A CULTURAL APPROACH TO

HIV/AIDS PREVENTION AND CARE

UNESCO/UNAIDS RESEARCH PROJECT

SOUTH AFRICA'S EXPERIENCE

COUNTRY REPORT

Special Series on
HIV/AIDS Prevention and Care:
A Cultural Approach

Since the mid-eighties, the fight against HIV/AIDS has gradually mobilized governments, international agencies and non-governmental organizations. However, it became evident that despite massive action to inform the public about the risks, behavioural changes were not occurring as expected. The infection continued to expand rapidly and serious questions began to emerge as to the efficiency of the efforts undertaken in combating the illness. Experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires close cooperation and therefore multidimensional strategies.

The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1994 initiated a new approach to the prevention and care of this disease. The first requirement stressed was the need for increased coordination between institutions. An emphasis was also made on the need to work on both prevention and treatment while considering the significant social factors involved. As a result UNAIDS was involved in several studies focusing on developing new methodological strategies with which to tackle the issue.

Following a proposal made by UNESCO's Culture Sector to the UNAIDS Programme, on taking a cultural approach to HIV/AIDS prevention and treatment for sustainable development, a joint project "A Cultural Approach to HIV/AIDS: Prevention and Care" was launched in May 1998. The goals were to stimulate thinking and discussion and reconsider existing tools with a cultural approach.

Taking a cultural approach means considering a population's characteristics - including lifestyles and beliefs - as essential references to the creation of action plans. This is indispensable if behaviour patterns are to be changed on a long-term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

In the first phase, of the project (1998-1999) nine country assessments were carried out in three regions: Sub-Saharan Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), Asia and the Pacific (Thailand and bordering countries) and the Caribbean (Cuba, Dominican Republic, Jamaica). The findings of these studies were discussed in three subregional workshops held in Cuba, Zimbabwe and Thailand, between April and June 1999. All country assessments as well as the proceedings of the workshops are published within the present Special Series of Studies and Reports of the Cultural Policies for Development Unit.

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I. INTRODUCTION

Within the framework of the UNESCO/UNAIDS joint project "A cultural approach to HIV/AIDS prevention and care", it was decided to carry out country assessments on the subject, in various regions of the world seriously hit by the epidemic, the first one being Southern Africa. Besides Angola, Malawi, Uganda and Zimbabwe, the case of South Africa appeared particularly relevant, as regards both the current situation in the country and the public priority given to the issue by the highest national authorities.

This assessment was carried out in co-operation with the UNESCO Pretoria Office, the WHO Liaison Office in South Africa and UNESCO's Culture Sector in Paris, through consulting the Section of Cultural Research and Management. Most of the information used in this work was drawn from discussions held in the Pretoria UNESCO Office, with various institutional partners. Complementary information and documentation was found in the WHO Information Center in Pretoria, supplemented by academic and cultural documentation devoted to Southern Africa in general and, in some cases, to South Africa.

As requested in the terms of reference of the project, the assessment dealt with two major topics:
(i)   the consideration of cultural factors in the South Africa National Plan for HIV/AIDS prevention and care;
(ii)   a first approach to in-depth investigation on the cultural determinants and effects of the epidemic. However, in-depth local studies on the subject could not be carried out, due to the novelty of the approach taken and the time requirements needed for sophisticated scientific field research.

The most important findings of the assessment made it possible to better understand the most crucial issues:
- the overall interactions between development, culture and HIV/AIDS in the South African context,
- the economic societal and cultural impact of the epidemic on the various sectors of the South-African population,
- the cultural references and resources to be taken into account to build culturally-appropriate strategies and projects for prevention and care, as a response to South Africa's National authorities' appeal;
- a description of the most culturally vulnerable groups,
- a concise presentation of the research findings and subsequent methodological proposals.

Various aspects of the HIV/AIDS crisis in the country show significant similarities with those identified in other countries of the Region, in spite of the enduring effects entailed by its specific economic system and the now abolished apartheid.

It is hoped that this work will be of use in building relevant and sustainable HIV/AIDS prevention and care methods with a cultural approach, for South Africa itself, as well as for the countries in the Region and other UN regions, faced with this terrible challenge.

I. THE PRESENT SITUATION

1. Overall features of the situation in Southern Africa

In the Southern-African sub-region, three countries were selected, on the basis of their specific situation and the actions already taken there: South Africa, Angola and Malawi. Two more country assessments were carried out after the first three, in Uganda and Zimbabwe.

In the three countries, the epidemic is spreading very rapidly and they all have undergone serious processes of social, political and cultural destabilization over the past twenty years, a period which corresponds roughly to the traceable history of HIV/AIDS at the world level and, more recently, in Africa. They all have been subject to important population movements, whether originating domestically or in neighbouring countries. These might explain the observation, made in the <u>Report of the recent Geneva Conference (June 1998),</u> that there is a growing trend of the epidemic - in terms of the people infected - to spread towards Southern Africa through North-South population movements, South Africa being the main attraction area, mostly for economic reasons. These population movements are probably also related to the recent or current armed conflicts in Central Africa, making it an area from which people tend to leave as refugees.

However, the fundamentals of the situation in each country are very different : a rough approximation would be to consider that in South Africa, HIV/AIDS is an urban or suburban phenomenon, spreading into the rural areas; in Malawi, a mostly rural one; in Angola, it is closely linked to the consequences of the civil war or wars in the neighbouring countries, with the flows of refugees and migrants that it involves and the difficulty for institutional action to cope with the size and seriousness of the situation.

Another significant difference is that, viewed in its general dimensions, the health and educational system is by far more developed in South Africa - though with spectacular internal unbalances - than in Angola and Malawi. However, South Africa ranks among the most heavily hit countries: given the fact that, starting from the first infection by the virus, an average delay of 5 to 10 years is observed until AIDS proper breaks out, this means that the detection and prevention system was either non existent or seriously defective at the end of the '80s and the beginning of the '90s. Thus its long-term consequences are presently prevailing. As regards Angola and Malawi, where the school and sanitary situation is much more complex, the rate of infection can be explained by the overall situations of the countries.

2. Traditions vs. dangerous practices?

A more culturally-based approach to the epidemic would be to consider whether the traditional rules of behaviour and value systems which might make people refrain from dangerous practices are still valid or if the crisis in these societies has more or less completely destroyed the norms which had, for a long time, governed relations within the family, group or local community.

A consistent question then to be asked would be whether a positive response to institutional recommendations and warnings against the spread of the disease could be secured in medical and educational terms only. Or rather, if it needs to exist within the framework of a general improvement of peoples' living conditions, thus becoming rooted in their attitudes and behaviours.

Of course, different variables will be identified through analyzing interactions between culture, development and HIV/AIDS in the various countries included in the research.

However these should be the key questions for the assessment of the extent of integration of cultural factors in actions taken to date and the cultural references and resources linked to peoples' perceptions, attitudes and practices regarding the epidemic.

II. ASSESSING THE SOUTH AFRICA SITUATION

1. Evolution of the HIV/AIDS infection

The national HIV/AIDS situation in South-Africa is one of the most serious in the Southern region of the continent. The general population has seen the fast growth of infection rates from the beginning of the '90s, more specifically from 1992. High prevalence (Kwazulu-Natal and the Free State) and relatively less high prevalence (Gauteng and Eastern Cape) areas show the same pattern: a sharp rise in less than five years. Some 2.9 million South Africans were thought to be living with HIV at the beginning of 1998 (2,4 M in 1994). More than 700.000 newly infected people were reported in 1997. At the border area between South Africa and Zimbabwe (a zone with numerous migrant workers), 70% pregnant women tested were HIV positive as early as 1995. The overall rate of the infected population jumped from 0.76% in 1990 to 14.7% in 1996 and 19,5% in 1997, i.e. was multiplied by 25,6 in 7 years. 1500 persons are infected daily. It is foreseen that, in the absence of a significant decrease, nearly 3 million people will be infected in 2000 and 4.4 million people in 2005. 140 000 adults and children died of AIDS in 1997 and 360 000 since the beginning of the epidemic at the beginning of the 1990s, while AIDS orphans amount to 200 000, which means that both (or one remaining) parents died during that period.

A. From geographical to societal-cultural disparities

Geographically speaking, the highest rates of infection are found in the North-West province (25% of the population is HIV positive), probably in relation with the highly populated areas close to Gauteng and Kwazulu-Natal (21%). In the same province, the number of orphaned children will grow from 100.000 to 250.000 approximately at the end of the century.

This geographical distribution already gives some information on the societal and cultural specific features of the endangered groups: mostly black or coloured, mostly urban or suburban, mostly young (from 15 to 40 years), more men than women. This does not mean that women are not at risk also. Their situation will be described in more detail further on. The major fact however remains that young men, already living in the big cities, most often in poor townships, shanty-towns or squatting areas, or young migrant workers or unemployed youngsters, from inside South Africa or the neighbouring countries, are by far the most endangered part of the population.

B. Isolated men infecting women or infection through prostitution

Of course, isolated men will infect women through sexual relations, either their regular partner or spouse, living with them in cities or when they go back to their original village or tribal community. They may also have been infected by full time or occasional prostitutes, mostly those migrant workers isolated from their family and community and living in squalid conditions in collective hostels (up to 10000 men in one settlement), with no other perspective than working hard for minimal wages and with no recreation facilities other than getting drunk or abusing drugs in filthy bars and having sex with prostitutes, without the least consideration for practising safe sex.

2. Assessing the institutional response

In front of the HIV/AIDS pandemic, "one of the greatest threats to South Africa's future", as said by President Mandela, the new government's policy is to consider HIV/AIDS as a national priority. But this evolution is very recent. Until 1994, there was no systematic policy to prevent the spread of the disease nor a national health care policy as a planned public health care system.

A. Before 1994

Before the great transformation of the country, the responsibility for the provision of health services was divided between 14 different authorities. Besides, while the overall expenditure on health in the country compared - and still does - very favorably with most countries in Africa, this masked enormous disparities between the high cost, high quality of care available to the affluent minority and the poor or even absent services for the majority of the population. Fragmentation, compounded by highly inequitable distribution of resources has meant that, for most people, medical or pharmaceutical services were both geographically and economically inaccessible or of very low quality.

This unbalance in access is of course a result of the geographical distribution of White or non-White population living areas, not to mention the so-called Homelands, a spectacular consequence of the apartheid period. In some remote areas, the only available medical doctors were those of the national or international NGOs. Moreover, 35% of the population had no access to either drinkable water nor sanitation facilities.

Thus the overall health situation of the majority has remained dramatic as regards the great epidemics, including STDs. This shows up clearly in mortality statistics: while the average life expectation was almost 64 years at the beginning of 1994, 17% of the population risked dying before the age of 40. Other health indicators give similar information: 25% children under 5 years of age suffered from malnutrition and, while child mortality was 9/1000 among the Whites, it reached up to 65/1000 for Blacks.

Similarly, the major diseases that most affect the black population areas: malaria and bilharzia in Kwazulu Natal, sleeping disease in the North-West, tuberculosis in the townships of the mining industry zones (6 million infected in 1994, almost 3 times more than the HIV infected population: 2.4 million people). It should be noted that these diseases frequently interact with other STDs such as syphilis and gonorrhea. Together with their miserable life conditions, this might explain why HIV is not always perceived by the poorest people as the most serious threat to their lives.

B. A new mobilization needed

As soon as it came to power, the new government committed itself to the "complete transformation of the entire delivery system in medical and pharmaceutical care". The new National Health Service is based on a single national health department, which works in collaboration with the 9 provincial health authorities. These in turn provide support to the district and local government health authorities who will eventually become responsible for ensuring equal access to and delivery of all public health services.

3. The National Plan for HIV/AIDS prevention

From February 1998, the South African Government launched a new National Plan to fight HIV/AIDS, since the virus is being transmitted very quickly among the population. President Mandela declared it a national priority. This Plan aims at mobilizing every sector of activity to reduce:
- the spread of the infection;
- the impact of the disease on individuals, families, the society, the Nation.

