2012-08-02

The Feminization of HIV/AIDS in the Republic of South Africa: Examining the Influence of Socio-Economic, Political and Cultural Determinants

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THE FEMINIZATION OF HIV/AIDS IN THE REPUBLIC OF SOUTH AFRICA: EXAMINING THE INFLUENCE OF SOCIO-ECONOMIC, POLITICAL AND CULTURAL DETERMINANTS

By

Wanda Denise Jackson

A DISSERTATION

Submitted to the Faculty of the University of Miami in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Coral Gables, Florida

August 2012
A dissertation submitted in partial fulfillment of
the requirements for the degree of
Doctor of Philosophy

THE FEMINIZATION OF HIV/AIDS IN THE REPUBLIC OF SOUTH AFRICA:
EXAMINING THE INFLUENCE OF SOCIO-ECONOMIC, POLITICAL AND
CULTURAL DETERMINANTS

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Worldwide few communities have escaped AIDS’ reach. However, epidemiological surveys reveal a significant regional variation in HIV/AIDS incidence and prevalence rates (UNAIDS, 2004). South Africa, which possesses one of the highest prevalence rates in the world, is located at the apex of the AIDS pandemic (UNAIDS, 2004). Furthermore, although both men and women are vulnerable in contracting HIV, women are disproportionately infected with the virus. While the lives lost to HIV/AIDS are lamentable for both sexes, this author maintains that the feminization of HIV/AIDS in South Africa presents deleterious consequences for the fiduciary and physical and mental health of the family and ultimately for the process of economic development and human security in South Africa. Increasingly researchers examine HIV/AIDS in the milieu of gender and social inequities. However, a more rigorous examination of the epidemic in its economic, political, ethical and cultural contexts is wanting. The objective of this dissertation is to advance a discussion which shows how the interactions between historical, socio-economic, political, and cultural factors have molded the disproportionate proliferation of the epidemic among women.
Acknowledgments

This dissertation would not have been possible without the support of my dissertation committee, my family and friends. Throughout this journey I thank God who has been the source of my strength.

Special mention must be made of the committee for their review of countless drafts and revisions. I wish to thank Dr. Edmund Abaka for meticulously examining the chapters and helping me to think more critically about the relationship between the history of apartheid and the proliferation of HIV/AIDS. I am ever grateful to Dr. Clair Apodaca for helping me to formulate the research question and variables. Also, she has served as a mentor and has guided me in the submission of proposals for conferences. I thank Dr. Goodman for helping me to work through the rigors of writing the dissertation. From the very beginning of my studies he has treated me as a colleague and has helped me to shape my professional goals. Professor Moss has been a beacon of encouragement throughout this very long process. He has offered thoughtful comments and suggestions for revisions which have better informed my study. Lastly, Dr. Weisskoff, my dissertation chair, has been extremely patient throughout the entire process. I am most grateful to him for not giving up on me.

I cannot say enough of the love and support I received from my father, George W. Jackson. He did not suffer my pity parties and helped me to push through this crossing. My sister, Dr. Angela Marie Jackson, was a source of love, patience and understanding. She offered words of wisdom which enabled me to pursue this goal. I shall be forever grateful to her. Additionally, I would like to thank Mrs. Deone Jones for her kindness and generosity, my cousin, Mrs. Gina L. Johnson, for being so supportive and Mrs. Susan Whitten for her ever-abiding friendship during these decades.
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List of Abbreviations

AIDS: Acquired Immune Deficiency Syndrome
ANC: African National Congress
ARV: Anti-Retroviral
AZT: Azidothymidine
CDC: Centers for Disease Control and Prevention
CIA: Central Intelligence Agency
CODESA: Conference for a Democratic South Africa
COSATU: Conference for South African Trade Unions
DP: Democratic Party
EC: Eastern Cape
FS: Free State
GP: Gauteng
GDP: Gross Domestic Product
GEAR: Growth, Employment and Redistribution
GPA: Global Programme on AIDS
HAART: Highly Active Anti-Retroviral Therapy
HIV: Human Immunodeficiency Virus
IFP: Inkatha Freedom Party
KS: Kaposi Sarcoma
KZN: KwaZulu-Natal
MMWR: Mortality and Morbidity Weekly Report
MTCT: Mother-To-Child-Transmission
MP: Mpumalanga
NAP: National AIDS Plan
NP: National Party
NGO: Non-Governmental Organization
NW: North West
NC: Northern Cape
NPRSA: Northern Province-Republic of South Africa
PCP: Pneumocystis Carinii Pneumonia
PEPFAR: President’s Emergency Plan for AIDS Research
RSA: Republic of South Africa
StatsAfrica: Statistics South Africa
STD: Sexually Transmitted Disease
TAC: Treatment Action Campaign
TB: Tuberculosis
TRC: Truth and Reconciliation Commission
UN: United Nations
UP: United Party
UNAIDS: Joint UN Programme on AIDS
WC: Western Cape
WHO: World Health Organization
CHAPTER ONE
INTRODUCTION – THE EMERGENCE OF THE EPIDEMIC

Between October 1980, and July 1981, physicians in New York and California identified 107 Caucasian males ranging from 15 to 52 years of age who were afflicted with Kaposi’s Sarcoma and/or Pneumocystis Carinii Pneumonia (PCP). Since both conditions are manifested in individuals who are immunosuppressed and are rare among the general population, the presence of these maladies among men who showed no outward symptoms of an immune deficiency proved a conundrum to physicians (Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report, 1981:30:409). Appendix A provides a discussion of the first scientists to identify the etiologic agent for HIV/AIDS as well as the earliest documented cases of HIV/AIDS. Laboratory tests indicated that the young men had low T-cell counts which signaled the presence of an immune dysfunction of unknown origin rendering the men vulnerable in contracting opportunistic infections that always proved fatal (CDC:MMWR, 1981:30:409). Appendix B is a pictorial representation of the structure of the virus.

Largely due to the work of science journalists such as Laurie Garrett, Jennifer Brower and Peter Chalk, communities worldwide acknowledge that pathogens transcend international borders and social and economic boundaries (Garrett, 1994; Brower and Chalk, 2003; Homer-Dixon, 1999). Accordingly, it is not surprising that, worldwide, few communities have escaped HIV/AIDS’ reach.
G.J. Ras, Simson, Anderson, Prozesky and Hamersma of the Departments of Internal Medicine and Anatomical Pathology and Divisions of Immunology and Virology, Department of Medical Microbiology, University of Pretoria and H.F. Verwoerd Hospital, Pretoria, revealed the discovery in 1982 of the first two HIV/AIDS cases in the Republic of South Africa (Ras et al. 1983, 64:140-142). Both cases in the Republic of South Africa involved Caucasian homosexual males who on several occasions had visited the United States during the course of their careers as flight attendants (Ras et al. 1983, 64:140-142).

Subsequent autopsies completed on both patients revealed the features of PCP as well as the presence of cytomegalovirus, which confirmed the existence of an immune deficiency (MMWR 1981:305). These cases marked the first known occurrences of HIV/AIDS in the Republic of South Africa. Such is the magnitude and trajectory of the AIDS pandemic today that its mortality rates now surpasses those of the Black Death pandemic which killed approximately one-third of Europe’s population in the 14\textsuperscript{th} century (McNeil, 2006).

1.1 The Statement of the Problem. The HIV/AIDS epidemic in the Republic of South Africa initially progressed at a pace that may be described as slow and indolent. However, by 2008 the authors of the Report on the Global AIDS Epidemic characterized the Republic of South Africa’s AIDS epidemic as one of the “worst in the world” (2008 Report on the Global AIDS Epidemic, 2008).
Their findings, which were based on data from an extensive antenatal clinic surveillance system and national surveys from the civil registration system, disclosed that an estimated 5.54 million people were living with HIV in 2005.

As illustrated in Figure 1.1 the rate of infection in the Republic of South Africa places the country at the apex of the AIDS epidemic in Africa.

![Estimated number of people living with AIDS](image)

Epidemiological surveys reveal a regional variation not only in the incidence and prevalence in the rate of infection but in the mode of transmission as well (Essex et al., 2002). For example, although the most efficient mode of transmission is via blood or blood products, the most common means by which individuals throughout Africa have acquired the infection is through the exchange of seminal fluid during penile-vaginal
intercourse (Mann et al, 1999). In the Republic of South Africa, 54-57% of the 5.54 million South Africans living with HIV were women between 15 and 49 years of age.

Social scientists contend that the disproportionate increase of HIV/AIDS among women in the Republic of South Africa results in a loss in human capital and a concomitant diminution in the labor force suggesting that the pandemic is not merely a public health problem but an economic development problem as well.

Indeed, this study argues that while the lives lost to HIV/AIDS are lamentable for both sexes, collective research asserts that the feminization of HIV/AIDS holds deleterious consequences for the financial security and physical and mental health of the family, and ultimately, for sustained economic development in the Republic of South Africa. In the absence of vaccines and microbicides to contain the devastation wrought upon families in the Republic of South Africa, it is imperative that research scientists, policy designers and relevant health ministries, identify those factors and patterns that give rise to the increase in the spread of the virus.

