Module Title: HIV and Aids Literacy
Module Code: AHIV 111
NQF Level: 5
Credit Value: 16 credits
Department: Communication Science
Faculty: Arts
AIMS OF THE MODULE

a) To empower students to make a difference in dealing with HIV and Aids crisis.
b) To provide students with information on HIV and Aids prevention and management.
c) To expose students to various areas on which HIV and Aids impacts

SPECIFIC LEARNING OUTCOMES

At the end of this module students should be able to understand the following:

1. The way immune system operates by being able to describe it’s operation.
2. Different types of viruses and how they invade the immune system.
3. How HIV and Aids can be prevented.
4. Strategies of how HIV and Aids can be managed.
5. The impact of HIV and Aids.

TYPE OF DELIVERY AND ESTIMATED NOTIONAL STUDY HOURS

<table>
<thead>
<tr>
<th>Contact Study</th>
<th>Notional Hours</th>
<th>Self Study</th>
<th>Notional Hours</th>
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<tr>
<td>Lectures</td>
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<td>Recourse Based</td>
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<tr>
<td>Practicals</td>
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<td>Self directed</td>
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<tr>
<td>Tutorial</td>
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<td>Assignment study</td>
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<td>Field trips</td>
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<td>Exam preparations</td>
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<td>Total contact</td>
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<td>Total Self study</td>
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<tr>
<td>Total Notional Hours</td>
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Assessment criteria against the specific learning outcomes for the module are assessed

Students will be assessed on their understanding of HIV infection and how it progresses to Aids. Issues of HIV and Aids prevention and management will also be considered.

Range Statement

Method of assessment to be used in the module (% weighting)

<table>
<thead>
<tr>
<th>Assessment Method</th>
<th>Weighting</th>
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<tr>
<td>Formal end module examination</td>
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<tr>
<td>Interim tests during module</td>
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<tr>
<td>Assignment</td>
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<td>Oral assessment</td>
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# COURSE STRUCTURE AND SCHEME OF WORK

<table>
<thead>
<tr>
<th>UNIT</th>
<th>THEME</th>
<th>STUDY UNIT</th>
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</table>
| 1 | INTRODUCTION AND BACKGROUND TO HIV/AIDS | 1.1 Origins of HIV and Aids  
1.2 Terminology  
1.3 Myths and Misconceptions  
1.4 HIV and the immune system  
1.5 Virology  
1.6 Transmission of HIV  
1.7 Symptoms, stages and diagnosis |
| 2 | FACTORS THAT FACILITATE THE TRANSMISSION OF HIV | 2.1 Risky sexual and social behavior  
2.2 Economic factors  
2.3 Psychosocial factors  
2.4 Political factors  
2.5 Cultural factors  
2.6 Community factors |
| 3 | IMPACT OF HIV AND AIDS | 3.1 Impact of the individual infected  
3.2 Impact of the individuals affected  
3.3 Impact in the society  
3.4 Impact in the economy |
| 4 | STANDARD UNIVERSAL SAFETY PRECAUTIONS FOR PREVENTION OF HIV AND AIDS | 4.1 Voluntary testing and counselling  
4.2 Sexuality education  
4.3 Changing unsafe sexual and social behaviour  
4.4 Universal safety precautions |
| 5 | MANAGEMENT OF HIV AND AIDS | 5.1 Anti-retroviral treatment  
5.2 Exercise  
5.3 Diet  
5.4 Support structures  
5.5 De-stigmatisation |
| 6 | GENDER AND HIV AND AIDS | 6.1 Gender stereotypes and HIV and Aids  
6.2 Gender inequality and HIV and Aids  
6.3 Gender-based discrimination and HIV and Aids  
6.4 Sexual abuse and HIV and Aids |
| 7 | RESPONDING TO HIV AND AIDS IN THE COMMUNITY, WORKPLACE AND IN THE CHURCH | 6.1 Developing an appropriate response the HIV and Aids  
6.2 Care and support of those infected and affected by HIV and Aids. |
| 8 | ETHICAL AND LEGAL ISSUES AND HIV AND AIDS | 8.1 National Strategic Plan (NSP) 2007-2011  
8.2 Human Rights |
Dear Student,

The Department of Communication Science welcomes you to your first year of study at the University of Zululand. This is the beginning of an exciting stage in your life where you will be setting goals for your future and determining how they will be fulfilled.

You are now becoming a member of the academic community; and you will be expected to live up to their high standards of excellence! This will be achieved through dedication and commitment to the academic programme set for you.

Communication is very exciting and dynamic; it is therefore the objective of this course to provide students with the understanding of theory and practice that makes communication more efficient. This guide is designed and planned for you and contains information that will help you plan for the year.

Should you require any other information, please feel free to contact the staff members in the Department.

Website: http://www.comsci.uzulu.ac.za
## COURSE WEEKLY OUTLINE

<table>
<thead>
<tr>
<th>DATES/WEEKS</th>
<th>ACTIVITIES OF THE WEEK</th>
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<tr>
<td>22-26 February 2010</td>
<td>Origins of HIV and Aids&lt;br&gt;Terminology&lt;br&gt;Myths and Misconceptions&lt;br&gt;HIV and the immune system&lt;br&gt;Virology&lt;br&gt;Transmission of HIV&lt;br&gt;Symptoms, stages and diagnosis</td>
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<td><strong>INTRODUCTION AND BACKGROUND TO HIV/AIDS</strong></td>
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<tr>
<td>01-05 March 2010</td>
<td>Risky sexual and social behavior&lt;br&gt;Economic factors&lt;br&gt;Psychosocial factors&lt;br&gt;Political factors&lt;br&gt;Cultural factors&lt;br&gt;Community factors</td>
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<td>15-19 March 2010</td>
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<td><strong>STANDARD UNIVERSAL SAFETY PRECAUTIONS FOR PREVENTION OF HIV AND AIDS</strong></td>
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<tr>
<td>22-25 March 2010</td>
<td>Anti-retroviral treatment&lt;br&gt;Exercise&lt;br&gt;Diet&lt;br&gt;Support structures</td>
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<tr>
<td>Date Range</td>
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<td>06-09 April 2010</td>
<td>GENDER AND HIV AND AIDS</td>
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<td>12-23 April 2010</td>
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<td>28 April-14 May 10</td>
<td>ETHICAL AND LEGAL ISSUES AND HIV AND AIDS</td>
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**LECTURE TIME TABLE**

<table>
<thead>
<tr>
<th>Days</th>
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<tr>
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<tr>
<td>Tuesdays</td>
<td>A2-75</td>
<td>11h30</td>
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<tr>
<td>Thursdays</td>
<td>A2-75/ A1-13</td>
<td>09h00</td>
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<td>Fridays</td>
<td>A2-75</td>
<td>12h00</td>
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## Assignments

<table>
<thead>
<tr>
<th>Task</th>
<th>Date Issued</th>
<th>Due Date</th>
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<tbody>
<tr>
<td><strong>Assignment One</strong></td>
<td></td>
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<tr>
<td>An investigation into safe infant feeding options by HIV+ mothers (20)</td>
<td>24 February 2010</td>
<td>10 March 2010</td>
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<tr>
<td><strong>Assignment two</strong></td>
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<tr>
<td>Discussion cultural and political factors that facilitate the transmission of HIV and Aids (20)</td>
<td>03 March 2010</td>
<td>17 March 2010</td>
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## Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
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<tr>
<td>Class test</td>
<td>9 March</td>
<td>10</td>
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<tr>
<td>Test</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Test – Term Ending</td>
<td>23 March</td>
<td>30</td>
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</table>
COURSE RULES AND RESPONSIBILITIES

1. Attendance to Lecturers
   Attendance to lecturers is compulsory. An attendance register will be taken at every lecture. Should you become ill, submit a copy of the medical certificate to your lecturer. Any other reasons for your absenteeism will have to be given to your lecturer in writing.

2. Assessments and tests
   - These must be written according to the official time-table. If a student is prevented from doing so, the student must inform the lecturer before the commencement of the test.
   - The student must also produce a medical certificate, covering the full period of absence, immediately upon return.
   - Should the student not write that test for non-medical reasons, then they will receive 0% (zero) for that test. There will be no re-evaluation under these circumstances.

3. Assignments
   - Assignments are to be submitted during the lecturer period (unless otherwise stipulated by your lecturer).
   - Meet deadlines and due dates as stipulated in the course outline.
   - Marks will be deducted for each day that the assignment is not late.
   - Submit original work, no plagiarizing or cheating. Abide by the University’s policies on Plagiarism and Cheating.

4. Course Mark/DP (Duly Performed Mark)
   DP’s represent 50% of the semester-end final mark. This mark is made up of work produced by you throughout the year. It is made up of any of the following activities decided by your lecturer:
   - continuous formative assessments
   - assignments
   - projects
• oral presentations
• group work/presentations
• attendance to lectures
• other class activities

5. **Semester-end examination**

You will write a 3-hour examination at the end of the semester. This mark will contribute the other 50% of the final mark.

6. **Code of conduct**

• Attend ALL lectures, seminars and practical work as stipulated in subject outlines
• Ensure prompt lecture attendance
• SWITCH OFF cellular phone during lecture
• No eating during a lecture
• Conduct yourself in an orderly fashion and proper manner during the lecture or in any other place where such activity will adversely affect the working environment of others
• Do not LOITER about within the lecture halls
• Consultation with the academic staff should be done in an orderly manner

7. **Consultation Times**

Students are welcome to consult the lecturer regarding problems during the times stipulated by the lecturer.

8. **General Guidelines**

• Reading is the KEY instrument for successful completion of assignments. Ensure that you read your key texts and other related material found in the library and internet before attempting your assignment.
• Take notes while reading shaping a mind-map where you write questions and then work out a structure as to how you are going to answer the question.
• Dates of assignments and assessments are provided in advance so that you have adequate study and preparation time. If you miss an assignment deadline, your assignment will not be accepted and you will be given a ZERO. Should you experience problems, speak to your lecturer before the assignment is due and not on the due date.

• Assignments must be TYPED.

• Font size should be 12 and you should use either Arial/Times New Roman.

• Use 1.5 line spacing.

9. **Cover Page**

Ensure that the following appears on the front page of every assignment:

- Name and Surname
- Student registration number
- Due date
- The Topic
- Lecturer’s name

10. **Content of written assignment**

Your written assignment should consist of the following:

- **Table of contents**
- An **introduction** – this should briefly explain how you intend to answer the question (provide aims of the assignment)
- The **main section** of your assignment will consist of all the readings. This must be arranged in a logical way and should be the most important part of your assignment. You should ensure that you have answered the question.
- Your **conclusion** should consist of a summary of the main points.
- **List of references/bibliography**

11. **Important terms to consider for your assignment**

- **analyse** make a detailed examination of your topic and focus on strengths and weaknesses
- **assess** weigh up pros and cons and give your opinion
• compare  weigh up similarities and consider the difference
• contrast  analyse differences, but also comment on similarities
• criticize  express reasoned opinion of the validity of the topic
  (emphasising the weakness)
• define  set out the exact meaning of concepts
• discuss  examine all aspects of the topic, point out strengths and
  weaknesses and come to conclusion
• evaluate  means the same as the assess
• explain  show why a set of circumstances has arise. Do not just
  state the facts – give reasons for the facts
• illustrate  make the concept clear by using examples and
  diagrams
• justify  give adequate grounds for your conclusion
• list  enumerate, name set your information out in point form
• outline  get out the main points; leave out any detail
• review  critically survey the subject, highlighting the main
  points
• trace  state the development and the consequences of events
  from a given starting point
• skimming  read the text fast (without reading every word)
• scanning  headings, summaries, keywords, figures and graphs to
  give you a brief overview of the material

REFERENCING YOUR WORK

Referencing

is a standardized method of acknowledging printed or electronic
sources of information and ideas that you have used in your essay or
assignment. Direct quotations, facts and figures and ideas and theories
from published and unpublished works, must be referenced. There are
many acceptable forms/styles of referencing and the reference list at
the end of your essay gives full details of all your in-text citations.
**Test your knowledge?**

What is the difference between a reference list and a bibliography?

**Why include references?**

- To demonstrate that you have read widely and have a broad appreciation of the subject-matter for example naming leading theorists in the field
- To document the sequential development of knowledge and understanding in a particular field
- To provide illustrative examples of a particular theme
- To introduce a discussion within your essay for example using a quotation which summarises a point of view
- To substantiate your essay arguments

**Referencing examples**

**Book references**

Books with a single author


**NB.** The title of the book is always in italics

Books with two authors


**NB.** Always cite both authors everytime the reference occurs.

Books with three or more authors


**NB.** Cite three or more authors the first time the reference occurs in your text and in subsequent citations only the name of the first author followed by *et al* (‘and others’).

