

The Prevention of HIV Infections in South Africa Focusing on Attitude and Behaviour

Article by Imisani Simon Sirunwa

Texila American University and Polokwane Welfare Complex, Limpopo Province, South Africa

E-mail: issirunwa@webmail.co.za

Abstract

The prevalence of Aids in South Africa has pushed us to painting a picture of a "friendly HIV/Aids", and thus eliminated the fear that is crucially necessary. Socially (practically) South Africans are more exposed to Aids than to condoms (and other preventions). Condoms are plenty but we are shy. We are shy to talk about them, we are shy to get them, and we are shy to use them. This may be because there are stigmas attached to them, greater than those attached to Aids itself. Psychologically we are more exposed to Treatment than the reality of the virus and its effects. When we imagine ourselves being infected, the first thing that comes to our minds is the taking of treatment rather than suffering and "the possibility of death". So, there is more comfort towards Aids than prevention because treatment is regarded as the worst consequence. We have become numb to the true danger of Aids. If we start showing people reality, we can change the status quo. Aids is manageable but it is intensive, which is similar to smoking and secondary smoking. We need to show graphics of this killer. It will take real fear for people to be really careful. We should not allow the next entire generation to also be vulnerable to this disease by the superfluous shielding of the dignity of those who are already infected. This can be done within the confines of our National Health Act and without compromising human rights. Activists need to make this sacrifice for our future. A lot of people don't know what AIDS really is. They have never seen the extremes of it and the cruelty it has. No one is openly and publicly telling the true personal pain of living with AIDS but everybody is talking about treatment and survival. If we attach fear to our prevention efforts, we can save millions of people and South African Rands.'

Keywords: *AIDS: Acquired immune deficiency syndrome (AIDS) is the name of the fatal clinical condition that results from infection with the human immunodeficiency virus (HIV), which progressively damages the body's ability to protect itself from disease organisms.*

Alcohol: A colourless, volatile, flammable liquid synthesized or obtained by fermentation of sugars and starches and widely used, either pure or denatured, as a solvent and in drugs. Also called ethanol, ethyl alcohol. Intoxicating liquor containing alcohol put in drinks.

Circumcision: Circumcision is the surgical removal of the skin covering the tip of the penis. Circumcision is a religious or cultural ritual for many Jewish and Islamic families, as well as certain aboriginal tribes in Africa and Australia. Circumcision can also be a matter of family tradition, personal hygiene or preventive health care. Sometimes there's a medical need for circumcision, such as when the foreskin is too tight to be pulled back (retracted) over the glans. In other cases, particularly in certain parts of Africa, circumcision is recommended for older boys or men to reduce the risk of certain sexually transmitted infections.

GDP: Gross domestic product (GDP) is the monetary value of all the finished goods and services produced within a country's borders in a specific time period. Though GDP is usually calculated on an annual basis, it can be calculated on a quarterly basis as well.

HIV: HIV (human immunodeficiency virus) is a virus that attacks the immune system (targeting white blood cells), the body's natural defence system. Without a strong immune system, the body has trouble fighting off disease. Both the virus and the infection it causes are called HIV.

Literacy: Literacy is traditionally understood as the ability to read, write, and use arithmetic. The modern term's meaning has been expanded to include the ability to use language, numbers, images, computers, and other basic means to understand, communicate, gain useful knowledge and use the dominant symbol systems of a culture.

Unemployment: The World Bank defines unemployment as the share of the labor force that is without work but available for and seeking employment.

Introduction

Healthcare is not only expensive for individuals and government but also a setback for many other national developmental goals.

Aids is like global warming. We only see outcomes and so many become ignorant until they are personally touched.

HIV is the acronym for Human Immunodeficiency Virus, which is an infection that weakens the immune system and makes it harder for the body to fight infections. It is commonly spread by having unprotected sex. In the late stages HIV is also called acquired immunodeficiency syndrome (AIDS) which is often a combination of multiple infections and causes severe damage to the immune system.

This proposal is about the fight against HIV/AIDS, focusing on South Africa. It makes use of accredited research and statistics to uncover the truth about the spread of HIV/AIDS. The purpose of the research is to shift the attention of the world from the virus and disease themselves to the people. Analyzing the relationship between people and the disease will help us discover the cause of the easy spread of HIV/AIDS in South Africa by focusing merely on knowledge, beliefs and attitudes, using documented facts and interviewing ordinary youths and adults in South Africa, England, and Myanmar.

