV-positive family member places on his or her family has proven devastating to familial structures and prospects for ending the cycle of poverty and infection in the country. As infected individuals become increasingly sick, they can no longer work to support their families. Often this means that husbands and then possibly wives must stop working and their children must support the family. Although rudimentary schooling is mandatory in South Africa, the cost of school fees and uniforms as well as often dismal educational facilities means families must take their children out of school and away from a chance to break the bonds of poverty. In fact, in 2003 the World Bank published a report warning the South African government that it should begin subsidizing education so that children orphaned or impacted by a parent having AIDS could still attend school. It listed falling school attendance as a huge factor in the probable economic collapse of the country within three generations as the society ceases to have enough educated and qualified workers.<sup>122</sup>

Daughters may also become sex slaves or have “family friends” who give the family money in exchange for sexual favors, and boys may turn to stealing or leave the family and strike out alone. As the adult generation continues to have high infection rates, their parents have begun to take up the burden of their children’s children. The increasing number of grandparent-grandchild households illustrates the unfortunate destruction of the basic family unit within the country.<sup>123</sup>

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<sup>121</sup> UNAIDS, “South Africa,” [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007).

<sup>122</sup> “Treasury Dismisses AIDS Warning,” *Business Daily* (Durban), July 24, 2003.

<sup>123</sup> Gavin Kruger, interviewed by author, Durban, South Africa, May 24, 2007.



Although most people recognize that an education holds the only viable avenue for rising above the immense poverty faced by many families in South Africa, the economic realities of having HIV-positive parents or siblings means children are forced to make extremely difficult decisions. Scientific research has shown that something as simple as a balanced diet and happy home life can improve the number of years of survival for infected people, but without that food to begin with, the infected stand no chance.<sup>124</sup> The nonexistent safety net within the country and erratic and ineffective healthcare system means poor families' can offer little more than a bleak future to their orphaned children and overburdened heads of household.

#### **My Trip: MAY 17-29, 2007**

##### **Johannesburg, South Africa:**

Boarding the plane for Johannesburg, South Africa, I nervously wondered how I would possibly handle living with strangers 10,000 miles away when I get uncomfortable calling Domino's for delivery and talking to someone I do not know on the phone. More importantly, I worried I could never communicate the stories of the people I would meet in the compelling and eloquent manner they deserved. Besides, what if I never found the person or group I was looking for? Those fears dissolved when we arrived at the Thandanani Orphanage.

##### ***Thandanani Orphanage:***

Situated across the street from a large informal settlement of around 20,000 inhabitants called Sandspread, the orphanage houses nineteen children between the ages of five and eighteen who have been orphaned or abandoned due to AIDS. The building was purchased in 2002 from an older woman who felt the encroachment of the settlement

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<sup>124</sup> Emma Guest, *Children of AIDS* (Scottsville: The University of Natal Press, 2001), 135.

driving down her property value and saw an opportunity to contribute to a worthy cause. I interviewed the house parents, Sarah and Kholi, both women who decided to obtain their degrees in social work because they felt an obligation to help the children of the AIDS epidemic.

As the interview progressed, I realized how much energy, effort, and willpower Sarah and Kholi need every day to keep the orphanage functioning. The



disorganized and sometimes under funded bureaus of the South African government have made the application process for federal funding of orphanages an extremely difficult and drawn out affair. The Thandanai Orphanage has applied for federal funding but will likely continue to survive solely on private donations as the filing process can take as long as twenty years. With this in mind, Sarah and Kholi must not only feed and cloth nineteen children of varying ages, but also find schools that will take them and the money to pay for fees, uniforms, and books, all without governmental support.

The children attend a variety of schools depending on the availability of space and the educational background of the child. For instance, Kingsway is a local school with a fairly good reputation that many of the children attend. Sparrow, another school, focuses on basic skills like cooking, and sewing and targets children who have been traumatized or have missed too many years of school and thus have fallen too far behind to attend a

regular school like Kingsway. I had a hard time understanding this concept until I learned that in South Africa there are no mandated age requirements for each grade like in the United States. Because the children's families must pay for their children to attend school, poorer or neglected children often miss a grade or part of a school year. It is not uncommon for elementary grades to have children who are several years older than other students in the class who have not been forced to miss school. Unfortunately, after a certain point, returning to the missed grade or beginning school becomes impossible. One teen I met at the orphanage was around fourteen or fifteen and had basically never attended school. Rather than send her back to the equivalent of first grade, she attends Sparrow to give her some basic skills she can use to find work and take care of herself when she leaves.

I asked the house parents what happens to the other children who attend schools like Kingsway and eventually graduate from high school. They said many will end up working in a domestic shop of some sort. When I asked about the possibility of college, Sarah and Kholi explained that the cost of tuition makes sending them basically impossible. As they have no public funding, keeping the children they already have in primary school is an accomplishment in itself.

Another challenge for Thandanani is health services. The government will provide treatment free for children up to twelve years of age; however, the child must have a valid birth certificate and prove he or she is a citizen of South Africa. With AIDS orphans and many poor people in general, such documents have long since been lost or never existed in the first place; therefore, the social workers have an extremely difficult time getting basic medical care for their children.

Before we went upstairs to chat with the teenage girls on the top floor, I asked Sarah and Kholi what they need most to help keep their orphanage going. They said they will always need more funding, at least until the government finally gives them some assistance. They continually face challenges feeding the children, especially at lunch time. Although Woodsworth's, a grocery chain, donates food on a regular basis, the food is rarely suitable for lunch sacks, as it is mostly frozen. They also explained that warm clothes and money for school fees and the cost of transporting the kids to and from school every day continues to stretch their bank accounts.<sup>125</sup> As I walked up the stairs to meet the teenage girls, I was amazed to think that something as simple as lunches and gas money could make a significant impact of the ability of Sarah and Kholi to care for these nineteen children adequately.

The room in which the four teenage girls slept consisted of three bunk beds, a few dressers, and all the pink this former tomboy could handle. Later, when the girls told me more about their personal life stories, I could not help but appreciate the stark contrast between the chaotic, traumatizing lives they had left and the safe loving environment they now



inhabited. When we entered the room, three girls slept on bottom bunks and a fourth girls slept on the floor between two beds rather than sleeping on the top bunk. Later my

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<sup>125</sup> Sarah and Kholi. Interviewed by author, Johannesburg, South Africa, May 19, 2007.

host explained that after years of living in cramped, tiny homes and sleeping with perhaps a dozen or more family members in a single room, the girls had not yet gotten used to having their own space and preferred the closeness.

Unlike the other children I met on my trip, these girls were fairly close to my own age, a fact that was driven home for me when our conversation turned towards the subject of American singers. To my amazement, the girls asked me questions about various pop stars they had crushes on and if I'd ever met any of them. As they laughed and poked fun at each other's object of affection, I felt a stir of admiration well up inside me. Each of these girls has faced numerous terrifying and horrific life experiences that few adults have encountered, let alone overcome. They have no parents, no family to go home to apart from the orphanage, and still face many more obstacles. Yet, here they sat, smiling and laughing. Within a few short years they would leave the orphanage they called home and attempt to navigate the chaotic world they knew all too well and, hopefully, succeed against the numerous obstacles members of their own family had not been so fortunate to overcome.

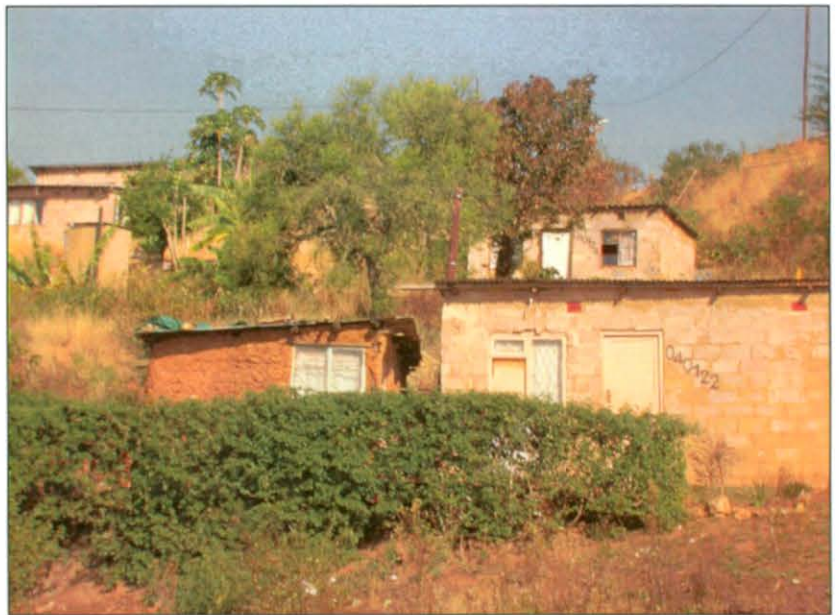
The girls told me they have learned the lesson of AIDS all too well. They have tried many times in vain to convince their girl friends at school that their lives and their self-respect are worth more than their cheating, disrespectful boyfriends give them. They experience the gender inequality issues that have largely aided the epidemics expansive hold on the entire country every day and believe that only by upholding their own sense of dignity and self-worth can they help stem the immense social tide called AIDS. No one can know for sure if these girls will leave Thandanani and successfully beat the odds

so against their favor; but leaving their room, I felt an enormous sense of hope that their passionate testimonies will carry them to a life better than their parents.