Books with unknown authors

Books with editor/s and editions other than the first.


Two books by the same author in the same year.


**NB.** The date is followed by a or b.

Articles or chapters in edited books.


**NB.** The chapter page numbers can be given in brackets either after the chapter’s title or after the publisher. Bibliographic detail of the book starts with In after the chapter details. The title of the book is in italics NOT the title of the chapter.

Encyclopaedias


**NB.** The place of publication and name of publisher are not necessary.

Dictionaries


**Journal, magazine and newspaper references**

Articles with one to two authors.


**NB.** The name of the journal is always in italics, followed by the journal volume, number and page references. For citing of authors, follow the guideline for books.

Weekly and monthly periodicals

Articles in daily newspapers.


NB. Treat newspapers like magazines or journals. A colon follows the title of the newspaper then the page reference is given. The month and day of publication follow the page reference.

Electronic references

World Wide Web (www) page references


For further reference style refer to the following book:

STUDY UNIT ONE

1. INTRODUCTION AND BACKGROUND TO HIV AND AIDS

1.1 ORIGIN OF HIV AND AIDS

AIDS first diagnosed in 1981 in the United States of America among gay men who suddenly developed opportunistic infections and cancers that were resistant to any treatment. AIDS did not have a name then but it was evident that all the men suffering from the same syndrome. The discovery of HIV, the human immunodeficiency virus, was made in 1983 by a French Scientist, Luc Montagnier.

There are three hypotheses about origin of HIV and AIDS:

- The polio vaccine hypothesis. This theory postulated that HIV-1, the widespread and deadly human AIDS virus, evolved from a polio vaccine contamination. It was thought that the contamination came from the polio virus taken from the kidney of a primate (monkey/chimpanzee) in the Republic of Congo.

- The cut hunters’ hypothesis: This theory postulates that a hunter would have been infected with a virus when from a primate when slaughtering the contaminated meat.

- The Norwegian sailor hypothesis: The postulates that a sailor would have had contact with contaminated blood of a primate and carried the virus to Europe.

None of these hypothesis has been proved.

HIV POSITIVE (HIV+): A person is HIV+ when the HIV antibodies are detected in his or her blood.

AIDS: Acquired Immune deficiency Syndrome. AIDS is a group of different diseases resulting from a breakdown in the body’s immune system.

WHY ACQUIRED? This means that the virus is not contracted through casual contact like flu, hand shake, living together, etc. In order to be infected one has to be exposed to the virus through blood or blood contaminated body fluid contact. To enter the blood stream of the infected person there has to be an open wound to allow the carrier of the virus to infect another person. It is passed from person to person; it is not inherited.

WHY IMMUNE DEFICIENCY?

The virus attacks a person’s immune system and makes it less capable of fighting infections. Thus, the immune system becomes deficient, in which case then it become inactive.

SYNDROME: Aids is not just one disease but it presents itself as a number of diseases that come about as the immune system fails. Hence, it is regarded as a syndrome.
HIV: This is a lentivirus. Lentivirus means ‘slow virus’ because it takes such a long time to produce any adverse effects in the body. Consequently, the infection takes a long time before becoming a full blown AIDS, usually about 10 years.

The risk associated with this is that one could be infected with HIV for years without knowing. Such people could therefore be spreading the disease to many people without being aware that they are positive.

It is therefore important that sexually active people is tested to know their status. It is also safer to know the status of your partner before going into any intimate relationship. HIV infected persons therefore develop AIDS symptoms in about 10 years. It could be earlier. Most people infected with HIV progress to AIDS and eventually die within about 10 years from infection. Children die much earlier.

When the infected peoples’ CD4 count falls below 200, then such people are having AIDS. By projection HIV would have been in existence from the early 1970s or earlier (if it takes about 10 years to progress to full blown AIDS).

Thus HIV has been in existence since the early 1970s and between then and when AIDS detected in 1981, HIV had spread to five continents: North America, South America, Europe, Africa and Australia. Since then over 65 million estimated to be living with HIV and Aids in 2006.

HIV is like any other virus, except that it attacks the immune system itself.

**Opportunistic diseases associated with HIV and Aids.**

A number of unique opportunistic infections take particular advantage of the depleted immune system. They include:

- Tuberculosis
- Pneumonia
- Skin rashes

There are new advanced drug therapies in market that make it possible for people to move back from a state of AIDS, when they are very sick, to being HIV positive. This makes it possible for such people to lead normal life again.

1.2 Myths and misconceptions

Some of the most common misconceptions are:

- Aids can be contacted through casual contact. No.
- Sexual intercourse with a virgin will cure AIDS. No, there is no cure and there is no vaccine for AIDS at the moment.
- HIV can infect only homosexual men and drug users. No. Heterosexuals and bisexuals are widely known to be infected.
- HIV doesn’t cause AIDS. HIV and Aids is one and the same thing. If you don’t have HIV you cannot have AIDS. If HIV is not properly managed, it progresses to AIDS and ultimately leads to death.
1. I cannot get HIV from tattoos or body piercing. No, you can, if tools contaminated with the blood of an HIV infected friend is used.
2. HIV can be spread through casual contact. No, HIV cannot be spread through casual contact like kissing (if people kissing don’t have open injury on the lips or tongue), use of public facilities like toilets, swimming pools, theatres, shower, etc or through tears, sweat and saliva.
3. HIV is restricted to gay men/black people/young people. Anybody, irrespective of race, gender, or colour can be infected if they involve themselves in risky sexual relationship.
4. Having sex with a virgin, animal baby or old person will cure HIV and Aids. This is a misleading social problem that has led men to rape babies/young girls and old ladies. AIDS has no cure.

There are many more myths/misconceptions that you can add to the above, based on your experience within your communities. These misconceptions have led to a number of unwarranted stigmas throughout the world. Some of the ways by which infected people are discriminated against are:

1. Ostracism, rejection, discrimination and avoidance of HIV infected people.
2. Compulsory HIV testing without prior consent or protection of confidentiality.
3. Violence against infected individuals or people who are perceived to be infected with the virus.
4. Quarantine of HIV infected individuals.
5. Some infected individuals have been violently abused or killed by members of their communities.

Because of these stigmas and fear of violence many infected people would hesitate to go for testing or refuse to return for their results or even presenting themselves for treatment. Thus many people that could have received treatment and live, have misconceived HIV infection to be a death sentence.

1.4 Immunoology

As mentioned above, HIV is a lentivirus, a “slow virus” because it takes such a long time to produce any adverse effects in the body. HIV infection ultimately leads to AIDS, if not properly managed. HIV attacks the white blood cells, which causes the body to lose its capacity to fight infection.

Although the body produces billions of CD4 cells daily, HIV destroys them just as fast. (In a healthy person there are 1200 CD4 cells per microlitre of blood). HIV belongs to class of viruses called retrovirus. Retroviruses are able to replicate and grow in the gene of the host (i.e. the infected person). They have the ability to immortalize themselves by lying dormant within the host while they continue to produce new viral organisms that manifest as immune system damage in future.

HIV infection begins with viral penetration of the white blood cells involved in the defence of the immune system, the part of the body that protects individuals from viruses and other infections.
HIV infects specific white blood cells of the host’s immune system, known as T-helper lymphocytes (often called CD4 or T4 cells) and destroys them.

Some signs of immune damage include:
- Fevers
- Lymph node enlargement
- Persistent infections with fungi or viruses, and
- Unexplained weight loss.

These symptoms can reach a level that they become what is called “AIDS-related complex” (or ARC). At this stage the damage to the immune system is severe and symptoms like pneumonia and some unusual cancers set in. It is at this stage that the infection is classified as AIDS.

1.5 Virology

Virology is the study of biological viruses and virus-like agents. This includes:
- Their structure and classification,
- Their ways of infection and
- The exploitation of cells for replication (reproduction),
- The diseases they cause,
- The techniques to isolate and culture them, and
- Their potential uses in research and therapy.

A researcher in virology is a virologist.

1.6 Transmission of HIV and AIDS

The existing hypotheses point to HIV originating from human contact with certain primates (chimpanzees). Transmission from chimps to probably occurred while animals were being butchered for food in sub-Saharan Africa with animal blood contaminating wounds of human beings. The transmission would have passed unnoticed for many years before the polio vaccines using chimp kidney was developed in the 50s.

The scramble for Africa’s wealth and the wars in central Africa and the presence of many international agencies working/fighting in Africa would have exposed Europeans and Americans to the virus, who, on return, spread it to other people.

The virus is transmitted from one individual to another through the exchange of blood or blood products or body fluids containing blood, breast milk, semen, or vagina secretions. Transmission can also occur from mother to child during pregnancy or at birth. Saliva, tears, urine, faeces, casual non-sexual contact, coughing or sneezing, sweat and blood sucking insects like mosquitoes do not cause transmission of the virus.

TRANSMISSION TAKES THREE MAIN ROUTES:

Sexual contact: (causes about 86% of infections)
The majority of HIV infections are acquired through unprotected sexual relations between partners, one of whom has HIV.

- Sexual transmission occurs with contact between:
  - Sexual secretions of one partner with the rectal, genital or oral mucous membranes of another.
  - Unprotected receptive acts are riskier than unprotected insertive sexual acts.
  - Insertive anal intercourse is riskier than insertive virginal intercourse or oral sex.
  - Transmission through saliva is considerably smaller than risk from exposure to semen (HIV in saliva is too small to cause infection unless one has to swallow gallons of saliva!)

- Sexual violence is a key driver of HIV infection.
  - Studies have shown that the first sexual experience of 30% of women was either forced or coerced.
  - Incidences of rape have also increased the risk of infection.
  - The practice of ‘dry sex’, whereby a woman/lover is made to have sex with a partner without a foreplay (romance or massage) that allows her to secrete lubricating vaginal fluid before sex, also contributes to the HIV infections.
  - Multiple sexual partners make it possible for one infected person to infect many other individuals.
  - HIV is expected to be high where sexually transmitted diseases are prevalent.

In all these instances, injury to the woman’s vagina and to the man’s organ through ulceration would result in the semen or vaginal secretion or the blood of the already infected partner to pass on to the body of the uninfected partner through the injury.

- HIV can also be transmitted readily through genital ulcer caused by syphilis.
- Sexual transmission can be heterosexual, homosexual or bisexual.
  - Heterosexual: between man and woman
  - Homosexual: between man and man.
  - Bisexual: sexual relationship between man and man and between the man and women.

- Transmission can therefore occur through male to male, female to male, male to female, and, very rarely, female to female.
- Transmission in industrialized nations is predominantly through homosexual and bisexual relationships, whereas it is through heterosexual relationships in Africa and other developing countries.
- Some of the factors that promote heterosexual transmission in developing countries include:
  - The high proportion of the population that is in the age range.

- Blood and blood products (causes about 6% of infections)
  - Transfusion of HIV infected blood
Injections, through shared contaminated needles and syringes, by drug users.

- Injections through sharing of needles, syringes, blades or any sharp objects contaminated by infected blood.
- Bodily contact with open bleeding wounds (e.g. in accidents, crimes).

Mother to child transmission

- HIV infected mother can transmit the virus to her baby via what is called vertical transmission.
  - During pregnancy through the maternal circulation.
  - At the time of delivery by inoculation or ingestion of blood or other infected body fluids or soon after birth through breast milk.
  - Mother to child transmission is more common in developing countries than in the Western World.

Needle sticks among health care professionals.

Through open sores and wounds.

The following conditions aided the massive transmission of HIV in Africa:

- Migration from rural to urban areas.
- The break-up of family units due to human migration/ in search of work.
- Changes/migration favoured commercial sex.
- Increasing sexual freedom, particularly because of availability of family planning services to prevent pregnancy.
- Increasing global travels facilitated the spread of HIV to developed countries by tourists.
- Multiple sex partners and
- Violence against women.

1.7 Symptoms, stages and diagnosis.

- The symptoms of HIV and Aids are not normally found in individuals with healthy immune systems.
- Most of the symptoms are caused by bacteria, viruses, fungi, and parasites that are normally fought by individuals’ healthy immune systems.
- HIV therefore affects nearly every organ system.
- A number of opportunistic diseases are associated with AIDS patients.
- They also stand the risk of developing a number of cancers, like cervical cancer and cancers of the immune systems.
- Most patients die of the opportunistic diseases or cancers associated with progressive failure of the immune system.