A. Principles of the Plan

- Call on everybody to practice protective behaviour (abstinence, faithfulness to one's spouse or regular partner, use of condoms, fighting the use of intravenous drugs, protective material and behaviours for those medically at risk: medical doctors, nurses and hospital clinic or welfare centers staff)
- Develop a mass mobilization campaign ("focus, integrate, synergize the battle") :
  - **participation of all** in a non-party and non-political approach :
    (i) all levels of Government ;
    (ii) Governmental and non-Governmental structures (sectors and levels);
- Raise public **awareness** in order to obtain **behaviour changes**.

B. Ways and means

a) Political declarations and measures
- official statements from the Presidency;
- mention of HIV/AIDS in speeches made by Ministers and members of Parliament;
- laws to be adopted in combating the epidemic and **discrimination** against HIV-positive people and PWA;

b) Information and media
- information campaign involving the use of billboards, pamphlets, posters, T-shirts, etc. ..;
- messages aired on the **media** during **prime-time** (TV and radio) as well as debates, discussions, information documents, investigation articles (**in all official languages**);
- special events, gala dinners, concerts, rallies;

c) Mobilizing stake-holders and common people
- political debates : in Parliament, Ministers of Education and Culture, Provincial legislators, Councils;
- mobilization of **business people** (economic impact of HIV/AIDS on productivity) and labour (Trade Unions);
- information and condoms distribution in the work-place and distributors at shops on highways;
- local manufacturing of condoms;

d) High-risk areas and people (action targets)
  (i) Risk areas:
      public and private areas : hotels, airports, airlines, truck driver shops;
      hospitality industries : hostels, bars, escort agencies, massage parlors;
  (ii) Endangered groups :
- mobile professionals: soldiers, traders, travelers, students, long distance truck drivers;
- commercial sex workers;

- workers in **mining industry** (already vulnerable to TB);
- migrant workers (living away from families);
- jobless women and girls forced into prostitution.
- Infected parents' children (breast-feeding and promiscuity);

C. Co-ordination needs

Mandate of the **Essential National Health Research Committee** (ENHRC) : evaluate research proposals and studies (Cf. further on: Research and Development).
- Inter-ministerial Committee
  Chairman : Deputy President (He must report to Cabinet)
- National AIDS Advisory Council (NAAC)
  Members : stake-holders from all sectors of South African society;
              appointment approved by ENHRC;
              membership gender- and culture-sensitive;
- Intergovernmental Forum: for co-ordination between Provinces;
- Local Governments: co-ordination within the South Africa Local Government Association (SALGA).

D. Sectoral policies

1. Education
- Draw up **educational material** sensitive to different perceptions in different communities (adults and children);
- Train teachers and lecturers to **talk freely** to pupils and parents;
- Special education to street children (outside regular structures);
- Students councils and organizations.

2. Health systems (facilities and staff)
- Training in care and **counseling;**
- Development of cheap or free and voluntary testing facilities;

3. Media policy (Cf. above)

4. Arts and Culture, Sports and Recreation
- Identify and encourage aspects of South African culture complementing the **mobilization campaigns:** arts forums, dance, song, drama, poetry, story-telling;
- Artists and sportsmen to champion the fight through: public discussion, role models for safe sex;
- Messages at all major sporting events;
- Red ribbons on national sportswear;
- Sports and arts fund-raising events.

5. Legislative measures
- Legislative abolition of discrimination (work-place, banks and insurance companies, people's prejudices against infected and sick persons, even relatives);
- abolition of the pre-employment HIV-testing (public and private sectors);
- prohibition of dismissal linked to HIV (except in situation of work incapacity).

E. Mobilizing the civil society

(i)   *Religious communities* (one sermon/month and at funerals)

(ii)   *Traditional leaders* (messages at local meetings and public events);

(iii)   *Women* (Women's organizations - emphasis on their vulnerability to the epidemic);

(iv)   *Youth* (through school and non-school education programs).

(v)   *PWA* (educational messages).

(vi)   *Person-to-person links*
   - Encouragement of partner's notification
   - Confidentiality (between medical staff and patient, man/woman)

F. Community-based care and support

-   Community-based health care systems:
    through hospitals, hospices and home-care;
    care through farming and burial societies;
    care to infected orphans.
-   Social and economic support to:
    families having lost income and livelihood;
    orphaned children;
    care providers : parents and grand-parents.
-   Staff training for recognition and counselling;
-   Establishment of local AIDS committees;
-   Information channelled via drama, music, story telling.

G. Research and development (Cf. mandate of the ENHRC)
Objective: developing a knowledge base on:
            perceptions
            attitudes /similar/specific by age groups
            practices.

Social sciences: research to be developed concerning the impact of HIV/AIDS on:
            society;
            family;
            HIV/infected people and PWA.

4. Two innovative experiences

A. Soccer, love and HIV/AIDS: The LADUMA project

A photo-comic was initiated by the National AIDS Committee of South Africa. The story was generated through <u>workshops</u> with youth from Khayalitsha and Gujalitu, two townships in Greater Cape Town area. <u>Focus groups</u> were also held with youth in Kwanashu, Inando and Thornwood (Kwazulu-Natal).

It was funded by the Department of Health Western Cape, the Levi Strauss Foundation, the Australian Agency for International Development (AUSAID) and the British High Commission. Sponsorship for the project was given by the European Union.

The scenario deals with what happens to a young African from Khayalitsha, "who has big dreams for the future and a beautiful girlfriend to share them with". Moreover he is a brilliant soccer player, who may "head for the top of the soccer league". Unfortunately, he has a casual sexual relation with a girl already infected by one of his friends, without using condom and thus gets infected. He in turn infects his regular girl friend and this almost leads to breaking up their relationship and his dreams of a soccer career. There is however reconciliation, mutual notification and promise to practice safe sex thereafter.

This photo-comic is followed by a set of questions to be discussed either in school or in youth groups, sport teams, church groups, political groups or even informal parties of friends. Role-playing can also be developed on the basis of the story. Then, a practical demonstration of putting on a condom is made. An information section is presented after, in the shape of questions/answers. The final section summarizes the pedagogical content of the story by subjects: healers and clinics, partner notification, love, trust, clinic attendance, gaining respect.

Conclusion: This example is particularly interesting to describe, since its expected impact is based in two major values of young South Africans culture: sports, especially soccer, among the young Blacks, and the compound love/sex, both important components of the culture of modernity.

B. The workplace: a strategic site for prevention

The South Africa Department of Health and the European Union have carried out, in co-operation with the Community Agency for Social Enquiry, a handbook entitled: **Guidelines for developing a workplace policy and program in HIV/AIDS and STDs**. As noted in the foreword of the Handbook, "the business community in general and the South African business community in particular is in a unique position to make a difference in facing this new challenge, by developing workplace programs concerning HIV/AIDS and STDs.

The arguments for developing workplace programs are based on an entrepreneurial and market approach. Thus, it is emphasized that "HIV-related absenteeism, loss of productivity and the cost of replacing workers threatens the survival of a certain number of businesses and industrial sectors in the increasingly competitive world market". Besides, as the foreword of the Handbook points out, HIV/AIDS does not affect only workers, but, "by claiming a large part of the urban population with disposable income and by impoverishing families and communities, it also affects the market base of African business".

Thus, the mainstream approach of the Handbook is clearly entrepreneurial and economic. As such, it aims at involving the business sector, whose role in the new South Africa is crucial. But it emphasizes that, in order to make a significant advance in the fight against the epidemic, it is indispensable to build a true partnership by involving Government, the private sector and the community, in other terms civil society and, within the workplace, all employees.

The Handbook is divided into 7 sections: basic definitions, elements of a successful strategies, policy development and legal issues, personal issues, prevention programs, illness management, monitoring and evaluation of programs. The Handbook includes practical proposals such as selling condoms together with other leisure goods: cold drinks, cigarettes, sweets, and chocolates, also available in vending machines.

It also contains certain informative data and mentions items of an explicit and implicit socio-cultural nature. For example, among the <u>socio-economic determinants of HIV/AIDS</u>, the Handbook mentions: migration and migrant labour;

single sex hostels;

overcrowded housing;

lack of recreational facilities;

lack of accurate information;

high unemployment;

women's exploitation.

All these are subjects that weigh on culture and cultural components and "make it difficult for people to take control of their lives", as said expressly in the Handbook. Among the concerns of employees, that of treating infected people and the preservation of confidentiality are considered as crucial, as well as collaborative approaches, discussions, consultations, peer education, commitment and credibility of those involved in the Program.

Two examples of successful prevention programs are described in the Handbook:

<u>David Whitehead Textiles</u>:

The main points in this example are the following: "to show workers that the company cares":

- production of a theater plays and comic books in various languages and places, including theaters, night clubs and school halls;
- informal information and advice to employees, individually or in small groups, including sex workers, possibly teams working on the field, in bars and beer-halls, on farms or local soccer matches.

Through wider distribution of condoms, less sexual wandering on the part of men, collaboration between management and employees, staff education, STD cases in the company decreased by about 50 to 75% from 1989 to 1992.

<u>Mutare HIV Prevention Project</u>:

The Health Department of MUTARE City, where 20,000 cases of STDs were already treated in 1990 (25% of the adult population) is developing a prevention program focusing on high risk groups and formal sector employees, which are met by peer educators in social settings, including beer-halls and sports fields, in meetings and at work. The educators were selected on the basis of age (18-30 years old), enthusiasm and capacity to communicate and give information, on the occasion of condom distribution for example. STD rates fell by 48% within the first year of the Program.

Conclusion: Thus, even if the major argument in the Handbook is the good management of the enterprise, the staff is also viewed as a human community, with its own societal and cultural features, which are taken into consideration to some extent.

5. International Co-operation: the British case (DFID)

The British Department of International Development has agreed with the South African Government to direct its support of National Health Policy in two key areas:

- Basic health care services available to all, especially the poor.
- Improvement of reproductive health, including STDS and AIDS.

<u>Support at Provincial level</u> will focus on three disadvantaged Provinces: Northern, North Western and Northern Cape, which, in spite of their world-famous mineral riches, have extremely poor black populations, whether miners, farming workers or tribal communities.

The current projects deal with general institutional issues like:
- the establishment of a national health care service,
- human resource development and organizational arrangements,
- essential medicine provision.

Other projects are more concerned with the issue of relevance:
- black farm communities;
- rural settings or urban population, notably within the Greater Johannesburg area;
- townships and informal settlements, like Khayalitsha;
- STD/HIV control in the mining industry.

III.   FIRST APPROACH TO IN-DEPTH INVESTIGATION

1. General interactions between development, culture and HIV/AIDS

The above general description of the National Plan against HIV/AIDS allowed for the identification of some of the cultural aspects involved, explicitly or not, in the National Plan. Taking a cultural approach to the prevention and care of the epidemic would require a much more in-depth analysis of the societal and cultural references and resources, which will enable the building of culturally-appropriate project designs, training/awareness, information and research.

From this perspective, as a preliminary work, it appears necessary to identify and describe the following characteristics of the present situation:
- Overall interactions between culture, development and HIV/AIDS in South-Africa;
- Socio-economic and cultural impact of AIDS
- Cultural references to take into consideration in building sustainable and relevant projects for preventive action and humane treatment of the infected and of People with AIDS;
- Cultural resources to mobilize, not only public institutions, but above all the civil society in a community-based and participatory approach.

A. Overall interactions

As the word "interaction" implies in itself, the relationship between culture, development and HIV/AIDS is a two-way process. On the one hand, it is crucial to assess the impact of HIV/AIDS on culture and development in the context of the South African economic and social system. However the real situation involves a more in-depth and interactive process between three sets of phenomena: cultural, developmental, pathological.

At the most fundamental level, the long-term effects of the former apartheid regime are present in all aspects of the country's life, whether in economic or social development, in spite of the considerable effort made by the present Government. But culture is a key issue where the scars of the past are still visible, as are the references and resources for creating a better future.

Thus, it is important, to adopt a societal and cultural approach when drawing up the outlines of a comprehensive strategy to fight the epidemic, in the wider context of the country's development. Since value systems and societal norms are the only reliable basis for the country to mobilize itself against HIV/AIDS, as part of defining its specific way to work for its development. This is how the overall economic and social development in the country must be understood in its major features.

B. The apartheid trauma

It should first be emphasized that, due to the long-term effects of the apartheid policy, deep traces are still visible in all sectors of the economic, social and cultural life of South Africa. Simultaneously, the present cultural resources are partly linked with these traumatizing experiences, which forged the spirit of the South African population as it is today, whether they maintained their cultural traditions or built, through the struggle for their rights, a culture of resistance, self-assertion in a more equitable society.