Back downstairs, I interviewed a married couple, Simon, a pastor, and his wife Caroline, who lived in a small house on the property and were the foster parents to seven teenage boys. Besides working in a soup kitchen, they divided food parcels, preached the gospel, and generally tried to serve the people of Sandspread. Simon said that one of the biggest problems faced by the community in trying to help orphaned children has been the governmental moratorium on children's homes. The government has told AIDS groups that their goal should be to limit orphanages as much as possible because they are not the optimal environment for the children. As a preferred alternative, the government supports foster parenting. Simon explained that often the government tries to find relatives to take in the children and then gives them a small monthly payment to help support the additional new member or members of the household. Problems, however, arise when people less scrupulous than Simon and his wife take in the children for the sole purpose of stealing their governmental check and then abuse or neglect them.

Throughout my visit, I could not stop thinking about the startling contrast between the situation of the people within Thandanani's walls and those across the street in Sandspread, so I asked Simon, someone with extensive interaction with both groups, what the people in Sandspread think about the disease, their situation, and the greatest challenges they face. His face sank a little before he spoke; no doubt the magnitude of the question and his emotional attachment to the subject had weighed on his heart. He said the problem has been an unwillingness to take responsibility for their situation. The people like to blame apartheid as not only the reason for their current circumstances, but

also the excuse for their reluctance to try to overcome it. Since apartheid began to crumble in the late 1980s, blacks have been taught to value and espouse their rights. Even today within a squatter



camp, inhabitants speak about their “right” to live how they like, even if it is responsible for the misery they endure. Thus, Simon has an extremely difficult time helping people get out of Sandspread. Ignorance and paranoia about the nature of not only the disease, but also people like Simon and Caroline’s intentions, has further made making headway difficult.<sup>126</sup>

When Simon finished answering my question, a hopeful and patient sparkle returned to his face. He seemed to understand better than most that his efforts within the camp would in all likelihood not substantially change the lives of most of the people within its boundaries. Yet, here he sat, across the street from perhaps the most powerful symbol of the AIDS epidemic’s effects bravely and boldly taking in seven teenage boys as foster children and continuing to serve people unwilling to serve themselves. Before I left Thandanani, Pastor Simon asked me if I thought people back in the United States would be willing to help the orphanage. Though he did not say it, I think he thought his story and those of Sarah, Kholi, and the other children at the home would not be compelling enough to spur distant Americans to action. After all, their stories were the

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<sup>126</sup> Pastor Simon and Caroline interviewed by author, Johannesburg, South Africa, May 19, 2007.

same as anyone else in South Africa. “Exactly,” I thought as we waved good bye and sped off down the pot-hold ridden road, “that’s why people will care.”

***Ikholwa Orphanage:***

After some lunch and a little break to digest not only my food, but also my first real interaction with the AIDS epidemic in South Africa, off we drove towards another orphanage. Ikholwa, which means hope in Zulu, opened in 2003 and represents probably the best possible scenario for children in orphanages. Founded by Sarah Taylor and her husband Andy, Ikholwa came about when Andy got the idea at church. As a wealthy international businessman, Andy had the best possible network for gathering



donations and bringing AIDS in South Africa to the forefront of corporate consciousness. Ikholwa now holds six fundraisers a year and continues to seek out new corporate sponsors. This had allowed the couple to hire more experienced and qualified staff including a preschool teacher, psychologist, house manager, and full time social workers. The orphanage is located within a safe and fairly upscale neighborhood where they eventually bought three neighboring houses, knocked down the privacy walls between them, and formed the orphanage from there.

The orphans at Ikholwa are generally very young children or babies, although a few children over the age of seven do live there, including a deaf eleven year old girl who





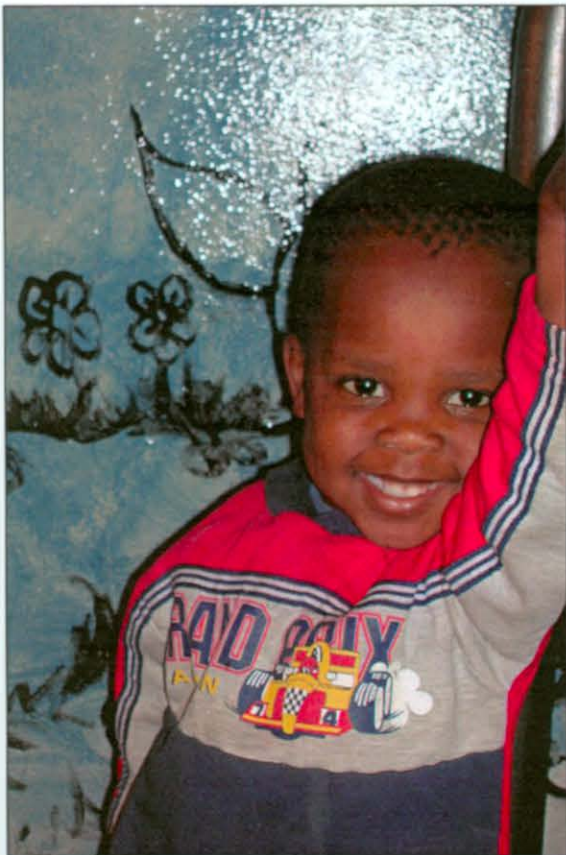
has AIDS. The children have all come to the orphanage because one or both of their parents has AIDS or has died from AIDS. Those children infected with HIV currently take HAART medications for their disease. These medications are a type of antiretroviral medicine commonly used in the United States and other Western nations to combat the destruction of the immune system by the disease. This is an impressive advantage

compared to nearly all other infected children in orphanages because the orphanages do not generally have the funds to pay for such expensive medications.

I am almost ashamed to say that I honestly did not think Sarah would tell me her orphanage faced any major challenges like Thandanani. I had almost forgotten that care for children extends far past proper meals, school fees, and a warm bed. Sarah said that there is an ongoing struggle to essentially bring back to life those children who have been abandoned because their parents and or they themselves have contracted HIV. Some of them have been abused or traumatized because of their home situations, and those that have the disease face slim odds that they will someday be adopted. Although the orphanage has been very successful at getting children adopted, there have been two cases where families have adopted children and then brought them back within three months because they have changed their minds. Such events can devastate the child.

I was very interested in how the staff at the orphanage dealt with the probable event that someday one of their children would die from AIDS. Despite the impressive funding for medications, I knew eventually some child would die. Sarah told me that

they thankfully had not had to deal with a death among the children, but that the entire staff had agreed that the best path would be the truth. None of the young children knew that their parents had died from AIDS; in fact, I do not think any of the infected children know they have HIV themselves, or what the disease is at all. When I visited Ikholwa, the staff was currently dealing with one seriously ill child and had decided not to really tell the other children. They explained that the children were too young to understand exactly what was happening, but that if the child did eventually die, they would explain why. This course of action made a lot of sense to me. The very youngest children had yet to be seriously affected by the chaotic world that had brought them to Ikholwa; and the older, abandoned children deserved the chance to feel safe, happy, and loved before they were reminded of the realities of their family history. If my visit to Ikholwa taught me nothing else, it taught me that with a little time and a lot of love and care, children



with horrific personal stories as dramatic as these could learn to smile and have hope.

The workers at the orphanage also face the difficult task of trying to make the twenty-seven children feel special and give them individual time. This came as no surprise to me. Herds of children followed us around the building, trying to sit in my lap or get their picture taken while I interviewed Sarah. One girl purposely attacked two other boys with her pink lipstick so she could get a laugh, which I have to

say, totally worked. To compensate for the lack of alone time the children get with individual adults, workers will take out only one or two children when running errands, or as a special treat, the older children may receive a trip to McDonald's or Kentucky Fried Chicken.<sup>127</sup> I had to giggle. Ten-thousand miles and a hemisphere away, small children are exactly the same.

As I left Ikhohwa, I could not stop smiling. True, the lipstick incident had definitely been a highlight of the afternoon, but really my smile was the product of all the smiling I saw while I was there. Every social worker, Sarah herself, and the entire herd that followed us around the building never stopped laughing and smiling themselves. Babies and small children are absolutely the least to blame for the course and progression of the AIDS epidemic in South Africa, yet they have involuntarily borne much of its effects. They did not have unprotected sex. They did not ask to be abused by a greedy and perverted uncle. They have the smallest chance of living with the disease, and they are forced to overcome obstacles at the start of life many adults never experience by the finish of it. Yet, there they stood, or sat, or crawled, happy, content, relaxed. Here too, the adults that have come to raise them, people who completely understand the world they have rescued these children from and some day must release them back into, laugh and smile. Like the name of their orphanage implies, they have hope, and with hope, they have a belief that the life these children have left will not be a life they ever have to return to. Suddenly, the smallest child, the tiniest baby seems to me the most powerful and important symbol of hope for South Africa.