1.7.1 Symptoms

Symptoms depend on the stage of infection. Each stage is based on the symptoms and the amount of virus in the body.
Initial stage (also known as Acute Retroviral Syndrome/window period)

This is an incubation period, a period between when a person is infected and when early symptoms develop. This could be a few days or several weeks.

- Flu-like symptoms are common and can easily be mistaken for influenza.

Symptoms may include:

- Fever
- Fatigue
- Muscle aches and joint pain
- Loss of appetite
- Diarrhea
- Digestive disturbances
- Weight loss
- Skin rashes
- Sore throat
- Headaches, and
- Enlarged lymph nodes in the neck, armpits and groin.
- About a quarter of infected individuals experience meningitis.

- Acute retroviral syndrome develops within 1-6 weeks after infection and last for 2-3 weeks.
- At this stage blood test cannot detect infection.

Latent period or Established stage or silent phase.

After the initial infection (the ARS stage), the disease becomes latent for up to 10 years or more before symptoms of advanced disease develop. However, the virus continues to replicate in the lymph nodes. During this period the infected person may not have any other sign of illness.

- Some of the symptoms are:
  - Painless swollen lymph nodes in the neck, jaw, armpits and groin.
  - Low grade fevers
  - Chronic fatigue
  - General weakness
  - Loss of appetite
  - Weight loss
  - Yeast infection in the mouth (thrush)
  - Open sores or ulcers and other infections of the mouth
  - Confusion
  - Diarrhea or other bowel changes
  - Poor concentration
  - Dry Cough
  - Nail Changes
  - Night Sweats
✓ Pain When swallowing
✓ Personality changes
✓ Shortness of breath
✓ Tingling, numbness, and weakness in the arms and legs
✓ Disease of the lungs and kidneys

Other symptoms that may suggest HIV in women include:

✓ More than three vaginal yeast infection in one year that are not related to the use of antibiotics.
✓ Recurrent pelvic inflammatory disease.
✓ Abnormal pap test or cervical cancer.

HIV can be passed on at this stage.

Late Stage (AIDS)

During the last stage of HIV infection, the disease progresses to AIDS.

- A very low number of CD4 count (less than 200 cells per cubic millimetre (200 cell/mm cube) accompanied by a rise in the frequency of opportunistic infections, like pneumonia and cancer, are indicative of AIDS. These opportunistic diseases are likely because the immune system is weakened.
- Other symptoms are:
  ✓ Weight loss
  ✓ Diarrhea
  ✓ Persistent fever
  ✓ Night sweats and
  ✓ Persistent thrush

If HIV is not treated, AIDS can develop in most people within 10-13 years after the first infection.

1.7.2 Opportunistic infections

Any HIV patient whose CD4 count is less than 200 can be subjected to a number of infections, like:

- Fungal diseases, yeast infections of the mouth, and meningitis.
- Protozoan infections
- Bacterial infection of the skin and digestive tract
- A number of other viral infections that can lead to progressive loss of the brain tissue.
- Loss of reasoning ability, loss of memory, inability to concentrate, apathy and loss of initiative.
- Unsteadiness or weakness in walking
- Inflammations of the muscles and pains in the joints.
- A number of AIDS related cancers like skin cancer and cancer of the cervix.
1.7.3 Symptoms of HIV and AIDS in children

Symptoms in children include the following:

- Delays in growth or development.
- Enlargement of the liver or spleen
- Persistent yeast infection of the mouth (thrush).
- Recurrent bacteria infections
- Swollen lymph nodes in the neck, armpits and groin.

Each stage can be categorized by CD4 counts:

Stage 1: More than 500 CD4 cell per microlitre of blood
Stage 2: 200-499 CD4 cells per microlitre of blood
Stage 3: Fewer than 200 CD4 cells per microlitre of blood.

1.7.4 Diagnosis

Diagnosis falls into three stages:

- Physical examination targeting all those symptoms that are specific to HIV and AIDS, particularly cancers of the tongue and skin. (Many of the symptoms listed above are also found in some other diseases.)
- Laboratory tests on blood samples taken from the patient.
  - The enzyme-linked imminosorbent assay (ELISA) test is used to detect the presence of HIV antibody in blood.
  - Positive ELISA results are then tested with Western Blot or immune-fluorescence (IFA) assay for confirmation.
    - The combination of the two tests is more than 99.9% accurate.
    - CD4 cell counts provide information about the health of your immune system.
    - Viral load measures the amount of HIV in your blood.
    - There are other tests that can be used track infections
    - Doctors use a variety of tests to detect opportunistic infections and other sexually transmitted diseases.

Some of the additional tests are:

- A complete blood count, to identify the numbers and types of cells in your blood.
- A chemistry screen, to measure the blood levels of certain substances (such as electrolytes and glucose) and how the liver and kidney function.
- Syphilis testing.
- Screening for hepatitis A, B and C, to test for past or current infection with viruses.
✓ Tuberculosis (TB) screening, to detect bacteria that cause TB.
✓ A chest X-ray, to detect lung problems associated with HIV.
  o HIV is treatable, if detected early and medications associated are used religiously. People treated for HIV are living longer than ever before because of the availability of drugs that slow down of progressing.
  o The state of the HIV also needs to be monitored regularly to enable the doctor to know if the disease is progressing and when to commence treatment.

2. FACTORS THAT FACILITATE THE TRANSMISSION OF HIV AND AIDS.

2.1 Risky sexual and social behaviors.

2.1.1 Risky sexual behavior.
✓ The greatest risk is associated with:
✓ Those who do not practice safe sex.
✓ Those who are not monogamous.
✓ Those who practice anal intercourse.
✓ Those who have sex with a partner with symptoms of advanced HIV infection and/or other sexually transmitted disease (STDs).
✓ Those who keep many sex partners.
✓ Those who are unfaithful to their partners.
✓ Women married to bisexual partners or partners that need regular blood transfusion or intravenous drug users or women that live in neighbourhoods with high prevalence of infections among heterosexuals.
✓ Dry sex, as practiced in certain parts South Africa, could cause infection.

2.1.2 Risky social (or anti-social) behaviours.
❖ Use and sharing of un-sterilized tools for tattooing.
❖ Rape
❖ Gang rape
❖ Kissing people who have open wounds on their lips or in their tongues; more risky if you also have an open wound.
❖ Sexual promiscuity/number of concurrent sexual partners.
❖ Untreated STDs.
❖ Partonizing sex workers.
❖ Drugs and alcohol abuse among young people.

2.2 Economic factors

Poverty: Poverty and inequality are fundamental in the spread of the HIV and AIDS. More people are infected among the poor communities and among the marginalized people of the society because of:
✓ Over crowding, e.g. in informal settlements,
✓ Unemployment,
✓ Ignorance about the disease,
✓ Inaccessibility to health services or too poor to access health services,
✓ Poor sanitation.
✓ Absence of basic social services.
✓ Exploitation of the poor by the rich, who lure young boys and girls to sex for money.
✓ Rural urban migration, whereby people migrate to cities for better life but with no job in sight.
✓ Many people work far away from home and family because of the nature of their work; e.g. long distance drivers, mine workers, etc.
✓ Poor nutrition, which makes poor people more susceptible to infection because of their weak immune system.
✓ Treatment is unaffordable for the poor, since treatment has to continue for life. Ant-retrovirals are not affordable to the poor.
✓ There is a general tendency for the poor to feel powerless, which aggravate the feeling of hopelessness.

2.3 Psychological factors.

Each stage of infection is always a traumatic experience for the infected person.
Three major problems that could lead to psychological problems are:

- Facing the reality of being infected: The natural feeling is like one has been sentenced to death.
- Facing the reality that the disease cannot be treated
- Facing the reality of ultimate death.
- Stigmatization of the infected by their community/society. This could affect:
  ✓ Employment prospects,
  ✓ Social discrimination and unfair treatment
  ✓ Openness and encourages secrecy and denial
  ✓ Delays HIV testing, essential treatment and other preventive activities
  ✓ Pregnant women from seeking testing, leading to mother to child transmission.
  ✓ Development and some developing countries have counseling services to help people deal with these problems and create awareness that even though the diseases incurable it can be managed like any other chronic diseases like diabetes, high blood pressure, heart problems, etc.

2.4 Political factors

Government and public response to HIV and AIDS in Africa has been very slow and controversial.
Many Governments see HIV and AIDS as a threat to investment and tourism and this explains the apparent slow response of African Government to the pandemic.
Political instability is a major problem in Africa as countries at war are more at risk that country at peace. The prevalence of HIV infection is much higher among military personnel deployed to conflict areas.
Because Africa houses the largest people infected with the virus, Government are unable to provide adequate resources to control and manage the spread of the disease, and facilities to test citizens for infection. Government cannot also meet foreign aid to manage the pandemic.

2.5 Cultural factors

- Polygamy is a social practice in many African countries.
- Early marriages.
- Where this cultural practice is dying down because of education, many people engage in extra-marital activities with other women/men, particularly the young ones.
- Young people are put at risk of infection by those who believe that having sex with virgin can cure their infection. This is rubbish.
- Widow inheritance, failing which she and her children are disinherited of the late husband’s possessions.
- Dry sex.
- Forced sex (rape) against a woman’s will as a result of male domination of women.
- Circumcision, which is now recognized as one practice that can reduce HIV infection.
- Female genital mutilation, which is being banned in many African countries, because of the scar that is left behind. This practice has not been shown to increase risk of HIV infection.
- In most African countries there is a general discrimination against women, which has aggravated sexual violence against women (married or unmarried).
- High illiteracy level affects how a person responds to cultural issues.
- Many male Africans are reluctant to use condom because of the perception that condom is not meant for Africans!

2.6 Community factors

There are different layers of the community:
- The immediate family (nuclear and extended)
- Friends and neighbours
- The larger community
- The school you attend
- The place of worship (Church, Mosque, traditional, or you may have no faith!)

All the above have impact on the rate at which HIV and AIDS spread. Let us take each of them and see how they can positively or negatively affect the spread or reduction of HIV infection:

Your family:

Is the family stable? Are father, mother and other siblings living together in peace and supporting each other? Or are they always quarrelling? Or are children brought up by single parents who are always jumping from one partner to another, thus setting bad examples of sexual indiscretion? Or are children brought up by single parents who
maintain high moral standards? All these could affect how a young person lives his life and relate with the opposite sex?

Friends and neighbours

Often we are positively or negatively influenced by our friends either within the neighbourhood or at school. If one is brought up in the neighbourhood where young people are into drugs, one could be influenced negatively. If a community is known to be notorious of rapes (single or gang rapes) a child could grow up to think that it is the way of life. If your neighbours are peaceful, friendly and supportive, then children within such neighbourhood will be positively influenced.

The larger community:

If the community is built on love and self respect and each other is supported, then drugs and incidences of rape will be minimised and infection will be low in such community. There are negative and positive cultural practices within a community that can affect spread or control of infection. There are communities that have well established support structures to support youths, the HIV infected people and orphans. These are positive attributes that can minimize the rate of infection.

The school

The tone of the school (i.e. the overall discipline of a school) could affect young people positively or negatively. If the discipline is high and learners are brought up with high discipline then they will live a disciplined life. If the moral tone of the school is low and learners could do what they like, including learners having sex with each other, injecting drugs, stealing etc, these are high risk behaviours that can aggravate infection.

The place of worship

Children that are brought up in Christian, Islamic or true and genuine traditional discipline are better behaved and have self respect and respect others, if they practice what they are taught or brought up with such people are more faithful in their relationship with the opposite sex. They are likely not to get involved in sexual relationship at early age. There are also polygamists that are also faithful in their relationships with their wives [the problem here is that once one member of a polygamous family is infected other member are put at risk.]

3 IMPACT OF HIV/AIDS ON INFECTED AND AFFECTED

When a person finds out that s/he has contacted HIV \ AIDS, life changes suddenly. The impact varies from individual to individual. However, many people at this stage feel: rejected, lonely, felt a sense of denial, angry, angry with God, stigmatized, feels like committing suicide, embarrassed, isolated, feels guilty, unhappy, depressed, anxious, frightened and uncertain about the future and dying, feels like s/he has lost his/her freedom, unworthy, unaccepted, helpless, loses confidence, and abandoned.
WHO ARE THE INFECTED

- Young people, infected by their friends or through rape.
- Mothers, infected by their husbands or through infidelity.
- Husbands infected by their wives or through infidelity.
- Children infected through mother–to-child transmission.
- Health workers infected through occupational hazard.
- Those infected through accident.
- Those infected through drug injection using contaminated needles.