Nevertheless, apartheid, though in principle abolished since 1990, has had long-term consequences on the greatest part of the non-White population which go far beyond medical and sanitary issues. This requires that a comprehensive response be built, if a culturally-appropriate understanding of the epidemic and the strategy to combat it are to be found.

More specifically the former Homelands and Bantustans system also left deep traces on the geographic distribution of populations, entailing socio-economic and socio-cultural unbalances with the inherent consequences on the HIV/AIDS issue.

C. Development: Economy above society ?

a) Demographic vs. income disparities.
In the first place, it may be of use to recall the main population data. According to the **UNESCO Statistical Yearbook for 1997**, the total population in South Africa in 1995 amounted to 41.465.000 people, of which 30.613.000 (more than 65%) were black Africans, 3.472.000 coloured, 1.039.000 Asians and 5.092.000 (12%) Whites. In other terms, about 88% of the total population were non-White.

These proportions were not adequately reflected in the economic development of the country. For instance, the average GNP/inhabitant was 4.291 dollars en 1994. At the international level, South Africa ranked 29th for GNP in 1996 (128 billion dollars), overtaking some European countries, like Finland.

b) Income gap between communities and regions
According to the **UNDP Report on Human Development for 1997**, the GNP/inhabitant in South Africa raises from 516 dollars for the 20% poorest inhabitants to 9897 dollars for the 20% richest ones. 24% of the total population was living with less than 1 US dollar/day from 1989 to1994. It should be recalled that, at the world level, 80% of the global resources are consumed by 20% of the total population and 20% by 80%.

Deep inequalities can be observed between the average household income for the Whites : 4.695 R, the Indians : 3.371 R, the Coloureds : 1.744 R and the Blacks : 757 R. In other terms, the average GNP for the black population is almost seven times lower than the average for Whites.

Similarly, the income situation is very contrasted between the Provinces: 35% GNP for Gauteng (7.2 millions inhabitants), 13.5% for Western Cape (4.1 million), 7.5% For Eastern Cape (6 million people), 7.2% for the Free State (2.6 million). Thus 63% of the GNP is absorbed by 20% of the population and 27% by 80% people, and more specifically, 35% by 3.5% of the total population.

All these figures obviously relate to a possible map of the extension of HIV. Such a study would help to visualize the correlation between economic poverty and the areas where the infection prevails.

D. Social development

These dramatic inequalities are reflected in all fields of social development, especially education, health and sanitation, whose impact on the epidemic is notorious.

(i) School education
In 1995, as regards school education, almost 28% (more than 10 millions) of the black population had had no schooling (only 500.000 Whites), 33% incomplete primary school, 13.5% complete secondary and 0.5% university degrees. These figures should be borne in mind when testing the potential receptivity of the non-White population to information-education-communication (IEC) in its classical forms, especially as regards HIV/AIDS prevention and care.

Another critical factor linked to the past is the contrast between the gross number of teaching personnel and their cultural capacity to shift to new teaching patterns, needed for preparing children and young people for their future.

(ii) Health and sanitation

 The health and sanitation situation in South Africa, which relates mainly to the non-White population, gives a set of valuable indicators of the difficult life conditions of almost 90% of the total population and the state of diseases generally speaking. 17% of the population risk dying before 40 years of age while the average life expectancy is almost 64.

Other impressive health indicators are the following: 25% of children under 5 years suffer from malnutrition, child mortality rates range from 9/1000 among the Whites to 65/1000 among the Black people, while the major diseases affect mainly the Black population areas: malaria and bilharzia in Kwazulu Natal, tuberculosis in the townships of the mining industry zones (6 million infected).

Access to medical care and pharmacists is also very unequal according to the importance of the White or non-White population. Moreover, most medical doctors belong to the private sector and the poorest patients cannot afford to consult them. Besides, the lack of cheap transportation to medical centers also bars access to health care, for people living in remote townships or rural areas. This might contribute to explaining people's concepts and behaviours concerning a specific disease like AIDS and their frequent recourse to traditional healers.

(iii) Employment

The employment situation also reflects the other inequalities in the country: 32 to 40% of the population living in the townships and poor suburbs of the major cities are not employed. The average unemployment rate ranges from 8% of Whites to 37% of Blacks (23% of the Coloured population). Among the 300.000 young people looking for a first job each year, only 10% will find it within reasonable delay. Most of the new jobs are created in the two richest areas of the country: Gauteng and Western Cape Provinces, though with large wage differences.

2. The multifaceted impact of HIV/AIDS: Economic, social, societal and cultural.

A. Economic and social impact

The economic effects of the infection on the country's economy have already been described, in terms similar to those used for showing the impact of the disease on Africa's general development. By the year 2000, if the epidemic continues to grow, as much as 20% of South Africa's economically active population may be HIV-positive. The strongest impact of HIV/AIDS will be on productivity, costs and the national economy. Industry, trade and services employers can make a positive contribution in combating the epidemic by implementing and sustaining on-the-spot programs on HIV/AIDS and STDS.

(i) Productivity will be reduced by absenteeism or loss of morale.
(ii) Costs will increase if the employer has to pay for additional employee benefits. The loss of skilled workers due to AIDS means there will be a need to train new workers.
(iii) The macroeconomic effects of AIDS are more difficult to assess. It appears that the epidemic will reduce national output and people will spend their savings on health care and insurance rather than invest them in the production or consumption of goods. Over a 20-year period, economic output could decrease by 25%, as compared with what it would be without AIDS. More specifically, growth may slow down and fewer services may be provided (and needed). As concerns capital for the private and public sector, the effects on life insurance and pension funds can be dramatic.

For the general population, the HIV-infection will in all cases mean expenditure for medical care if a free care-system is not available or not physically or culturally accessible. Very often also, it will lead to dismissal from jobs which in turn implies the end of money-sending to families, whether living near the work area or in the original village or tribe, especially for those in neighbouring countries (Lesotho or Swaziland for instance). If father or mother dies, taking care of orphaned children can be accomplished by the family, especially grandparents, in the best hypothesis. If not, widows and children can be expelled from their previous lodgings and orphans abandoned in the streets of big cities (92% abandoned children in 1992 were Blacks).

B. Cultural/societal impact

Many infected people remain fully unaware that they are HIV-positive, since testing systems are far from being available everywhere.

But, when detected through HIV testing, the societal and cultural short and long term effects of the infection are generally disastrous, for the infected person as for his/her human environment (family or group).

a) It is frequently a motive for rejection of the infected and even more the sick person from their job, pushing them at the same time into the disease, socio-economic collapse, moral and cultural distress. They may also be pushed away from their family or village, especially for women.
b) This is why the infected person, may in many occasions feel so depressed and ashamed of the situation that he/she will not dare to inform his/her sexual partner, even if they are spouses or regular partners.
c) In other cases, he/she will pay no attention to being infected, because of their generally

disastrous situation or due to lack of concern regarding an occasional sex mate.

d) In the most extreme situations, AIDS can result in an <u>AIDS rage</u>, when the infected person will purposely infect new sexual partners, as a revenge against getting the virus.
Another possible attitude is to take the risk consciously as a kind of challenge or gambling attitude, somewhat similar to using fire arms or driving stolen cars at maximum speed, an attitude which can be met among certain urban segregated groups of young people.

e) Another frequent reaction may push the infected person to hesitate between whether he/she should choose <u>modern medical service or traditional healing</u>. For the most-educated and city-integrated part of the society, and also, to a more limited extent, the younger generation, recurring to modern medicine or social service will be the obvious choice, provided it is geographically and economically accessible. For many others however, especially among the poor and segregated, recurring to a traditional healer will appear more natural, familiar and reliable - and also a better guarantee of confidentiality.

f) But the most aggravating factor is the <u>cultural shock</u> generated among the younger population by fast emergence of the urban/modern worlds where new migrants, whether from foreign countries, rural and tribal or semi-tribal zones, must face at once the world of material interests, individualism, ruthless competition, unemployment, poor or no housing, and other aspects of the daily lawless "struggle for life".

3. A cultural shock: urban/modern vs. traditional/rural model

<u>A. Urban explosion</u>

Contrary to other African countries, South Africa, though it includes vast unexploited regions of natural life (some of them classified as National Parks), is definitely an urban, modernity-aware society. The national rate of the urban population growth is 55,4%, with great differences according to the Provinces : 96% for Gauteng, 90% for Western Cape, 43% in Kwazulu Natal and 12% only for the Northern Province. These percentages however reflect considerable differences : Johannesburg and Soweto amount to 5 million people, with 1 million in Pretoria. It is foreseen that these two cities merge into a conurbation of ten million people before the next generation. The other major urban centres are Durban (3 million people), Cape Town (2 millions) and Port Elizabeth (1 million). All of them are surrounded with huge townships: Alexandra, Soweto and Sharpeville near Johannesburg, Malemodi near Pretoria, Kwamashu near Durban. Other big townships have a reputation of being specially squalid: Khayelitsha, near Cape Town, Edendale, Kwanabuhle, Dimbaza, Botsabelo, etc...

However a new urban policy is being developed by current Government, notably in Soweto. Habitat is gradually improving, with four broad categories of housing, though very unequally distributed:

- comfortable bungalows where lower middle and middle class Black families will live
- government-built three-room houses with running water and personal sanitation.
- makeshift cabins built by people on government allocated pieces of land, with outside running water and toilets.
- Last but not least, large quantities of shacks built in backyards, innumerable squats and large dilapidated hostels with big dormitories for single men.
These are the areas where great poverty, social disturbance, poor education and health and violent behaviours converge.

At the national level, migrations from the rural to urban areas are growing at a fast pace: 50% of the Black people (around 16 million) are living in cities (most often in poor townships and suburbs), while about 90% of the Whites live in urban centers (about 4.6 million). These migrations have resulted in the growth of slums, shantytowns and squatting areas (25% of which are found in Gauteng). The most precarious housing system however is the huge hostels, where up to 10000 people are squeezed into one location.

Generally speaking, urban development is extensive, with highly-concentrated downtown districts, with high buildings including skyscrapers (the central district of Johannesburg for instance), residential areas for upper middle class, carefully segregated from downtown, very extensive and remote suburbs of little houses (match boxes) and informal housing, deprived of commercial, social or cultural facilities and, very frequently, water, sanitation and public transportation networks. The only places for socializing are the churches of the numerous branches of the South African Protestant Church or, for popular recreation: "shebeens", informal bars and discos. Cultural facilities are still very scattered and most new creative activities take place in informal settlements or in the open.

B. Urban life and violence

As in many fast-growing cities and city suburbs all over the world, the rate of crime and violence has grown quickly since the '80s, parallel to the "wild" urbanization rush and the climax in the official repression policy during the national struggle against apartheid. It evolved gradually towards fire arms trafficking and the banalization of their use by gangs or hooligan groups, which further inflated the unemployment rate among young people.

Drug addiction and smuggling (cannabis, mandrax and hard drugs), which had not been in use for a long period, also grew very quickly and alcoholism worsened. "Dirty money" from various traffics was easily washed in Bantustan casinos. Presently, among the biggest international drug mafias, more than 25% operate in South Africa. In spite of the efforts made by the new Government, criminality remains unchanged at a high level in the biggest cities: 67.000 hold-ups with fire arms in 1996, 250.000 housebreak-ins, 51.000 rapes and 26.000 murders. Car robberies with arms can even occur during the day, whether downtown or on the road.

Contrary to the publicized opinion, the most heavily affected victims are the Black population, especially those living in townships, where security services are very frequently absent. It also affects, though less heavily, the White residential suburbs, where redundant protection systems and, more and more frequently, private watchmen, are commonplace.

All these manifestations of violence and the growth of crime can be considered as indicators of a culture of despair, which grew out of the enduring social, economic and cultural exploitation of the Black community, which dates back more than one century and still keeps a large part of the poorest population seriously wounded.