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<sup>127</sup> Sarah Taylor interviewed by author, Johannesburg, South Africa, May 19, 2007.

*Interview with Amanda:*

After I returned to my hosts' house, I learned I would have one final appointment for the day, a secret appointment of sorts. The teenage girl I would have the opportunity to interview attended Trinity House where two of the girls at the home I was staying in also attended. The appointment was secret because the girl had not told any of her classmates that her mother was dying from AIDS; indeed, she had only told a few of her teachers, my host included.



I was dumbfounded. How a sixteen-year-old girl found the strength to live with such an enormous secret and care for her dying mother alone I could not fathom, but I was about to find out. In truth, my interview with Amanda became the most enduring and unforgettable conversation I would have for the entire trip.

My host and I met Amanda at a local coffee bar ten minutes from their home. She had a maturity that showed no signs of resentment for the unfair events that had been its catalyst. Methodically, she explained her deeply personal experience with AIDS in her own life. Her mother told her when she was in seventh grade, nearly four years earlier. Her white blood cell count is only 252, almost half that of a normal person and only 52 above what is considered the danger zone. Never once did Amanda's face betray some underlying desperation or utter hopelessness. Never once did she complain.

Of course, that did not mean her mother's disease did not profoundly affect her every day, but only that she had found some way to overcome the urge to give up, to let it over take her. She spoke about her guilt when she chose to go out with her friends rather than stay with her mother and the difficulty in speaking about the eventual day when her mother and sole guardian would die. Her father left her mother because he did not want to stay committed to just her, and she has never known him as a result. So, when her mother dies, that is it. No more parents. No immediate family to go to.

Yet, Amanda counts herself as lucky compared to many other children dealing with a parent dying of AIDS in South Africa. She has a foster parent, Ariana, who has agreed to look after her when her mother dies, and she continues to make excellent grades at Trinity House where she has a scholarship. Amanda is also hopeful that she will have the opportunity to attend college and support herself with the help of the inheritance she will have access to from her mother when she turns twenty-one. Her decision not to tell her classmates about her mother was not made out of shame, but more out of a craving for normalcy. The last thing she wants is pity or to be reminded by well-meaning but naïve classmates in the one place of refuge from the tumultuous realities of her life.

At the end of our interview, Amanda explained that her mother's illness has forced her to be more mature and more grown up than she would like to be. She regrets the loss of innocence many of her classmates still have; yet, she said she rarely thinks about the differences between them and her. This astounded me more than any other thing Amanda said in the entire conversation.<sup>128</sup> How she had not allowed herself to become bitter or resentful at her situation, I did not know; but I admired her strength and

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<sup>128</sup> Amanda interviewed by author, Johannesburg, South Africa, May 19, 2007.

courage. She had no other choice, she said, other than to look ahead to the future and play the hand she has been dealt.

Saying good-bye to Amanda, I felt confident that this girl would be a great success story in the devastating face of AIDS. She would graduate from high school, attend college, and take the lessons of her mother's mistakes to heart and not repeat them. I had spent only an hour and a half with Amanda, and I was so proud of her. Surely there was hope for the people of South Africa. Amanda's story had proven it.

### **Durban, South Africa:**

Only two days into my visit to Johannesburg, I had to catch another plane for Durban, a coastal city an hour flight away. Part of why I was so interested in visiting the city was because KwaZulu-Natal, the province it is located in, has the highest infection rate of any region in South Africa with an estimated 40.7 percent of the population living with HIV/AIDS.<sup>129</sup> The heart of the AIDS epidemic resided in this area of the country and although exhausted and still fighting the effects of jet lag, I knew I needed to spend time there. I had already decided the Thandanani Orphanage would be the human face I wanted to use to make the AIDS epidemic in South Africa a personal appeal to people's sense of humanity, my starfish, and I had met unbelievably courageous and inspirational people like Sarah Taylor, Amanda, and Pastor Simon. My short visit, unfortunately, had not allowed me much time to experience much of the culture or environment, but that would change when I finally got to Durban.

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<sup>129</sup> Anokhi Parikh and Alan Whiteside, "Twenty-Five Years of HIV/AIDS," 62.



### *Experiencing African Bureaucracy:*

Unlike Johannesburg, I had about a week in Durban. This meant I had time not only to interview more people, but also the chance to ask my hosts more questions about their beautiful country and just look out the window. After meeting some family friends who had more contacts for me to meet with and establishing my busy schedule, I had my first lesson in African bureaucratic inefficiency. My hosts worked at a private school near their home and were planning a

festival. They wanted to advertise the festival by posting large signs around their area, so we took a trip downtown to the administrative center to have the signs approved. The government mandated that advertisements had to have a specific colored sticker, which the owner of the signs had to purchase at the building we were headed to.

One of my hosts left the rest of us in the car while he checked to make sure we had made it to the right place. Meanwhile, I asked everyone else questions about Durban, apartheid, AIDS, and anything else I could think of. As a city right in the middle of one of the regions most affected by AIDS, Durban exemplifies the epidemic and the devastation it has caused. My hosts had always opposed apartheid and were glad to see it fall, but the gulf that divided them from the poor black people we saw walk past our car on the street was apparent. I could sense the fear they had that their beautiful country, once a symbol of economic prosperity and order within the chaotic African continent,

was beginning to show signs of erosion from poor governmental administration and the effects of AIDS.

After apartheid, the new government essentially turned out most of its white officials in favor of blacks, a kind of extreme affirmative action policy. Unfortunately, the decades of poor educational systems for black students and immense poverty had left too few blacks as viable replacements for white workers. The government has continued to leave blacks in those positions regardless of the effects the policy has had on administration and the general quality of governmental policy. My hosts' opinion was that the government chose disorganization over reinstatement of white officials out of resentment and suspicion that they would again try to oppress blacks. My hosts thought this fear bordered on ridiculous paranoia, which I later decided illustrated the gulf that still persists between black and white citizens in South Africa. I could understand my hosts' frustration with the continued suspicion of blacks. The prospect of reinstating apartheid or anything like it in South Africa even if a majority of whites wanted to (which they do not), is next to nothing. However, I could also empathize with the suspicion of whites by many black people. Their entire history has taught them to hate, fear, and distrust them, and history cannot be easily forgotten in thirteen short years. I believe in the sincerity of my hosts and most white and black people in South Africa that they would like to overcome racial issues that have so long plagued their country, but it will take many more decades before the social, cultural, and economic scars of apartheid have healed.

Over forty-five minutes into our conversation, my host finally returned from his search for the correct office to buy the stickers for the posters. My mouth gaped as he



recounted his, what seemed to me, absolutely insane ordeal in the name of a few trivial stickers. He went to the same office he had gone to last year for the stickers only to find it had been moved up two floors. Upon knocking at that door, the office worker informed him the room he was looking for had relocated another two floors up and at the opposite end of the building. "Alright," he thought, and he climbed the additional two flights of stairs only to learn from another official that the entire office had moved next door in another building. At this point I would have given up, but then I did not have the patience that nearly fifty years in Africa afforded my host. He then knocked at the allegedly correct door, but his hopes were dashed again when another bureaucrat informed him the person and office he needed had recently been reorganized under a different department two blocks away on the fourth floor.

This most recent instruction had finally brought my host back to our car, which coincidentally, sat in front of the most recent building in question. He quickly checked to make sure he finally had the correct office and all four of us grabbed a stack of posters and made our way to the fourth floor. The man in charge of the stickers slowly, painfully slowly, placed them on each of our eighty posters. My host offered to help him, but he said he could not allow anyone to help. Finally, over an hour after we had arrived, the sticker ordeal's end seemed to be in sight when the official arrived at the final dozen or so posters. These posters had a different date on them and "Thanks Coca-Cola!" scrolled at the bottom as a thank you for the previous year's contribution. The official told my hosts that these posters required a different, much more expensive sticker on account of the bottom inscription. My host tried to explain that they were going to change the date of the posters anyway since they were being reused from last year and that he could

scratch out the “Thanks Coca-Cola!” on the bottom while he was at it. The official would have none of it. If he wanted to use the posters he had two choices: pay more for the stickers now, or come back tomorrow with the posters changed.

We left and had no intention of coming back the next day. I could not believe the events of the previous hour and a half. Even more unbelievable, my host never once grumbled. He smiled happily and accepted the frustrating reality of the situation. Apparently, he told me, this kind of thing happened all the time. If he went to the trouble of getting upset he would go crazy. This was Africa after all. His wife would later tell me that she would not mind leaving South Africa if she could live close to her family, but her husband loved his country, faults and all, too much to ever consider it. That day I found yet another reason to have hope for South Africa.