While researchers increasingly examine HIV/AIDS in relation to gender and social inequities, a more rigorous examination of the epidemic in its economic, political, ethical and cultural contexts is wanting. The objective of this dissertation is to advance a discussion, which considers the interaction among historical, socio-economic, political, and cultural factors and which identifies how these determinants may have molded the disproportionate proliferation of the epidemic among women.
The dissertation aims to answer the question: What are the socio-economic, political, and cultural factors which explain the disproportionate increase in HIV/AIDS among women 15 to 49 years of age in the Republic of South Africa?

I present the chapters in this dissertation under three general headings: gender power inequity, socioeconomic status (SES) and sexual violence. These variables are significant because they have been attributed to women’s vulnerability in contracting HIV/AIDS.

Chapter one documents the evolution of HIV/AIDS in the United States and the Republic of South Africa. It highlights the importance of identifying factors which may contribute to the proliferation of HIV/AIDS among South African women. The chapter evaluates the implications of the feminization of HIV/AIDS as an impediment to the economic growth of the country and the physical and mental health of South Africans.

Chapter two examines the methodological approach to this study and reviews the secondary sources used in this investigation. Additionally, the chapter speaks to an historical discussion of the mineral revolution (the discovery of diamonds and then gold in Transvaal and Witwatersrand). This revolution transformed the Republic of South Africa into a racialized society (Abaka, March 11, 2011) and has important implications for a discussion on the impact that apartheid policies have had upon the proliferation of gender-based violence, the freedom to acquire education without the threat of violence or vulnerability in contracting HIV/AIDS and high poverty rates and low status for women.
Lastly, the chapter presents an historical analysis which spans forty-six years that begins with the emergence of the apartheid regime in 1948 and ends with the 1994 election of Nelson Mandela, the first South African president to be elected in a democratic election. This historical analysis will enable us to understand the effect of the legacy of apartheid upon the restructuring of the economic system and subsequent high unemployment rates in the Republic of South Africa.

Chapters three through five have been assembled in three sections. Each chapter contains an introduction where I present a brief summary of the literature pertinent to the variable. Following the introduction I give a synopsis of published studies, my analysis of variable data in relationship to HIV seropositive rates, and upon women’s vulnerability in contracting HIV. Lastly, I discuss the government’s passage of legislation used to redress women’s social and economic vulnerability in the Republic of South African society.

Chapter three examines how power wielded publicly and privately via a patriarchal system has contributed to the disproportionate increase in HIV/AIDS among women. This chapter hypothesizes that the less power a woman exercises in negotiating the use of male prophylactics during sexual relationships the more vulnerable the woman may be in contracting the HIV infection. Women’s powerlessness has significant ramifications for their ability to protect themselves in their relationships.
Chapter four is a discussion of the relationship between violence and a woman’s vulnerability in contracting HIV. The study offers the hypothesis that as a woman’s exposure to violence increases, so does her vulnerability in contracting HIV. The United Nations Special Rapporteur on violence against women estimates that the Republic of South Africa has the highest reported rape incidence in the world “for a country not at war” (Wojcicki, 2002). These studies illustrate the violence contraction of HIV link and claim that coerced sex is a byproduct of the structural violence sanctioned by the apartheid state and can be traced back to micro political struggles in provinces such as Kwazulu-Natal (Kaarsholm, 2005).

Chapter five considers the correlation between a woman’s socio-economic status (SES) and her vulnerability in contracting HIV. The socioeconomic status is a “composite measure that typically incorporates the economic status, measured by income; social status measured by education; and work status measured by occupation” (Dutton and Levine, 1989:30), and is widely regarded as a powerful risk factor in determining one’s vulnerability in contracting diseases. Low SES may result in poor physical and/or mental health by operating through various psychosocial mechanisms such as poor or “risky” health-related behaviors, social exclusion, loss of sense of control and low self-esteem (NICHD 1998:1). For women, a lower SES may limit access to education, leaving them with a paucity of technological skills and knowledge. Since their career options are constrained, their only recourse may be to insert themselves into the
informal work sector. These positions are often insecure and may involve commercial sexual work which increases their vulnerability in contracting the HIV infection (Nattras, 2004).

Lastly, in chapter six I summarize how power inequities, gender-based violence and socio-economic status have contributed to women’s vulnerability in contracting HIV/AIDS. I discuss how the government’s inability to protect the reproductive rights of women has kept women mired in poverty where they are still vulnerable in contracting HIV/AIDS. We find that as we approach almost three decades since the first AIDS case was acknowledged among the medical community in the Republic of South Africa the discovery of a vaccine or microbicide to prevent the contraction of HIV/AIDS and the government’s efforts to contain the pandemic remain elusive.

Ultimately, it is hoped that this study will assist policy makers in developing programs for women that will result in the diminution of the disproportionate incidence of HIV and AIDS. In order to accomplish this objective this study suggests that a multidisciplinary analysis, which considers how socio-economic, cultural and political factors underlie sexual behavior, is important in reducing the incidence of HIV/AIDS among women. Inherent in this discussion is the understanding that the pandemic in the Republic of South Africa is “rooted in historical antecedents, government policies and cultural politics” (Craddock, 2004:158).
1.2 Outlining the Course of the Epidemic in the Republic of South Africa. As documented in Table 1.1 and illustrated in Figures 1.2 and 1.3, the Republic of South Africa maintained a low prevalence of AIDS from 1982 through 1986.

<table>
<thead>
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<th>Year</th>
<th>Number of Cases of HIV in RSA</th>
<th>Number of Cases of HIV in USA</th>
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<tr>
<td>1982</td>
<td>2</td>
<td>940</td>
</tr>
<tr>
<td>1983</td>
<td>6</td>
<td>3315</td>
</tr>
<tr>
<td>1984</td>
<td>14</td>
<td>8001</td>
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<tr>
<td>1985</td>
<td>22</td>
<td>16632</td>
</tr>
<tr>
<td>1986</td>
<td>43</td>
<td>30037</td>
</tr>
<tr>
<td>1987</td>
<td>79</td>
<td>50977</td>
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Table 1.1 Source: Ras et al. 1983.

Figure 1.2 RSA – AIDS Growth, Source: Ras et al., 1983

Figure 1.3 USA – AIDS Growth, Source: Ras, et. al., 1983
As in the earlier stages of the epidemic in the United States one may also glean, a pattern, however small, whereby homosexual\(^3\) males were overwhelmingly afflicted with the virus.

The analysis conducted by G.M. McGillivray and Drs. Lyons Schoub and Sher confirmed this finding indicating that individuals who tested positive to human T-cell leukemia type II were Caucasian male homosexuals who had traveled to the United States or had engaged in sexual contact with other homosexuals who had spent time in the United States. The authors of the study concluded that only individuals in high risk groups, such as homosexuals, were found to have antibodies to HTLV III and that AIDS was not endemic to the Republic of South Africa in 1987 (Lyons et al. 1985).

![Number of women HIV seropositive. Results of HIV testing in ante-natal patients](image)

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<tr>
<th>Tested</th>
<th>HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,762</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 1.4 - Source: Shapiro et al., 1989:245
The measured rate of HIV/AIDS infection among the general population permitted a laissez-faire policy at the onset of the syndrome. According to the Director General of the Health Department, AIDS was the “homosexual community’s own affair and not the business of the state” (Fassin, 2007:218). However, in 1987 researchers noted a shift in the mode of transmission and the population afflicted with the virus. A review of the results of a study conducted from May 1, 1987, to October 31, 1988, by the Republic of South African Blood Transfusion Service revealed an increase in the incidence of black women affected with the virus. The study, which involved the screening of 104,683 antenatal blood samples for the HIV antibodies, comprised four population groups: Blacks, Whites, Coloreds and Indians.

**Incidence of HIV delineated in six successive three-month periods**

**Black Women**

<table>
<thead>
<tr>
<th>Period</th>
<th>Tested</th>
<th>HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-July</td>
<td>13,762</td>
<td></td>
</tr>
<tr>
<td>Aug.-Oct.</td>
<td>13,922</td>
<td>6</td>
</tr>
<tr>
<td>Nov.-Jan.</td>
<td>14,417</td>
<td>9</td>
</tr>
<tr>
<td>Feb.-Apr.</td>
<td>14,241</td>
<td>12</td>
</tr>
<tr>
<td>May-July</td>
<td>13,921</td>
<td>19</td>
</tr>
<tr>
<td>Aug.-Oct.</td>
<td>14,264</td>
<td>31</td>
</tr>
</tbody>
</table>

Figure 1.5 – Black Women Tested and Exhibiting Seropositivity, May, 1987- October, 1988. Source: Shapiro et al., 1989:24.
Figures 1.5 and 1.6 demonstrate the gradual increase in the incidence of HIV among black women as recorded in “six successive three-month periods” and show that Black South African women were disproportionately infected with the virus. (Shapiro et al. 1989).