WHO ARE THE AFFECTED.

- Parent of young people
- Other relatives/extended family members
- Husband/wives of infected partners.
- Orphans
- Young children who turned care-givers.

NATURE OF SUPPORT

The type of support depends on mode of infection and the social-economic status and environment of the infected. However, support can include the following:

- Social support
- Psychological support
- Material support
- Spiritual support
- Financial support
- Educational support
- Skills development for self sufficiency

WHERE ARE ALL THESE SUPPORT COMING FROM.

- Friend/peers (youth groups for peers support, social, sport and cultural activities and crime prevention)
- Family (nuclear of school age) (caring teachers and principals of local schools, schools counsellors)
- Religious organizations (Churches, Mosques, Temples, etc)
- Community [some communities have local AIDS support groups]
- Government [social welfare/development department]
- Non-Government organizations, such as Hospice Associations and Civil organization]
- Local authorities
- The local clinic/groups
- Women’s groups

WHY DO THE INFECTED NEED SUPPORT
They need to be support to;

- Accept their HIV +status positively;
- Meet their nutritional requirement;
- Be able to reach their full potentials in life;
- Cope with the emotional problems that follow awareness of the status;
- Access treatment;
- Be able to support themselves;
- To manage the impact of discrimination and stigma;
- Cope with the attendant stress of managing their status;

**WHY DO THE AFFECTED NEED SUPPORT**

- Most affected persons are least prepared for the new role trusted on them by the infection of their loved ones; they also need psychological support;
- Some are too poor to provide adequate nutrition and medication;
- Children caregivers [to their orphaned siblings] are too young to cope. They also need support [material, psychological, and education];
- Most affected could be aged grand-parent that depend on pensions or on regular source of income.

3.1. **IMPACT ON THE INDIVIDUAL INFECTED**

Physical (changes in the body, compromised immune system, vulnerable to opportunities illnesses/infection, side effects of medication, etc)

- Psychological/emotional (worries about acceptance, especially by peer group; feeling of insecurity and loss o belonging; loss of self-esteem because of emotionally vulnerability, feeling of inferiority complex and negative feedback from adults/peers that could diminish the ego; mood swings are common; signs of depression; social withdraw; absence from school; etc).
- Attitudinal (Attitude is a settled opinion or way of thinking that is often reflected in the person's behaviour) This could manifests in the following due to the HIV + status of the person:
  - Prejudice: implies a biased/unreasonable/preconceived opinion or idea of someone else;
  - Stigma: mark or sign of disgrace or discredit, loss of reputation, false accusation;
  - Discrimination: when some is unjustly/unfavourable treated, based on prejudice, especially because of race, colour, sex, religion or illness;
  - Fear: when someone experiences an unpleasant emotion caused by exposure to danger, expectation or fear.
- Social impact
  - Constant illness and frequent hospitalisation can disrupt the formation and maintenance of peer relationships and friendships; this could ultimately result in exclusion for the group.
  - Rejection of the learner infected is also common;
  - The infected learner may withdraw from peers
  - Friends may feel isolated by the learner especially if the infected
learner is popular with peers
  o Rejection or withdrawal may can prevent the effected to socialize adequately thus limit making friends.

Educational /academic impact
  o Linked to cognitive and social impact;
  o May not see the need for further studies or a career, in anticipation that they may die soon;
  o Learners may fall behind academically due to prolonged or frequent absence from school and emotional instability.

3.2 Impact on individuals affected
  o Sickness or death of a family member;
  o Household resources are compromised;
  o Work output is reduced;
  o Medical expenses increase;
  o Disruption of family and community life;
  o Children are kept away from school to care for adults;
  o Limited family resources spent on care an funerals;
  o Food production declines;
  o Poverty and crime increase.

Impact on economy

HIV/AIDS hits active young adults and adults in their most productive years, and is therefore a killer of the fittest. It has a greater impact when it affects the more skilled, the better educated, and the bread winner of a family. Economically productive adults stay away from work to cater for the sick member of the family. Schools loose teachers, health care workers become sick/die, fathers and mothers lose their jobs (Particularly if they are on daily paid employment or temporary employment).

The lead to the need for more doctors/nurses/social workers to cater for the sick. As a result of deaths from AIDS, large numbers of vacant posts are unfilled. Sick workers result in loss of revenue as a result in lower productivity.

Government spends billions of Rand on
  o Awareness programs;
  o Condoms;
  o Medication-ART's
  o Health services-treatment of opportunistic infections
  o Social grants
  o Support to orphans

Impacts negatively on capital:
  o Increases budget expenditures through increased treating and caring for opportunistic infections associated with HIV/AIDS;
  o Increases pension payments as civil servants are forced to take early retirements and the training of newly recruited professionals affect the national
budgets;
  o Reduces both quantity and quality of labour force.

4. Standard Universal safety precautions for prevention of HIV and AIDS infection

Voluntary testing

- The cry has always been that everybody should know his/her status. Why?
- Knowing your status can help in saving your life.
- Going for the test may be scaring but thereafter life can change completely.
- It always good for one to know the implications that the results could have on ones life.
- It is good for each person that have been involved in any unsafe sexual relationship or have been exposed to other risks (like casual sex with someone whose status you don't know, prostituted, rape or if you can shared needles or have blood contact when you have an open wound, etc.).
- Any doubt in your mind that you may be infected calls for a test. This may be what you need to put your mind at rest.

  o If you are positive,

Then you seek counseling and support from clinics and centers that are provided by government, community, or schools.

- You seek treatment. HIV is no longer a death sentence. It can be managed like any other disease.
- You avoid infecting others my avoiding unsafe sexual relationships.
- You can reach an understanding with your partner on how to make your relationship work. This way you protect people close to you from being infected.

  o If you are negative,

    □ You avoid acts that can put you at risk of being infected.
    □ You can adjust your sexual lifestyle, so as to avoid being infected.

4.1.2 Counseling

There are pre-test and post-test counselling procedures:

  o Protest-test counselling: A trained counsellor helps to make informed decision about having the test and this covers:
    ✓ Helping one to think through the reasons for being tested.
    ✓ The potential implications of testing positive on ones life and people around one.
    ✓ If negative, the need to continue to remain negative and ways to do this.
    ✓ If positive, how to cope.
  o Post-test counselling: Counselling at this stage depends on the result.
Negative result: Counselling focus on:
✓ Behaviour to remain negative
✓ Advise for a re-test after three months to be sure one is not tested in the window period, that can give false negative results.

Positive result: Counsellor will advise on:
✓ How to manage your life with HIV and avoiding transmission to others, e.g. using condom correctly.
✓ Issue of disclosure; you may or may not but disclosure will help your family and friends to understand your status and support you.
✓ Knowledge of opportunistic infections; what they are and how to treat them.
✓ How to live a healthy life to delay or even avoid the onset of AIDS.
✓ Counsellors are trained to listen and to give the right information to help people make decisions.

There are voluntary counselling and testing centres, where you can have an HIV test, get your results within 15 minutes and discuss your results with a trainer, professional HIV/AIDS counsellor in a private counselling room. Such centres as called “New start”. There is one such centres in Durban. (The University Clinic is also equipped to do the testing)

There are many organizations that give counselling services all over the country:
✓ Voluntary counselling and testing sites.
✓ AIDS training, information and counselling centres (ATICCs) in most big towns.
✓ The free 24-hour AIDS Helpline 0800012322.
✓ Social workers and some community organizations.

4.1.Sexuality Education

Some sexually education encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles.
Parents, peers, schools, religion, the media, friends and partners all influence the way people learn about sexuality.
Early sexual activity and the involvement in the struggle to win and keep boyfriends and girlfriends are particularly common among young people, particularly those from poor families.

What is the purpose of sex?

- Traditionally (in African context): For reproduction to perpetuate a family line.
- For God: For reproduction as a continuation of God’s creation.
For modern man and woman: For fun; for exploitation of the vulnerable groups; for money (e.g. male and female prostitutes and the back-burner for procreation subject to family planning).

As you can see, the purpose of sex for the modern man and woman contradicts traditional values and God’s values hence the world has become sexually permissive.

The modern person has perverted the sanctity of sex for the sustenance of humanity.

Many young people don’t know the purpose of sex. Experiment with sex to their own detriment.

What is the consequence of our permissive society?

- Unwanted pregnancies that have led to unlimited number of abortions among young women.
- This has led to barrenness among many women.
- Many instances of abandoned babies.
- Many fatherless and motherless children.
- Many street children.
- Worst of all the HIV and AIDS pandemic
- All these create social problems for the society

What is the solution?

- Children need to be provided with sexuality education right from young age by the parents. Each child should know how she/he was born.
- They should know how he/she was born.
- They should know that they will also become parents in future, when they are of age to carry the challenges of parenthood.
- They should know when a man has sex with any woman, pregnancy could result and that the pregnancy is carried for nine months before birth.
- They should know the challenges of parenting.
- They should know that traditionally and from religious perspective children should be born within marriage and that having children outside marriage is not approved by God and by African tradition.
- They should be brought up to respect themselves and the opposite sex.
- Sex is not for children who are not ready for marriage.
- Children can have friends of opposite sex but this does not necessarily mean parenthood/ the consequence of their action.
Where do children receive sexuality education in a modern world?

From Home:

Many African families see discussing sexuality with their children as a taboo and carry a wrong option that a child will become promiscuous. This notion is wrong. The more a child at a tender age can share his/her sexual feelings with parents, the greater the chances that the child will not make the mistakes of engaging in irresponsible sexual relationships. When such a child is confronted with sexual overtures and he/she is confused about what to do he/she will be free to approach their parents for advice.

From school:

The school is well placed to provide sexuality education to learners and some of the guidelines to teachers from the Department of Education in 1999 are:
- To make young people like and respect themselves.
- To help learners see sexuality as natural and positive part of life.
- To teach skills to make informed and responsible decisions.
- To help learners act in accordance with their values.
- To teach understanding, tolerance, and respect for different sexual needs, orientation and values.
- To teach learners to protect themselves from exploitation and not exploit others; and
- To teach learners how to use health services and how to find information they need.
- The purpose of comprehensive sexuality education is
- To create a climate in schools where pupils will be free from abuse
- Teachers will be living examples of the values enshrined in the sexuality education curriculum.

For teachers to be viewed as trusted and accessible sources of advice on individual problems related to sexuality.
Sexuality education is a big challenge to teachers. Unfortunately there are many instances of teachers having sex with or abusing learners sexually. Many teachers are being dismissed from duties because of this.

The media:

The media is at a vantage position to play a big role in sexuality education. Youths must, however, be aware that the media can also mislead them.

From peers:

Youths can benefit from their informed peers but quite a number of youths have also been misled by their peers. The most vulnerable group is found among those youths that have no parental or school guidance on sexuality education.

From adults:
Responsible adults can also play positive roles in supporting youths but there are reported instances where adults have taken advantage of young people. The most vulnerable are those youths from poor backgrounds that can be lured with money and expensive gifts.

**From religion:**

There is no religion that encourage people to live irresponsible sexuality life and all religions advocate delay of sex until marriage. Most religion also discourage abortion.

**From trial error:**

Many youths have experimented with their sexuality to their detriment. Some also have learnt bitter lessons from their mistakes and are able to share such experiences with other younger people so that they can learn from their own mistakes.

It is evident that sexuality education is a very complex subject and teachers (and parents) should be more vigilant with children put their care.

**4.3. Changing unsafe sexual and social behavior**

- We have discussed factors that have aided the HIV and AIDS pandemic.
- You should look at those factors again and avoid being indulged in them.
- Some of the behaviours that have to change are:
  - Violent sexual relationship that can lead to injury of both parties:
  - Rape is criminal and wicked. Respect each other and yourselves.
  - Responsible men don’t rape; they love and care!
  - Dry sex is injurious to both parties and should be avoided.
  - Having sex with virgins do not cure HIV and AIDS
  - Abstain from sex if you cannot practice safe sex.

In any case wait until you are old enough to take responsibility for your sexual life before having sex. Better still preserve yourself and delay having sex until you get married. Sex is not a game of whether you win or lose attractive guys or girls ;it has become a game of life and death .You either contact HIV and AIDS or not and either die or live .Avoided exercise consumption of alcohol if being drunk will push you to anti-social behaviours towards the opposite sex. This is particularly rife when young people come together in groups at parties, shebeens, and other social gatherings.