C. Rural development: productive agro-industry vs. subsistence agriculture

The situation of rural development in South Africa is also very contrasted. 76.000 White farmers practice productive agriculture, highly mechanized for the domestic and export markets: corn, cereals, wine, sugar, fruit and vegetable, cattle and animal products. 1.2 million agricultural workers, mostly Black, are employed in big plantations. An important number of them, employed only temporarily, are clandestine immigrants, who live in very uncomfortable hostels, while others live in small local cabin villages with their families. Regarding land ownership, 13

million Blacks own 13% of the cultivable soil, mostly in bad lands and dry, non irrigated areas - another enduring outcome of apartheid. The land tenure reform, though already planned and designed, is very slow to put into practice, for technical and political reasons. Consequently, subsistence agriculture on small plots remains the main source of income for many people and poverty is growing.

Thus life conditions for the rural populations are very difficult: 74% of these live below the poverty line. This is obviously one of the major motives for the continued rise of migratory movements to the big cities. In the poorest regions, the North and North-West Provinces and, to a lesser degree, Kwazulu Natal, rural populations are highly affected, families are disintegrated by men's migrations for economic reasons, and tribal communities, increasingly impoverished and culturally destabilized both by the former Bantustan system and the crushing modernization process. In some areas, the recent situation has been compared with the life conditions of the Amerindian communities living in reservations.

IV. CULTURAL REFERENCES AND RESOURCES

1. Cultural traditions

Generally speaking, tradition advocates in South Africa want cultural differences to be notorious. During the apartheid period, they would even speak of cultural weapons. In this respect, the most striking example is the Kwazulu community, among which traditional costumes and other visual signs of cultural identity are still frequently displayed and their feeling of self-dignity is still powerful and publicized. Respect for authority is also one of their most important values, more specifically for their traditional chiefs, above all the King of Kwazulu Natal. The two enclaved countries of Lesotho and Swaziland have also their own kings.

Another important feature is their concern for preserving African cultural ways of thinking, knowledge and values, contrasting what they consider the progressive Americanization process at work in the country, according to their opinion. In this respect, they are opposed to the Western-oriented modernization policy practiced by the present government. The Xhosa culture is the second most important among the Black population: it rests on strong beliefs in natural forces, white and black magic and the community is ruled according to a flexible hierarchical system.

In a matter of health and medical issues, they would rely on traditional medicine and traditional healers, which some of the authorities see as possible intermediaries for shaping and conveying health messages to rural populations and underprivileged urban areas. Moreover, the influence of the chiefs and the elders can be used to advise the younger generations against sexual carelessness, to the extent that young people are not losing necessarily their traditional cultural references. When still observed, rituals for youth initiation, circumcision, marriage and funerals may involve sexual information and relations.

2. Traditions and Medicine

Traditional knowledge, though not truly exploited, is a more or less complete corpus of scientific-like knowledge, know-how and conceptual representations and a source of references concerning the body, health and disease, life, death and after-life.

People's attitudes and opinions, as regards recurring to traditional healers, is a strategic part of their cultural traditions, whether in urban or rural areas, whatever their religion, education and income might be.

These have to be distinguished from fortune-tellers or black magic sorcerers. If the first ones are frequently consulted by numerous people, sorcerers on the contrary, are feared and hated by most people, many of whom still believe in their fatal power, especially among the Kwazulu and Xhosa population. Their activity is forbidden by the law.

As regards traditional healers, it is very frequent to consult them for common health problems: bone-setting, light diseases, curable by herbs or medicinal drinks. In more serious cases, traditional healers will be asked to remove voodoo or the evil eye, which are considered to be the origin of emotional problems and even certain diseases.

There are some whose traditional healers in South Africa. They practice their profession even in big cities and the largest townships like Soweto. 80% of the patients consult them for medical reasons, most often before going to medical centers or doctors. This is even the case with STDs

and specifically HIV/AIDS, because of their faith in these healers and their cultural and practical accessibility.

When asked how they view their responsibility and efficiency in this respect, some traditional practitioners reply that they can alleviate certain effects of STDs, and remind people of their duties and responsibilities towards their own body and their people. Moreover, patients will ask them for help in clearing up their life issues, understanding their future and counselling them for personal or family decisions. Thus traditional healers play an important role by being open to people's concerns, listening to their daily troubles or serious challenges and counselling them, with their own cultural world representation, language and semantic stock. After several years of lobbying, they were finally recognized by the Government as forming part of the national health care system.

3. Religious beliefs and practices

Another crucial aspect of South African cultures is linked to religious beliefs and practices, whether Christian, animist or syncretic. Each religion coexists with other ones, in a kind of culturally stratified and interactive system.

A. Christian churches

The importance of Christian churches, mostly Protestant, in South Africa's evolution and popular practices should be emphasized. Religious adherence is a crucial constituent of social life in all communities. The Afrikaans and English speaking communities are committed to their religious faith and celebrations. The most important religious community is however the Dutch reformed church, with 5 million followers, 1.5 of which are Blacks and 1 million Coloureds, while the remaining 2.5 millions are Afrikaans. The Anglican church, a famous leader of which is Bishop Desmond Tutu, amounts to 3 million devotees. 5 million Methodists are strongly supported by the American Methodist church. Other groups are the Roman Catholics 3.5 million (80% Blacks), and the Presbyterians and Lutherans with 2 million adherents, supported by British or Dutch missions.

All these religious communities have a strong and official influence on the country's life. Many of them developed solidarity networks and social, educational, cultural or sport associations and clubs during the apartheid period. They used to- and still do - intervene openly in public life and political matters, even the most difficult ones. From the institutional side, reciting Christian prayers or asking for God's protection of the country is a common practice, even at the highest levels. Many churches and missions played an important role in the fight against apartheid and have in the past provided education to the emerging Black political leaders, first within the framework of the religious education, then to train African elites for the future.

B. Towards syncretic cults.

Another original feature of religious life in South Africa is the flourishing of local churches in which Protestant Christianity and heavy emphasis on the Bible is combined in collective ceremonies with singing, dancing, ecstatic trances and "miraculous" disease relief. However, these churches are violently opposed to traditional healers and witchcraft. Besides these ceremonies, these local churches develop considerable charitable and compassionate actions in taking care of spiritual and social distress, due to diseases – such as HIV/AIDS - and great poverty among the most deprived people. Some 8 million faithful follow more or less regularly

their ceremonies and observe their charity rules. One of the most active ones is the <u>Zionist Christian Church</u>, supported by the US Pentecostal church, it counts around 3 million devotees.

C. African animist religions.

In spite of this wide spread Christian religiosity, African animist religions are still very much alive, especially in the rural areas and tribal populations, for instance the Venda community at the border with Botswana. Other tribes live in dry areas where rain making is a highly prestigious religious activity. In spite of specific features linked to tribal and location differences, all these religions have the belief in one supreme God with several less important divine figures in common. Communal and personal taboos are strictly observed. The cult of ancestors, as bearers of lineage and tribal identities, whose knowledge is carefully recorded and kept alive by tradition experts, their benevolent or malevolent powers vis-à-vis their descendants, if respect and rituals towards them are not carefully observed, is another important aspect of animist beliefs in the country. These practices and beliefs can be linked to the celebration of all Saints community in christianized areas - another example of religious syncretic religiosity frequently met in the country. Similarly, the nearest ancestors (parents or grandparents) are invoked in a semi-Christian semi-animist spirit. Both types of religious beliefs coexist with many people - another manifestation of emerging religious values and practices.

Birth, puberty, marriage, death, are all celebrated through important religious ceremonies, including sacrifices, dancing and singing. Boys' initiations are linked with circumcision, an opportunity which could be taken advantage of to inform them about HIV/AIDS. Whether such initiatives are undertaken is not documented.

D. Islam and Hinduism.

Hindus make up 70% of the Indian community, of whom 20% are Muslims. They are known for their great sense of solidarity and hard fight against drug smuggling and addiction and sexual carelessness both outside and inside the community.

4. The Rainbow Country: A Multicultural Challenge

From its beginning, the new South African challenge was to shift from division and hate to a multicultural society which Bishop Desmond Tutus called the Rainbow country. A National commission for Truth and Reconciliation, whose report is now passionately discussed, was appointed to this effect. Diversity in communities and language is only one facet of the country's fundamental plurality, which will have to be managed responsibly and with respect of all.

A. Communities

a) The Bantu peoples
As previously mentioned, 30,6 million South Africans belong to the Bantu cultural and linguistic area, with the exception of the <u>Khoisan</u> (Bushmen and Khoikhoi), two other very small ethnic and cultural groups.

Most Southern African <u>Bantu</u> peoples are either Nguni (Zulu, Swazi, Xhosa) or Sotho (Tswana, Pedi, Basotho). The Nguni live around the South and East coasts and the Sotho-Tswana are mainly grouped on the high veld. As for the <u>Venda</u> peoples, their origin is still being discussed.

Zulus are the largest group in the country (7 million), followed by the Xhosa (6 million) and the various Northern Sotho people, most of whom are Tswana. The smallest group is the Venda (500 000). While the Zulus live mostly in Kwazulu Natal, the Xhosa are concentrated in the Eastern Cape Province, the Tswana and Sotho in the neighbouring areas to Botswana and Lesotho and the Venda in the Northern Province.

The Homelands system, abolished in 1994, nevertheless left traces in the population's geographical distribution, both in the concentration of peoples in rather poor areas or in badly equipped zones in terms of public health services.

b) The African immigration
Another important group in the Bantu population is the recently immigrated African community, originating in the neighbouring countries. It amounts to more the 1 million people, whether in legal or illegal situations. Around 250.000 Mozambican refugees from the war period have remained in South Africa since. Other immigrants come from Lesotho and Swaziland due to the dire economic situations of these two countries. Working emigration from the two enclaved countries is very high: 60% of Lesotho men's work income comes from South Africa and 200.000 immigrant workers come from Swaziland. Congolese immigrants come mainly from the Katanga region, for reasons of political instability in that area.

c) The Coloureds
Under the general name "Coloured", a rather heterogeneous group of people is categorized: either descendants of Black slaves, especially Khoïkhoï, and European first settlers, as well as African or Asian people from various origins, including descendants of Chinese miners. The most important Asian community however is of Indian origin, descendants of the sugar plantation workers, and now specialized in trade and commercial professions.

d) The White communities
The White population amounted to around 5. 092. 000 in 1995. 60% of them are of Afrikaans descent and most of the rest are of British descent. Their presence in the country dates back to the 17th, 18th and 19th centuries, according to a well-known historical process. The most recent White immigration wave developed during the apartheid period, amounting to 40.000 a year in 1975, with a total of more than 700.000 from 1970 to 1990. Most of them originated in the Mediterranean countries, Italy (through Ethiopia), Cyprus, Portugal (through Angola) or Eastern Europe (mostly from Jewish communities) and from Israel. The Jewish community in South Africa (100.000) plays a very active role in the trade and business sectors, as well as in educational and religious life, while immigrants from the Mediterranean countries work frequently in the food and catering sector and belong to the Roman Catholic or Orthodox Church.

B. Languages

South Africa has 11 official languages. This complex situation is co-ordinated by the **South African Language Board**, which watches that these languages can be spoken and written in the administration and are equitably represented on radio and TV. Another problem in this respect is their use in the school teaching system.

The oldest languages are Khoi and San, the famous click tongues hardly spoken today among the few thousands remaining and more or less mestized aboriginal tribes. These are presently confined to the semi desert areas of South Africa, Botswana and Namibia, but now benefit from a great deal of public attention aimed at preserving their survival.

Among the <u>Bantu languages</u>, the most wide spread are the Zulu, Xhosa, Swazi, Ndebele and Tsonga. The second most important official languages are Sotho, Tswana, Venda, Swati and Xitonga.

Roughly speaking, 8 million people speak Zulu, 7 million Xhosa, 1 million Swati and 0.6 Ndebele, amounting to 16 millions. Sotho and Tswana are spoken by 10 million people, Xitonga by 2 million people and Venda by 0.7 millions. These figures give a good idea of the cultural diversity of the various components of the Black community.

The use of these languages is not limited to purely ethno-cultural communities. Several languages are sometimes spoken in the same family or group. Thus most people have to speak several languages, for reasons of individual and inter-community relations and even more now due to the increase of urban migration.

The social and private use of these languages is widely differentiated. For example, Tsonga is mostly spoken at home, by women, while Zulu is used in public places, and mostly by men. Some people speak a mixture of several languages, for instance one of the Bantu languages as well as Afrikaans and English.