Figure 1.7, which illustrates HIV seroprevalence among blood donors in the Republic of South Africa, also depicts this growing trend in the disproportionate infection of HIV among black females. The table also reveals the materialization of a new mode in transition. A comparison of the ratio of white HIV seropositive males (white males = 14/113,457 = .00012) to black seropositive males (black males = 48/104349 = .00046)
reveals that the HIV seropositivity among the black male population is nearly four times that of the white male donors. However, black women have a ratio of \( \frac{49}{72630} = 0.00068 \) which is 1.5 times higher than black men, and 68 times higher than white women (ratio for white women \( \frac{1}{74890} = 0.00001 \)) \( \frac{0.00068}{0.00001} = 68 \).

![HIV Seroprevalence in Blood Donors in RSA](image)

**Figure 1.7 – HIV Sero prevalence in Blood Donors in RSA**
Source: Shapiro et al., 1989: 247

In the late 1990s the pandemic increased almost ten-fold among the heterosexual population. Although the findings were not conclusive there was reason to suggest that HIV-1C, which is found in Africa, appears to have a higher replication rate and concentration in bodily fluids and may be more infectious than HIV-1B which is found in the United States and Europe (Nattrass, 2004).
The literature on AIDS research considers other explanations for the disproportionate incidence of HIV/AIDS among women.

1.3 Literature Summary. Mary Crewe, who has been working in the field of AIDS awareness since 1988, published one of the first books to examine AIDS in the Republic of South Africa. *AIDS in the Republic of South Africa: The Myth and the Reality*, comprises three chapters which examine the etiology of AIDS, racism and stigma associated with the virus, and apartheid and AIDS. In the first chapter she gives an encyclopedic analysis of the virus and describes opportunistic diseases such as PCP, micro bacterium tuberculosis and persistent diarrhea, which may indicate seropositive conversion. In the second chapter she discusses the means by which one may contract the virus. Lastly, she examines how apartheid may have contributed to the proliferation of the virus. Crewe’s pocket-sized book is one of the first discussions on AIDS which were written for the general public.

The economists, Alan Whiteside and Clem Sunter, directed their discussion of the topic to a rebuttal of the myths and rumors associated with HIV/AIDS. In the first half of *AIDS: The Challenge for the Republic of South Africa*, published in 2000, the writers examine the etiology of HIV/AIDS and review prevalence rates both in the Republic of South Africa and other African countries. The information presented in the first half of the book is a recapitulation of other general studies on HIV/AIDS. However, in the second half of the book the authors present an analysis of the economic development and
social impact of AIDS in The Republic of South Africa. In this section the authors present a theoretical framework, which suggests that, the severity and speed with which HIV/AIDS is spread is determined by the degree of social cohesion and the overall level of wealth in a society.

_AIDS and South Africa: The Social Expression of an Epidemic_ is a publication of papers on the South African AIDS crisis that was presented at a two-day conference held in 2002 from April 19th to April 20th at Wellesley College in Wellesley, Massachusetts. This anthology comprises a three part examination of strategies to mitigate the spread of HIV. In the first part of the discussion the authors outline how the state can minister prevention programs to individuals and provide the funding necessary to implement them. In the second part of the book the authors suggest determining which programs are best suited for individuals living with HIV. Lastly, the authors look at the role that educational programs play in developing and utilizing communication programs that are culturally sensitive to the needs of the population. They suggest that knowledge of the general background of the pandemic is critical in understanding how it has shaped women’s lives. Within the last five years (2005-2010) there has been a surge in the range of topics discussed in the literature related to the HIV/AIDS epidemic in the Republic of South Africa. Formerly, the work of international relations scholars who were pursuing a study of the relationship between global health and foreign policy as well as an examination of the complex nature of the political, economic and cultural determinants
and the expression of disease was considered less rigorous. However, in light of the emergence and re-emergence of infectious diseases and the alacrity with which individuals may be infected globally nation-states have had to review and reconfigure their infrastructure to meet new health demands which influence the economic, social and political structure of their countries. In response to this new concern academicians and professionals who participated in conferences organized by the International Studies Association, the African Studies Association and Caribbean Studies Association assembled panels which looked at the pandemic’s impact upon democracy as well as HIV/AIDS as a threat to human rights and human security. We may organize this literature into three broad categories: 1) HIV/AIDS and Governance; 2) HIV/AIDS and the Denialist Theory; and 3) Local and global responses to HIV/AIDS.

In the context of HIV/AIDS and governance there are four prominent studies. In the anthology *AIDS and Governance*, Nana Poku, Alan Whiteside and Bjorg Sandkjaer have compiled thirteen studies which address both the impact of HIV/AIDS on political institutions and local and international responses to HIV/AIDS. Nana Poku and Bjorg Sandkjaer, begin the book with a chapter on the impact of HIV/AIDS on the African state. In this chapter the authors suggest that the decline in life expectancy rates is responsible for a more fractured state and is a threat to human security. In the chapters that follow the authors offer a discussion of the impact that the epidemic will have on democratization in the Republic of South Africa and responses by the pharmaceutical
companies to an increasing demand for antiretroviral drugs. The more compelling chapters present the argument that the continued proliferation of the epidemic may reverse “hard-won gains” in democratization in the Republic of South Africa. Per Strand, the author of the chapter *Comparing AIDS Governance: A Research Agenda on Responses to the AIDS Epidemic*, suggests that the present HIV/AIDS policies, which may be dependent upon ideals of human rights and transparency, have not necessarily been the most effectual in reversing or halting the spread of the epidemic in Africa. Dr. Strand proposes exploring methodological approaches which examine empirical and comparative studies in understanding the most effective “governance” templates in ameliorating the prevalence and incidence HIV/AIDS rates.

Per Strand, Khabele Matlosa, Ann Strode and Kondwani Chirambo, the editors of the anthology, *HIV/AIDS and Democratic Governance in South Africa: Illustrating the Impact on Electoral Processes*, present the results of their investigation on the impact of HIV/AIDS in the electoral process as a “key facet in democratization” (Strand et al., 2005:4). The editors hypothesized that AIDS may be affecting the electoral process and ultimately democracy in the following manner: 1) The reduction in the population due to mortality and morbidity rates would reduce the pool of voters. Morbidity and mortality rates would also reduce the number of skilled personnel available to work at the polling stations. This situation might affect the efficiency with which voting was carried out; and 2) People living with HIV/AIDS would be disenfranchised and turned away from the
voting process due to stigmatism and discrimination. The book is divided into three parts. Part one examines democratic governance in the context of the HIV/AIDS epidemic. Part two discusses AIDS’ impact on the central electoral institutions. Lastly, in part three the authors investigate AIDS effect on voter participation.

Angela Ndinga-Muvumba and Robyn Pharoah, in *HIV/AIDS and Society in South Africa*, investigate HIV/AIDS as a threat to human security. The anthology comprises chapters by Nana Poku and Bjorg Sandkjaer who have emerged as specialists on HIV/AIDS and governance. Drs. Poku and Sandkjaer examine how HIV/AIDS has made the lives of orphans, the military, and the education sectors less secure. In the concluding chapters Alan Whiteside and Pieter Fourie consider how better data collection, the establishment of new approaches to HIV/AIDS, and more extensive research may lead to sustained commitment in the prevention and treatment of people living with HIV/AIDS (PLWHA).

In *AIDS, South Africa and the Politics of Knowledge*, Jeremy Youde considers how divergent groups of AIDS experts affect policy. A central component of the book is his examination of how the government’s empowerment of the counter-epistemic community of AIDS dissidents resulted in an AIDS policy that, by his account, could be described as schizophrenic. Ultimately, the influence of the AIDS dissidents was instrumental in influencing Mbeki to adopt a policy which helped to fuel the growing AIDS epidemic in the RSA.
In July of 2000 the global community called former President Thabo Mbeki’s opening remarks at the 13th International AIDS Conference in Durban, South Africa, a grievous response to the HIV/AIDS epidemic in the Republic of South Africa. The scientific community railed against former President Thabo Mbeki for refuting the claim that HIV caused AIDS. Additionally, the international community was incensed that Mbeki’s health minister, Dr. Mantombazana 'Manto' Edmie Tshabalala-Msimang, would promote the use of beetroot, garlic and lemon to reduce the viral load of HIV seropositive individuals over the proven and effective use of antiretroviral drugs. In the body of literature on HIV/AIDS, scientists increasingly examine the ramifications of the Republic of South African government’s ARV treatment program on the pandemic.