Avoid concurrent sexual relationship [i.e. having many partners at the same time]. If one us infected within the relationship are at risk.

**UNIVERSAL SAFETY PRECAUTIONS AT SCHOOLS AND CLASSROOMS**

*Universal precautions involve a series of strategies and actions to minimize the risk of transmission of infectious agent (e.g. blood borne and non-blood borne), which are spread by contact (Source:’ Universal Blood and body Fluid precaution’, Centre s of Disease Control, Atlanta, Georgia, USA, 1987).*
The implication of this is the recognition that all blood and body substances, including tissues, of all patients are potentially infectious. Schools should implement good hygiene and first aid procedures always. Any student with moist skin lesions or abrasions which are ‘weeping’, bleeding, or discharging, and which cannot be covered should remain away from school, as a precaution, until wound has healed.

The following precautions are therefore to be taken where a staff or a learner has contact with blood or body fluids:

All human blood or other body fluids and tissues should be considered as potentially infectious. Gloves must be worn wherever there is a likelihood of contact with blood or body fluids, when handling anything contaminated with blood or body fluids and while handling and cleaning first aid equipment. Hand must be washed with soap and running water before and after administration of first aid. Soiled equipment should be soaked in a bleach solution for 30 minutes then rinsed, or washed in cold water and detergent and boiled for 10 minutes. Learners should be advised of the dangers associated with carrying out procedures where skin is broken. First aid waste should be placed inside a plastic bag, tied securely, then placed inside a second plastic bag, which should also be securely tied and then disposed of with normal domestic waste. Avoid mouth-to-mouth resuscitation if you have an open wound on your lips or mouth. (There do not appear to be any documented cases of HIV infection from mouth-to-mouth resuscitation, however).

- Staff involved in providing first aid to a student must always:
  - Exercise strict hygiene;
  - Wear disposable gloves;
  - Clean and disinfect wound or broken skin;
  - Cover any cuts or broken skin with waterproof dressing to prevent any contact with the student’s body fluids;
  - Removes gloves and place in disposable plastic bags as described above.
  - Wash hands with soap and running water.

- If staff members have open cuts or weeping sores on hand or lower arms they should not treat students or other staff members, but send immediately for assistance.

- If a learner or students has an exposure to blood or body fluids, the following should be done:

  **Immediately:**

  - Wash away the blood or body fluid with soap and running water;
  - If the eyes are contaminated, rinse eyes while open with tap water or saline;
  - If blood gets into the mouth, split it out and the repeatedly rinse with running water.
What to do next:

✓ After carrying out the appropriate first aid measures outlined above, the incident should be reported to principal/workplace manager (in the University, report to the Health Clinic).
✓ In the case of a staff member, they should be referred immediately to a doctor or a hospital for risk assessment and if necessary, appropriate testing, treatment and counseling.
✓ In case of learners, the principal should ensure that parents are advised to immediately contact a doctor or a hospital for risk assessment of the learner, and if necessary, appropriate testing, treatment and counseling.

4.4.1 Cleaning and Removal of blood spills:

- Wear rubber gloves
- Using absorbent materials, mop up the bulk of the blood or body fluids.
- Dispose waste materials in double plastic bags as described earlier.
- Clean contaminated surfaces by covering for 30 minutes with paper towels which have been soaked in the strongest solution of bleach. Remove and place in double plastic bags. Wash the wet areas with water and household detergent and dry them thoroughly
- Wash gloves and hands with soap and running water.
- Soak any utensils used in bleach solution for 30 minutes, then rinse (or wash in cold water and detergent and boil for 10 minutes).
- Avoid splashing when washing

4.4.2 Sporting, playground or classroom injuries

If there is any bleeding, teacher should ensure that:

- A student who is bleeding should leave the activity are until bleeding stops, all body parts contaminated by blood are cleaned and the wound covered securely with waterproof bandage or dressings.
- Where possible bystanders in the immediate vicinity are removed from the area until the area is cleaned.
- All contaminated equipment is replaced and contaminated surfaces cleaned, prior to the game or activity recommencing.
- Contaminated clothes are changed for clean ones once the wound has been treated. Contaminated clothes should be handled with surgical gloves and stored in leak-proof double plastic bags until they are washed.
- Disposable surgical gloves are worn by all those with the blood spill.
- A record of the injury is taken and forwarded to the appropriate authority. If bleeding recurs, the above procedures should be repeated. If bleeding cannot be controlled and the wound securely covered, the student must not continue in the activity.

4.4.3 Disposal of needles/syringes and other sharp tools used in First aids procedures
The needles/syringes and other sharps refer to items used in emergency first aid procedures.

- A container for sharps must be provided and kept open.
- Wear gloves on both hands.
- Pick up the syringe/needle as far from the needle end as possible. Tongs may be used to pick them up.
- Place into sharps container, needle first.
- Close sharps container and store in a safe place prior to collection.
- Sterilize tongs by soaking them in bleach solution for 30 minutes then rinse (or wash in cold water and boil for 10 minutes).
- Do not dispose sharps containers in normal waste disposal bins or landfills.

### 4.4.4 Disposal of needles/syringes and other sharps found in school grounds

*Learners must be instructed not to pick up syringes or other sharps under any circumstances but to stand and watch while another learner gets a member of staff.*

- Schools should ensure that learners are aware of the potential danger of needlestick injuries and they should be warned against handling needles.
- When broken glass, condoms or other hazardous waste are found students should be instructed to follow the above directive.

### 4.5. Life Skills training: Learning for life

Life skills are increasingly important in preparing learners for the world of work and life in general. Life skills component are now being accommodated in the formal curricula of learning programs and form a core of the academic strategy of most institutions.

There is a separate module on life skills where this will be treated in details

- For the purpose of this module life skills are supposed to:
- Communicate relevant knowledge (about sexuality, HIV and AIDS, accept responsibility for ones life, cultivating positive outlook for life, etc).
- Engender appropriate values and attitudes, particularly in our relationship with opposite sex/partners.
- Build personal capacity among learners to maintain or adopt behaviors that will minimize or eliminate the risk of becoming infected with HIV.
- Equip learners with skills such as decision-making, problem-solving, effective communication, etc, when faced with difficult situations.

### 5.1 MANAGEMENT OF HIV AND AIDS

- Antiretroviral drugs
- Exercise
- Diet
- Support Structure
- Life Skills
- Addressing the stigma attached to HIV/AIDS

*Antiretroviral drugs (Also called anti-retroviral/anti-HIV drugs/ARVs).*
Antiretroviral drugs are medications for the management of infections by retroviruses, primarily HIV. There are different classes of drugs for managing different stages of the HIV life-cycle. Combination of several (usually 3 or 4) antiretroviral drugs is known as **Highly Active Anti-retroviral Therapy (HAART)**.

- HIV anti-retroviral drug treatment is not a cure, but it can prevent people from becoming ill for many years after infection.
- They also slow down the progression of HIV infection to full-blown AIDS.
- The drugs work by slowing down the replication of HIV virus in the body.
- The prescribed to be taken everyday for the rest of ones life.
- Usually patients take at least two but preferably three drugs at the same time.
- Single drug therapy can lead to resistance.

**Antiretroviral drugs-therapy can be changed if:**

- There are side effects which may be mild or severe.
- If the drugs failed to work, i.e. not slowing down the replication of HIV in the body.

**Factors that determine the drugs to take**

The type of drugs to be made available in any country is decided by Government and depends on:

- Available at all times.
- Price of drugs. Would it be affordable?
- The number of pills to be taken per day.
- The side effects of the drugs
- The laboratory monitoring requirements.
- When there are co-blister packs or fixed dose combinations available.

A co-blister pack is when two or more pills, capsules or tables are packaged in one unit of use of a plastic or aluminum blister pack.

A fixed dose combination ([FDC]) is when two or more drugs are combine together in one pill, capsule or tablet

The advantages of FDC are:

- FDC reduces the number of pills or tablets to be taken.
- The patient cannot leave out one of their drugs by not taking one of the pills.
- The patient is therefore able to take the drugs correctly are reduces the chances of developing resistance.

On the contrary co-blister packs:

- Helps patients to take the pills at the correct times by packaging them together.
- One problem is that the drugs can still be separated.
- Co-blister packs do not reduce the number of pills or tables to be taken.
Terminology in antiretroviral drug treatment

Adherence means taking the drugs exactly as prescribed by the doctor. It also means taking the drugs on time and following any dietary restrictions.

**What makes adherence work?**

- First there is need for education before patients start taking the medication.
- Knowing basic information about HIV and its effects.
- Knowing the benefits and side effects of antiretroviral medications.
- Knowing how the medications should be taken.
- The importance of not missing any of the drugs.

**EXERCISES – HIV AND AIDS**

People living with HIV also need regular exercise to maintain fitness and optimal health.

**BENEFIT/ADVANTAGES OF EXERCISES**

- Regular moderate exercises have many advantages for everybody and for those with HIV AND AIDS diseases.
- It helps many peoples living with HIV and AIDS to feel better.
- It helps with good blood circulation.
- It helps to strengthen the immune system.
- It helps to fight many of the side effects of HIV disease and HIV medications.
- Exercise can improve muscle mass, strength and endurance.
- It improve heart and lungs endurance.
- It reduces cholesterol and triglyceride levels [less risk of heart disease].
- It improves and increases energy level and reduces tiredness.
- It reduces stress.
- It facilitates regular bowel function.
- It enhances the sense of well-being.
- Helps to stabilize or prevent declines in the CD4 cell count.
- It strengthens the bones.
- It decreases fats in abdomen.
- It improves appetite.
- It improves sleep.
- It improves the way the body uses and control blood sugar [glucoses].

Moderate aerobic exercise for 10 weeks, three times a weeks for 45 minutes each session significantly improve function of the nervous system and blood circulation of those with HIV diseases.

People with HIV who engaged in moderate aerobic exercise enjoy greater control of blood pressure compared with those who are positive but do not exercise.

**WHAT ARE THE RISK OF EXERCISE?**

Dehydration-loosing too much of water: Drink plenty of water to keep up the fluid levels.
Injuries may take more time to heal.
Using wrong from of exercises.

**EXERSICE GUIDELINES FOR PEOPLE WITH HIV and AIDS**

**DON’T OVER DO IT:** A moderate exercise is recommended to help the body turn foods into muscles and improve fitness.

**EAT AND DRINK CORRECTLY:** Drink a lot of fluids after exercising to replace the lot fluids during exercise.

Don’t eat when exercising. It is best to wait up to 2 hours after a full meal before exercising. Wait four an hour after exercising before eating the next meal.

**CHOOSE SOMETHING YOU ENJOY:** Choose activities that you like, running, jumping, bicycling, jugging, etc.

**EXERCISE WITH WEIGHT:** This helps to increase lean body mass that maybe lost through HIV disease and aging. However exercise can improve the strength of HIV + people. It can fight fatigue, depression, and improve endurance and increase fitness.

**DIET:** Nutrition and HIV – Why is it important?

A healthy nutritious diet is important for everybody, but more important for people living with HIV.

- A poor diet weakens the functions of immune system, and hastens the progress of HIV infection to AIDS.
- Variety of foods such as carbohydrates, plenty of vegetables and fruits; beans, peas, and lentils should be eaten regularly.
- Chicken, Fish, milk, meat, eggs, can be eaten often.
- Facts and salts should be eaten sparingly.

Nutritionist can be consulted on a regular basic especially HIV + people attending government service points. The nutritionist provides information about:

- Healthy eating and life style
- Food preparation
- Nutritional supplements.
- Vitamins such as multivitamins, Vitamins B-complex, Vitamin B12 Taken in correct dosage will also help t boost the immune system.

**GENDER and HIV / AIDS**

The Longmans Dictionary of Contemporary English defines gender as the state of being masculine, feminine or neuter.

For the purpose of this module let’s understand gender as referring to the way in high the society constructs us as male or female, hence masculine or feminine. This construction has implications for the spread of HIV / AIDS. It is the aim of topic to
highlight the consequences of gender inequality in terms of stereotypes, inequality, gender based discriminations and sexual abuse.

**GENDER STEREOTYPES and HIV / AIDS**

- Harmful stereotypes around sexuality exist and may have damaging influence regarding HIV / AIDS.
- Societal stereotypes: Men and women are usually brought up to think only penetration counts and other forms of sexual expression are childish and unsatisfying for themselves and their partners.
- Partners are secretive their premarital or casual sex and this prevents them from ever discussing the possibility of prior infection. It is taboo to discuss a woman’s past sexual experiences else she would be labelled a whore or infidel.