***Interview with Gavin and Reward from Focus on iThemba:***

The next day, I had the pleasure of interviewing two of the most enjoyable, funny, and at the same time, dedicated people of my entire trip: Gavin Kruger and Reward

(Unfortunately, I never learned his last name.). Their program, No Apologies, is part of a larger organization called Focus on iThemba, which has existed since 2003 because of the vision of Danie van den Heever, a local businessman, and Jim Daly,



president and CEO of Focus on the Family in the United States. Focus on iThemba

responds to the need to provide care and support for the increasing number of orphaned children in KwaZulu-Natal. Their two-pronged attack seeks to establish cluster foster homes as well as reach out in the community and educate young people on the realities of HIV/AIDS and promote abstinence until marriage as the best course of action in combating infection. The cluster foster homes include a married couple and six foster children. The organization has a goal to establish eight of these homes and help provide parenting and life instruction for the foster parents and parents of the community surrounding iThemba.<sup>130</sup> My interview, however, focused on the No Apologies abstinence program Gavin and Reward headed.

When I met Gavin and Reward, the power had been out in the building the entire day. The country continues to struggle with allotting power during the winter months, a result of poor administrative management, which has unfortunately made power outages a common occurrence. An office worker led me to a corner of the large floor of cubicles where several employees busily worked away with the help of generators. Gavin, a tall, quirky so-called English South African offered me some tea and motioned for Reward, an equally tall, wise-looking black man, to join our chat.

I immediately liked them, and I think they liked me, too. Despite the seriousness of our topic, they seemed excited and relaxed to explain their program to me. They made fun of my tape recorder, acting like they were talking to it rather than me, and told me to tell George, as in President Bush, they said hello. For all their joking, however, they immediately exuded seriousness when our light-hearted chat turned to the real topic for the day: AIDS prevention.

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<sup>130</sup> *Focus on iThemba*, pamphlet

No Apologies got its name because their organization does not feel like it needs to defend the Christian principles its abstinence policy draws from. Gavin and Reward explained that their group does not place direct evangelizing as the main focus of their efforts, but they also do not try to lessen Christianity's influence on why they believe their program can best combat HIV's spread. If they did choose to explicitly evangelize, they explained, many people would be chased away, and a dead person cannot be converted anyway. The real focus of No Apologies is to attack the mixed and confusing cultural messages young people receive from the media with regards to relationships with each other and the AIDS epidemic. Boys learn that having lots of girlfriends makes them more of a man, while girls learn that this treatment is acceptable.

No Apologies also teaches children and young people the consequences of their actions and the difference between true love and hormonal lust teenagers often mistake for love. The love vs. lust battle has continued to be one of the most difficult. The influence of the media has made it difficult to teach young people how to separate the two, and that having lust does not mean also having love.<sup>131</sup> Young people always argue, Gavin said, that if they love this guy or that girl, then they should be allowed to have sex with them; however, they fail to fully consider the implications of their actions. If they did, Gavin argued, they would choose abstinence until marriage, even if they did really love the person, which often is not the case.

Gavin and Reward said that they try to explain why sex within marriage and faithfulness to that person matters within the context of future aspirations and goals. The program seeks to not only identify the consequences associated with premarital activity, such as contraction of an STI, HIV, or pregnancy, but also understand the value of

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<sup>131</sup> *No Apologies Student Workbook*, Focus on the Family, Hillcrest, South Africa, 2000.

healthy behaviors, and practice the skills necessary to achieve the goal of premarital abstinence. They contend that abstinence must be emphasized and not given up on as an impossible goal. This approach downgrades teens as animals that cannot control themselves.

The argument that the program is too directive in that it clearly preaches abstinence as the best and preferred method of HIV prevention rather than non-directive and preaching all options as equally valid ignores the need to present a clear message. After all, telling children, "It's okay if you wait until marriage, but it's also okay if you don't," really just preaches a message of "safe sex" with contraceptives. Gavin and Reward pointed out that a 2001 survey found that 54.4 percent of 15-18 year olds in South Africa have never had sex. However, surveys of consistent and correct condom use show much lower rates. Maybe then, the goal of abstinence until marriage is a more realistic goal than preaching safe sex. People still contract HIV from safe sex practices, but no one does in monogamous, mutually faithful relationships.

One of their greatest challenges is trying to get young people to make morality transcend perceived necessity as in the case when a young girl may sleep with a "family friend" in exchange for the man paying her family's bills. Reward said convincing a girl like this that any man who demands sex in return for his "generosity" and any family member who allows that kind of behavior does not really care about her is difficult. Culture has taught girls like this that such arrangements benefit everyone and her personal feelings about it do not matter.

Gavin said that having Reward as such a fantastic example for young, poor black teenagers to look to as someone who could successfully abstain until marriage has been

an excellent addition to the program. Reward maintained, however, that the race of the person teaching the program matters less than his ability to gain the respect of the teenagers he is talking to. Gavin also pointed out that the AIDS epidemic can no longer be ignored by the white community as a black endemic. "We are all being touched by the disease now," he said. At the time of my interview, white people had overtaken blacks as the demographic with the fastest growing rate of new infections in the country.

Before I left Gavin and Reward, I was anxious to ask them their opinions of the most likely successor to Mbeki as president, Jacob Zuma, and the general governmental response to the epidemic. For the first time in our entire conversation, both men became stern. I needed to be careful who heard me ask questions like that, they said. Zuma had become almost a cult-like hero to the poorest and least educated blacks of South Africa, a substantial segment of the population. Reward said the most disconcerting aspect about Zuma is his character, or lack of. He does not seem to respect women and publicly stated that a person can get rid of HIV by taking a shower after sex.

Both men agreed that although Mbeki was slow to address the seriousness of the AIDS epidemic, he has been influential in the success of the last five years. The Department of Education even thanked Focus on iThemba for its help in combating the disease. The real issue, they said, was that South Africa is a new democracy and its people have not yet learned the responsibility of their rights. The rebellion against apartheid encouraged violence and agitation as the means to solve the country's problems. Thus, such ruthless and controversial leaders as Jacob Zuma have gained a dangerous following among the masses. The cultural consensus that fairness for all people has not yet totally taken root in South Africa as only one generation has grown up

in freedom. Therefore, Zuma could potentially gain immense power and ruin the monumental democratic gains of the previous decade and any prospect for an African AIDS success story in the country.<sup>132</sup>

It was finally time to go. Almost two hours after our conversation had begun; I said good-bye to my new friends Gavin and Reward. Despite the subject matter, our AIDS interview over tea seemed refreshingly upbeat and optimistic. These men knew the challenges they faced in teaching such a blunt and straightforward message and yet they never seemed to doubt its correctness. As I shook their hands and went to meet my hosts at the car, they complemented my interviewing skills and reminded me to give George their best wishes. I had to laugh. It was not every day I got to meet abstinence-preaching, South African Baptists who drink tea, and like George Bush.

*Visit to Hillcrest AIDS Center:*

A day or two later, I visited the Hillcrest AIDS Center, an organization with around six different sub-programs. With thirty-seven employees and roughly seventy volunteers, Hillcrest AIDS Center represents a well-organized and far-reaching attack. I wanted to know more about their feeding scheme, education, and income generation programs. I first met with the head of the organization, a tired, but busy woman, so busy in fact, that I never caught her name. I met only briefly with her before being handing off to the heads of the programs I wanted to know more about.

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<sup>132</sup> Gavin Kruger and Reward, interviewed by author, Durban, South Africa, May 24, 2007.

She said that her organization exists because a government-run program similar to it would have so much corruption and mismanagement, nothing would ever get accomplished. She went on to explain that Hillcrest AIDS Center is based on the idea



of unconditional love. As a Christian organization, it faces some of the same dilemmas as the No Apologies program. Hillcrest AIDS Center does not expressly preach the gospel, nor does it directly address Christianity, but its members are all Christian themselves and the benefactors of their programs know it.

The challenge of unconditional love, she went on to explain, manifests itself when people they are trying to help do not want it. For example, the organization has had a few incidents where recipients of food parcels would look into their sacks and say they wanted something else, that the food was not good enough. "In those moments," she explained, "one must realize that unconditional love also means serving people you may not necessarily like." Because of such cases, the center has placed a six month limit on the amount of time a family can receive food parcels. If people know they cannot count on the food coming in every week, they are less likely to feel a sense of entitlement, behave more gratefully, and try to improve their current situation.



I next met with the head of the education program whose name I could not pronounce, let alone spell. She told me that their AIDS education programs have been taught in area schools for the past seventeen years. Her staff gives around six hundred talks a year to primary and high school students in two schools. The curriculum used to just focus on abstinence, but has now added talks about gender issues. One of the greatest challenges of the program has been the cooperation of the students' teachers. In South Africa, children get a one to two hour break in the middle of the day where they can leave campus and basically do whatever they want. In the poorest and most dangerous areas, this often means students go home and get drunk or do drugs before returning to the classroom. Coincidentally, this is also the time that many of the teachers choose as the center's allotted teaching time. Thus, an already difficult challenge becomes that much more difficult as many of the students are not coherent, let alone paying attention.