*The Virus, Vitamin and Vegetables, the South Africa HIV/AIDS Mystery* is a compilation of thirteen chapters which documents the progression of the AIDS denialist movement. Kerry Cullinan and Anso Thom begin the book with a discussion of Virodene, an antiretroviral drug that was said to destroy the virus and reverse full-blown AIDS with minimal side effects. The promotion of the use of Virodene by Thabo Mbeki’s Health Minister and other members of the ANC, without adequate evidence “beyond the results of the ethically and scientifically flawed pilot study of 1996” (Cullinan, 2009:10), was one of the first indications that former President Mbeki was willing to consider measures of prevention and treatment for the HIV seropositive population in the Republic of South Africa which did not adhere to obligations of
beneficence. Subsequent chapters describe former President Mbeki’s affiliation with the dissident scientific community and alternate treatment supported by some members of his cabinet. Lastly, the authors review the work of the Treatment Action Campaign (TAC). TAC is an advocacy organization created by Zachie Achmat for People Living with HIV and AIDS (PLWHA). Mr. Achmat worked with pharmaceutical companies and members of the international community to convince President Mbeki to reverse his AIDS policy. The book chronicles the journey from AIDS denialism to the government’s acceptance of global mandates for treatment and prevention methods.

In Mortal Combat, AIDS Denialism and the Struggle for Antiretrovirals in South Africa Nicoli Nattrass examines the political economy of antiretroviral drugs and presents a comprehensive discussion on government policy, government action, and civil society action in context to the AIDS denialist policy.

Nattrass points out that the government’s refusal to provide antiretroviral drugs has resulted in a reduced quality of life for individuals living with HIV/AIDS, an increase in deaths due to illnesses associated with HIV/AIDS, and a reduction in productivity in the educational and industrial sectors due to an increase in short or long term disability of individuals who have contracted HIV/AIDS.

In the third category of the literature summary, which addresses local and global responses to HIV/AIDS, David Dickinson, the author of Changing the Course of AIDS, takes a departure from the growing number of books on HIV/AIDS and its impact on
governance and the AIDS Denialism Theory and its impact on HIV/AIDS proliferation. Dickinson revisits earlier paradigms which proposed changing social strategies in order to make the lives of South Africans less dangerous. Dickinson believes that peer education is the key to sexual behavioral change. Behavioral change may be achieved by altering individual behavior and transforming social relationships through collective mobilization.

Lastly, Corinne Squire, the author of *HIV in South Africa*, describes her interviews with individuals who are HIV seropositive. Her discussions recount individuals’ physical and mental responses to the syndrome as well as their accesses to treatment. Squire begins the book with a synopsis of diverse theories surrounding the etiology of HIV/AIDS. Additionally, the introduction offers a brief account of how the dynamics of gender, economics, the racialization of HIV and social and cultural norms impact those who live with HIV. In chapter one she reviews the implications of the denialist policy upon those who sought ARV treatment to manage their viral load. Also, the chapter explores alternate treatment such as the Africa Solution promoted in 2004 by a Dutch nurse and her mother, Tine and Nelly van der Maar, as well as the infamous Beetroot tonic proposed by President Mbeki’s health minister, Manto Tshabalala-Msimang. In the remaining five chapters she introduces the reader to the human subjects in her ethnographic study. The author records their experiences,
relationships with families, friends, and lovers, as they navigate the course of HIV/AIDS and its effect upon their body and mind.

The above cited books represent some of the themes which abound in the body of HIV/AIDS literature in the Republic of South Africa. Although this list is not exhaustive it shows a dearth of literature which examines the ramifications of the feminization of HIV/AIDS upon the RSA. In the following section I discuss the importance of examining this topic.

1.4 Why the Study of HIV/AIDS in the Republic of South Africa Matters: The Implications of the Feminization of HIV/AIDS. During the Republic of South Africa’s apartheid past and post-apartheid present the scarcity of employment opportunities forced men to migrate to more promising communities, and prompted women to seek employment in the informal labor force. Studies conducted in industrialized and developing countries by UNESCO inform us that no matter how integrated women may be in the labor force they also hold the primary responsibility for providing basic healthcare and sustenance for their offspring and members of their household, and invest far more of their income into the household than do fathers (UNESCO, 2004). Amartya Sen attributes women’s essential role in the growth of the family, and by extension to the process of development of the country, to the importance that mothers attach to the welfare of the children (Sen, 1999).
In acknowledging women’s prominent role in the economic and physical viability of the family it is not surprising that children living in households in which the mother is HIV positive will experience food insecurity, malnutrition and poor hygiene. In fact, statistics reveal that children with HIV negative status living with HIV-positive mothers experience a mortality rate that is 2.4 to 3.6 times that of HIV-negative children living with HIV-negative mothers (Gow and Desmond, 2002). These findings suggest that one of the effects of the feminization of HIV/AIDS may be an increase in child mortality rates and a weakening of the mechanisms that promote the formation of human capital. This occurrence is attributed to the fact that if the mother dies the potential productive capacity of the family is weakened and the loss of income due to death reduces lifetime resources for the children (The World Bank Group, 2003). The loss of the female head of the household also has a profound impact upon the number of orphaned children in RSA.

In 2006, statistics showed that sub-Saharan Africa counted eleven million AIDS-orphaned children who either lived in households independently, resided with an older relative, who may have limited resources to provide for their care, or became members of the homeless population (UNAIDS, 2006).

Not everyone believed the statistics on orphanhood. In an article in the African Journal of AIDS Research, Rachel Bray (2003) argued that the consensus concerning the state of orphan-hood in the Republic of South Africa was unfounded. Ms. Bray disagreed with the “apocalyptic predictions” that high AIDS mortality rates would
produce high numbers of orphans and rejected the stance that the loss of one or more parents would propel the orphans into anti-social behavior.

Lorraine Townsend and Andy Dawes (2004) expressed discordance with her assertion and cautioned individuals against suggesting that children would be taken in by members of their extended family. In fact, in one study the authors discovered that members of households did not have a realistic plan for caring for children should they be orphaned by the death of one or both parents.

In another study conducted in 2004 by Simpson and Raniga, the authors asked community leaders and community workers to comment on the feasibility of housing orphans in four different types of urban and rural settings in KwaZulu-Natal. All but one participant group was enthusiastic about the alternative housing.

All of these situations have negative implications for the prospects of the future generation but the first two conditions directly affect the economic outlook for girls and young women, who must often abandon their pursuit of an academic degree in order to take on the responsibilities of sustaining a household.

Studies show that a lack of education for girls and young women translates to reduced skills, technical knowledge and leads to greater financial dependence on men. Women’s financial dependency gives men greater license to control when, where and under what conditions sexual relations takes place (Manuh Takyiwaa, 1998). Since many men refuse to wear prophylactics their actions leave both parties vulnerable to HIV.
On the other hand, women who are literate avail themselves of more health care services, which results in lower mortality rates for children and generally greater access to healthcare for the entire family (Aikman, Sheila, 1998). Not surprisingly, higher levels of education for women also lead to higher market productivity for the country and increased income for women who may provide better living conditions for their families. More importantly, economic independence gives women more options to care for their family without engaging in transactional or commercial sexual work (The Economist, 2006).

In summary, the feminization of HIV/AIDS removes from the family the one individual who is best suited to provide sustenance for the family, influence family decisions and serve as a mediator for economic and social change.

1.5 The Burden of HIV/AIDS in sub-Saharan Africa. The Joint United Nations Program on HIV/AIDS’s 2006 Global Report on AIDS revealed that 40.3 million people were living with HIV/AIDS (UNAIDS, 2006). Moreover, although sub-Saharan African comprises only 10% of the world’s population, the region accounts for nearly two-thirds (64.5%) of HIV/AIDS cases worldwide (UNAIDS, 2006). The uneven distribution in the rate of infection suggests that the yoke of the pandemic has fallen upon the poor in less developed countries (Kreniski, 1997).
The most obvious effect that HIV/AIDS has upon the population is an increase in morbidity and mortality rates and in the use of private and public medical expenditures to improve the quality of life for individuals who are HIV seropositive (Ainsworth and Over, 2004).

The AIDS pandemic differs from other infectious diseases in that it is a “disease of young adults” rather than a disease which infects primarily the very young because of their immature immune system or the very old due to their suppressed immune system (Epstein, 2004). The HIV infection adversely affects young adults as they seek to enter the work force, and may present dire consequences for the region’s socio-cultural, economic and political development.

1.6 Human Capital. Chronic absences by those employees in poorer health due to HIV infection often cause consternation among healthy personnel who must work longer hours without additional payment in order to offset a potential loss in productivity. Birdsall and Hamoudi (2004) contend that the reductions in human capital are especially problematic for the continued viability of the educational system in the Republic of South Africa. They suggest that human capital acquired through formal education is a necessary component of production at the individual, household and firm levels.