Gender stereotypes: The statue of women does not afford them power to make decisions about their own lives including the choice of a life partner.

Many myths about men’s and women’s bodies and about sexual intercourse override factual information abut HIV /AIDS. e.g.

- a) Some men believe that multi partnership will cover them as they must avoid their women when they have menstrual cycle
- b) There is a mistaken belief in some countries that taking birth control pills. Can protect men and woman from getting HIV.
- c) HIV + men lure young girls into having sex with them because they assume that young girls are not HIV +.
- d) Having sex with a virgin cures AIDS

The above and many more other stereotypes and misconception about HIV / AIS tend to disadvantage women more men.

**Attitude**

Common attitudes about gender inequalities often associate masculinity with – taking, This is likely to result in men disregarding possible damaging consequences due to their (men’s) neglect for safe sexual practices and sexual responsibility.

**Gender inequality and HIV/AIDS**

*Women are in some socialized to* believe in the superiority of men and they will therefore always condone male permissiveness.

**Power relation**

Unequal power relations give women a subordinate and make them socially independent on male family members. In certain of the community they have less access to health care, employment, education, information etc.

**Masculinity over femininity**

Both men and women often have expectation of masculine behavior that discourage boys or men from discussing problem and feelings exclude them from participating in
caring practices. As a result they deal with sexual and HIV/AIDS situation using violence and sometimes force, dissociating themselves from both the problem and the solution.

**Male entitlement**

There exist socially defined norms of masculinity make men reluctant to use economic survival and will therefore lack the skill and confident to insist on their right to sexual health (Campbell, 2001)

**Implications for HIV/AIDS**

With regards to HIV/AIDS women are in a poorer position to control when, with whom, or in what circumstances they have sex. While men have greater control over this, it has negative implications for women contracting the HIV Virus.

**Gender based discrimination and HIV/AIDS**

Masculinity dictates that males behave in a particular fashion and females in another. Masculine is associated with strong and athletic while feminine is associated with gentle and caring. While this has implications for behavior, and participation, it may also have implications with which one mixes and exploit ones sexuality with.

There is a notion that women are vulnerable to HIV while men are at risk.

**Health and Risk**

More men are in the core group, i.e., hey are liable to contract ad transmit the virus.

**Vulnerability.**

Women, girls and effeminate boys are likely to be sexually abused by stronger men who may in turn transmit the virus to them. It is argued that for a female to refuse to have sex is to call into question the males masculinity; and when this happens, violence frequently results. (Morrell, 19999).

**Male entitlement**

There exist socially defined norms of masculinity that make men reluctant to use condoms. Some women are over socialized to over respect men and depend on men for economic survival and will therefore lack the skill and confidence to insist on their right to sexual health.
HIV in sub-Saharan Africa constitutes some 64% of the global total of 39.5 million people living with HIV. Levels of infection vary throughout the region with countries in the north and west having adult (15-49) prevalence levels of between 1% and 5%, while those in southern Africa have prevalence in the region of 10% to 20%, with some countries (Botswana, Zimbabwe, Lesotho and Swaziland) even higher. HIV prevalence has declined in some African countries, starting with Uganda in the early and late 1990s followed by Zimbabwe and urban areas of Ethiopia, Kenya and Malawi.

These declines appear to be linked to a combination of factors including changes in key sexual behaviour: delayed sexual debut amongst young people, declines in partner turnover and increased condom use with casual sexual partners. Southern Africa remains the most affected region, and the HIV epidemic in South Africa is interlinked with epidemics occurring in neighbouring countries. South Africa, Swaziland, Lesotho and Botswana reported the highest antenatal HIV prevalence levels in the world in 2006.

HIV prevalence is relatively low in neighbouring Mozambique, although increasing rapidly along transport routes and there is some evidence that prevalence may have peaked in Botswana. The severity of the epidemic is closely linked to the region’s poverty, relative lack empowerment, high rates of male worker migration, and other social factors. Even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people and women in poor countries.

**HIV & AIDS AND STI STRATEGIC PLAN 2007-2011**

**1.1 The epidemiology of HIV and AIDS in South Africa**

A clear understanding of the nature, dynamics and character of an epidemic is critical in informing strategies that should be reviewed and adapted to fit local conditions. UNAIDS and WHO description of the HIV and AIDS epidemics is based on prevalence rates and population affected. These organizations assert that HIV and AIDS is not the same everywhere.

Given the dynamic nature of an epidemic, one country may move from one category to another. Even within a country there may be a series of multiple, changing and overlapping micro-epidemics, each with its own character (the populations most affected), dynamics (patterns of change over time) and characteristics (severity of impact).

By this definition, the South African HIV and AIDS epidemic is generalized. It is firmly established in the general population and sexual networking in the population is sufficient to sustain the epidemic independent of sub-populations at higher risk of infection. A numerical proxy of HIV prevalence consistently more than 1% in
pregnant women has been used to qualify a generalized epidemic (World Bank and WHO use more than 5%).

By this definition alone therefore, South Africa has a generalized epidemic. HIV prevalence has been consistently monitored in South Africa including through antenatal HIV and syphilis prevalence surveys, which have been conducted since 1990, and two national population-based surveys which were conducted in 2002 and 2005. A national prevalence survey of youth was also conducted in 2003/4. Figure 1 illustrates antenatal HIV trends from 1990 to 20057, and Figure 2 illustrates HIV prevalence by sex and age group in 2005 in the general population.

A number of other national and sub-national studies have been conducted including employees, the military, health workers, educators10, health care workers and hospital patients11, amongst children attending health care facilities12, and in various other communities and sectors. Not all, of these data are available in the public domain, and thus it has not been possible to paint a comprehensive picture of the epidemic in different sectors in South Africa.

However, the reasonably comprehensive data that is available has allowed HIV prevalence, incidence and AIDS mortality to be estimated using demographic modelling as shown showing an estimated 5.4 million people living with HIV in South Africa in 2006, of which a total of 294 000 were children aged 0-1413.

These estimates are consistent with those of the Department of Health and UNAIDS of 5.5 million people living with HIV or AIDS of which 235 000 are children for 2005. The annual number of new HIV infections in South Africa peaked in the late 1990s. National antenatal HIV prevalence has continued to increase in females over 20, although prevalence levels have remained relatively stable amongst young females aged 15-19 and begun to stabilize in the 20-24 age group over the 2001 to 2005 period.

Figure 3 illustrates antenatal HIV prevalence patterns by age group since 1991. There was a sharp increase in HIV prevalence in most age groups until about 2000 when the increase slowed down. In recent years there has been, however, a discernable increase in HIV prevalence in older age groups.

**SITUATION ANALYSIS**

**HIV & AIDS AND STI STRATEGIC PLAN 2007-2011**

**Births**

- Uninfected births (over calendar year) 1 057 000
- HIV+ births (over calendar year) 38 000
- Infected through breastfeeding 26 000

**People living with HIV/AIDS**
Total HIV infected 5 372 000
Adults (20-64) 4 880 000
Adult men (20-64) 2 179 000
Adult women (20-64) 2 702 000
Adults (15-49) 4 756 000
Adult men (15-49) 1 946 000
Adult women (15-49) 2 810 000
Youth (15-24) 1 012 000
Male youth (15-24) 181 000
Female youth (15-24) 831 000
Children (0-14) 294 000
New infections 527 000

Prevalence

Total HIV infected 11.2%
Adults (20-64) 19.2%
Adult men (20-64) 17.8%
Adult women (20-64) 20.4%
Adults (15-49) 18.3%
Adult men (15-49) 15.4%
Adult women (15-49) 21.2%
Youth (15-24) 10.4%
Male youth (15-24) 3.7%
Female youth (15-24) 16.9%
Children (0-14) 1.9%

Incidence

Total population 1.3%
Adults (20-64) 1.7%
Adult men (20-64) 1.9%
Adult women (20-64) 1.5%
At or before birth (of births) 3.5%
Breastfeeding (no. infected through breastfeeding in year/uninfected births in that year) 2.4%

Number adults (14+) infected by stage

Stage 1 1 451 000
Stage 2 1 084 000
Stage 3 1 813 000
Stage 4 (not on treatment) 511 000
Receiving antiretroviral treatment 200 000
Discontinued antiretroviral treatment 18 900

Number children (<14) infected by stage

Pre-AIDS 240 000
Stage 4 (not on treatment) 27 000
Receiving antiretroviral treatment 25 300
Discontinued antiretroviral treatment 1 500

AIDS sick

New AIDS sick during 2006 479 000
Total AIDS sick mid-year 599 000
Source: Dorrington, Bradshaw, Johnson and Daniel (2006)

SITUATION ANALYSIS
HIV & AIDS AND STI STRATEGIC PLAN 2007-2011

Heterogeneity of the South African epidemic

HIV prevalence varies considerably throughout South Africa. Some provinces are more severely affected than others, with the highest antenatal prevalence in 2005 being in KwaZulu-Natal (39.1%) and the lowest in the Western Cape (15.7%).

Figure 4: HIV prevalence of antenatal attendees by province: 1990 – 2005

Prevalence also varies sub-provincially by genotype of residence with population-level HIV prevalence (for persons two years and older) in informal urban areas being nearly twice as high as in formal urban areas (17.6% vs 9.1%) in 2005. Levels in informal rural areas were 11.6% and in formal rural areas, 9.9%.

An analysis of sub-provincial antenatal data in the Western Cape has illustrated a high degree of heterogeneity within the province, but also varying growth patterns in the various districts. Districts comprising predominantly informal urban areas have highest overall prevalence.


The reasons for the variable growth of the epidemic are not clear and a combination of factors is attributed to the variation. It is argued that geographical heterogeneity in HIV trends reflect the degree of urbanization, in addition to other factors such as sexual risk behaviours, sexual networks, population demographics, unemployment, social deprivation, migration, high population density, unemployment and unstable communities. In the case of the Western Cape, there has been rapid urbanization and migration from rural areas to towns or from other provinces.

HIV Prevalence by Area in the Cape Metropole District versus the Western Cape and South Africa: 2005

SITUATION ANALYSIS
HIV & AIDS AND STI STRATEGIC PLAN 2007-2011

National-level HIV prevalence also varies markedly by population group, sex and age group. In 2005, Black Africans were found to be most affected (of the order of six to seven times
higher than non-Africans), whilst females aged 15-29 were three to four times more likely to be HIV positive than males in the same age group. HIV was around 3% amongst children aged 2-14, much higher in those aged 15-59 and nearly 4% for people in their sixties. Women bear the brunt of the epidemic of HIV and AIDS. Women account for 55%. This phenomenon is more pronounced in the age groups 20-24 and 25-29 years where the HIV prevalence rates are 23.9% for women to 6.0% for men and 33.3% for women to 12.1% for men, respectively. The peak age for HIV infection in women is 25-29 years while for men it is the 30-35 years age group.

There is no single HIV epidemic in South Africa. In addition to the pronounced gender dimension, there are other wide variations. These relate to the different new infection, illness and death epidemics. There is clear correlation between poverty and high HIV prevalence, with communities in informal settlements who often are the poor being most vulnerable.

These communities are often also the most underdeveloped, with poor access to social services including HIV and AIDS prevention, treatment, nutrition and care programs. The vast majority of the population in informal rural and urban settlements are Black African. The HRSC data also show that children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129,621 children. In the slightly older age group of 5-9, 4.2% of boys and 4.8% of girls have HIV - an estimated 214,102 children, and in the 10-14 age group, this figure drops to 1.6% among boys and 1.8% among girls.

The context of the national social and sexual networks is that of a newly democratic society emerging from a history of social disruption and racial and gender discrimination associated with inequitable distribution of resources as a result of apartheid. The inequitable distribution of resources massively disadvantaged the majority of the population. Poverty related diseases including HIV and AIDS, TB and malaria affect mainly the previously disadvantaged sections of the population. Many factors influence the heterogeneity and overall high levels of HIV prevalence in South Africa. These include biological, individual and social/contextual factors.

Factors influencing the reproductive rate of HIV transmission

Whilst HIV is spread predominantly through unprotected sexual intercourse, other modes of infection remain important and are summarized below:

- **Mother-to-child HIV transmission:** HIV is transmitted to approximately one third of babies of HIV-positive mothers if there is no medical intervention. Use of antiretroviral drugs, obstetric practices including caesarean delivery, and safe infant feeding practices can reduce transmission to very low levels.