Among the White community, <u>Afrikaans</u> is widely spoken in Gauteng, Free State, Eastern and Western Cape. <u>English</u> does not dominate in any Province, but is continuously gaining ground everywhere, especially among the Black population. On the contrary, 90% of the Coloured community speaks Afrikaans.

This linguistic diversity is only partly reflected in the mass media (see above: Media policy). This gives an idea of the complexity of the language problem in the matter of information, education and communication on all subjects, including HIV prevention.

V. THE MOST CULTURALLY-FRAGILE GROUPS

The most endangered group is by far the <u>African population between 15 to 40</u>, not including orphans or abandoned children, among which the infection has multiplied by 20 from 1990 to 1996. Each day, 1500 new persons get infected. The highest rates of infection are found in the Northwest Province: 25% of the population is HIV positive, probably due to its proximity with border areas or townships and shantytowns surrounding the Gauteng industrial area (Johannesburg and Pretoria). The other highly infected area is Kwazulu Natal (21%), this is surprising given the impressive strength of the Zulu cultural identity which might be thought to act protectively. The foreseen growth of the infected population is 2.8 millions in 2000 and 4.5 millions in 2005.

The aggravating factors of the epidemic's expansion are linked with poverty, migrant labour, lack of education, unemployment, poor or in-existent housing and health services. In terms of recreational activities, lack of sports and social centers for young people is another factor that leads to a shift to informal leisure activities related to the "disco" culture, with its possible risky behaviours. But the deepest reasons are grounded in the overall value crisis and dramatic weakening of community links with regards to the poor and sick, including those infected with HIV/AIDS. More generally, a widespread cultural destabilization interacts with destabilizing factors in the political and economic situation of Southern Africa (in terms of bi-directional cause-effect process), as emphasized in the running of the UNAIDS Workplan.

1. The crisis of family patterns

Concerning poverty, the aggravating factor is the family crisis, linked to the separation of parents for economic reasons, or artificial rigidity in family power structures, in reaction to the crisis itself: submission of women and children to the worst aspects of poverty and their interaction with it. The most serious consequences of this situation is the accentuated abuse of increasingly younger girls, possibly through incest, or forced prostitution on the one hand and the absence of education, leading to early work, paid or not, and illiteracy on the other. Together with insufficient nutrition and miserable living conditions, this situation creates attitudes of resistance to HIV/AIDS prevention messages, leading among others things to complicating the accessibility that young women and girls have to sanitation or health facilities. These difficulties of course increase the risks of catching diseases, among which lie STDs in general, and HIV/AIDS in particular. This in turn results in a growing incapacitation to work and aggravated poverty, thus supplying yet another shock to existing family patterns.

Moreover the growing urbanized population weakens the traditional solidarity which has long existed within the extended family system, progressively replaced by the nuclear family pattern derived from the modern life-style or more individualistic behaviour, an characteristic of the market economy ethics.

2. Migrations: breaking cultural identity

Another important aspect of the epidemic's expansion is directly linked to domestic and country to country migrations from Central African countries to South Africa. Refugees, migrant workers in general, and people subject to great professional mobility are important actors in the dissemination of the virus. Certain professions are specially at risk of catching diseases: for instance, long distance truck drivers and seasonal farming workers, employed for harvesting or picking fruit.

In most cases, migrant workers employed in big firms, mining or industrial farms, live in collective hostels, where they are separated from their wives or regular sexual partners. They may then turn towards prostitutes, occasional sex partners or share women. These practices often go together with alcoholism and increasingly drug addiction, especially among the younger generations, all these factors lead to unsafe sexual behaviours, while reflecting the overall human isolation of this sector of society.

3. Culture, AIDS and gender

Women represent 52% of the South African population. The average life expectation for women is higher than for men (almost 67 vs. 61 years), the average literacy rate is similar (82/80%). However, their economic status is far less equitable: women contribute only 31% of the total work income in contrast with 69% for men, probably due to their lower wages and non paid work, as is the case in many developing countries. This situation would probably be even more distorted, if it was related to income distribution between the various ethnic communities.

The average birth rate, which is slowly decreasing, is presently 3.6%, with 4.2 % among the Black women, 3.7% among the Coloured people, 2.2% for Asians, and 1.7% for the White population. The present demographic differences will continue to grow the non-White population will probably represent 90% of the total by the beginning of the 21st century.

As regards school education, girls are less present than boys: 93% at the primary level, 49% at the secondary level and only 1.2% in the higher education system.

As regards women's participation in political and economic life, women are twice more numerous than men in non-qualified service tasks, 88% of women are in secretarial or commercial services and 20% of men are in management and senior services. There are still very few Women in executive functions, whether in the political, administrative or economic sectors.

The basic set back that women face remains their lack of education and subsequent economic dependence, in the present gender and family pattern prevailing in most regions, although this is starting to change in the new emerging urban middle classes, where the nuclear family model is valued. In most cases, women with children depend on men for their economic survival. Unwanted pregnancies are still very frequent. Breast-feeding of infants remains a prevalent habit, deeply rooted in mother-child relation patterns as an image of life-giving and fertility, an immemorial belief in traditional cultures.

If their husband or regular partner does not give a woman sufficient money to cover the daily expenses, they will sometimes turn to prostitution or abandon their children. Thus, women have little choice when it comes to money-making activities or protection against unwanted pregnancies or HIV transmission by their partner. On the other hand, sexual infidelity is by far less common among women than among men: 80% of HIV infected women have only one partner.

Of course, the most endangered groups among women are professional sexual workers, who cannot usually refuse unsafe sexual practices and often cannot even identify their customers. Also endangered are young girls, frequently forced into sexual practices, sometimes within the family group or raped for reasons of sexual "cleansing" by infected adult men - a belief unfortunately still held by traditional cultural knowledge holders, even those living in the cities.

4. Subcultures: Sexual carelessness and drug addiction.

The respective situation of men and women in this terrain is significantly different. In certain tribal groups, polygamy is still practiced, in spite of its economic constraints. Multiple-partner sexual relations are however much more frequent among men living in urban areas. Many of them will obviously turn to this sexual behaviour pattern, due to their isolation from their usual family and community environment and support as well as a way of giving them a feeling of superiority. Moreover, in the absence of other leisure activities, sex will be the most obvious recreation for young men, even more so since sexual conquest and the multiplication of female partners is an important source of prestige among groups of young males. To some extent, urban life also makes boys and men more available and easier to approach for women, at least in the new middle class. Thus for adults as well as young men and women the importance of sexual activities should not be underestimated.

Up to now, it does not appear that the use of infected needles in <u>drug injections</u> plays an important role in the spread of the infection. However, the situation in this respect is changing quickly and the diagnosis could be significantly different within a few years.

Another important phenomenon is that homosexual relations between men are considered as a highly taboo subject. It does not seem to be a wide spread practice among the Black population, as far as can be seen from the information that is available on the matter. The only recognized exception is the imprisoned population for reasons of sexual isolation and promiscuity (141.000 prisoners, among which 46% were under 25, in 1997). It should be noticed however that gay movements and lobbies are developing, mostly among the White community, especially in the Capetown area, and struggling to make the Government take more important measures against HIV/AIDS.

5. Young people: A culture of hope or despair

The situation of young people is very critical. Because of incomplete school education (see above), many have no or very poor qualifications when entering the working world to try to earn a living. As previously noticed, only one of every ten young persons will find their first job within a reasonable period of time. For the rest, unemployment will be the rule, together with the absence of housing leading to their daily lives being spent wandering the city streets looking for a way to survive, this is the situation of teenagers and children, with or without parents (including AIDS orphans). Consequently, since the 1994 national elections when Nelson Mandela was elected president, one of the most pressing demands made by the population, especially the Black community, has been for jobs - especially for the young.

A. Young people and the city

Two different lines of development can be observed among young people, originating for the most part from the apartheid period, but that have continued to grow in the new political environment.

One trend is linked to the massive migration of young men to big cities, where they expect to make a living, through official jobs or working in some informal sectors, mostly non qualified and poorly paid jobs.

The second trend is the serious under-proletarization of the urban population and subsequent emergence of a counter-culture. Unfortunately, many young people, not even finding a job in the

informal sector, shift to illegal activities. Even those who do find a job often live in squalid locations or hostels, where they live cramped together in small spaces, isolated from their families for most of the year. In addition they are most likely locked into precarious work contracts, heavily exposed to alcohol, drug abuse and risky sexual behaviours and, due to the "wild" urbanization in an environment full of sometimes violent and criminal adventures.

B. The future and the past: hope or no hope

Rather paradoxically, according to opinion polls, among the Black urban population (50% of the total Black community) young people between 18 and 30 years of age show clearly differentiated life and culture patterns:
- 25% of them feel well integrated into the western, urban and industrial cultural model, and this can be seen from their value systems, life styles, preferences for the nuclear family and views about the future;
- another 25% feel strongly linked to traditions, in terms of their identity and origins and the need for respectful attitude towards authority and the elders;
- a third group, though still seriously bruised by apartheid in their socio-cultural values and behaviour norms, remains militant-oriented, even with the political changes in the country and this may result in reactions to what they consider to be the unacceptably slow pace of institutional reforms;
- the fourth group feels deeply segregated, with the daily life struggle and with no project for the future; they live in small groups and are receptive to some extent to pop music and some sports, but also highly exposed to alcohol, drugs and violence.

The two latter groups are at the highest risk regarding HIV infection, even more so for girls than boys. Some of these girls will turn early on to prostitution.

On the contrary, the first two groups are probably the most likely to find cultural resources in order to prevent the spread of the virus. For the first group, the strongest motivation will be securing their progress towards social achievement: good education, reasonable housing, "Ebony" style of life and good health. These are seen as a set of prerequisites to consolidating their new social legitimacy. However, the pursuit for this free style of life can also lead to risky sexual behaviour.

For the traditionalists, cultural resources are of an almost the direct opposite: keeping one's value systems and power structures can be called upon as major support through hyper-differentiation against the destroying power of uncontrolled modernization. The family pattern remains much more valid with them than among the three other groups.

VI. RESEARCH FINDINGS AND PROPOSALS

1. Research conclusions

A. Cultural Implications of the National Plan

As summarized above, the National Plan to combat HIV/AIDS explicitly entails - or subsumes - through its all-embracing scope, a number of cultural aspects or factors in many of its orientations and instructive directions. To this extent it is possible to assert that some cultural implications can be identified in the Plan - a fact that seems little publicized and not frequently observed in other cases.

The most important of these implications are linked to the following aspects of the Plan:
- Launch mass-mobilization at all levels and in all sectors, involving institutions, the society, families and individuals;
- Raise public awareness with a view to obtain sexual behavioural changes;
- Reach people where they are: people at risk, the HIV-positive, PWAs, socially segregated urban groups, also in remote rural or tribal populations;
- Develop messages on the media and through the educational system;
- Co-operate with the civil society: women, young people, students associations and movements, business and corporations, trade unions;
- Build community-based prevention and care systems;
- Adapt training for educators and medical staff;
- Recur to religious communities and traditional cultural leaders (and healers).
- Support new creativity related to AIDS (arts, sports, recreation)
- Focus action on the specially endangered groups: young people, women, and people professionally at risk;
- Develop research on people's attitudes, perceptions, and practices regarding HIV/AIDS.

a) Motivation for change
The core of the issue is the identification and mobilization of motivations which could make people change their sexual behaviours on their own initiative. The paradox is indeed that, according to the observations and judgments of high-level medical and IEC specialists, the actual content of messages devised to give people a clear understanding of the infection's origin and manifestations only reaches them in intellectual terms but does not influence behaviour patterns. Thus, this understanding does not entail the inward conviction needed to make people modify their sexual practices. This is of course where cultural references and resources come in, for groups as well as for individuals.

b) Mass-mobilization: from duty to consensus
A fundamental difference needs to be emphasized at this stage between the reaction of the institutional networks and agents which, through their professional culture, play a certain role in interpreting the instructions of decision-makers. To this extent institutions and their staff are used to implement instructions from above, which they understand through their training and experience, through their institutional culture. However they then need to make an effort at translating these orders through the top-down process in order to adapt their working methods to people's cultures and habits.