Amartya Sen asserts that education is both constitutive of and instrumental in the process of development and is necessary to sustain human development (Sen, 1999, as cited in The Macroeconomics of HIV/AIDS) and poverty reduction. In the
Macroeconomics of HIV/AIDS, a compilation of articles by experts in international agencies and organizations, the authors discuss the mechanisms by which AIDS may affect the new human capital formation and the repercussion of this configuration with respect to education. The writers maintain that the loss of teachers reduces the educational system’s ability to train subsequent generations. Additionally, they point out that the mortality rate may reduce the demand for school since orphaned children are often removed from the educational system to take on the burden of caring for members of their household. The deaths of the already-educated reduce the number of individuals available for training another generation. Ultimately, the lower investment and higher production costs as well as a decline in physical health reduce educated people’s ability to contribute to economic production.

Lynn R. Brown (2004) agrees with Birdsall and Hamoudi’s assessment that a reduction in human capital may result in negative economic growth by virtue of a loss of an educated workforce, which, is also in poorer health. Brown adds the caveat that HIV/AIDS imposes an immediate burden upon society because the costs of maintaining a healthy labor force and costs of economic growth will increase in proportion to the need for more specialized health care. She writes that the demand for health care for HIV seropositive individuals usurps other health care needs. This assertion is confirmed by regional hospital records which reveal that AIDS patients require 50% of the available beds displacing individuals with other health care concerns. Not unexpectedly the loss
in human capital increases the competition for all services in addition to feeding the burgeoning poverty rates.

1.7 Poverty and Inequality. Historically, writers have observed (Thucydides 431 BC) and/or recorded (Hans Zinnser, 1935; William McNeil, 2006) the link between poverty and the spread of pandemics (Basch, 1990; Kosa, 1975; Hoff, 2000). Studies also reveal that a pandemic exacerbates and prolongs poverty and has a particularly destructive impact upon households (Shishana, O., et al 2004; Brittain, 1977; ILO, 2005).

In an effort to show empirically the link between poverty, HIV/AIDS and inequality, the International Labor Organization (ILO) conducted an experiment using HIV prevalence rates in the Republic of South Africa. The ILO wanted to understand the relationship between poverty and HIV prevalence rates among impoverished adults.

The results of the study revealed that the higher the level of inequality the higher the HIV prevalence rates of adults from 15 to 49 years of age. The authors discovered that the poverty head count, or proportion of the population living under $1.00 and under $2.00 per day was also predictive of HIV prevalence.

In a three-year study on individuals from 405 HIV seropositive and sero negative and/or unexposed South African households, Bachmann and Booysen (2006) revealed that economic causes and effects of AIDS work bi-directionally. Their findings indicated that illness, but not death, reduced expenditures for food and housing. The study revealed that all incoming wages go toward the medical care of the HIV seropositive
member of the household. The medical costs incurred may include the purchase of antiretroviral drugs as well as other medicines to stave off opportunistic infections and round trip transportation costs to the medical facility. For the individual in a lower SES the medical costs are problematic because they have no savings to cushion the added expenses.

However, the impact on the wealthy household is much less dire. In addition to having personal savings which they may access if needed, generally they may have medical insurance, which will absorb the cost of medicine and hospitalization. Essentially individuals who work in the private or public sector have greater entrée to medical care and other resources including better strategies to support their family during their illness (ILO, 2005; Tullock, 1986).

In Witness to AIDS Justice Edwin Cameron of the Republic of South Africa (2005) discussed how his own position of affluence enabled him to purchase drugs that in the year 2000 when only a handful of individuals could afford to do so. Appendix C outlines the class of antiretroviral drugs available to prevent the replication of the virus. Cameron wrote:

“In wealthy countries, the public health services were simply buying the drugs for AIDS patients at astronomical prices. But in Africa – where the huge majority of the world’s people with AIDS and HIV live – prices were a death-delivering obstacle. Only the miniscule number of people with AIDS who could afford to pay the cost of combination therapy from their own pockets stood to benefit from the new treatment. I can afford monthly medication costs of about US$400 per month. Amidst the poverty of Africa,
I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself” (Cameron, 2005:58).

1.8 Socio-Cultural Economic Ramifications of HIV/AIDS. The mining community of Carletonville, South Africa, which is the biggest gold-mining complex in the world, is an important test case of the relationship between migration and HIV contraction. Carletonville is the site of a working population of 85,000 individuals 95% of whom are migrant workers. Epidemiologists noted that the prevalence rate of HIV/AIDS in Carletonville increased from .76% in 1990 to 27.4% by 1999 (Williams et al, 2000). In 1999 65% of the adults in Carletonville were found to be HIV seropositive. At the time this rate was considered higher than in any region in the Republic of South Africa (Williams, et al., 2000). In an effort to thwart the effect of migration on the village elders who reside in the rural areas and urban dwellings have returned to or have adopted the use of indigenous and indigenized medicines for physical and mental well-being.

In the province of KwaZulu Natal, which is home to the largest Zulu speaking groups and has one of the highest HIV infection rates in the Republic of South Africa, members of the Isivivane, Amagugu, and AseAfrika ethnic groups have returned to virginity testing as a distinctive African solution to the AIDS problem. They view virginity testing as the “only way to impose lost cultural values of self-respect and pride to their people” (The New York Times, December 30, 2005). The practice is supported by
well-educated (and predominantly male) advocates of African renaissance and includes government ministers, educators and health officials. Virginity testing represents a return to traditions lost during the onslaught of colonialism, Christianity and apartheid. Some Zulus support the custom because it is said to discourage early sex and to protect young women from contracting HIV/AIDS (The New York Times, December 30, 2005).

Virginity testing is said to be a function of the Zulu model of the female body as both the source of male sexual pleasure and of his wealth (through his children), as well as a potential source of danger. For example, dry vaginas were perceived as being clean and disease free. Conversely, wetter vaginas were thought to house more germs and were environments in which STIs and HIV might flourish. The testing procedure opens with a discussion about the importance of the procedure and each girl is asked to lie on a grass mat. The practice involves testers who assess the external genitalia of girls who range from 5 to 22 years of age. The testers believe that the color and texture of the labia indicates a hymen that is intact and is a sign of virginity. They look for labium that is pink in color and dry. Girls who pass the inspection are given a certificate attesting to their virginity. On the other hand, it is their belief that the presence of bruises, cuts, pimples, sores and discharge are considered signs that the young woman is not a virgin (Leclerc-Madlala, 2008). Virginity testing derives from indigenous, rather than biomedical practices. Human rights agencies label the methods as archaic, unscientific and discriminatory. They point out that the absence of a hymen (reflected as a white dot
or thin white film similar to a veil) may be attributed to horseback or bicycle riding and that vaginal ‘lubrication’ may vary throughout the menstrual cycle. Virginity testers disregard this information in favor of the cultural standards for testing virginity. When Nomagugu Ngobese, a Zulu virginity tester in Pietermaritzburg was asked about the soundness of the practice she exclaimed,

“This is none of the government’s business. People are devaluing our things, but we are not going to quit. They must come and imprison me if they like, because this has helped our children” (The New York Times, December 20, 2005).

Another example of a cultural practice is the use of the sangoma or witch doctor. Routinely health care providers have enlisted the assistance of witchdoctors (sangoma) in dispensing ARV to HIV seropositive individuals (Kalichman, 2004; Nachega, 2005). There is little wonder that in rural and some urban areas as well individuals trust sangomas. Sangomas have multiple roles as “spiritual guides, healers and counselors” (Ashforth, 2005:20). In the example cited by Adam Ashforth (2005) of a citizen in the Republic of South Africa, a woman consulted her Tembe or local sangoma because she had developed a harsh cough and believed she had been bewitched. The sangoma recognized that her cough was a symptom of TB and sent her for an HIV test. The HIV test was positive. At the Tembe’s suggestion the woman began taking anti-retroviral drugs.
The world of the supernatural has a significant place in post-Apartheid rural South Africa. The belief in another’s ability to inflict illness and ultimately death through the use of supernatural powers or witchcraft is pervasive (Ashforth, 1996). The iconography of witchcraft in the Republic of South Africa is rife in “ambiguities and contradictions.” At one level Europeans and Africans both use the term “witches” or “witchcraft” to describe a realm of the supernatural. However, Africans believe that the phrase carries offensive connotations which relate more to European descriptions of covens and broomsticks rather than to African iconography. According to recent literature much of the iconography on witchcraft in Soweto focuses on the knowledge of the healing and destructive power of herbs. The traditional healers and diviners (inyangas and sangomas) derive the power to heal afflictions of the body and mind from their ancestors (Bähre, 2002).

In some ethnic groups the belief in witches is so omnipresent because “there is no such thing as a natural death [therefore, any sick person] may be regarded as bewitched” (Ashforth, 1996: 146). For example, witches would be blamed for the rapidity with which a person with plasmodium falciparum, one of the species of plasmodium that causes malaria, may experience debilitating symptoms which often lead to death. So-called wasting diseases such as AIDS may be said to be caused by witches “devouring the victim limb by limb”.

In this sense it is the “soul of the flesh” which is being consumed. However, any strange or unexplained disease may be attributed to witchcraft (Ashforth, 1996).

