UNDERSTANDING THE PROBLEM OF HIV/AIDS

Human Immunodeficiency Virus (HIV) is the retrovirus\(^5\) responsible for Acquired Immunodeficiency Syndrome (AIDS) in human beings. The HI virus is contained within the body fluids (for instance, semen, breast milk, and vaginal fluids) of infected individuals and is transmitted between individuals when these fluids are transferred from one person to another (Holden, 2003). HIV is a predominantly sexually transmitted infection (STI) with unprotected heterosexual contact as the primary mode of infection in South Africa and the majority of the developing world. This differs to Western European and North American HIV epidemics where injection drug use and unprotected homosexual contact are the dominant modes of transmission. In contrast to the misgivings of President Mbeki and Health Minister Msimang regarding the nature of the HI virus and the cause(s) of AIDS, HIV is the cause of AIDS within the realm of scientific knowledge (Whiteside and Sunter, 2000). This is not to say that HIV/AIDS is not disproportionately present within and does not disproportionately affect certain groups (for instance, the poor). Rather, it is an affirmation of existing scientific knowledge regarding the biology of the HI virus. I will forego any discussion of the social epidemiology of HIV/AIDS in South Africa. Rather my aim is simply to reassert that within the bounds of scientific knowledge, HIV is the cause of AIDS.

Passing through six clinically defined stages, HIV infection eventually results in the condition known as AIDS. The end phase of HIV infection, Acquired Immunodeficiency Syndrome is a state characterised by the presence of one (or more) of 26 clinical conditions in HIV positive individuals with advanced HIV disease. The majority of AIDS defining conditions are opportunistic infections (for instance, Kaposi’s sarcoma, Pneumocystis carini pneumonia, and oral candidiosis\(^6\)) that are rarely fatal and/or harmful in HIV negative persons (Holden, 2003). Parasitic in nature, the HI virus utilises the body’s own cellular machinery in order to propagate itself. Upon infection, HIV establishes itself within the body’s immune system attacking and infecting those cells

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\(^5\) The prefix ‘retro’ simply refers to the manner in which HIV replicates within host cells.

\(^6\) A thrush inducing fungus.
(primarily CD4 lymphocytes) responsible for defending the body against illness inducing foreign pathogens. Although the rate of progression through the stages of infection is determined by an individual’s particular circumstances (for instance age, genetic make up, and lifestyle\textsuperscript{7}), HIV has an immediate, detrimental and lasting effect upon an individual’s health.

HIV infection often goes unnoticed by HIV positive (HIV+) individuals in its first three stages (a period that can last up to 10 years). This period is known as the asymptomatic phase of infection during which HIV is still infecting, multiplying within and killing host cells, but in which there are no serious macro level physical manifestations of infection. Thus, the asymptomatic phase of infection is a period in which infected individuals experience no serious and persistent illness due to the presence of HIV. Given the similarity between the symptoms of primary infection and flu, the invisible nature of the virus during the asymptomatic period and the stigma associated with a positive status (a barrier to voluntary counselling and testing), HIV+ individuals are often unaware of their status until the mid to latter stages of infection. As such, HIV/AIDS education is vital for increasing awareness of the disease, its nondescript nature, and the very real potential for infection.

The stealthy, nondescript period ends in the fourth stage of infection. Symptomatic HIV is the final stage of infection before the progression to AIDS. AIDS can be managed through the timely use of antiretrovirals (ARVs). ARVs inhibit the replication of HIV, thus preventing the further deterioration of the immune system. In this way, ARVs prolong the functioning of weakened immune systems, thereby providing infected individuals some protection against opportunistic infections and other illnesses associated with immunodeficiency. The use of ARVs to inhibit viral replication requires extensive clinical monitoring, specific nutritional intake, and is associated with numerous and varied side effects. Nevertheless, in conjunction with appropriate monitoring, access to nutrition and water and treatment of opportunistic infections, ARV treatment can prolong

\textsuperscript{7} I use this term generally to refer factors including: (1) a person’s access to adequate nutrition, sanitation and water, (2) consumption of alcohol and/or other drugs, and (3) general level of health.
and improve the quality of life for persons with AIDS. Notwithstanding these assertions, and given that there is no cure for HIV despite being the most thoroughly studied virus in medical history, AIDS is always fatal. As such, HIV infection is only terminated with the death of the HIV+ individual due to AIDS.