- **Blood transfusion:** The risk of HIV transmission via infected donor blood is high. However, donor and biological screening procedures allow for risk of HIV transmission through blood donation to be contained. Such procedures are followed rigorously in South Africa and risk is estimated to be very low – 1:400,000.
• **Exposure to blood:** In healthcare settings HIV can be transmitted between patients and health care workers in both directions via blood on sharp instruments, and may also be transmitted between patients through re-use of contaminated instruments. A number of studies have highlighted the importance of infection control measures in such settings as well as post-exposure prophylaxis in the case of sharp instrument injuries.

Exposure to blood can also occur in a wide range of institutional settings and in emergency situations where people are injured. Not much is known about the extent of the risk in informal health care settings and with traditional practices. Universal precaution practices including use of gloves and other protective measures are recommended.

• **Injecting drug use (IDU):** IDU has long been recognised as a high risk practice for HIV transmission, as needles and syringes may be shared between users. The extent of intravenous drug use in South Africa is under-researched, mainly because of the legal environment and stigma associated with this behaviour. In regions where HIV occurs amongst injecting drug users, prevalence is very high.

**Contextual Factors**

(a) **Poverty**
Poverty operates through a variety of mechanisms as a risk factor for infection with HIV and AIDS. Its effect needs to be understood within a socio-epidemiological context. It works through a myriad of interrelations, including unequal income distribution, economic inequalities between men and women which promote transactional sex, relatively poor public health education and inadequate public health system.

Poverty related stressors arising from aspects of poverty in townships such as poor and dense housing, and inadequate transportation, sanitation and food, unemployment, poor education, violence, and crime, have also been shown to be associated with increased risk of HIV transmission.

(b) **Gender and Gender-based violence**

South Africa has one of the highest rates of violence against women, with over 53 000 rapes reported to police in 2000, translating into a rape reporting rate of 123 women per 100 000 population. Sexual violence is linked with a culture of violence involving negative attitudes (e.g. deliberate intention to spread HIV) and reduced capacity to make positive decisions or to respond appropriately to HIV-prevention campaigns. More significantly, the experience of sexual assault has also been linked to risks for HIV infection.

Equally interesting, two recent studies conducted among men in a township community and in an STI clinic both showed that men with a history of sexual assault were also at significantly higher risk for HIV transmission than their counterparts without such a history. In South Africa, the gender system fosters power imbalances that facilitate women’s risks for sexual assault and sexually transmitted infections.
South African men, like men in most societies, possess greater control and power in their sexual relationships.

Women with the least power in their relationships are at the highest risk for both sexual assault and HIV infection, both stemming from the inability of women to control the actions of their sex partners. Men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women.

Importantly, sexist beliefs and negative attitudes toward women are held by men who have not been sexually violent as well as men who have a history of sexual violence. In fact, negative attitudes toward women are so pervasive there is evidence that they are often held by women themselves. Power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms.

Unfortunately, men’s attitudes toward women impede HIV preventive actions and can culminate in the acceptance of violence against women. Qualitative studies in South Africa consistently show that men believe they are more powerful than women and that men are expected to control women in their relationships. There is also evidence that men often hold attitudes that accept violence against women including beliefs that women should be held responsible for being raped.

One in three men receiving STI clinic services endorsed the belief that women are raped because of things that they say and do and half of men believed that rape mainly happens when a woman sends a man ‘sexual signals’.

(c) Cultural Attitudes and Practices

The relationship between culture and HIV is under-researched. There is some evidence that cultural attitudes and practices expose South Africans to HIV infections. First, gender inequalities inherent in most patriarchal cultures where women are accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place.

Such decisions are frequently constrained by coercion and violence in the women’s relationships with men. In particular, male partners either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main source of livelihood.

Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, prohibition of post-partum sex and also during breastfeeding, and
rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife’s sister) are also believed to spread HIV infection. HIV infection is also believed to occur during some of the traditional health practices conducted by traditional healers when they use unsterilised sharp instruments such as knives, blades, spears, animal horns and thorns during some of the healing practices and/or recommend sex with a virgin as part of their treatment of patients.

(d) Stigma, denial, exclusion and discrimination

HIV and AIDS is perhaps one of the most stigmatised medical conditions in the world. Stigma interferes with HIV prevention, diagnosis, and treatment and can become internalized by people living with HIV and AIDS.

In the UNGASS declaration, governments committed themselves, among other things, to confront stigma, denial and eliminate discrimination by 2003. Although still prevalent, AIDS stigma appears to be declining in South Africa as shown by the findings of the 2005 national HIV and AIDS household survey, when compared to the 2002 survey.

A recent large survey conducted among 1 054 people living with HIV (PLHIV) in Cape Town found high levels of internalised stigma. This is mostly due to the fact that HIV infection, as with other STIs, is widely perceived as an outcome of sexual excess and low moral character, with a consequent strong culture of silence by PLHIV because of fear of rejection and isolation by close relatives and the community at large. Stigma appears to be more severe for women than for men.

One of the consequences of the problem of stigma, exclusion and discrimination of people living with HIV and AIDS is that it forces people who are infected to hide their condition and to continue engaging in high-risk behaviour. Another consequence is denial. Both silence and denial about HIV and AIDS are lethal because they prevent people from accurately assessing their own personal infection risk as well as accessing the broad range of available services in this regard.

(e) Mobility and labour migration

Poverty and unemployment are linked to economic disempowerment and this affects sexual choice-making and exposure to wider sexual networks. Over and above gender vulnerability that flows from economic disempowerment, individuals who engage in work-seeking, mobile forms of work or migrant labour are at increased vulnerability to HIV as a product of higher likelihood to have multiple sexual partners, higher exposure to sex for exchange of money, amongst other risk factors.

Mobile individuals include informal traders, sex workers, domestic workers, cross-border mobility, seasonal agriculture workers, migrant workers (e.g. mine-workers, construction workers, and soldiers), long-distance truck, bus and taxi drivers, travelling sales persons and business travellers. These forms of mobility are pervasive in southern Africa. Various studies have illustrated the higher likelihood of mobile
groups to be HIV positive. Migration patterns in South Africa have shifted from being predominantly male migration, to a trend towards increasing mobility and migration by women. Mobility and migration not only increase vulnerability to HIV of mobile individuals, but also sending and receiving communities.

(f) Informal settlement

Informal settlement is associated with higher levels of HIV prevalence in South Africa, with HIV prevalence for people aged 15-49 in urban informal areas being nearly twice that of prevalence in urban formal areas (25.8% vs 13.9%). There is often social fragmentation within informal settlements that may increase the likelihood of exposure to unsafe sex. In addition, there is a greater likelihood that individuals at higher risk of HIV, including work-seekers, temporary workers, and labour migrants, are resident in these areas. Informal settlements frequently lack adequate housing, sanitation and health service access, and these exacerbate overall health risks.

1.3 Populations at higher risk

(a) Women

Women, especially black women, have been on the bottom rung of the ladder in terms of participation in the economic, social, and political life of the country. For many years black women have experienced triple oppression - discriminated against on the basis of their class, race and gender. Some practical challenges facing women because of these three forms of oppression relate to violence against and abuse of women, poverty and poor health status in general.

Acknowledging the fact that gender inequality hinders social and economic development, the current government has made great strides towards empowerment of women, and gender equality is one of the critical elements of the transformation agenda in the country. Women are beginning to regain their appropriate place in society and are taking responsibility for their lives. Patriarchal attitudes are changing, with men participating in efforts to address challenges such as violence against women.

Gender transformation is part of a broader transformation agenda that also seeks to reduce the gap between rich and poor and between historically disadvantaged black communities and white communities with many more resources. However, the high levels of gender-based violence in the country indicate that a lot still needs to be done in this area. Notwithstanding the abovementioned achievements, women remain one of the most important vulnerable groups in the country. The difference between men and women is more pronounced in the age groups 20-29 years but particularly striking in the age group 25-29 where the HIV prevalence in the same survey were 33.3% for women compared to 12.2% men.

A youth study by the Reproductive Health Research Unit (RHRU, 2002) found that among the 10% of youth who HIV positive, 77% are women. In addition to biological, economic, social and other cultural vulnerabilities, women are more likely to experience sexual abuse, violence (in particular domestic violence) and rape.
They take the brunt of caring for sick family members and are the soldiers at the forefront of community-based HIV and AIDS activities. The HIV epidemic and AIDS is clearly feminized, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority.

Teenage females have been underemphasized as a target group, even though pregnancy levels are high in this age group. The fact that the burden of the epidemic falls more on women and girls than on men and boys remains a central challenge to the national response.

(b) Adolescents and young adults (15-24 years)

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) identified young people aged 15-24 as a priority group in reducing new HIV infections and set a global target of reducing incidence of HIV in this group by 20% by 2015. Data from a decade or more of extensive national antenatal surveys in South Africa show that HIV prevalence among adolescent girls and young women in this age group may be stabilizing; albeit at very high rates.

Prevalence in the age group 15-19 has remained at around 16% for the past five years, while in the 20-24 years it has risen only slightly (28%-30%) over the same period. Although current HIV prevention programs in South Africa have invested significantly in this age group, they are yet to demonstrate the desired impact. Continued investment in and expansion of carefully targeted evidence based programs and services focusing on this age group remain as critical as ever.

Young people represent the main focus for altering the course of this epidemic. UNAIDS data on the experience of several countries including South Africa, confirm that positive behaviour change is more likely in this group than in older ages. The greatest increase in pregnancy and HIV infection is associated with school-leaving.

School-leaving is a time of insecurity for young people, the aspirations that existed in school of getting a job and earning an income are often dashed and personal motivation to achieve and the psychological rewards of school achievement are no longer there, and there are family pressures to contribute to household income or to leave. In the absence of career opportunities, many young women find fulfilment and affirmation in being a mother – by definition requiring unprotected sex.

(c) Children 0 – 14 years

Children under the age of 18 comprise 40% of the population of South Africa. In 2004, it was estimated that there were 2.2 million orphaned children (meaning 13% of all children under 18 have lost either a mother or father); nearly half of all orphans were estimated to have lost parents as a result of AIDS. Some of the worst affected children – those in deeply impoverished households – may experience various forms of physical, material and psychosocial deprivation and assaults on their health as a result of poverty and/or a lack of parental care and nurturing environment.
Often these children are separated from caregivers and siblings and sent to stay with other relatives or other carers or social networks. A significant number of children in South Africa are living with HIV and AIDS. According to the 2005 HSRC survey, there is an estimated 129,621 children aged 2-4 years and 214,102 children aged 5-9 in 2005 living with HIV or AIDS. HIV is thought to have contributed to an increase of 42% in under-five mortality in this country in 2004.

Also, there is evidence to suggest that 60% of hospital deaths were HIV-related in 2005. Children usually do not have sufficient access to AIDS treatment and care because available services are mostly designed for adults. Serious challenges around the skills of health workers and capacity to manage and treat children with AIDS, including lack of appropriate ART formulations for treating children, remain. Children are vulnerable to HIV infection through child sexual abuse.

Whilst little is known as to the extent of child sexual abuse in South Africa anecdotal estimates suggest that it is quite extensive and thus is a risk that needs to be monitored.

(d) People with disabilities

People with disabilities constitute a significant part of the population (12%). Yet, this group has been particularly neglected in the AIDS response. There are often erroneous perceptions that people with disability are asexual. To date the national response has not addressed the special needs of the various categories of people with disability in terms of prevention, treatment, care and support programs.

People with disability suffer double stigma arising from discrimination as result of their disability status and their HIV status. Increasingly AIDS is a cause of disabilities and the more people’s lives are prolonged while infected so this will become a significant issue and it will be necessary to provide for care, support and treatment. This sector is actively involved in ensuring that people with disabilities respond to the HIV and AIDS challenges that facing the often with little support. The special needs of people with disabilities demand conscious efforts to ensure equitable access to information and services.

(e) People in prisons

Incarceration is a risk factor for HIV and is correlated with unprotected sex and injecting drug use in correctional facilities, but may also include risk of blood exposure as a product of violence and other factors. Interventions for risk reduction include provision of voluntary testing and counselling, condom provision, addressing rape, and addressing intravenous drug use.