Women, who generally are in positions of low status and marginalization, bear one of the greatest burdens with respect to the pandemic. Almost exclusively, women must care for sick children and partners as well as dying relatives and friends. Quinton Mageya, an activist for LoveLife, commented that in performing home based care women and girls are not afforded the opportunity to pursue their educational goals, and nor will they have the freedom to assume leadership roles in the community. Mageya likens the position to “women carrying hospital beds on their heads” (Toronto Star, 2001). She opined that the care of the individual “should be the responsibility of the government” (Toronto Star, 2001).

1.9 The Absence of a Tenable Vaccine or Microbicide. The 2008 Global Report on AIDS citing the decline from 2.5 million to 2 million in the death rate from AIDS, was welcome news to the international community (UNAIDS 2008). However, Peter Piot, the former Director of UNAIDS, admonished the international community for declaring success in fighting the virus. He stated that “It’s true that the number of infections is declining, but consider this: If the world can be satisfied with 2.7 million people infected per year, 7,500 per day, then I’m not sure where the standards are for declaring something a total disaster, there’s no doubt that we’ll need a vaccine” (UNAIDS, 2008:15). Identifying an AIDS vaccine to thwart the proliferation of the virus has been
a quagmire for virologists who seek to develop a chemical prophylactic which may protect individuals against all strains of the virus known for its genetic hyper variability.

Initially, social scientists suggested that microbicides would be a more realistic prophylactic for women because they inhibited the attachment, absorption, fusion and/or entry of the virus into host mucosal cells in the vaginal wall. Furthermore, microbicides were deemed important as a female-controlled option because they were inexpensive, easy to use and could be employed without the partner’s knowledge. However randomized, placebo-controlled, double blind trial in three South Africa sites found that a microbicide, Carraguard, “was unlikely to have a meaningfully protective effect” (*The Lancet*, December 6, 2008).

Although the study failed to show the microbicide’s efficacy in preventing male to female transmission of HIV, researchers proposed the continuation of HIV microbicide trials (*The Lancet*, vol. 372, December 6, 2008).

In 2007 there was renewed optimism that an AIDS vaccine would soon be available to the global community. The design of the vaccine was based upon knowledge about how to use HIV genes to stimulate human immune defenses or to use HIV proteins rather than genes to stimulate immunity (*Scientific American*, January 23, 2007). There were two vaccines which were undergoing large-scale trials at the time. One trial comprised a chemotherapy based upon two vaccines used in previous trials. ALVAC comprised HIV genes inserted into canary pox virus and the AIDS VAX comprised a synthetic
gp120 protein found on HIV’s surface (New Scientist, November 16, 2007). This collaborative effort between Aventis and VaxGen was tested on 16,000 HIV negative volunteers in the Rayong and Chon Buri regions of Thailand (New Scientist, November 16, 2007).

The second efficacy trials were carried out by Merck pharmaceuticals and, like most vaccines, had been created to produce “cell-mediated immunity.” The vaccine was composed of a weakened cold virus carrying three HIV genes. Not only did the vaccine fail to protect individuals against HIV but it doubled the infection risk in men who had immunity to the cold virus. In September 2007, Merck pharmaceuticals discontinued Phase II of its AIDS vaccine STEP trials in the United States and “paused” the Phambili trails in The Republic of South Africa (New Scientist, August, 2007).

Dr. Seth Berkley, the former president of the International AIDS Vaccine Initiative (Iavi), conceded that “There is less feeling now that one of these first or second generation vaccines will produce a home run”, but was optimistic that the trials may serve as “the building block” for additional research. He added that “If you go back 10 years, it was as bleak as could be. Ten years later, we have a wide pipeline; we have multiple efficacy trials; everybody making vaccine is considering the needs of the developing world; there is political leadership and there has been a 500 percent increase in money” (Scientific American, January 23, 2007).
Researchers at the XVIIth International AIDS Conference in Mexico in August 2008 suggested that vaccine trials should be abandoned and “money spent on basic science” (The Economist, August 9, 2008). Researchers such as Helene Gayle, director of the Global HIV Prevention Watch Group, and Peter Piot, former head of the UNAIDS, are promoting the watch and combination prevention theory. This strategy combines a pro-condom, pro-circumcision, pro-abstinence approach which may work in tandem with a combination therapy of AIDS.

Although the global community of natural and social scientists reports a decline in the number of new HIV/AIDS infections and organizations such as the Joint United Nations Program on HIV/AIDS report vaccine research gains, the pandemic continues to be a burden to the most vulnerable members of the Republic of South African society (IAVI, August, 2009). The strain on the Republic of South Africa’s economic and social infrastructure underscores the need to design and expand treatment services to those infected with HIV. Virologists acknowledge that even when a vaccine has been identified it will be necessary to implement an integrated prevention and treatment strategy (Walker et al., 2009).

This discussion shows that adopting a multi-sectoral approach in understanding how the virus proliferates is the only way to reduce the prevalence and incidence rates among South African women.
CHAPTER TWO
METHODOLOGY AND HISTORY – THE PREMISE OF THE DISSERTATION

The underlying premise of this dissertation is the concept that inequities in gender power, as reflected in a nation state’s interpretation and adherence to ethical principles which apportion access to fundamental freedoms, and as exercised through its social and cultural mores and economic and political infrastructures and policies, may limit women’s access to health choices that enable them to reduce their vulnerability in contracting HIV/AIDS (UNAIDS, 2004). Using process tracing as a form of analysis I will examine condom usage data, rape statistics and income and education levels and evaluate these factors in tandem with prevalence and incidence of HIV rates in order to determine the possible source(s) of women’s disproportionate levels of HIV in the Republic of South Africa. More recently Bennett and George (2005) have indicated that a critical and rudimentary means for analyzing case studies is process tracing. Process tracing is a form of analysis of increasing importance to case study because it enables the researcher to conduct a robust examination of “causal process – the causal chain and causal mechanism between an independent variable (or variables) and the outcome of the dependent variable” (Bennett and George 2005:206). Moreover, “process tracing forces the investigator to take equifinality into account, that is, to consider the alternative paths through which the outcome could have occurred, and it offers the possibility of mapping out one or more potential causal paths that are consistent with the outcome and the process-tracing evidence in a single case” (Bennett and George 2005:206-207). This approach is the most appropriate for uncovering causal mechanisms and discerning who
has the power to effect change and the conditions under which a policy is formulated. The investigator uses secondary data analysis such as historical documents, vital statistics, newspaper reports, archival documents and interview transcripts to support existence of the causal-mechanism (Apodaca, 2007).

One may define the concept of vulnerability in relationship to political, socioeconomic and cultural life histories which increase one’s risk of engaging in risky sexual activities (LeCoeur et al. 2005:474). Vivien Igra and Charles E. Irwin, Jr. describe risky sexual activities as those practices conducted with multiple partners, and with/or without the use of contraception (Igra and Irwin, 1993). I maintain that it is prudent to modify the definition to include the caveat that risky sexual activity is the act of engaging in oral, vaginal and/or anal intercourse with or without multiple partners without using a dental dam or latex male condom and water-based lubricants to minimize the risk of latex male condom breakage and to increase the effectiveness of this contraceptive device.

In the body of HIV/AIDS literature condom usage, rape statistics and income and education levels have been cited frequently as variables which drive the disproportionate prevalence rate among women. The discussion which accompanies this diagram examines why these determinants prove so pervasive in the literature.

In Perspectives on Gender and AIDS in Africa, Carol Baylies (2000) points out the importance of gender in the analysis of the proliferation of HIV/AIDS. She states that the “grip which AIDS has in Africa” is a result of social change brought about by migration, delayed marriage and loosening of social and cultural attitudes towards sex, regimes of structural adjustment and restricted access to health services.
According to Baylies all of these mechanisms have led to changing patterns in sexual behavior, and for this reason, gender analysis is critical in understanding the growth of HIV/AIDS among women (Baylies, 2000).
As I outline in chapter four, acts and/or threats of violence may inhibit a woman’s ability to negotiate the use of condoms. In ongoing research conducted by Geeta Gupta and her colleagues, they discovered that “physical violence, the threat of violence, and the fear of abandonment were significant barriers for women who wished to negotiate the use of condoms” (Gupta, 2000:5). In a study conducted by Beadnell, Baker, Morrison and Knox, they found that women in physically abusive relationships were at significantly greater overall risk for HIV or STI transmission because they reported having less say about engaging in unwanted sex and having lower self-efficacy in convincing their partners to use condoms. The researchers reached the conclusion that the sociodemographic factors (education, income and employment) accounted for a correlation between interpersonal violence and greater propensity for contracting HIV or STI transmission (Beadnell, et al., 2008).