In summary, HIV is the STI responsible for AIDS. Unprotected heterosexual coitus is the primary mode of transmission in South Africa. HIV attacks the immune system resulting in immunodeficiency that ultimately leaves infected individuals susceptible to illnesses uncommon in healthy, HIV negative (HIV-) persons. AIDS is the final phase of HIV infection and is always fatal. Antiretrovirals are used to combat HIV and improve quality of life during the final stage of infection, but are not a cure for HIV. Given that there is no cure for this virus, the best and safest way to avoid infection is through preventative measures such as condom use and monogamy.

**Impacts of HIV/AIDS**

It is important to note that for the remainder of this paper I will make no distinction between HIV and AIDS. This approach is justified by the facts that: (1) AIDS is merely the end stage of HIV infection, and (2) the aims of this paper do not include distinguishing between and investigating the relative economic, social, political, psychological and/or any other impacts of HIV and AIDS respectively. For the purpose of this report it is therefore more appropriate to refer to HIV and AIDS collectively as HIV/AIDS. The nature of the HI virus, its effect on the body during various stages and the limited capacity of modern medicine to mitigate these adverse health impacts, ensures that HIV+ individuals are destined to suffer from gradual and sustained immunodeficiency. Weakened immune systems render HIV+ individuals susceptible to gradually deteriorating health, illness and in the overwhelming majority of cases, death – the ultimate consequence of an incurable, though highly preventable disease. In this section, I examine the numerous ways in which HIV infection effects the lives of HIV+ individuals and illustrate some of the ways in which these effects are transmitted through infected individuals to their families, societies and even entire nations. In no way is this
brief discussion intended to serve as a thorough review of the individual, familial, societal and national impact of HIV/AIDS. On the contrary my aim is simply to highlight the extent of the impact of a single infection, thereby demonstrating the seriousness and potentially catastrophic consequences of the South African HIV/AIDS epidemic.

The stigma of HIV/AIDS is a devastating force that facilitates social decay. Goffman describes stigma as the personal and societal devaluing of an individual (to both himself/herself and so-called ‘normal’ others) arising from a revealed or apparent imbalance in the individual’s virtual and actual social identities (Williams, 1987). In this context HIV/AIDS stigma is the result of wholly false, though widespread and persistent notions that deviant sexual behaviour⁸ (involving sexual practices that necessarily fall outside the scope of the appropriate or normal actual social identity) is the source of this deadly and sinister disease. Thus, as soon as an infected individual’s status becomes known this individual is regarded as an alien, or unfamiliar, whose deviant ways resulted in him/her acquiring a disease of wasting, prolonged and highly visible suffering and painful death. To reiterate the stigma of HIV/AIDS, based on: (1) the false perception that HIV/AIDS is contracted through deviant sexual behaviour, and (2) the highly visible and grotesque effect of HIV/AIDS on the body, results in HIV+ individuals being regarded as inferior, unworthy of attention, sympathy and assistance, and deserving of their suffering.

The effects of HIV/AIDS stigma are varied and operate on numerous levels. Internal stigma, that stigma experienced by infected individuals due to their own sense of shame regarding their status is a powerful force motivating HIV+ persons to deny their condition. This feeling of shame is reinforced by the sense of guilt that accompanies awareness of infection and is based on dominant perceptions of the source of the disease, fear derived from the horrific and fatal nature of the disease, and the affected individual’s sense of responsibility for his/her own health. Significantly, internal stigma is not restricted to HIV+ individuals. In fact, the fear and shame derived from internal stigma

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⁸ The traditional example being homosexuality.
are a powerful force motivating those susceptible\(^9\) to infection to deny their risk of contracting HIV. Denying their status, HIV+ individuals and those susceptible to infection refuse attempts to confirm and manage their conditions through voluntary testing, counselling, appropriate treatment and lifestyle change. Consequently, these individuals further isolate themselves from support structures that exist to help them avoid infection or manage their condition. In this way, the probability of an individual acquiring (in the case of an HIV- person) the virus and/or passing the virus on to others is increased. In the case of HIV+ individuals, denial also reduces their capacity to cope with deteriorating health and its concomitant social, economic, familial and psychological impacts (for instance, decreased earning capacity, family breakdown and depression). To reiterate, HIV+ persons who deny their status increase their vulnerability to the disease by isolating themselves from those structures (familial and public) that exist to mitigate the impact of adverse shocks. As such, the risk of these individuals unwittingly spreading the virus is magnified. Further, they experience a significant reduction in their potential life-spans and quality of life with the virus.