She said that she was not sure the curriculum or method of instruction was working in the schools. She felt like the younger they got to the children, the higher the chance they could have some effect, but as the infection rates in the area are still rising, she could not honestly tell me the program was having that much of an impact. The fact that throughout our very candid conversation she never lost the hope on her face absolutely stunned me. I could tell as she described different students she had personally taught that she identified with and cared deeply about all of them. Somewhere inside her she just knew the program had to be reaching at least some of the children. I think she must have thought that if even the curriculum positively influenced the lives of even just a few students each year, it was worth the frustration and heartache of each class period.

Her resilience astounded me. If South Africa had people like her trying to combat the AIDS epidemic, surely the country had a chance of success.

Finally, I met a short, hyper woman named Paula, who headed the income generation project that Hillcrest AIDS Center is most known for. The staff teaches poor



woman pottery, sewing, and other crafts by which they can generate an income and support their families, even in the face of AIDS death or illness. Recently, the center took part in a 1.7 million rand campaign for GAP. Participants made little beaded doll pins called traveler dolls, which were then sold in GAP

stores across the United States. At just roughly 1.50 USD, each doll represents economic independence for many women who otherwise would live in extreme poverty.<sup>133</sup> Paula explained to me that the income generation project does not function to make a profit for Hillcrest AIDS Center, which markets the goods, but only to continue to function, pay for itself, and sustain its contributors. The program is so important, she explained, because earning an income allows these women to look into the future with hope. If they have the self-confidence that they have the ability to take care of their families, they stand a much better chance of not engaging in risky behaviors that could repeat the cycle of HIV infection within themselves and their children.

Before I left, Paula took me on a short tour of the facilities, including where much of the merchandise is made. I saw a dozen or so hard-at-work women, proudly creating

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<sup>133</sup> *Hillcrest AIDS Center*, pamphlet

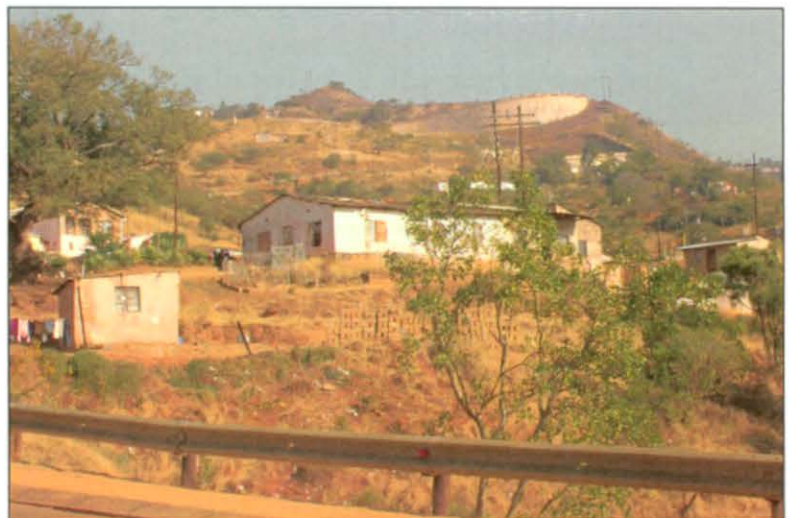


unique and interesting crafts of every kind. Where once these women would have been destined to a life of immense poverty and the risks that go with it, they now had a reliable source of income, and a new found sense of self-worth. I left Hillcrest AIDS

Center with probably a dozen or so objects of every size and shape imaginable. Best of all, I was not merely donating to a group of needy people; these women were anything but.

#### *Valley of a Thousand Hills:*

The trip through the Valley of a Thousand Hills represented one of the most beautiful and sad places I have ever been. The area is something of a paradox. I have never seen a more beautiful valley with more fantastic views and scenery, yet I was told the residents of the area are some of the poorest in all of Durban, a city of almost five million people. They say the misery and sadness of the valley prevents its people from appreciating its magnificence. I had the opportunity to travel to the area with a local church group that made and distributed sandwiches to the orphaned children of the valley. Before we left, I stood assembly line style at a table for



about an hour methodically pasting butter and apricot jam onto slices of white bread. In the end, I think we made somewhere around two hundred sandwiches. While patiently pasting, I met a hilarious Brazilian guy who mixed in a fascinating life story about how he ended up in South Africa with a little shameless flirting. He had come from Brazil knowing almost no English at all with a desire to use the game of soccer to bring people closer together. Amazing. Somehow, an absolutely devastating disease had brought an American girl and Brazilian guy together in South Africa. Maybe AIDS and not soccer was what people needed to be brought closer together.

With the sandwiches finished, we filed into a large van and set out for the valley. Everyone happily chirped away, asking me questions about America and pointing out different spots along the winding road. The van stopped at three designated points to let out people. The orphaned children already gathered at the various points along the road,



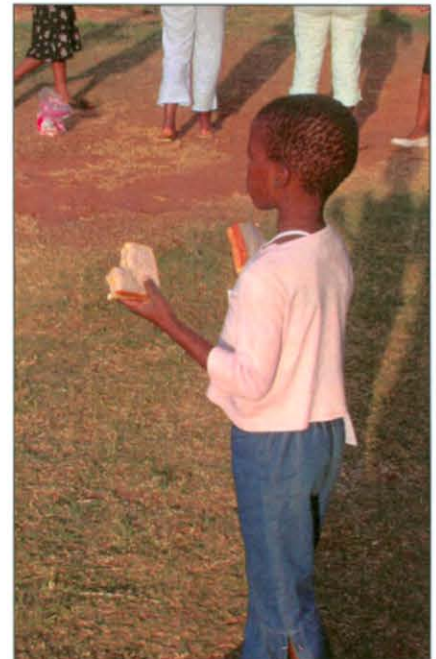
waiting patiently for their sandwiches and a chance to color pictures the group had brought for them. Finally, we reached the last gathering spot, the home of a foster grandmother who had eight children in her care, and many more congregating on her porch.

It was only forty-five or fifty degrees outside, but almost none of the children had coats to wear or proper shoes. The church members herded the kids onto the porch and began telling them the story of Jesus' life with the help of an interpreter. The story teller stopped periodically to ask the group questions



about the story. I felt like I was watching an American kindergarten class as various children's hands shot up enthusiastically hoping they could answer them. All the while, the grandmother looked on contently from her rocking chair at the brood before her. For a half an hour one would never guess the difficulties they all endured every day.

Finally, with the story over, we distributed crayons and paper, and the children busied themselves coloring. I had to be sneaky about my picture-taking because whenever they knew the camera was on them, they immediately stood up excitedly and tried to get in every shot. Before we left, we got the sandwiches from the back of the van to hand out to the kids. They quietly and quickly swarmed the van, holding out their hands for two or three sandwiches each. I thought back to the times when I was young that I turned up my nose to something my mother would prepare for me and felt a little ashamed and embarrassed. The sandwiches we had made did not have much to them; nor did we spend the time to carefully and lovingly put them together like my mother did when I was little, yet these children hungrily and eagerly devoured them. For just a few minutes until their sandwiches disappeared, these children felt taken care of, the most basic of their needs being met by strangers. In those same few minutes, I



also felt a new sense of gratitude and thankfulness for the good fortune I have undeservedly received in my life. If something as simple as butter and apricot jam sandwiches could light up the faces of these children, perhaps one day they would again have enough hope and optimism in their lives to again appreciate the beauty of the valley.

### *Just Being a Tourist:*

The day before my last appointment I finally had a chance to enjoy Durban as a tourist and not a sleep-deprived AIDS researcher. My hosts drove me all around the city. At first glance, I could have mistaken it for any city in the United States, except that the cars drove on the other side of the road. The highways were large and modern, with the crisscrossing overpasses so characteristic of America, and many sophisticated office buildings and shopping centers. In fact, I visited two malls that put any mall I had ever visited to shame. One had three car dealerships inside! We strolled by the beautiful



beach and had lunch near the water. A man and his children did acrobatic tricks for passing tourists, and signs for Kentucky Fried Chicken and McDonald's littered the roads. We walked along the board walk, spotting a large amusement park in the distance and observing numerous fancy beach front pools, condos, and apartments. If I had not known better, I would have thought I was in Malibu, not the most AIDS-inflicted province in the most AIDS-inflicted country on Earth.

Then I took a closer look. The city was not as perfect as I first thought. My host warned me not to open my window at traffic lights to take pictures because my camera could be snatched by a passing thief. I also realized that while many of the people bustling past us on the sidewalks looked wealthy and prosperous, many more did not. I also noticed that while large, private neighborhoods lined the bluffs near the highways, so too did large informal settlements and tiny government-made housing projects. In fact, my hosts told me the government had begun to shift people out of the squatter camps into the government housing because it reflected poorly on the city and discouraged tourism.