All of the aforementioned factors create the optimal environment in which rape, which is recognized as one of the key features in HIV proliferation, may increase a woman’s vulnerability in contracting HIV. Rape has this central role because of the part that physical trauma plays in creating abrasions in the vaginal or anal walls. Abrasions create an optimal portal for the entry of the virus. The high percentage of rapes committed in a victim’s home is consistent with the observation that women have a greater risk of sexual violence from an intimate partner, spouse, or even an acquaintance. Rachel Jewkes, President of Gender and Health Research Unit, South African Medical
Research Council, maintains that often violence is used by men who may feel their status and identity threatened and is used to re-assert their masculinity and control (Jewkes, 2009).

The September 2008, report released by the World Health Organization reveals that economic forces may be important in determining morbidity rates and one’s propensity in contracting certain diseases. It has been suggested that wealthy individuals with a high amount of disposable income enjoy greater access to quality healthcare, optimal nutrition and leisure activities and, in general, have opportunities to reduce stress in their lives. All of these factors reduce structural factors that lead to poor health and exposure to highly infectious diseases. Conversely, it is believed that individuals in the lower economic stratum who have a lower amount of disposable income, lower access to quality healthcare, optimal nutrition, and who have less control in modulating the stress in their lives may increase their risks in contracting HIV/AIDS because of compromised health and/or immune systems and/or engaging in leisure activities that encompass risky sexual practices.

Brooke Schoepf maintains that the virus was fueled by women’s need to survive economically. Women are forced to engage in unprotected transactional sex which may increase their vulnerability in contracting HIV (Schoepf, 1998). Women in South Africa are considered vulnerable because the majority of them hold lower paid positions and because so few maintain powerful administrative posts they are absent from agencies which formulate the financial and monetary policies and tax systems (Schoepf, 1998). Moreover, due to challenges surrounding childcare and barriers in the workplace they
often encounter discrimination in hiring, education and training and have fewer opportunities to pursue promotions and higher salaries (Schoepf, 1998).

Deborah Posel deviates slightly from the views expressed by Farmer and Schoepf. Posel speaks to the relationship among HIV/AIDS, the legacies of Apartheid, and poverty, as contributing factors to the HIV/AIDS crisis in South Africa. In her estimation apartheid policy facilitated the severance of family ties and the creation of new patterns of sexual behavior which placed both men and women at increased risk for contracting STDs and HIV/AIDS. The government’s influx control system placed women in the position of caring for their families single-handedly. Since women held limited literacy and technical skills there were few economic positions open to them. Women learned that they could earn more from part time domestic work and/or petty entrepreneurial activities such as the brewing and sale of sorghum beer and commercial sexual work than from full-time wage labor (Posel, 1991). Although both activities yield a more substantial income than formal employment (when one can find it), commercial sexual work placed women at a more vulnerable position for contracting sexually transmitted diseases and/or HIV/AIDS. Studies suggest that women who engage in commercial sexual work use condoms at a higher rate than women in monogamous relationships. Yet, in practice, commercial sexual workers will forego the use of a condom when clientele offer them more money to engage in sexual relations without it. The practice of sexual relations without a condom increases women’s vulnerability in contracting HIV/AIDS.
2.1 The Basis for the Study. My decision to investigate South Africa was predicated upon two factors. South Africa has one of the largest prevalence rates of HIV/AIDS in sub-Saharan Africa. Women have contracted HIV and AIDS at a rate that is between 1.7 and 2.0 times that of men. The feminization of HIV/AIDS in South Africa has had a detrimental impact upon the economic growth of Namibia, and has had profound ramifications as a public health concern. Lastly, from 2003-2005, I served as one of the research coordinators for the USA/RSA International AIDS organization. The founders of this organization have collaborated with Archbishop Desmond Tutu and HIV/AIDS researchers at the Desmond Tutu HIV Research Clinic in Cape Town, South Africa and with researchers in HIV/AIDS Clinics in Tampa, Florida. The mission of this organization is to identify the causal mechanisms which drive the disproportionate propagation of HIV/AIDS among women of African descent in South Africa and the United States. On account of my affiliation with this organization, I planned to accompany the group to South Africa where I was prepared to do my fieldwork at the Desmond Tutu HIV Research Clinic in Cape Town, South Africa.

I planned to conduct a qualitative field-based study comprising interviews with young women ranging from 18 to 24 years of age who resided in the urban and peri-urban areas of Cape Town, South Africa. Unfortunately, insufficient funding to conduct the international field research as well as political unrest in South Africa due to unemployment and attacks attributed to xenophobic violence in 2005 and 2006 and outbreaks of violence in 2007 in neighboring Mozambique and Zimbabwe curtailed those ambitions. Since the option to generate original data was no longer available I have had
to rely upon the use of secondary and tertiary data. The potential setback to secondary and tertiary data has been the recognition that the original data set was conceived and collected considering different objectives and research questions. Yet, although primary data may be the most desired form of analysis one must not view secondary or tertiary data as necessarily inferior.

Secondary data includes government reports and archival data sets which have been generated by government services and agencies. Secondary data may be desirable for the individual who typically has limited funding to collect data in sufficient quantity to render the data statistically significant. In this sense the reason why primary research is not undertaken more frequently involves cost. Increasingly, only government departments and agencies have the financial resources and personnel to collect large sets of data. Another advantage involves reciprocity (Frankfort-Nachmias and Nachmias, 1996). While this search may prove more challenging because of the use of secondary and tertiary data it is not impossible to acquire the appropriate statistics for this study. William Trochim (2001) outlines six steps to guide one’s data search: 1) Specifying one’s needs; 2) Familiarity with the guides, catalogs and data archives or organizations; 3) Utilize people familiar with the archives; 4) Locate professional staff who may verify the information; 5) Speak with other individuals who have utilized the data to discern potential problems; and 6) Obtain additional data if needed (Trochim, 2001). One may assume that the efficient employment of all of these steps will enable the researcher to forge a well written document.
2.2 *The Study Design.* I will utilize a single case study of South Africa using document analyses.\(^{11}\) In 1952 Goode and Hart extolled the use of the case study citing its unique characteristics which “preserve[d] the unitary character of the social object being studied” (Goode and Hart, 1952:331). They regarded this research strategy as “a mode of organizing data in terms of some chosen unit, such as the individual life history, the history of a group, or some delimited social process” (Goode and Hart 1952:339).

Both Robert K. Yin and Van Evera advocated in favor of the case study as a mechanism which enabled individuals to use complex data. In the research manual *Case Study Research Design and Methods*, Robert K Yin pointed out that case studies were methodological strategies used frequently in thesis and dissertation research. He suggested that the case study was so popular because of its logic of design. Yin described this research mode as an empirical inquiry in which one may: 1) Investigate a contemporary phenomenon with its real-life context, especially when the boundaries between phenomenon and context are not clearly evident; and 2) Work with more complex variables of interest by means of triangulation of data (Yin, 1994).

However, while Yin considered the case study’s logic of design Van Evera (1997) looked to the strategy’s applicability to theoretical design. He maintained that the case study was ideal for: 1) Establishing a theory or theories; 2) Testing theories already in use; 3) Identifying which determinants may drive the phenomenon; 4) Establishing the importance of each determinant; and 5) Discerning how the case may be used in other examples (Van Evera, 1997).
Mary Bailey concurred with this assessment and pointed out that while case studies may be “descriptive, interpretive, critical or used for the formulation of a theory,” the most useful studies were valuable for “both practitioners and scholars” (Bailey, 1994). Indeed due to its ease of use researchers in traditional fields such as psychology as well as practice oriented fields such as urban planning, public administration and public policy use this research strategy with frequency.

Both McNabb (2004) and Stake (2000) discussed the case study’s effectiveness as an analytical tool. The scrutiny may bring to light unique, ignored and/or forgotten information about the study. McNabb compares the case study to the nuances observed in an oil painting of the Old Masters. In viewing any painting the individual recognizes vestiges of a figure or object that have been re-worked and refined by the artist only after the researcher examines the painting via x-ray. Within the context of the political arena the case study helps the researcher and reader to remember that the political world and phenomenon associated with it are “as complex as the people who live and function within it” (McNabb, 2004:143).

Robert Stake defines the case study in the perspective of six structural concepts. These concepts include the identification of the object of the case study, the selection of the phenomenon that will form the research question, the analysis of the material to discern the appropriate data source, the triangulation of key data, the examination of the data and the interpretation of the findings and lastly the documentation of the conclusions (Stake, 1995).
Of course, the case study has its detractors. Blaikie is one of several authors who view the case study with skepticism and malign scholars who use this research method citing its soft approach to analysis. There have been three principal arguments against the use of the case study. The first argument is that there is greater opportunity to afford “sloppy research and biased findings being presented” (Blaikie, 2000:218). Secondly, researchers believe that the case study is not optimal for generalization. Thirdly, researchers point out that because case studies may generate large amounts of data it will take far too long to analyze the findings (Blaikie, 2000). For example Christopher Achen and Duncan Snidal (1989), in the article “Rational Deterrence Theory and Comparative Case Studies,” maintain that while single case studies “provide interesting insights” they are not appropriate for enabling us to understand other similar situations. King, Keohane and Verba share this sentiment and argue that it is unlikely that one may successfully analyze a theory using the single case method. Moreover, they suggest that often in so-called single case testing there are “a small number of observations within cases” with which the individual may make comparisons” (King, Keohane and Verba, 1994).