Methods

A compare and contrast analysis are used. The author selected five distinctive countries and used them to deduct South Africa's failure in addressing HIV/AIDS from various variables, including prevalence, statistics, knowledge, beliefs and attitudes over HIV to explore the differences and find meaning in the importance of our knowledge, beliefs and attitudes as the perfect tools to fight the AIDS epidemic through behavioural change.

We will use the following research instruments and evaluations:

- Reaction to HIV/Aids and condoms from different age groups.
- Reactions from hospital visits.
- Putting up banner at night on busy streets with graphics and messages and seeing by passers' reaction in the morning. We will look at how long will they stare? and how many will ignore.
- Setting up testing tents on sidewalks and invite pedestrians to get tested.
- Questions based interviews.

Questions for adults to assess parental intervention.

- What can you tell me about HIV/AIDS?
- When how old were you when you first heard or read about HIV/AIDS?
- Has anyone who is HIV positive ever disclosed their status to you, personally?
- How many people do you personally know who are HIV positive?

Questions for youths

- Can you tell me anything about HIV?
- Are you taught about HIV/AIDS at school?
- Have you ever had a HIV/AIDS activist come to your school or community?
- Have you ever seen posters, billboards, etc. about HIV/AIDS?
- Where?
- How were they?

- Do you and your friends talk about HIV/AIDS?
- How often?
- When last did you come across something that covers anything about HIV/AIDS in the media?
- Where was it?

Results

Looking at a country with a much bigger population than South Africa such as Bangladesh which has one of the lowest AIDS rates in the world would be less relevant because AIDS is not contagious. Similarly, looking at a country with a much smaller population such as Samoa which also has one of the lowest rates would be less ideal because it is more manageable.

Bangladesh had a population 1000 times the size of Samoa in 2016 (162,910,864 to 194,523) while the AIDS rate in 2015 was almost equivalent at 0,1% to 0,01%. This can give us confidence in ruling out population as a causal factor.

Yet it is highly significant because it showcases the relevance of awareness through outreach education and socialization. It is also noteworthy that Samoa is an isolated island with limited migration and immigration trends. However, it is a very tiny nation that connects all citizens to one another, which would make it vulnerable to diseases. Bangladesh is a very cultural nation with customary traditions in socialization and relationships. However, it is one of the countries with the highest rape statistics.

Bangladesh identified its first HIV case in 1989, while Samoa's first case was reported in 1990. Condoms were in both countries promoted by government as prevention measures in the early 90 thought religious and cultural organizations have been forces of resistance.

Common risk factors

- Unemployment- (4,50% and 5,70% in 2011).
- Drugs- we look at alcohol consumption because alcohol is the most prevalent drug. (0,0037 ltr and 1,4 ltr in 2001).
- Literacy (61,5% and 99% in 2015).
- GDP per capita (\$1,358.78 and \$4,027.76 in 2016).
- Injection use [prevalent vs. highly prevalent].
- We look at how much each of the two nations is spending on Aids and how their preventative programs differ (today and in the year of the first case report).
- Bangladesh [\$300] million to Samoa [\$70] million.
- Circumcision as another prevention measure has also played a significant role.
- In Bangladesh [above 80%] and Samoa [less than 20%].
- We now need to conduct a compare and contrast analysis of three countries with about the same population size, namely South Africa, England, and Myanmar.

Circumcision in South Africa is at a rate of 20-80%. Condoms have been freely distributed in South Africa since 1992. Today free condoms are available in clinics, hospitals, and other public places and institutions such as post offices and in universities. They are even distributed to hangout spots such as taverns and clubs.

HIV/AIDS testing in South Africa is free in all state health institutions, including universities and mobile clinics. In 2016 [66.5%] of the population was tested. [80.1%] of them tested positive. If the whole population tests for HIV the rate is inevitably to rise in a shocking way that may lead to the assumption that 1 in every 5 South Africans is HIV positive. Many people in South Africa are HIV positive but just don't know it.

An estimated [4,264,860] people are on ART's in South Africa. ART's are free and given to all HIV patients. Children born to mothers with the HI-virus are treated before birth to prevent transmission. However, most people with HIV are not on treatment.