Male prisoners are predominantly vulnerable but risks extend to female prisoners. Little is known about the extent of HIV in South African correctional services, nor the relationship between known risk factors and HIV acquisition in South Africa. However, a small study in Westville medium security prison near Durban in 2002 found an HIV prevalence of 29.6% amongst male prisoners.
(f) Men who have sex with men (MSM)

Whilst HIV infection amongst MSM was a focus in the early phases of the epidemic in South Africa, there is very little currently known about the HIV epidemic amongst MSM in the country. MSM have also not been considered to any great extent in national HIV and AIDS interventions. Biologically, MSM who practise receptive anal intercourse have an elevated risk for HIV infection. MSM practices are also more likely to occur in particular institutional settings such as prisons, often underpinned by coercion and violence. MSM behaviours and sexualities are wide-ranging and include bisexuality, and the HIV epidemic amongst MSM and the heterosexual HIV epidemic are thus interconnected.

(g) Sex workers

Sex work is not readily defined but includes a wide range of informal and formal activities that relate to the exchange of sex for material benefit. Key characteristics include frequent and repeated exchange of sex with multiple sexual partners usually for monetary gain. Sex workers are predominantly female. Sex workers are at high risk of HIV infection and are vulnerable as a product of high partner turnover and a limited capacity to ensure safe sex during each and every sexual encounter.

Very little is known about HIV prevalence amongst sex workers or their clients in South Africa, but both groups are linked to sexual networks that overlap with the broader epidemic.

(h) Mobile, casual and atypical forms of work

Truck driving, military service and other uniformed services such as security service provision may require regular and sustained travel and may in turn increase the likelihood of multiple sexual partnerships. Such activities have been linked to increased risk of HIV infection. Whilst very little is known about prevalence in these sectors in South Africa, it is likely that risk of infection is higher, and these groups also overlap with the broader epidemic as a product of linked sexual networks.

(i) Refugees

The disruption of services and support systems caused by conflict or unrest in their home countries means that many refugees have limited information about HIV and AIDS, and they are often not familiar with local services or systems in South Africa. In addition, while their legal status guarantees the right to access HIV-related information and services on the same level as South Africans, barriers such as language, cultural traditions and xenophobia often preclude their ability to access these services.

Therefore targeted programs are necessary to ensure that refugees and asylum seekers have access to information and services – including prevention, care, support and treatment – as an integrated component of the national response to HIV and AIDS.

(j) Injecting drug use
South Africa is a conduit country and market for drugs including injecting drugs such as heroin. Needle and syringe sharing is a common practice amongst injecting drug users, and is a highly efficient mechanism for transferring HIV. Intravenous heroin use in South Africa is presently very low, but has the potential to escalate. There are heroin detoxification programs available in the country, but no formal needle exchange programs exist.

**K) Sexual HIV transmission and biological risk**

The likelihood that an individual will become infected with HIV through sexual contact depends on the mechanism of sexual contact, the viral load of the HIV-positive person and the susceptibility of the individual. Whilst the probability of HIV transmission through a single coital act is relatively low, risk increases through repeat exposure and higher risk is strongly associated with higher viral load in the infected partner, coinfection with sexually transmitted infection(s), genital ulceration, genital maturity and anal sex, amongst other factors.

Prevalence data and various studies have illustrated the higher biological vulnerability of women and younger women and girls in particular. Biological factors include under-development of the genital tract in young women and girls, a greater surface contact area within the vagina, retention of fluids for a longer period, and the higher possibility of undetected STIs. Both males and females are biologically more vulnerable in the case of receptive anal intercourse, and uncircumcised males are also more vulnerable.

Concurrent sexual partnerships increase the likelihood of exposure of sexual partners to high viral load and consequently, higher likelihood of infection. High viral load in the late phases of HIV is reduced through antiretroviral therapy.

**L) Sexual HIV transmission and individual risk factors**

*Early sexual debut*

Earlier sexual debut is significantly associated with increased risk of HIV infection. Risks of earlier sexual debut also include higher likelihood of having multiple partners, lower likelihood of condom use at first sex and higher overall numbers of sexual partners, not to mention higher biological susceptibility to infection of adolescent and young girls.

Orphanhood, which increases as a result of deaths of parents from AIDS, has been found to increase the likelihood of earlier sexual debut. Shifts towards later sexual debut have been correlated with prevalence declines in a number of African countries.

*Older sexual partners amongst youth*

For young people, particularly girls under 20, having older partners is a significant risk factor for HIV infection as it exposes them to a pool of higher HIV prevalence. Both young males and females are more likely to be HIV positive if they have sexual partners five or more years older than themselves.
Transactional sex

Transactional sex involves the exchange of sex for material gain. Transactional sex involves disempowerment which may include a reduced ability to negotiate safer sex particularly condom use. In a study in South Africa, transactional sex amongst females with a non-primary male partner was associated with lifetime experience of partner violence, problematic alcohol and drug use, and substandard housing, amongst other factors.

Partner turnover and concurrent sexual partnerships

Having a higher overall number of sexual partners, having a high turnover of sexual partners and having concurrent sexual partners (or having a partner who has concurrent sexual partners) are all risk factors for HIV infection. People settle into permanent sexual relationships and marry at relatively older ages in South Africa. This results in a higher likelihood of having numerous life-time sexual partners. The length of the period of risky sexual activity prior to marriage has been shown to be closely correlated with HIV prevalence in a country, and declines in HIV prevalence have been associated with declines in number of sexual partners in the past year.

In South Africa, 27.5% of males and 6.0% of females aged 15-24 had two or more partners in the past year. In older age groups the proportions were 14.4% for males and 1.8% for females aged 25-49, and also high for males aged 50 years and older at 9.8%75. Higher proportions of having multiple partners amongst youth aged 15-24 were also reported in a national survey in 2004 – 44% for males and 12% for females.

Condom use

When used consistently and correctly, male and female condoms prevent HIV infection and other STIs. Consistent, but not necessarily correct condom use is estimated to provide 80% protection in comparison to non-use, whilst inconsistent use is not significantly protective.

Male latex condoms are widely distributed in South Africa including via the public sector, social marketing programs and commercial sales. Quality control and related logistics for public sector condoms is managed by the Department of Health and over 350 million condoms annually have been distributed on a demand basis in recent years.

Public sector distribution includes hospitals and clinics as primary distribution sites, with secondary distribution extending to non-governmental organizations, workplaces, and other locations. Female condoms are distributed to selected sites. Access to male condoms is perceived to be high. Reported levels of male condom use at last sex are high in South Africa, particularly amongst youth at 72.8% for males and 55.7% for females aged 15-24, and over 30% for males and females aged 25-49.

However, high levels of reported use have not translated into reductions in antenatal HIV prevalence over the past five years. Increases in condom use with non-regular partners have however been associated with prevalence declines in other African countries.
Male circumcision

Epidemiological analyses have demonstrated correlations between circumcision and HIV prevalence, and protective effects have been shown in a randomized controlled trial in South Africa and elsewhere. Although male circumcision reduces the risk of HIV infection of males through female-to-male transmission, it is not clear whether it reduces male-to-female transmission, although there are likely to be long-term epidemiological benefits.

It remains necessary for men to practise consistent condom use, as well as adopting or maintaining other HIV prevention strategies such as limiting numbers of sexual partners, whether or not they are circumcised.

Substance use

Alcohol and drug use have a disinhibiting effect on safer sex as a product of diminishing rational decision-making. Alcohol use has been associated with higher risk of HIV infection, with heavy alcohol consumption being linked to higher likelihoods of having unprotected sex with a non-monogamous partner, having multiple sexual partners, and paying for or selling sex.

Knowledge of HIV status

Knowledge of HIV status appears not to lead to increased adoption of HIV prevention practices amongst people who tested HIV negative, but has been linked to increased prevention behaviours amongst those who test HIV positive. Interventions focusing on people living with HIV who know their status – sometimes referred to as positive prevention – have also shown increases in the adoption of preventive practices. Around 30% of those aged 15 years and older report ever having tested for HIV in 2005, with a significant proportion having tested for HIV in the past year (eg. 49.5% of 15-24 year olds).

Demographic

The demographic impact of HIV and AIDS on the South African population is apparent in statistics such as the under-5 mortality rate, which has increased from 65 deaths per 1000 births in 1990 to 75 deaths per 1000 births in 2006. Mortality rates in 1990 suggested that a 15-year old had a 29% chance of dying before the age of 60, but mortality rates in 2006 suggest that 15-year olds have a 56% chance of dying before they reach 60.

Other estimates provided by the Actuarial Society of South Africa for 2006 include:

- 1.8 million AIDS deaths had occurred in South Africa, since the start of the epidemic.
- Around 740 000 deaths occurred in 2006, of which 350 000 were due to AIDS (approximately 950 AIDS-related deaths per day).
- 71% of all deaths in the 15-49 age group were due to AIDS.
• Approximately 230,000 HIV-infected individuals were receiving antiretroviral treatment, and a further 540,000 were sick with AIDS but not receiving antiretroviral treatment.
• 300,000 children under the age of 18 experienced the death of their mother.
• 1.5 million children under the age of 18 were maternal or double orphans (i.e. had lost a mother or both parents), and 66% of these children had been orphaned as a result of HIV and AIDS.

The economy

The ILO demonstrated in 2004, and again with more recent data in 2006, that the rate of economic growth in countries heavily affected by HIV and AIDS has been reduced by the epidemic’s effects on labour supply, productivity and investment over the last decade or more. According to this assessment, 3.7 million labour force participants aged 15 to 64 years were living with HIV or AIDS in South Africa. However, there is currently no clear evidence of the actual economic impact of HIV and AIDS in South Africa.

Families and communities

Households experience the immediate impact of HIV and AIDS, because families are the main caregivers for the sick and suffer AIDS-related financial hardships. During the long period of illness caused by AIDS, the loss of income and cost of caring for a dying family member can impoverish households. The problem of orphans and vulnerable children will persist for years, even with the expansion of prevention and treatment programs.

Studies in several districts in South Africa found that the majority of orphans are being cared for by grandparents, family members or through self-care in child-headed households. Orphans and vulnerable children are at higher risk for HIV infection, as they face numerous material, emotional and social problems.

They also face:

• Discrimination and stigma, as they are often shunned by society, lack affection and are left with few resources;
• Many of them drop out of school due to inability to pay school fees;
• They also often suffer from malnutrition and ill health and are in danger of exploitation and abuse.

Psychosocial impacts, mental health and HIV

Interventions to address HIV and AIDS have tended to focus on biomedical interventions including, for example, condoms for HIV prevention, and ART and PMTCT, for people living with HIV. Psychological distress and psychological disorders are also more prevalent amongst PLHIV, and the importance of mental health programming in relation to HIV has long been overlooked.

Less emphasis has been given to the psychosocial impacts of the disease which are related to illness and death of parents, children and other family members; caring for
people who are ill and dying of AIDS; and living with and coping with an HIV-positive diagnosis. A recent study in South Africa found a higher prevalence of mental disorders amongst PLHIV including depression, anxiety, increased anxiety amongst PLHIV with children, and alcohol-related problems.

**The health care system**

HIV and AIDS affect both the supply and demand of health care systems. On the ‘supply’ side of health systems, the human resource effects of HIV are two-fold: the stress and morale impacts of rapidly changing epidemiological, demand and mortality profiles in patients caused by HIV and AIDS, and HIV infection in providers themselves.

In a survey of 512 public sector workers in four provinces, 16.3% were HIV infected. An HIV prevalence study at Helen Joseph and Coronation Hospitals with a 91% response rate, found that 13.7% of 644 nurses were HIV infected and 19% had AIDS-defining CD4 cell counts 98.

**Education system**

The epidemic affects the supply and demand for primary and secondary schooling. On the supply side, infected teachers will eventually become chronically ill, with increased absenteeism, lower morale and productivity. A South African education sector study found a sero-prevalence of 12.7% among teachers and significant gender, racial and geographical differences.

In conclusion, the challenge of HIV and AIDS in South Africa requires an intensified comprehensive, multi-sectoral national response. This response should:

- address the social and economic realities that make certain segments of society most vulnerable;
- provide tools for prevention of infection;
- provide services designed to mitigate the wide-ranging impacts of the epidemic.

To achieve this there is a continuing need to guide policy and programmes at all levels and in all sectors and to inspire renewed commitment from all South Africans. The South African National AIDS Council (SANAC) recommended a rapid assessment of the NSP: 2000-2005 as a first step toward developing the NSP: 2007-2011.

A task team was formed to coordinate the assessment, which was done between August and September 2006. This evaluation enabled stakeholders to identify the strengths and weaknesses of the NSP 2000-2005. The NSP 2007-2011 thus partly builds on the findings of this assessment.