On the other side, the civil society needs to recur to its cultural references and resources before modelling its response. Thus the reply will be built on the basis of group and personal consensus,

acceptance, convictions and more precisely shared cultural references and resources, in terms of knowledge and perceptions, traditions, beliefs, attitudes and behavioural norms.

This is why a community-based health care system will have to be built on a fully participatory basis, with key local leaders, observers and families, including the HIV-positive and persons with AIDS. Thus people will feel mobilized only if they are reached on their own terms and on an equal footing.

c) Education: tailored to peoples knowledge
As a consequence, information, education and communication will have to be tailored to people's knowledge, value systems and cultural sensitivities. This will take place only with a two-way information system, where people's values will be integrated and accepted by those involved in collecting new medical data and explanations. These will be given in their language and using the available semantic stock through methods involving proximity and not exclusively through the mass media.

d) A cultural/societal treasure of energy
   (i) In this respect, the role of <u>religious communities, social movements</u> (women, young people, sports associations) and <u>trade unions</u> will be essential. They of course convey their own value systems and will observe whether the action undertaken to combat HIV/AIDS fits with what they consider to be their spiritual, ethical and practical mandate and related views.

   (ii) Along the same lines, <u>traditional cultural leaders</u> and specially <u>traditional healers</u>, might be approached to envisage their co-operation, since they are often consulted by people infected or afraid of being infected, not only as medical experts, but also as social and psychological advisers.

Concerning <u>individuals</u>, the Plan includes advice to practice abstinence, faithfulness to spouse or regular partner, and the use of condoms. This of course will be accepted only if people's principles, sexual culture and real life conditions fit with such moral requirements. It also recommends the notification of HIV-positivity to one's sexual partner (or partners). This recommendation raises even more difficult issues, since it is related to sexual taboos, spiritual/ethical models or, on the contrary, to social prestige through sexual conquests, especially among young men.

e) *The most culturally-endangered groups*
At an even more fundamental level, issues like unsafe sexual practices, the refusal to use condoms, drug abuse, alcoholism, sexual violence and prostitution are all parts of the overall situation of the South-African population. In addition, these socio-economic, educational and cultural factors interact with medical and health issues proper, such that these high risk behaviours are linked with the modernist mass culture popularized by certain media products and programs. They in turn can then spread out to a much wider part of the population.

This dynamic shows up even more clearly when considering risk groups. These groups are endangered at the same time by different types of difficulties, all of them with seriously destabilizing and segregating effects: unemployment, the poor state or absence of housing, poverty, lack of education. Each of these aspects is then further aggravated by a general cultural destabilization linked to migration, rural decline, instability in certain countries of the Region, prominence of production/consumer culture, rapid urbanization and, above all, the gradual transition from the apartheid period to the new Rainbow country project.

f) Research on a cultural approach to HIV/AIDS: A priority

In this perspective, crucial importance should be given to the decision, included in the National Plan, to start a <u>Research program on HIV/AIDS</u>, consisting of two major activities:

(i) Developing a knowledge base on people's perceptions, attitudes and practices vis-à-vis HIV/AIDS, with special emphasis on similarities and differences by age groups.

(ii) Evaluating the impact of HIV/AIDS on the South African society, family, infected persons or People with AIDS.

B. <u>Prerequisites to culturally-appropriate strategies, programs and projects for HIV/AIDS prevention and care.</u>

In order to fit with the general terms of reference of the South African country assessment (see Annex I) and the methodological proposals made in the UNESCO Manual "A cultural approach to development", it appears that in order to build culturally appropriate strategies, programs and projects in the South African context, the following prerequisites will have a to be observed:

a) Taking a holistic approach to HIV/AIDS prevention and care with a view to integrating its cultural determinants, impact and effects;

b) Building strategies and policies in a long term perspective, resulting in
   - ten-year strategies,
   - medium term programs,
   - short-term plans and projects.

c) Balancing regularities and diversities through defining common or specific objectives, modes of action and expected results, at the relevant level (national; regional, local),

d) Enhancing participatory action, in order to provide more concrete knowledge of the field and mobilizing the local population,

e) Building culturally-appropriate action, tailored to people's cultural references and resources.

2. Methodological proposals

The Methodological proposals can be summed up under four major headings:

A. Elaboration of a project design handbook.
B. Drawing up training/sensitizing programs (capacity building).
C. Information-data collection and processing.
D. Further research needs identification.

These four categories of activity are interrelated. Moreover, all of them have a high degree of urgency and they should be undertaken simultaneously, as a follow-up to the various country assessments.

They should allow to define and put into practice the actions and means of entailing significant changes in the sexual value systems and practices in an enabling environment.

ANNEXE

EDUCATION POLICY FOR HIV/AIDS NATIONAL POLICY FOR LEARNERS
AND EDUCATORS IN PUBLIC SCHOOLS AND STUDENTS AND EDUCATORS IN
FURTHER EDUCATION AND TRAINING INSTITUTIONS

PREAMBLE

AIDS (Acquired Immune Deficiency Syndrome) is a communicable disease that is caused by the Human Immuno deficiency Virus (HIV).

In South Africa HIV is spread mainly through sexual contact between men and women. In addition, around a third of babies born to HIV-infected women will be infected at birth or through breast feeding. The risk of transmission of the virus from mother to baby is reduced by anti-retroviral drugs.

Infection through contact with HIV infected blood, intravenous drug use and homosexual sex does occur in South Africa, but constitutes a very small proportion of all infections. Blood transfusions are thoroughly screened and the chances of infection from transfusion are extremely low.

People do not develop AIDS as soon as they are infected with HIV. Most experience a long period of around 5 - 8 years during which they feel well and remain productive members of families and work forces. In this asymptomatic period they can pass their infection on to other people without realizing that they are HIV infected.

During the asymptomatic period, the virus gradually weakens the infected person's immune system making it increasingly difficult to fight off other infections. Symptoms start to occur, and people develop conditions such as skin rashes, chronic diarrhea, weight loss, fevers, swollen lymph glands and certain cancers. Many of these problems can be treated effectively or prevented. Although these infections can be treated, the underlying HIV infection is not cured.

Once HIV infected people have a severe infection or cancer (a condition known as symptomatic AIDS) they usually die within 1 to 2 years. The 'estimated average time from HIV infection to death in South Africa is 6 to 10 years. Many HIV infected people progress to AIDS and death in much shorter times. Some live for 10 years or more with minimal health problems, but virtually all will eventually die of AIDS.

HIV infected babies generally survive for shorter periods than HIV infected adults. Many die within two years of birth, and most will die before they turn five. However, a significant number may survive even into their teenage years before developing AIDS.

No cure for HIV infection is available at present. Any cure which is **discovered <u>may well be unaffordable</u> for <u>most South Africans.</u>**

HIVIAIDS is one of the major challenges to all South Africans. The findings of the 1998 HIV survey of pregnant women attending public antenatal clinics of the Department of Health,

show that the epidemic of HIVIAIDS in South Africa is among the most severe in the world and it continues to increase at an alarming pace. The rate of increase is estimated at 33.8%. Using these figures it is estimated that one in eight of the country's sexually active population - those over the age of 14 years - is now infected. In the antenatal survey the prevalence of HIVIAIDS among pregnant women under the age of 20 years has risen by a frightening 65.4 % from 199 7 to 1998.

According to the United Nations Report of 1998: HIVIAIDS Human Development in South Aftica, it is estimated that almost 25% of the general population will be HIV positive by the year 20 10. The achievements of recent decades, particularly in relation to **life expectancy and** educational attainment, will inevitably be slowed down by the impact of current high rates of HIV prevalence and the rise in AIDS related illnesses, tuberculosis and deaths. This will place increased pressures on learners, students and educators.

Because the Ministry of Education acknowledges the seriousness of the HIV/AIDS epidemic, and international and local evidence suggests that there is a great deal that can be done to influence the course of the epidemic, the Ministry is committed to minimize the social, economic and developmental consequences of HIV/AIDS to the educational system, all learners, students and educators, and to provide leadership to implement an HIV/AIDS policy. This policy seeks to contribute towards promoting effective prevention and care within the context of the public education system.

In keeping with international standards and in accordance with education law and the constitutional guarantees of the right to a basic education, the right not to be unfairly discriminated against, the right to life and bodily integrity, the right to privacy, the right to freedom of access to information, the right to freedom of conscience, religion, thought, belief and opinion, the right to freedom of association, the right to a safe environment, and the best interests of the child, the following shall constitute national policy.

1.   **DEFINITIONS**

1.1   In this policy any expression to which a meaning has been assigned in the South African Schools Act, 1996 (Act No. 84 of 1996), the Further Education and Training Act, 1998 (Act No. 98 of 1998) and the Employment of Educators Act, 1998 (Act No. 76 of 1998), shall have that meaning and, unless the context otherwise indicates -

        "AIDS" means the acquired immune deficiency syndrome, that is the final phase of HIV infection;
        "HIV" means the human immune deficiency virus;
        "Institution" means an institution for further education and training, including an institution contemplated in section 38 of the Further Education and Training Act, 1998 (Act No. 98 of 1998).
        66 **unfair discrimination"** means no person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996);
        "universal precautions" refers to the concept used worldwide in the context of HIV/AIDS to indicate standard infection control procedures or precautionary measures aimed at the prevention of HIV transmission from one person to another and includes procedures concerning basic hygiene and the wearing of protective clothing such as latex or rubber gloves or plastic bags when there is a risk of

exposure to blood, blood borne pathogens or blood-stained body fluids.

"window period" means the period of up to three months before HIV antibodies appear in the blood following HIV infection. During this period HIV tests cannot determine whether a person is infected with HIV or not.

2.   PREMISES

2.1   Although there are no known cases of transmission of HIV in schools or institutions, there are learners with HIVIAIDS in schools. More and more children who acquire HIV prenatally will, with adequate medical care, reach school-going age and attend school. Consequently a large proportion of the learner and student population and educators are at risk of contracting HIVIAIDS.

2.2   HIV cannot be transmitted through day-to-day social contact. The virus is transmitted only through blood, semen, vaginal and cervical fluids and breast milk. Although the virus has been identified in other body fluids such as saliva and urine, no scientific evidence exists to show that these fluids can cause transmission of HIV.

2.3   Because of the increase in infection rates, learners, students and educators with HIVIAIDS will increasingly form part of the population of schools and institutions. Since many young people are sexually active increasing numbers of learners attending primary and secondary schools and students attending institutions might be infected. Moreover, there is a risk of HIV transmission as a result of the sexual abuse of children in our country", sexual abuse means abuse of a person by targeting their sexual organs, e.g. rape, touching their private parts, or inserting objects into their private parts). Intravenous drug use is also a source of HIV transmission among teachers and students. Although the possibility is remote, recipients of infected blood products during blood transfusions (for instance hemophiliacs), may also be present at schools and institutions. Because of the increasing prevalence of HIVIAIDS in schools, it is imperative for each school to have a planned strategy to cope with the epidemic.

2.4   Because of the nature of HIV antibody testing and the "window period" or "apparently well period' between infection and the onset of clearly identifiable symptoms, it is impossible to know with absolute certainty who has HIV/AIDS and who does not. Although the Department of Health conducts tests among women attending prenatal clinics of public health facilities in South Africa as a mechanism of monitoring the progression of the HIV epidemic in South Africa, testing for HIVIAIDS for employment or attendance at schools is prohibited.

2.5   Compulsory disclosure of a learner's, student's or educator's HIVIAIDS status to school or institution authorities is not advocated as this would serve no meaningful purpose. In case of disclosure educators should be prepared to handle such disclosures and be given support to handle the confidentiality issues.

2.6   Learners and students with HIVIAIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Likewise, educators with HIVIAIDS should lead as full a professional life as possible with the same rights and opportunities as other educators and with no unfair discrimination being practised against them. Infection control measures and adaptations must be universally applied and carried out regardless of the known or

unknown HIV status of individuals concerned.

2.6.1 The risk of transmission of HIV in the day-to-day school or institution environment in the context of physical injuries can be effectively eliminated by following standard infection -control procedures or precautionary measures (also known as universal precautions) and good hygiene practices under all circumstances. This would imply that in situations of potential exposure such as in dealing with accidental or other physical injuries, or medical intervention on school or institution premises in case of illness, all persons should be considered as potentially infected and their blood and body fluids treated as such.