Myanmar identified its first HIV case in [1988] and introduced free condoms in [1989], while England's first case was reported in [1981] and free condoms were introduced in [1981]

England has one of the lowest AIDS statistics in the world, with just [0.16%] in a population of [66,573,504] million people.

England only has [12] million people more than South Africa but has an AIDS rate that is multiple times lower than that of South Africa. Treatment is distributed to [96%]. This is the same treatment used in South Africa.

Myanmar also has one of the lowest AIDS statistics in the world, with just [1.3%] in a population of [52.89] million people. Myanmar only has [3] million people less than South Africa but has an AIDS rate that is [12.6%] lower than that of South Africa.

From these comparisons we can deduct that early intervention was critical in the prevention of infection.

There is only a slight difference in the HIV rate between England and Myanmar, but the prevalence might correlate if we equal the population of the two nations.

These three nations are of about the same population but differ by Wealth and Culture.

The similarity in population is vital when comparing density. South Africa has a population density of [46.1] while England is at [419] and Myanmar with [81.82]. South Africa's low density was supposed to be a resistance to the high spread of diseases.

The economy allows us to look at its relative influence. England is one of the wealthiest first world countries with a GDP of [\$2.629 trillion in 2016] while South Africa is a developing nation emerging with a GDP of [\$294.8 billion] and Myanmar's GDP is at [\$67.43 billion]. With this fact we can rule out both wealth and poverty as major causes. South Africa has also spent more on HIV than any other nation from its own budget and international donors.

It is of paramount importance that we look at some commonly listed factors contributing to the struggle against HIV/AIDS in South Africa.

South Africa has one of the highest crime rates in the world. In societal safety and security, South Africa ranks as the 15th worst country in the world, and the 8th most violent with a murder rate of 31 per 100,000 people. One (1) person is raped every 17 seconds. South Africa is the country with the highest rape rate at 53,2 to 100,000. The country with the second highest rape incidences is Sweden at 63 to 100,000 and had an AIDS rate of 0,18% in 2014.

Poverty in South Africa is high with 12 million people living in extreme poverty and 17 million people are on permanent welfare. Unemployment at 26,80% in 2016, it is one of the biggest problems faced by South Africans, particularly youths. Idleness which is caused by unemployment increases risk behavior, but this does not fully explain the AIDS problem faced by the country when compared to other nations, as in Syria where unemployment is at 50% has a HIV/AIDS rate of only 0,01%.

Drugs play a major role in most of South Africa's social ills. Pure alcohol consumption (per litre) in South Africa was at 11.5 litre per capita per year in 2016. We are the third biggest drinking nation in Africa and the 19th biggest drinking nation in the world. Drugs increase the vulnerability of contracting HIV.

Same sex marriage was legalised in South Africa in 2006 with The Civil Union Act. Today there is an estimated 4,9 million homosexuals in South Africa. Though homosexuals are more vulnerable to contracting HIV/AIDS, other countries with higher statistics of homosexuals, such as England and America have very low HIV/AIDS rates.

South Africa is not the worse in all these lifestyle patterns. However, they may not pose remarkable danger individually but their combinations can be hazardous, which is the case for South Africa.

Discussions

From these comparisons, can we say that South Africans lack information or is South Africa the most ignorant nation in the world?

The advancement of the spread of HIV and the global advancement in fighting it have long run parallel.

In 1980 the United States of America was hit by a series of cases that led to the diagnosis and recognition of AIDS, to be the first nation to report a case of AIDS.

Two years later the first case of AIDS in South Africa was identified in 1982 in a homosexual man who contracted the virus while in California (USA).

Today more than 25 million people have died of AIDS worldwide since the first case was reported, with at least 1 to 2 million dying each year from the disease.

An estimated 34 million are currently living with HIV/ AIDS, with Sub-Sahara Africa having around 22.9 million people living with HIV/AIDS.

The country with the highest HIV/AIDS rate is Swaziland with 27% of its population living HIV/AIDS, while South Africa has the biggest epidemic, with well over 6 million people living with HIV/AIDS, which comes down to above 12,6% of its population of only 54,95 million people.

This statistic has increased from zero in a period of just thirty-five years. In 2016 it was reported that the country has been spending R23 billion on HIV/AIDS annually. The figure is distributed across prevention, testing and treatment.