Driving around, I also started to realize the dramatic gulf that exists between the rich and poor in South Africa. My hosts lived in a nice walled home with a pool, tennis



court, and amazing view overlooking the city; yet, five minutes away, we passed poor black house servants walking along the road besides straying cows and chickens. The houses were run down and much shabbier. Indeed, I realized the gulf that exists between the United States and South Africa in general. My hosts were considered middle to upper-middle class people. They owned three cars, had a nice home, and could afford a maid to do much of their house work. Yet, they also had no central air or heat.

They explained to me that only the very richest people in the country can afford such a luxury, a luxury I no longer take for granted now that I have had the unfortunate pleasure

of sleeping in a room with the windows open when the temperature is only twenty-five degrees outside.

Perhaps the most striking example of the country's difference from the United States occurred when one member of the household told me she loved to visit the U.S. during Christmas time. I did not immediately understand what she was getting at until she told me that, sadly, people cannot put up Christmas lights in South Africa. They get stolen within a day or two. She marveled that people could place all kinds of decorations on the outside of their homes, with no high walls to protect against thieves no less and nothing would be taken. Why anyone would want to take Christmas lights, I have not yet figured out. That I never stopped to realize how lucky I am and that I can enjoy that apparent luxury, no longer happens.

I also heard first-hand accounts of the immense crime problem in the country. One day in particular, my hosts told me two stories of crime their family had personally experienced. Their son was held at gun point in the parking lot of a grocery store a few months earlier. The thieves wanted his car and instructed him to get in the back seat while they drove off like "mad men" miles and miles from the area. Finally, they pulled the car over near a steep hill and told him to run down the hill as fast as he could. If they could see him in three minutes, they would shoot him dead. Luckily, he had been on the phone with his girlfriend in Canada when he was held up and she immediately called his family, who went out looking for him. He eventually walked to a warehouse and met a security officer who let him use the phone to call his parents. They found his car two weeks later completely stripped and utterly trashed in a ditch. Later, family and friends would ask him how he was doing and some people suggested he see a therapist so he



could get over the incident. He just shrugged and maintained he was fine. He said things like that were just a part of living in South Africa. If he could not accept it, he should not be living there.

I was beginning to understand exactly why their alarm system and high walls were necessary for security when they told me that not long before my visit a burglar had broken into their home and tried to steal a television. A screw driver had been left on the window sill and he had used it to open the window. By some chance, the father had gotten up for some water at the exact moment the burglar was taking the television. The two men saw each other and the burglar was frightened enough to drop it and run away. The father told me that he was lucky his story had a happy ending, which is not always the case.

I went to bed that night appreciative that nothing like that had ever happened to my family. I awoke later that same night to the burglar alarm going off and was absolutely sure of my imminent death. However, an hour later, no scary, bloodthirsty thief had invaded my room and I finally relaxed enough to fall asleep. No sooner had I drifted off when the family cat jumped through the open window from outside onto my bed. I nearly had a heart attack and did not sleep for the rest of the night. Later the family would apologize for not coming and telling me their son had accidentally tripped the alarm. Apparently, they were much less worried about another burglary than I was.

The evening before I left, the family had a nice traditional South African barbeque. It really looked and smelled a lot like the family barbeques I have had with my family, complete with avid sports-watching and lots of fantastic finger food. The only glaring difference, however, was that rather than watch a baseball or football game, the

family gathered around the television for formula one racing and a rugby match. We traded information about our country's favorite national pastimes, and I learned the difference between seven- and eleven-man rugby.

That night before my last interview and plane ride home, I thought back to my personal experience with South African culture. Undoubtedly, the families I had visited did not represent the entirety of South African culture. After all, a country with eleven official languages could hardly be pigeon-holed, but I did think I found several commonalities between their culture and my own. The globalization of the world had spread every nation's culture to the far reaches of the world. I remembered the devotion of the family to American Idol and their anger when the city's power went out just before the semifinals were broadcast. I remembered how much they said they loved McDonald's and how much of a star Charlize Theron, a native South African, was in the United States. I even learned that South Africa had its very own version of a redneck, the Afrikaners, who were descendents of the Dutch colonists and apparently bare an uncanny resemblance to NASCAR devotees in the United States. I guess it was fortunate that I had already been on this line of thinking, because the next day, my interview with Professor Alan Whiteside would ultimately prove to tie not only all of my research together, but also illustrate the importance of the AIDS crisis in South Africa for the rest of the world, including the United States.

***Interview with Alan Whiteside and Visit to University of KwaZulu-Natal:***

During the entire drive to the University of KwaZulu-Natal, I was extremely nervous. I had contacted Professor Whiteside because his name appeared in several of the books I had read for my research, and I wanted to interview him about the economic

and political impact of the epidemic on the country. It felt like I was about to take an exit exam for college; if I did not pass the test, all the work would be for nothing. Throughout the entire trip I felt confident that I knew what I was talking about and that my questions had been useful and insightful, but this was a real expert. I read his books so that I could have the authority to ask the questions I asked. I could only hope I did not sound like an idiot.



Luckily, I felt more at ease once we entered the facility. I had done some research a few days earlier at another campus of theirs in another part of the city where I meticulously plodded through dozens and dozens of catalogued archives of previous articles on the epidemic. Somehow I felt like I had an idea about the university's general research program. The professor met me at the door to the research offices and offered me some tea and coffee before we made the trip down the hall to his large and important-looking office. I tried my best not to look intimidated, but I am sure I failed miserably. He did not seem to notice though and soon dove right into a flurry of graphs, charts, and other data. He began by explaining that the data on prevalence comes from two sources: antenatal surveys and the Nelson Mandela Surveys. The latter includes the influx of refugees and migrants to the infection rate, while the former focuses on the prevalence of pregnant women who visit clinics.

He then went into the impact of AIDS illnesses and deaths on the political and economic future of the country. He reminded me that sick and dead people are not productive people. Of course the epidemic has also caused a dramatic increase in the number of orphans, 205,305 in 2006 alone. The professor then explained that the biggest impact on the political realities of the country is the number of people voting in elections. The data has shown that women, for example, were less likely to vote in the 2005 election than previous elections. This decline in democratic participation was a worrying trend the researchers continued to monitor; however, no major effect on voting patterns had yet emerged.

Professor Whiteside also gave me the names of several books and websites from which I could gather more information, some of which I have used. He cited a book by Alex De Waal called AIDS and Power: Why There is No Crisis Yet to illustrate the valley that separates those with and without power in the country. So far, those that have died have not really been people who “matter.” People with unskilled jobs can be replaced easily. Unemployment rates for poor blacks hovers around thirty percent in some areas, and these are the people from which unskilled labor jobs are filled. However, as the sick put more and more pressure on the healthcare system, eventually a true crisis will occur, but until the haves are more strongly affected by the disease’s wrath, the country will continue to teeter on the edge of crisis.

I also wanted to ask the professor his opinion of the government’s handling of the epidemic. He pointed out that the epidemic has been a long wave event. There is a lag time between infection and major impact as the disease can lay undetected for years before health problems steadily accrue. Thus, the problem and the solution are extremely

complex and governmental handling of it cannot be totally blamed for its spread. The greatest weakness of President Mbeki, he said, was that he had no “man of the people” quality that makes people want to follow him or believe in what he says. Whiteside judged him to be a good technical president as in he could administer the laws, but his reaction to and leadership during the height of the epidemic has been confusing and poor. Jacob Zuma, another favorite topic for me to ask about, on the other hand, represents the gender issues that plague the country. As someone who can legitimately call himself a man of the people, he further stymies efforts to resolve the gender inequality that has contributed to the spread of the disease.

The collapse of moral culture, Whiteside explained has impacted AIDS’s spread more than governmental action. One day while we looked for souvenirs, I heard a shop owner talk about the practice of labolo as a source of soaring infection rates. Labolo involves a man saving more and more money until he can afford a wife. One article I found at the University of KwaZulu-Natal stated that the rising cost of labolo coupled with the fear of contracting AIDS has made even young couples try anything to ensure that their partners are faithful. This even includes a notable increase in the sale of African love potions and charms. For male clients, they want assurance that their wives will not divorce them after the huge labolo sum has been paid. Conversely, female clients want assurance that their partners will not cheat and possibly pass on AIDS to them.<sup>134</sup> Whiteside said that this collapse of the moral culture, not the cost of labolo, is really to blame for the multiple partners and refusal to wait to have sex or use condoms.

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<sup>134</sup> Zukile Majova, “Bound to be Forever Faithful,” *The Independent on Saturday* (Durban), April 16, 2005.

My last question for the professor was what he thought Americans could do to positively affect the AIDS epidemic in South Africa. He stopped, looked out the window for a moment and said, "You know, the United States is a country where a person has extraordinary potential to better himself, to succeed, probably more than any other nation in the world, but it is also a country with no safety net if someone fails. Your country is not an equal one. There are those with the power and influence and then those without it. In the broader context of the world, there are a few countries like the United States, Canada, Europe, and others with all the resources and all the power, and then there are those without it."