2.6.2 Strict adherence to universal precautions under all circumstances in the school or institution is advised.

2.6.3 Current scientific evidence suggests that the risk of HIV transmission during teaching, sport and play activities is insignificant. There is no risk of transmission from saliva, sweat, tears, urine, respiratory droplets, handshaking, swimming-pool water, communal bath water, toilets, food or drinking water. The statement about the insignificant risk of transmission during teaching, sport and play activities, however, holds true only if universal precautions are adhered to. Adequate wound management has to take place in class, a laboratory or on the sports field or playground when a learner or student sustains an open bleeding wound. Contact sports such as boxing and rugby could probably be regarded as sports representing a higher risk of HIV transmission than other sports, although the inherent risk of transmission during any such sport is very low indeed.

2.6.4 Public funds should be made available to ensure the application of universal precautions and the supply of adequate information and education on HIV transmission. The State's duty, to take all reasonable steps to ensure safe school and institution environments, is regarded as a sound investment in the future of South Africa.

2.6.5 Within the context of sexual relations, the risk of contracting FIN is significant. There are high levels of sexually active persons within the learner population group in schools. This increases the risk of HIV transmission in schools and institutions for further education and training considerably. Besides sexuality education, morality and life skills education being provided by educators, parents should be encouraged to provide their children with healthy morals, sexuality education and guidance regarding sexual abstinence until married and to stay faithful to their partners. Sexually active persons should be advised to practice safe sex and to use condoms. Learners and students should be educated about their rights concerning their own bodies to protect themselves against rape, violence Nolence" means violent conduct or treatment that harms the person of the victim, for example assault and rape), inappropriate sexual behaviour and contracting HIV.

2.7 The constitutional rights of all learners, students and educators must be protected on an equal basis. If it is ascertained by a suitably qualified person that a learner, student or educator poses a medically recognised significant health risk to others, appropriate

measures should be taken. A medically recognised significant health risk in the context of MAIDS could include the presence of untreatable contagious (highly communicable) diseases, uncontrollable bleeding, unmanageable wounds, or sexual or physically aggressive behaviour, which may create the risk of HIV transmission.

2.8 Furthermore, learners and students with infectious illnesses such as measles, German measles, chicken pox, whooping cough and mumps should be kept away from the school or institution to protect all other members of the school ' or institution, especially those whose immune systems may be impaired by HIVAIDS.

2.9 Schools and institutions should inform parents of vaccination/inoculation programmes and of their possible significance for the well-being of learners and students with HlV/AlDS. Local health clinics could be approached to assist with immunization.

2.10 Learners and students must receive education about HIVIAIDS and abstinence in the context of life-skills education on an ongoing basis. Life-skills and HIVIAIDS education should not be presented as isolated learning content, but should be integrated in the whole curriculum. It should be presented in a scientific but understandable way. Appropriate course content should be available for the preservice and in-service training of educators to cope with HIV/AIDS in schools. Enough educators to educate students about the epidemic should also be provided.

2.10.1 The purpose of education about HIVZAIDS is to prevent the spread of HfV infection, to allay excessive fears of the epidemic, to reduce the stigma attached to it and to instill ijci-tdiscriminatory attitudes towards persons with HIVIAIDS. Education should ensure that learners and students acquire ageand context- appropriate knowledge and skills in order that they may adopt and maintain behaviour that will protect them from Hl V infection.

2.10.2 In the primary grades, the regular educator should provide education about HIVIAIDS, while in secondary grades the guidance counsellor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life-skills and HIVIAIDS education in the school and province. The educators should feel at ease with -the' _&*nieint arfd should be a role-model with whom learners and students can easily identify. Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of, and skills to deal with, HIV/AIDS.

2.10.3 All educators should be trained to give guidance on HIVIAIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIVIAIDS.

2.11 In order to meet the demands of the wide variety of circumstances posed by the South African community and to acknowledge the importance of governing bodies, councils and parents in the education partnership, this national policy is intended as broad principles only. It is envisaged that the governing body of a school, acting within its functions under the South African Schocls Act, 1996, and the council of a further education and training institution, acting within its functions under the Further Education and Training Act, 1993, or any provincial law, should preferably give

operational effect to the national policy by developing and adopting an HIV/AIDS implementation plan that would reflect the needs, ethos and values of a specific school or institution and its community within the framework of the national policy.

3. NON-DISCRIMINATION AND EQUALITY WITH REGARD TO LEARNERS, STUDENTS AND EDUCATORS WITH HIV/AIDS

3.1 **No** learner, student or educator with HIVIAIDS may be unfairly discriminated against directly or indirectly. Educators should be alert to unfair accusations against any person suspected to have HIV/AlDS.

3.2 Learners, students, educators and other staff with HIVIAIDS should be treated in a just, humane and life-affirming way.

3.3 Any special measures in respect of a learner, student or educator with HIV should be fair and justifiable in the light of medical facts; established legal rules and principles; ethical guidelines; the best interest of the learner, student and educator' with HIVIAIDS; school or institution conditions; and the best interest of other learners, students and educators.

3.4 To prevent discrimination, all learners, students and educators should be educated about fundamental human rights as contained in the Constitution of the Republic of South Africa, 1996.

4. HIV/AIDS TESTING AND THE ADMISSION OF LEARNERS TO A SCHOOL AND STUDENTS TO AN INSTITUTION, OR THE APPOINTMENT OF EDUCATORS

4.1 No learner or student may be denied admission to or continued attendance at a school or an institution on account of his or her HIVAIDS status or perceived HIV/AIDS status.

4.2 No educator may be denied the right to be appointed in a post, to teach or to be promoted on account of his or her HIV/AIDS status or perceived HIV/AIDS status. HIV/AIDS status may not be a reason for dismissal of an educator, nor for refusing to conclude, or continue, or rene'w an educator's employment contract, nor to treat him or her in any way differently.

4.3. There is no medical justification for routine testing of learners, students or educators for evidence of HIV infection. The testing of learners or students for HIV/AIDS as a prerequisite for admission to, or continued attendance at school or institution, to determine the incidence of HIV/AIDS at schools or institutions, is prohibited. The testing of educators for HIV/AIDS as a prerequisite for appointment or continued service is prohibited.

5. ATTENDANCE OF SCHOOLS AND INSTITUTIONS BY LEARNERS OR STUDENTS WITH HIV/AIDS

5.1 Learners and students with HIV have the right to attend any school or institution. The needs of learners and students with HIV/AIDS with regard to their right to basic education should as far as is reasonably practicable be accommodated in the school or institution.

5.2 Learners and students with HIV/AlDS are expected to attend classes in accordance with statutory requirements for as long as they are able to do so effectively.

5.3 Learners of compulsory school-going age with HlV/AlDS, who are unable to benefit from the attendance of school or from home education, may be granted exemption from attendance in terms of section 40) of the South African Schools Act, 1996, by the Head of Department after consultation with the principal, the parent and the medical practitioner where possible.

5.4 If and when learners and students with HlV/AlDS become incapacitated through illness, the school or institution should make work available to them for study at home and support continued learning where possible. Parents should, where practically possible, be allowed to educate their children at home in accordance with the policy for home education in terms of section 51 of the South African Schools Act, 1996, or provide older learners with distance education.

5.5 Learners and students who cannot be accommodated in this way or who develop HIV/AIDS-related behavioral problems or neurological damage should be accommodated, as far as is practically possible, within the education system in special schools or specialized residential institutions for learners with special education needs. Educators in these institutions must be empowered to take care of and support HIV-positive learners. However, placement in special schools should not be used as an excuse to get HIV-positive learners out of mainstream schools.

6. DISCLOSURE OF HIV/AIDS-RELATED INFORMATION AND CONFIDENTIALITY

6.1 No learner or student (or parent on behalf of a learner or student). educator, is compelled to disclose his or her HIV/AlDS status tc school or institution or an employer. (in cases where the mer, condition diagnosed is the HIV/AIDS disease, the Regulations relating to communicable diseases and the notification of notifiable medical conditions (Health Act 1977) only requires the person performing the diagnosis to inform the immediate family members and the persons giving care to the person and, in cases of HIV/AIDS death, the persons responsible for the preparation of the body of the deceased.)

6.2 Voluntary disclosure of a learner's, student's or educator's HIVIAIDS status to the appropriate authority should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair discrimination is not tolerated. In terms of section 39 of the Child Care Act, 1983 (Act No. 74 of 1983), any learner or itudent above the age of 14 years with HIV/AlDS, or if the learner is younger than 14 years, his or her parent, would, however, be free to disclose such information voluntarily.

6.3 A holistic programme for life-skills and HIV/AlDS education should encourage

disclosure. In the event of voluntary disclosure, it may be in the best interests of a learner or student with HIV/AIDS if a member of the staff of the school or institution directly involved with the care of the learner or student, is informed of his or her HIV/AIDS status. An educator may disclose his or her HIV/AIDS status to the principal of the school or institution.

6.4   Any person to whom any information about the medical condition of a learner, student or educator with, HIV/AIDS has been divulged, must keep this information confidential.

6.5   The unauthorized disclosure of HIV/AIDS information could result in legal liability.

6.6   No employer can require that a job applicant have an HIV test before they are employed. An employee cannot be dismissed, retrenched or refused a job simply because he or she is HIV positive.

7.   A SAFE SCHOOL AND INSTITUTION ENVIRONMENT

7.1   The MEC should make provision for all schools and institutions to implement universal pre-cautions such as the following, to eliminate the risk of transmission of all blood-borne pathogens, including HIV, effectively in the school or institution environment.

7.1.1   The basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to HIV, all persons are potentially infected and all blood should be treated as such. All blood, open wounds, sores, breaks in the skin, grazes and open skin lesions, as well as all body fluids and excretions which could be stained or contaminated with blood (for example tears, saliva, mucus, phlegm, urine, vomit, faeces and pus) should therefore be treated as potentially infectious.

(a)   Blood, especially in large spills such as from nose bleeds, and old blood or blood stains should be handled with extreme caution.

(b)   Skin exposed accidentally to blood should be washed immediately with soap and running water.

(c)   All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water or other antiseptics.

(d)   If there is a biting or scratching incident where the skin is broken, wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing.

(e)   Blood splashes to the face (mucous membranes of eyes, nose or should be flushed with running water for at least three minutes.

(f)   Disposable bags and incinerators must be made available to dispose of sanitary wear.

7.1.2   All open wounds, sores, breaks in the skin, grazes and open skin lesions should at all times be covered completely and securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.

7.1.3   Cleansing and washing should always be done with running water and not in containers of water. Where running tap water is not available, containers should be used to pour water over the area to be cleansed. Schools without running water should keep a supply - e.g. in a 25 litre drum - on hand specifically for use in emergencies. This water can be kept fresh for a long period of time by adding a disinfectant, such as Milton, to it.

7.1.4   All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes, open skin lesions, body fluids and excretions should wear protective latex gloves or plastic bags over their hands to eliminate the risk of HIV transmission effectively. Bleeding can be managed by compression with material that will absorb the blood, e.g. a towel.

7.1.5   If a surface has been contaminated with body fluids and excretions which could be stained or contaminated with blood (for instance tears, saliva, mucus, phlegm, urine, vomit, faeces and pus) that surface should be cleaned with running water and fresh clean household bleach (1:10 solution), and paper or disposable cloths. The person doing the cleaning must wear protective gloves or plastic bags.

7.1.6   Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to an appropriate disposal firm. Tissues and toilet paper can readily be flushed down a toilet.

7.1.7   If instruments (for instance scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong household bleach solution for at least one hour before drying and re-using.

7.1.8   Needles and syringes should not be re-used, but should be safely disposed of.

7.2   All schools and institutions should train learners, students, educators and staff in first aid, and have available and maintain at least two firstaid kits, each of which contains the following –

(a)   two large and two medium pairs of disposable latex gloves;

(b)   two large and two medium pairs of rubber household gloves for handling blood-soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate);

(c)   absorbent material, waterproof plasters, disinfectant (such as hypochiorite), scissors, cotton wool, gauze tape, tissues, containers for water and a resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids.

(d)   Protective eye wear; and

(e)   protective face mask to cover nose and mouth.