Compared to the United States of America where the AIDS epidemic was first reported. America only has 1,2 million people diagnosed with HIV in a population of 325,816,150 people.

So, where did South Africa go wrong?

Majority of South Africans will say they have never seen someone with AIDS because they have never seen someone with the full-blown disease because these people are hidden at homes and hospitals.

It is easy to see a person with HIV/AIDS but difficult to see HIV/AIDS in a person. If (1,3) in every (10) people in South Africa is HIV positive, who is that one?

How many people today, living with HIV/AIDS know where they got it?

What is even more frightening is, how many people in the world today know their status?

Conclusion

HIV is a common enemy and the biggest threat to our society, so we cannot glorify it and shield it. We have marketed treatment and the Aids ribbon more than we show people what aids is. Even at health settings. We only see graphic posters of TB, Malaria and other diseases.

There is a need to redefine Aids in South Africa. There is also a need to not only give people risk information but also explain to them 'how it feels to live with it' socially, emotionally, psychologically, and physically.

We must show people what's really happening in cases of repulse. The full length of HIV and Aids from infection to the full blow of it. We cannot continue to only show cases of survivors and the strong and healthy. These stories only encourage treatment. Safety will only be encouraged by the publication of those cases of despair, vulnerability and death.

The passage of this legislation will save lives and taxpayer rands.

Furthermore, the promotion of the DIY HIV test kit is a self-defeating practice. It is going to disadvantage statistics, counselling, and treatment. So, it must be accompanied by necessary measures to address this crucial process. If not, statistics will go down but deaths and infections will continue to rise without being adequately monitored.

We must remember that counselling is not only a preparation to diagnosis but also to urge against anger, vengeance, and intentional spreading of the virus. It is dangerous to have undocumented people out there who know they are infected. It is like giving a gun to an untrained person. Testing is the beginning phase of a critical health process that must be done intensively.

Therefore, this research will have the following recommendations:

1. The mass publication of graphic footages in public spaces and true-life stories of HIV/Aids in the media.
2. Send children to hospitals with chronic AIDS patients for exposure.

3. Send activists to schools and communities for campaigns with extreme graphics.
 4. Distribute condoms in school, giving them to every child rather than put them somewhere for pickups because young people are shy.
 5. Acknowledge and disclose the incapability of ART.
 6. The reviewing of the allowance of the sale of DIY test kits.
- If this is made a territorial implementation effectiveness can be efficiently measurable.

Tables

Table 1. Comparison between Bangladesh and Samoa

	BANGLADESH	SAMOA
Population	162,910,864	194,523
Aids Rate	0.1%	0.01%
Year of First Case Identification	1989	1990
Unemployment	4.50%	5.70%
Alcohol Consumption	0.0037 ltr	1.44 ltr
Literacy	61.5%	99%
Circumcision	80%	20%
GDP	1.358	4.027

Table 1. Comparison between South Africa, England and Myanmar

	South Africa	England	Myanmar
Population	54.95 million	66.573 million	52.89 million
Population Density	46.1	419	81.82
Aids Rate	12.6%	0.16%	1.3%
Year of First Case Identification	1980	1981	1988
Year of free condoms	1996	1981	1989
GDP	\$294.8 billion	2.629 trillion	67.43 billion

References

- [1]. Department of Health. Annual Report 2013-2014. Pretoria: NDoH; 2014.
- [2]. Department of Health. Annual Report 2014-2016. Pretoria: NDoH; 2016.
- [3]. Male circumcision: Global trends and determinants of prevalence, safety and acceptability (PDF). World Health Organization 2007.
- [4]. Statistics South Africa Mid-year population estimates 2017 www.statssa.gov.za
- [5]. UNAIDS. UNAIDS Report on the Global AIDS Epidemic, http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf (2010, accessed 25 September 2017).
- [6]. UNAIDS. UNAIDS Report on the Global AIDS Epidemic,
- [7]. http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf (2014, accessed 25 September 2017).
- [8]. UNAIDS. UNAIDS Report on the Global AIDS Epidemic, http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf (2016, accessed 25 September 2017).
- [9]. Van Dyke, A. 2005. HIVAids Care & Counselling: A Multidisciplinary Approach. 3rd ed. Cape Town: Pearson Education.