The characteristics of internal stigma, namely fear, shame, guilt and denial are transmitted to society by numerous paths (Cameron, 2005). Internal stigma is a significant barrier to any meaningful reductions in HIV incidence and prevalence and thus a direct source of measurable increases in morbidity and mortality. A significant contributor to the incidence and prevalence of HIV/AIDS, the problem of internal stigma deflects resources (social, economic, and political to name a few) from other urgent social problems such as violence (especially violence against women and children), and drug and alcohol abuse. Clearly the impact of HIV/AIDS is not contained to infected individuals, but transmitted throughout society to the detriment of all.

External stigma is the experience of discrimination due to the presence of a stigmatising condition (Williams, 1987). With respect to HIV/AIDS external stigma takes many forms. HIV+ individuals are known to have lost their jobs, been denied access to public

\(^9\) Please note that susceptibility refers to the risk of infection, whilst vulnerability refers to an individual’s ability to cope with infection.
schooling and, in the most sinister cases, physically and emotionally abused due to their status. In South Africa, discrimination against and persecution of HIV+ persons is exemplified in the case of 7 year old Nkosi Johnson who was initially barred from attending a Gauteng school, and KwaMashu’s Gugu Dlamini who was murdered shortly after declaring her status on a rural KwaZulu-Natal radio station. In both cases, in spite of laws against such behaviour, these individuals were victims of the external stigma of HIV/AIDS. Both Gugu Dlamini and Nkosi Johnson were abandoned, isolated, and actively and unjustly prevented from exercising their rights due to their HIV+ status. These gross violations are a manifestation of society’s paranoia regarding HIV/AIDS and are significant barrier to social development.

It is important to note that the stigma (both internal and external) is not restricted to HIV+ individuals. In fact, the families and friends of HIV+ individuals are often the victims of internal and external stigma. For instance, the widows and (nuclear) families of HIV+ individuals are frequently abandoned and ostracised by their relatives and communities, thus increasing the risk of these persons acquiring HIV/AIDS (for instance, by forcing them into commercial and/or transactional sex in order to survive), and reducing their ability to emotionally and economically cope with the effects of infection and the illness and eventual death of a loved one. In this way, the probability of violence in society, drug and alcohol abuse, crime and other social evils is enhanced, thereby widening the impact of HIV/AIDS from affected individuals (that is, HIV+ positive individuals) to afflicted families and entire nations.

The issues of child headed households, HIV/AIDS orphans and HIV/AIDS affected children are additional examples of the enormous social impact exerted by HIV/AIDS. Upon infection of one or more adult family members, children are often removed from school in order to supplement lost income and care for sick parents or relatives. In KwaZulu-Natal, HIV/AIDS prevalence is so high and the situation so desperate that primary school enrolment has dropped by an astonishing 60 percent, with an estimated 300 000 children of school going age unable to attend school due to the effects of

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10 That is, their respective rights to education and life.
HIV/AIDS (Schneider, 2002). Careful observation reveals an additional dimension to this problem. Data from KwaZulu-Natal indicate that those children most often forced to stay at home to look after the sick or assist in generating household income are young girls. Thus, for the first time in KwaZulu-Natal more boys are attending school than girls (Ibid., 2001). Not only does HIV/AIDS exert a considerable developmental impact upon those it affects, but it also amplifies the existing unjust, restrictive and precarious societal gender power imbalance that exists in South Africa to the added detriment of all (that is, the infected, affected and unaffected).

HIV/AIDS impinges on the rights of HIV/AIDS affected children and in doing so diminishes their potential development and any future development of the communities in which they reside, ultimately affecting the development of South Africa as a whole. To clarify, these children are robbed of their education and are forced to adopt a societal role (that of care-givers) that they are ill equipped to fulfil. This role reversal represents an irreversible loss of social capital whose impact upon development is not easily measured, but intuitively signifies a substantial loss to society that may ultimately even threaten the existence of civil society (Whiteside and Sunter, 2000). Upon the death of infected adults, the extended families of HIV/AIDS affected children (be they orphans or not) and the state are forced to adopt responsibility for their care. In this way, the social and economic burden of HIV/AIDS is shared by all within a society, and most significantly, spread over entire generations.