He then explained that the best thing Americans can do is be informed. They must understand the situation in countries like South Africa and not allow themselves to believe it does not affect them. The plight of South Africa and nations like it should be understood in the context of global economics and politics. Globalization means that what happens in one part of the world necessarily affects the rest of it, and until it can be a more equal place; the AIDS epidemic, poverty, and civil war in the have-not corners of the Earth will continue to have a greater and greater impact on the haves of the world until they can no longer ignore what happens on the other side of the ocean. Professor Whiteside then looked at me very carefully and said, "I think I know how you can end your paper. HIV has and will continue to profoundly affect this nation and the world. You should end your paper with a question. Will HIV bring South Africa and ultimately the world closer together, or will it tear it apart?"<sup>135</sup>

This question stuck with me as I left his office, packed for the flight home, and continues to even now. My trip has taught me that the world and not just South Africa is

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<sup>135</sup> Alan Whiteside interviewed by author, Durban, South Africa, May 27, 2007.

at a crossroads. We can no longer ignore the global reality of our time, let alone escape it. It is globalization that brought American Idol to my hosts' living room and Charlize Theron to ours. What happens on the southern tip of the African continent does and should affect our lives in the United States, even tiny Ouachita Baptist University. Thus we are all faced with a choice: to act or continue to be indifferent, and I sincerely hope we choose the former.

### **The Future of AIDS in South Africa:**

Today the UN estimates that between 4.9-6.1 million of South Africa's population of 55 million people are infected with HIV/AIDS, the largest number of people living with the disease within one country on the entire planet. Life expectancies have fallen to under 50 years of age for both men and women, and an estimated 240,000 children under fourteen live with the disease.<sup>136</sup> AIDS-related death rates are rising, with mortality among females aged 20 – 39 years, more than tripling between 1997 and 2004.<sup>137</sup> Over the same period, deaths due to opportunistic infections such as malaria and tuberculosis for 25-29 year olds have more than tripled for men and increased 600 percent for women.<sup>138</sup>

Although the South African government has finally sped up its implementation of programs of distribution of antiretroviral medication and other treatments as 300,000 HIV-positive people have received treatment and the number of public campaigns to promote education and awareness of the realities of the AIDS epidemic have increased, the new policies have yet to slow the infection rate. The internal division between public

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<sup>136</sup> UNAIDS, "South Africa," [http://www.unaids.org/en/CountryResponses/Countries/south\\_africa.asp](http://www.unaids.org/en/CountryResponses/Countries/south_africa.asp) (accessed December 9, 2007)

<sup>137</sup> Anokhi Parikh and Alan Whiteside, "Twenty-Five Years of HIV/AIDS,"

<sup>138</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 179.

advocacy groups and the government has finally lessened as Mbeki has shifted policy so as to improve coordination and communication between the two aspects of AIDS society. Plans have also begun to restructure the National AIDS Council and develop a government-led inclusive National Strategic Plan for 2007 – 2011.<sup>139</sup> Perhaps these new steps will finally give South Africa a viable chance to confront and combat the overwhelming AIDS epidemic facing it. Unfortunately, the echoes of the disease will remain for many years to come, and the severity of it could have lasting and resounding effects upon the democracy of the relatively young republic, as well as the economic and societal futures of its people.

***Possible Effect on Democracy:***

The Institute for Democracy in South Africa's Governance and AIDS Program has established an empirical link between HIV/AIDS and democratic governance using the electoral process as its basis. The research presupposes that democracies, as sensitive forms of government, especially when they are as new as in South Africa, place a high premium on delivering services that people want and need. If the services are not delivered, the electorate's support of the system falls; and the legitimacy of the political institutions diminished significantly. The perceived legitimacy of the government also involves the perception that the elections and governmental process are run in a fair and free way. With minimal fraud and corruption, people believe the system has credibility and legitimacy. The HIV/AIDS epidemic in South Africa has put these aspects of maintaining democracy into jeopardy.<sup>140</sup>

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<sup>139</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 184-186.

<sup>140</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS* (Cape Town: Institute for Democracy in South Africa, 2006), 3.



In South Africa, where the stigma surrounding AIDS still runs high, no elected officials have publicly declared their HIV-positive status; and few have even declared their negative status.<sup>141</sup> Indeed, during campaign season, candidates perceived as being ill are surrounded by speculation of a possible positive HIV test. As a result, political parties do not adopt candidates who appear or really are HIV-positive. Undoubtedly, some elected official has contracted the disease, but the political establishment's reluctance to have a candid and honest conversation about its own likely inclusion in the epidemic serves only to make the people feel alienated and further stigmatizes the disease. It also raises questions about the effectiveness of governance by elected officials in denial about their own HIV-status and the best way to represent the electorate.<sup>142</sup>

Furthermore, registered voters, especially in the 30-49 range, have begun to die off in alarmingly high numbers, over 1.4 million out of a possible 20.6 million registered voters between 1999 and 2003,<sup>143</sup> most likely because of HIV/AIDS. This may affect political bases of support for political parties which cannot effectively represent a group of people if from election to election it does not know which supporters have not yet died from AIDS.<sup>144</sup> Similarly, though there seems to be recognition of the importance of participating in the political process by those who have contracted the disease, physical and social barriers often prevent them from exercising their right to vote. These obstacles include time constraints, physical challenges, distance to polling stations, and stigma and discrimination.<sup>145</sup> In South Africa people with the disease have indicated that stigma is

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<sup>141</sup> "Millions to Fight Stigma of HIV/AIDS," *Sowetan* (Durban), April 24, 2003.

<sup>142</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 13.

<sup>143</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 29.

<sup>144</sup> Robert Mattes, "HIV/AIDS and Democratic Practice: What Do We Need to Know and How Do We Get There?" presented to the Rockefeller Brothers Fund, October 17, 2003.

<sup>145</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 13.

the number one reason why they do not participate in elections. People feel and apparently rightly so, that they will be marginalized for appearing at public events. Participants in the South African Department of Health Study of 2002 indicated that the sense of stigma most obviously presented itself when infected people were symptomatic. For example, other members of the community would not stand in the same line as someone with visible sores or rashes.<sup>146</sup>

The high death tolls as the result of the epidemic has also created a new challenge for the government: purging dead citizens from its voter registration rolls. The technology used to register voters and track deaths are somewhat inadequate and subject to possible voter fraud as “ghost voting” has become more prevalent.<sup>147</sup> The noticeable increase in deaths of elected officials has also been a cause for alarm. Though never confirmed as the result of HIV-positive status, at least some of these representatives have likely contracted the disease.<sup>148</sup> The by-elections used to replace the vacant seats have had a much lower turnout in recent years, indicating an alarming attrition on the part of the South African electorate that could spell danger for the country’s democracy.<sup>149</sup> A vacant seat means a particular district has no representation; this could, in turn, alienate the district if a by-election takes a long time to occur. It also may disadvantage smaller, less resourced parties which cannot compete as well with the larger parties in by-elections.<sup>150</sup> Furthermore, the cost of holding so many by-elections further burdens an already busy and strapped government. By 2003, South Africa’s by-elections cost the

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<sup>146</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 38.

<sup>147</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 14.

<sup>148</sup> Robert Mattes, “AIDS and Democracy: What Are the Linkages?” discussion paper for workshop, May 2003.

<sup>150</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 24.

government 2.3 million rand per ward, or about 400,000.00 USD. There are approximately 3,754 wards.<sup>151</sup>

Without a more open and honest approach to HIV/AIDS within the government and electorate in South Africa, the democratic system within the country could be in jeopardy. As fewer and fewer registered voters come to the polls and elected officials succumb to the disease, the system of representative government fails to achieve the legitimacy and credibility needed to sustain a public trust in government. As the country desperately calls out for the government to bring immediate and effective solutions to the overwhelming epidemic called AIDS, it may also push its relatively new and somewhat fragile democracy over the edge.

***Possible Effect on Economy:***

Just over twenty-five years after the first reported cases of HIV in South Africa, the ripple effect of the disease has begun to have a monumental effect on the economic environment of the country. Mortality rates for new born and young children and working age people ages 25-50 are the highest among all demographics. New born and young children generally contract the disease from their mothers and die within four years; then the rates drop off until adulthood. However, the incredibly high rates of prevalence and mortality for adults mean a diminished and less efficient work force. The CGE macroeconomic model shows the disease will have a crippling impact on the economy as human capital declines and intergenerational transfer of knowledge disappears. The difference in GDP growth by the end of 2008 would be 2.8 percent, and by 2010, the economy would be 17 percent smaller and per capita income could fall 8

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<sup>151</sup> Kondwani Chirambo, *Democratization in the Age of HIV/AIDS*, 25.

percent.<sup>152</sup> Thirty-four percent of the variance in growth would be due to slower productivity caused by the reduced workforce capacity.<sup>153</sup>

Much of the explanation for the difference in growth of the economy (nearly 45 percent), however, rests with the most likely shift in government resources to healthcare. This shift would mean less money towards investment and would result in a budget deficit.<sup>154</sup> Because HIV and AIDS attacks the immune system, infected people are more susceptible to opportunistic infections like malaria, tuberculosis, or even chicken pox. The enormous increase in hospital admissions as the result of HIV positive adults has meant overcrowding in hospital wards and possible exclusion of HIV negative patients as a result.<sup>155</sup> There has also been an alarming rise in the tuberculosis rates of admitted patients, rising 360 percent from 1993 to 1997.<sup>156</sup>

The disproportionately high rates of pediatric admissions compared to surgical admissions indicates that pediatric HIV has begun to have an impact on pediatric health care services. Because HIV positive children are more likely to continue contracting various infections and diseases, they are more likely to see the doctor more often than children not infected. The inefficient and still ineffective distribution of ARV medications and mother-to-child transmission prevention programs has meant more children suffering from HIV and AIDS than should be.<sup>157</sup>

Because it is unlikely that the public health sector will be able to continue a sustained increase in the cost of treating more and more cases of opportunistic infections,

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<sup>152</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 306.