7.3   Universal precautions are in essence barriers to prevent contact with blood or body fluids. Adequate barriers can also be established by using less sophisticated devices than those described in 7.2, such as -

(a)   unbroken plastic bags on hands where latex or rubber gloves are not available;

(b)   common household bleach for use as disinfectant, diluted one part bleach to ten parts water (1:10 solution) made up as needed.

(c)   spectacles; and

(d)   a scarf.

7.4   Each classroom or other teaching area should preferably have a pair of latex or rubber household gloves.

7.5   Latex or rubber household gloves should be available at every sports event and should also be carried by the playground supervisor.

7.6   First-aid kits and appropriate cleaning equipment should be stored in one or more selected rooms in the school or institution and should be accessible at all times, also by the playground supervisor.

7.7   Used items should be dealt with as indicated in paragraphs 7.1.6 and 7.1.7.

7.8   The contents of the first-aid kits, or the availability of other suitable barriers, should be **checked each week** against a contents list by a designated staff member of the school or institution. Expired and depleted items should be replaced immediately.

7.9   A fully equipped first-aid kit should be available at all school or, institution events, outings and tours, and should be kept on vehicles for the transport of learners to such events.

7.10   All learners, students, educators and other staff members, including sports coaches, should be given appropriate information and training on HIV transmission, handling and use of first-aid kits, and the application of universal precautions and the importance of adherence thereto.

7.10.1 Learners, students, educators and other staff members should be trained to manage their own bleeding or injuries and to assist and protect others.

7.10.2 Learners, especially those in pre-primary and primary schools, and students should be instructed never to touch the blood, open wounds, sores, breaks in the skin, grazes and open skin lesions of others, nor to handle emergencies such as nosebleeds, cuts and scrapes of friends on their own. They should be taught to call for the assistance of an educator or other staff member immediately.

7.10.3 Learners and students should be taught that all open wounds, sores, breaks in the skin, grazes and open skin lesions on all persons should be kept covered completely with waterproof dressings or plasters at all times, not only when they occur in the school or institution environment.

7.11 All cleaning staff, learners, students, educators and parents should be informed about the universal precautions that will be adhered to at a school or an institution.

7.12 A copy of this policy must be kept in the media centre of each school or institution.

8. PREVENTION OF HIV TRANSMISSION DURING PLAY AND SPORT

8.1 The risk of HIV transmission as a result of contact play and contact sport is generally insignificant.

    8.1.1 The risk increases where open wounds, sores, breaks in the skin, grazes, open skin lesions or mucous membranes of learners, students and educators without HIV are exposed to infected blood.

    8.1.2 Certain contact sports may represent an in-reased risk of HIV transmission.

8.2 Adequate wound management, in the form of the application of universal precautions, is essential to contain the risk of HIV transmission during contact play and contact sport.

    8.2.1 No learner, student or educator may participate in contact play or contact sport with an open wound, sore, break in the skin, graze or open skin lesion.

    8.2.2 If bleeding occurs during contact play or contact sport, the injured player should be removed from the playground or sports field immediately and treated appropriately as described in paragraphs 7.1.1 to 7.1.4. Only then may the player resume playing and only for as long as any open wound, sore, break in the skin, graze or open skin lesion remains completely and securely covered.

    8.2.3 Blood-stained clothes must be changed.

    8.2.4 The same precautions should be applied to injured educators, staff members and injured spectators.

8.3 A fully equipped first-aid kit should be available wherever contact play or contact sport takes place.

8.4 Sports participants, including coaches, with HIV/AlDS should seek medical counseling before participation in sport, in order to assess risks to their own health as well as the risk of HIV transmission to other participants.

8.5 Staff members acting as sports administrators, managers and coaches should ensure the availability of first-aid kits and the adherence to universal precautions in the event of bleeding during participation in sport.

8.6 Staff members acting as sports administrators, managers and coaches have special opportunities for meaningful education of sports participants vAth respect to HIV/AIDS. They should encourage sports participants to seek medical and other appropriate counseling where appropriate.

9. EDUCATION ON HIV/AIDS

9.1 A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Measures must also be implemented at hostels.

9.2 Age-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students, and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners. This should include the following -

9.2.1 providing information on HIV/AIDS and developing the life skills necessary for the prevention of these;

9.2.2 inculcating from an early age onwards basic first-aid principles, including how to deal with bleeding with the necessary safety precautions;

9.2.3 emphasising the role of drugs, sexual abuse and violence, and sexually transmitted diseases (STDs) in the transmission of HIV and empowering learners to deal with these situations;

9.2.4 encouraging learners and students to make use of health care, counselling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organisations and other disciplines;

9.2.5 teaching learners and students how to behave towards persons with HIVAIDS, raising awareness on prejudice and stereotypes around HIV/AIDS;

9.2.6 cultivating an enabling environment and a culture of non discrimination towards person with HIV/AIDS

9.2.7 providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions.

9.3 Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in language and terms that are understandable.

9.4 Parents of learners and students must be informed about all life-skills and HIV/AIDS education offered at the school and institution, the learning content and methodology to be used, as well as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as

sexuality educators and importers of values at home.

9.5   Educators may not have sexual relations with learners or students and should this happen, the matter has to be handled in terms of the Employment of Educators Act, 1998.

9.6   If learners, students or educators are infected with HIV, they should be informed that they can still lead a normal, healthy life for many years by taking care of their health.

10. DUTIES AND RESPONSIBILITIES OF LEARNERS, STUDENTS, EDUCATORS AND PARENTS

10.1   All learners, students and educators should respect the rights of other learners, students and educators.

10.2   The Code of Conduct adopted for learners at a school or for students at an institution should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission.

10.3   The ultimate responsibility for a learner's or a student's behaviour rests with his or her parents. Parents of all learners and students:-

    10.3.1 are expected to require learners or students to observe all rules aimed at preventing behaviour that may create a risk of HIV transmission; -and

    10.3.2 are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school or institution, and to attend meetings convened for them by the governing body or council.

10.4   It is recommended that a learner, student or educator with HIV/AIDS, and his or her parent, in the case of learners or students, should consult medical opinion to assess whether the learner, student or educator, owing to his or her condition or conduct, poses a medically recognized significant health risk to others. If such a risk is established the principal of the school or institution should be informed. The principal of the school or institution must take the necessary steps to ensure the health and safety of the other learners, students, educators and other staff members.

10.5   Educators have a particular duty to ensure that the rights and dignity of all learners, students and educators are respected and protected.

11. REFUSAL TO STUDY WITH OR TEACH A LEARNER OR STUDENT WITH HIV/AIDS, OR TO WORK WITH AN EDUCATOR WITH HIV/AIDS

11.1   Refusal to study with a learner or student or to work with an educator or other staff member with, or perceived to have HIV/AIDS, should be preempted by providing accurate and understandable information on HIVIAIDS to all educators and staff, as well as to learners, students and their parents.

11.2   Learners and students who refuse to study with a fellow learner or student, or

educators and staff who refuse to work with a fellow educator or staff member or to teach or interact with a learner or student with or perceived to have HIV/AIDS and are concerned that they themselves will be infected, should be counselled.

11.3 The situation should be resolved by the principal and educators in accordance with the principles contained in this policy, the code of conduct for learners, or the code of professional ethics for educators. Should the matter not be resolved through mediation and counselling, disciplinary steps may be taken.

12.   SCHOOL AND INSTITUTIONAL IMPLEMENTATION PLANS

12.1 Within the terms of its functions under the South African Schools Act, 1996, the Further Education and Training Act, 1998, or any applicable provincial law, the governing body of a school or the council of an institution may develop and adopt its own implementation plan on HIV/AIDS to give operational effect to the national policy.

12.2 A provincial education policy for HIV/AIDS based on the national policy can serve as a guideline for governing bodies when compiling an implementation plan.

12.3 Major role-players in the wider school or institution community (for example religious and traditional leaders, representatives of the medical or health care professions or traditional healers) should be involved in developing an implementation plan on HIV/AIDS for the school or institution.

12.4 Within the basic principles laid down in this national policy, the school or institution implementation plan on HIV/AIDS should take into account the needs and values of the specific school or institution and the specific communities it serves. The consultation on school or institution implementation plan could address and attempt to resolve complex questions, such as discretion regarding mandatory sexuality education, or whether condoms need to be made accessible within a school or institution as a preventive measure, and if so under what circumstances.

13.   HEALTH ADVISORY COMMITTEE

13.1 Where community resources make this possible, it is recommended that each school and institution should establish its own Health Advisory policy, in accordance with their responsibilities in terms of the Constituton of the Republic of South Africa, 1996, and any applicable law. Every education department must designate an HIV/AIDS Programme Manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the Department's HIV/AIDS programme, to advise management regarding programme implementation and progress and to create a supportive and nondiscriminatory environment.

13.2 The principal or the head of a hostel is responsible for the practical implementation of this policy at school, institutional or hostel level, and for maintaining an adequate standard of safety according to this policy.

13.3 it is recommended that a school governing body or the council of an institution should

take all reasonable measures within its means to supplement the resources supplied by the State in order to ensure the availability at the school or institution of adequate barriers (even in the form of less sophisticated material) to prevent contact with blood or body fluids.

13.4 Strict adherence to universal precautions under all circumstances (including play and sports activities) is advised as the State will be liable for any damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school or institution.

14. REGULAR REVIEW

This policy will be reviewed regularly and adapted to changed circumstances.

15. APPLICATION

15.1 This policy applies to public schools which enroll learners in one or more grades between grade zero and grade twelve, to further education and training institutions, and to educators.

15.2 Copies of this policy must be made available to independent schools registered with the provincial departments of education.

16. INTERPRETATION

In all instances, this policy should be interpreted to ensure respect for the rights of learners, students and educators with HIV/AIDS as well as other learners, students, educators and members of the school and institution communities.

17. WHERE THIS POLICY MAY BE OBTAINED

This policy may be obtained from The Director: Communication, Department of Education, Private Bag X895, Pretoria, 0001, Tel. No. (012) 312-5271.

This policy is also available on the Internet at the following web site: http://education.pwv.gov.za

For further information, please see the attached ANNEXURE.

DOCUMENTARY SOURCES FOR:

A CULTURAL APPROACH TO HIV/AIDS PREVENTION AND CARE

South Africa's Experience

General:
- Encyclopedia Britannica: Southern Africa, pp. 838-935, London, 1993.
- Encyclopedia Universalis: Articles "Afrique du Sud" et "Bantu", Paris, 1985.
- South Africa, Lesotho, Swaziland: LP Publications, Hawthorne, Australia, 1998.
- Georges LORY, Afrique du Sud, Karthala, 1998.
- UNESCO Statistical Yearbook 1997.
- UNDP Human Right Report, 1998.

Assessment documents:
- SA Department of Health/UNICEF Country Programme: Situation Analysis Workshop, Capetown, May 1995.
- STIDs management in the private sector: A national evaluation, Centre for Health Policy, Department of Community Health, University of Witzwatersrand, Pretoria, August 1997.
- National Institute for Economic Policy (NIEP): Children, Poverty and Disparity Reduction, Pretoria, May 1995.
- Francis WILSON: Overview of Poverty Research in South Africa, Crop Scientific Symposium, Paris, December 1994.

Strategies and policies:
- National Plan for AIDS Prevention, February 1998.
- British Development co-operation in Southern Africa, Department for International Development, February 1998.
- UNDP Regional Project: HIV/AIDS and Development in Sub-Saharan Africa (RAF/91/004)
- UNAIDS/WHO: Report on the Global HIV/AIDS Epidemic, Geneva, June 1998.

Other documents:
- Guidelines for Developing a Workplace Policy and Programme on HIV/AIDS and STDs, South African Department of Health, Directorate HIV/AIDS and STDs.
- LADUMA Project: A Story of Love, Sex and Dreams, National HIV/AIDS and STI)s Programme, Health Department, 1996.

HIV/AIDS in developing countries:
- John CLELAND, Benoit FERRY, Sexual Behaviours and AIDS in the Developing World, WHO, Taylor & Francis, London, 1995.
- WHO/Global Programme on AIDS: TASO Uganda Project, Participatory Evaluation of HIV/AIDS counseling, medical and social services (1993-1994), WHO Documentation Centre, Geneva.
- Inter-linkages between Culture, Tradition and HIV/AIDS in Uganda, UNAIDS Uganda Theme Group, Makerere University, Kampala, 1998.