By harming an individual’s health, HIV causes a decrease in that individual’s productive capacity. With ever increasing health problems, HIV+ persons are able to devote less and less of their time to income and/or income in kind\(^\text{11}\) generating activities. Furthermore, HIV infection results in decreased productivity when an individual is working (Gillis et al., 2001). As such, the capacity of HIV+ persons to cope with infection, that is, the ability to stay well nourished, and access the drugs necessary to treat ailments associated with HIV infection and combat the HI virus in the end stage of infection (antiretrovirals or ARVs) is reduced. In this way, the economic burden of care is transferred from HIV+

\(^{11}\) In the case of subsistence production.
individuals to their families, friends and the state, each of whom is forced into sharing their resources in order to fill the gaps created by the HIV+ individual and provide the additional care and treatment required by these individuals. As the percentage of the labour force with HIV increases, so too does the economic cost of the epidemic. At the level of the national economy HIV/AIDS is estimated to have had an enormous impact on present and future economic production. For instance, a model of the impact of HIV/AIDS on the labour force in South Africa predicts that it will be 21 percent smaller than in an HIV/AIDS free environment by 2015 (Bolin, undated in Cheetam, 2003). Coupled with a possible total of between 5 000 000 and 7 000 000 HIV/AIDS related deaths (the majority of which are predicted to occur amongst the 15-49 age group), and a 15 year reduction in life expectancy from 55 years in 2000 to 40 years in 2010 the potential economic impact of HIV/AIDS is singularly catastrophic (Pelser, 2002).

Nattrass (2002 in Cheetam, 2003) observes that it is exceedingly difficult to measure and report the potential economic impact of HIV/AIDS on the macro economy by a single, simple instrument. This is especially so given the lack of data on the effect of HIV/AIDS on key economic determinants (for instance, aggregate productivity, and the effect on investment) at the macro level (Cheetam, 2003). Nevertheless, in spite of the difficulties and vagaries of such an estimation, the Bureau for Economic Research predicts that GDP in 2015 could be as much as 5.7 percent lower than in an HIV/AIDS free environment (Ibid., 2003).

Whiteside and Sunter (2000) provide an adequate graphical representation of the myriad routes through which HIV/AIDS impacts upon society’s present strength and potential for future development. An adaptation of this graphical representation is presented below as a means of concisely revisiting aspects of the above argument.
**Figure 1. The individual as an economic and social actor** (Whiteside and Sunter, 2000). This figure depicts the numerous routes through which HIV/AIDS may affect an individual’s social and economic well-being. This figure only partly depicts societal level effects of HIV/AIDS and does not describe national level impacts of HIV/AIDS.

In summation, HIV/AIDS is clearly a source of social and economic decay and a leading developmental challenge. This decay is not restricted to infected individuals, but is shared by all members of a society through the many avenues discussed above. As such, HIV/AIDS represents a gradual, chronic and diffuse shock whose impact is borne by all within a society and spread over time through a variety of mechanisms and a diversity of scenarios (Cohen, 1998 in Cheetam, 2003). Given the extent of HIV/AIDS in South Africa and the existing strain on family networks and state facilities, HIV/AIDS is a credible threat to the (future) existence of a vibrant, dynamic and strong South African society.
Notwithstanding the potentially catastrophic impact of HIV/AIDS, this disease does provide the opportunity to create a thriving society characterised by equality, health, a high level of cohesion and low levels of social ills such as violence and crime. This scenario will only be realised if the general response to HIV/AIDS is framed by openness, honesty and action. Accordingly, the above extensive discussion on the nature of HIV/AIDS and its potential impacts in South Africa is intended to highlight: (i) the complexity of the virus, (ii) the potential scale of its impact, (iii) the necessity for a widespread response (of which life skills education is a fundamental component) that recognises HIV/AIDS as a social disease incapable of resolution through a purely biomedical response, and (iv) provide some context for the figures on national prevalence and incidence supplied in this report. Finally, this chapter is intended to demonstrate that although the HIV/AIDS epidemic will take a heavy toll on the South African population, action against the virus in the form of interventions such as the life skills education programme (which raise awareness of HIV/AIDS, and equips highly susceptible and vulnerable individuals\(^\text{12}\) with the skills and knowledge to prevent and cope with the disease), are necessary in order to significantly alter the course and impact of South Africa’s HIV/AIDS epidemic.

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\(^{12}\) That is, the youth.