<sup>153</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 309.

<sup>154</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 310.

<sup>155</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 336.

<sup>156</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 338.

<sup>157</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 342.

rationing of services will occur and may already be occurring now.<sup>158</sup> This could be indicated by the increasingly shorter and shorter hospital stays of HIV-positive children. The rising mortality rate of HIV-negative patients also indicates possible falling healthcare standards. However, roughly 15 percent of South Africa's population utilizes private health care services, which are accessed through membership in a medical insurance scheme. Usually linked to employment, this form of health care is generally for the wealthier sectors of society. Anticipating the economic impact of HIV on their business insurance and medical aids industries essentially excluded benefits for those with HIV. In response, health care providers did not disclose the HIV status of patients and provided treatment for their opportunistic infections. This practice was largely eliminated with the Medical Schemes Act of 1988, which banned discrimination by those industries.<sup>159</sup>

The private sector has dealt with the epidemic through managed care programs. Based on the premise that while antiretroviral medication is expensive it can reduce morbidity and improve survival, it has been more successful at managing HIV and AIDS care than the public sector. Though the rates of infection for those using private care is lower than those using public care, this can mostly be attributed to the higher socioeconomic status of its patients who are less likely to contract the disease. In the managed care schemes that cater to the lower end of the market where prevalence rates are higher, the programs may face similar runaway costs as the public sector.<sup>160</sup>

Possibly the most unfortunate impact AIDS has had on the health care system has been the discouraging impact it has had on people aspiring to practice medicine. Fear of

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<sup>158</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 336.

<sup>159</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 344-346.

<sup>160</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 347.

contaminated needles exposing and infecting them with HIV tops the reasons many people may not become doctors. Furthermore, the overwhelming nature of the disease has negatively impacted, "...doctors' perception of themselves, their technical proficiency, their ability to care and feel for others and themselves, and for some, their entire sense of self..."<sup>161</sup>

On a smaller level, those infected with the disease or those who have few resources to work with, namely the poor and disadvantaged, may be less willing to invest what few assets they have for the future when their short-term survival needs outweigh everything else. So, a poor high-risk South African living in a squatter camp may believe his chance of living past thirty-five almost impossible will probably not invest in education, proper housing, or savings.<sup>162</sup> Girls are also much more likely than boys to be kept out of school if financial constraints require it.<sup>163</sup> This means further disempowerment of women in a society of pervasive gender inequality and the reduction of qualified and contributing members of the economy. Conversely, while this demographic will likely be risk-adverse when it comes to their limited resources, they will also likely be more willing to make short-term risks that relate to their health if it means more resources or if they feel completely hopeless. This could mean unprotected sex, which could in turn fuel higher infection rates.<sup>164</sup>

### ***Future Generations of South Africa:***

The South African AIDS crisis represents the equivalent of one September 11<sup>th</sup> attack every three days. Over one million children have been orphaned as the result of

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<sup>161</sup> S.S. Abdool Karim and Q. Abdool Karim eds., *HIV/AIDS in South Africa*, 348.

<sup>162</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 290.

<sup>163</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 294.

<sup>164</sup> Tamar Kahn, "Incomes Suffer as AIDS Cuts Deep into Families," *Business Daily* (Durban), October 1, 2003.

the crisis and millions more may be.<sup>165</sup> Poverty and chaos characterizes much of the country as the cycle of misery, tragedy, and death seem to repeat itself over and over again while the world watches a once proud symbol of peaceful democracy within the chaotic African landscape crumble from all sides.

The monumental impact of the HIV/AIDS epidemic in South Africa will echo for generations to come. Scientists estimate that life expectancies within the country will fall 31.9 years from expected levels by 2010 from 68.4 years to just 36.5 years.<sup>166</sup> This alone has obvious ramifications for the future members of society. During the 1999-2000 school year over 100,000 children lost their primary school teacher, undoubtedly many to the epidemic.<sup>167</sup> The deaths of such key members of society as teachers, doctors, policemen mean an enormous impact on the safety, health, and development of the country's children. The fact that the government does not fully fund education and that an alarming number of children are being orphaned every year means fewer and fewer children may receive the chance to better their lives and get out of high risk socioeconomic groups.

The deaths of so many 30-49 year olds because of the disease means the society will have to deal with a large generational gap between the young and very old. As increasing numbers of grandparents take over the parenting duties left by their children, the family unit will fundamentally change. Many children, forced to leave school and help support the family will not have the opportunity to take the place of skilled professionals dying off because of the disease. These are also the children who will inherit the difficult economic and political challenges the epidemic has created.

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<sup>165</sup> Fourie, *The Political Management of HIV and AIDS in South Africa*, 173.

<sup>166</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 299.

<sup>167</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 330.

The AIDS epidemic has really become an international issue as globalization, increased communication and travel, and exchanges of cultures have bound all countries and continents to each other. Just as the teenage girls of the Thananandi Orphanage in Johannesburg, South Africa, and I found common ground over the topic of American pop stars, so too should the United States and the West in general find commonalities with the people of Sub-Saharan Africa. The world has gotten a lot smaller, more flexible, and certainly too changeable and variable for Americans or any other seemingly unaffected country to avoid the realities of the AIDS epidemic, not only in South Africa, but all over the world.<sup>168</sup> The epidemic called AIDS economically impacts not just South Africa or Sub-Saharan Africa, but the entire world. The interconnectedness of societies because of globalization has seen to that. Thus, not only would it be inhumane to pretend like the suffering of millions of people thousands of miles away does not affect us, it would be flat out wrong.

Yet, much of my research and my trip to South Africa illustrate the prospects for hope. While the adults suffering from the disease will likely die before any vaccine or cure is discovered, the real hope of the country lies with future generations. The deep-seeded cultural and historical realities that have provided AIDS an alluring avenue for spreading throughout the country can be confronted and challenged. The inspiring and relentless work of such people as Gavin and Reward, from the No Apologies Program, and the members of the Hillcrest AIDS Center's educational and income generation programs prove that attacking mistaken and outdated cultural beliefs and providing people an avenue for real economic success and independence can be a successful methods for changing hearts and giving hope to the South African people.

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<sup>168</sup> Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century*, 375.



Science and medicine, though helpful, cannot defeat the behemoth that is the AIDS epidemic; only the actions of real people can. If the future generations of South African people can be taught to change their way of thinking about their place in society, culture, and relationships with each other, the now hopeless case of South Africa can be turned into an unbelievable story of success. Though the disease has provided incredible obstacles, it has also provided not only South Africa, but the entire world a choice: whether the seemingly insurmountable disease will destroy democracy and hope for an entire people, or unite all of us in the possibility of economic, social, and political equality.

So the crisis of AIDS in South Africa comes full circle back to a story about a few starfish washed up on the beach. Today in South Africa those starfish are the key to saving the country; they are its future generations, and a small little college with a funny sounding name can legitimately and drastically affect the path of life of nineteen orphaned children. These children, whose lives are at once so different from our own, are also at the same time so intimately and unconditionally bound to us as compassionate and empathetic human beings that we can no longer afford to flip the channel past a news story on the subject or sigh indifferently about its unfortunate effects. These are the stories of real living, breathing children, not just mind-numbing UN statistics.

The most inspiring and memorable person I met on my entire trip to South Africa is someone whose name I do not even know and probably never will. He is an approximately four-year-old boy who was unceremoniously brought to one of the orphanages I visited in Johannesburg. He spoke a sort of child tribal babble that none of the social workers could identify, and he had only been in the orphanage for about a week

when I met him. The most remarkable thing about this child was his captivating smile that never left his face from the moment I arrived until I reluctantly left.

He laughed heartily and insisted on commanding my attention and lap during my entire visit. Here was a child whose life had been characterized by who knows what horrible conditions, and yet he had a resilience I would contend few adults anywhere in the world could match, probably precisely because they are adults. Still young enough to hope and love, he has become for me a symbol of the possible future of South Africa and the world for that matter. He can be helped to rise above cultural, economic, political, and historical realities and in turn not just overcome the vast pandemic called AIDS, but also change the entire society in which he lives. Not half bad for a little starfish washed up on the shore.

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