In spite of these misgivings, researchers suggest that the case study is thriving and is being utilized with great success among political economists and “quantitatively inclined political scientists” (Gerring, 2007). Moreover, they define this methodological approach as an empirical inquiry which one uses in investigating and understanding contemporary phenomenon (Yin, 1994; Gerring, 2007).
In the remaining section of this chapter this author suggests that while the “engineers” of the Apartheid system may not be implicated directly in driving the disproportionate incidence of HIV/AIDS among women certainly the policies passed during the apartheid period have contributed to the socio-economic, educational and cultural malaise under which many South Africans now live. Since the dissertation purports to show that socio-economic, political and cultural factors may drive the spread of the pandemic it is reasonable to examine the implication of the discovery of diamonds and gold at Transvaal and Witwatersrand. The discovery of diamonds and gold has important ramifications for the racialization of society and labor in South Africa. The legacy of apartheid is said to have made “South Africa unique in terms of how the socio-political context wrought by apartheid led to the spread of the virus in this country and how the political system underscored the inequities creating the social conditions for its spread” (Fourie, 2006:57). As epidemiological statistics such as incidence and prevalence rates and their interrelationship with social, economic and political inequalities comprise the bulk of data in this study it is important to provide a discussion defining the HIV surveillance, prevalence and incidence rates and data sources.

2.3 The Historical Overview of Apartheid. S. Terreblanche affirmed that the legacy of apartheid and accompanying unequal distribution of health was a historical framework of exploitation that led to a system where “comprehensive, coordinated and effective policies for alleviating poverty and preventing AIDS are not implemented, poor health and [hence] AIDS will remain an important –and ominous—poverty trap leading to the further pauperization of especially the poorer half of the population”
The portents to the apartheid policy appeared in the guise of pass laws as early as the 19th century upon the discovery of gold, diamonds and coal in South Africa.

The second half of the 19th century marked an era of gold discoveries in North American, Australia, South Africa and Asiatic Russia. In North America the gold discovery began in 1849 and took place in California where between the years 1849 and 1852 the population grew from 14,000 to 250,000. During the 1850s and 1860s Australia was the principle source of the discovery of new gold deposits. In the 1860s and 1870s gold was discovered in New Zealand and in Queensland. Yet, the most spectacular phenomenon was the discovery of gold in 1886 in the Transvaal colony of Witwatersrand. The discovery of gold coincided with the unearthing of coal deposits in the Transvaal colony. Both of these discoveries were preceded by the discovery of the largest source of diamond deposits in 1866 at Kimberley in Griqualand West. This tripartite discovery was said to transform the political and economic constellation of South Africa (Richardson and Van Helten, 1984). The mining of these minerals had an important role in the development of migrant labor and, in particular, the passage of laws which foreshadowed the ensuing apartheid legislation which drove the political, economic and cultural subordination of South Africans for more than one century.

The first diamond was discovered on a farm named ‘De Kalk’ in the Hopetown area of the Cape Colony. When Schalk van Niekerk saw the stone some weeks later he believed that it had value and offered to purchase it from the family. The stone was valued at £500. The discovery was considered a fluke and attracted very little attention.
Three years later a Griqua farm employee brought another stone to Schalk van Niekerk’s attention. This time Schalk van Niekerk received £11,200 for the diamond. However, it was later purchased in London for more than twice that amount; the stone brought in £25,000. Prospectors learned of the find and began a search for additional deposits that spanned an eighty mile stretch of land. Individuals from Australia, California, London, Germany and Ireland descended upon the diamond mines of Griqualand. The mining settlements quickly morphed into bastions of disease and despair as much of the rewards for the diggers were in fact meager (Meredith, 2007). The farms of Adriaan van Syk (Dorstfontein farm) and Cornelius du Plooy (Bultfontein farm) generated additional deposits. The farm owned by Johannes de Beer and his brother yielded even greater deposits. Alas, when the excavation began yielding low quality diamonds Johannes de Beer believed that he had exhausted the diamond supply. Therefore, in 1871 Johannes de Beer sold the 16,400 acre farm to Vooruitzigt for £6,000. All three farms would later be known as the most valuable pieces of real estate in the world. Meanwhile the British, the inhabitants of Orange Free State and the Transvaal battled for the territory. The British prevailed and they proceeded to change the name of the town from Vooruitzigt (foresight) to Kimberley (an English-sounding name). As more prospectors came to Kimberley the town was overtaken with rough hotels and boarding houses in which individuals could partake of drinking and gambling vices in addition to prostitution. The prospect of obtaining money brought in Coloreds, Africans and bi-racial individuals. Black migrants came from Pediland in the Transvaal region, which was 500 miles away, as well as from the Gaza territory of Limpopo (Meredith,
The Black migrants stayed from three to six months and returned home when they had acquired sufficient sums to purchase cattle or guns. White diggers began to complain about the presence of Black labor calling them “unmanageable and the most expensive [labor] in the world” (Meredith, 2007:43). Additionally, white diggers resented the black laborers for changing employers if they found someone who was kinder or offered them better pay. Proclamation Number 64 of December 1871 was the first of the legislative acts which acquiesced to the white diggers’ demands to control the economic independence of black laborers (Smalberger, 1976). The commissioners stated that:

“The prosperity of the fields depends on a constant supply of native Labor. For the native servants summary punishment alone is of any Avail; and for their masters nothing could be more vexatious than to be deprived of the services of even a bad servant at a critical time by imprisonment. The lashes, instead of being inflicted by the sentence of the magistrate would be, without this provision, inflicted with unrestrained severity by the masters, and it would be extremely difficult to bring such employers to justice” (Commissioners to colonial secretary, February 22, 1872 as cited in Smallberger, 1976:427).

But, Proclamation Number 14 of August 10, 1872 “provided all that the white diggers wanted” (Smalberger, 1976:432) in making blacks suffer under the labor constraints. This act of legislation produced guidelines for labor contracts as well as for a system of pass laws that would foreshadow the method of controlling the movement of black labor during the twentieth century. When black laborers, who were now called servants, arrived they were required to register at the depot and then obtain a daily pass until they found employment. Once they found work the pass had to be signed by their ‘Master’.
Masters were given the authority to search the individual and/or his property or residence at any time and without warning. Although the law was supposed to be applied to everyone, it was only enforced with black migrants (Meredith, 2007).

Vast profits in gold mining were realized until 1895 when there was a collapse in the stock market boom as well as political problems brought on by the Jameson Raid. Due to “rising costs and because of the difficulty in raising development capital in a stock market” (Jeeves, 1985:39), mining profits during the three years prior to the Anglo-Boer War of 1899-1902 were at their most dismal. The Chamber of Mines Labor Importation Agency (CMLIA) took over the representation of the migratory labor system and proceeded to enlarge the “pool of potential workers” (Massey, 1983). In terms of supply and demand, a surplus of workers produced a shift of the supply labor curve to the right (or increased supply) and resulted in the depression (reduced demand) of wages (Massey, 1983). The CMLIA was able to control cost inflation in five ways: 1) Supplying a large external supply of labor; 2) Maximizing Chinese labor; 3) Chinese labor was cheap and the workers docile; 4) Enabling the mining industry the opportunity to fight against inflation; and 5) The CMLIA sought to work with the Portuguese East African labor market in increasing labor for the mining operations (Richardson, 1977).

During the years previous to the Anglo-Boer War, the industry had experienced little difficulty in securing black migrant workers for the mines. However, by the mid 1899s the situation had changed due to the fact that the military and civilian administrations had commandeered a large number of black laborers for the railway and harbor work (Jeeves, 1985). The black laborers received large wages and were reluctant
to return to the mining system where wages were notoriously low. Since the large
supply of labor could not be met by the local South Africans, mine owners recruited
workers from foreign countries. The importation of Chinese indentured mine laborers
for work on the Transvaal gold fields (after the South African War of 1899-1902) is
considered an important facet of intracontinental labor mobilization (Richardson, 1977).
Between February 1904 and November 1906, 63,296 Chinese men emigrated from north
and south China to South Africa (Ricardson, 1977). The experiment of exploiting
Chinese labor was short lived and the Chinese workers were repatriated in 1908. The
Mine and Works Act (known as the Color Bar) of 1911 and other amendments enabled
“white miners to maintain higher paying positions and helped the government to solve its
supply problems, deal with the security issues and manage labor relations” (Crush, Jeeves
and Yudelman, 1991:8). From 1920 to 1970 the mining system entered an expansionary
phase in which recruiting levels rose from about 200,000 men in 1920 to a peak of
427,000 men in 1961. The mining system is also said to have ushered into the country an
era of violence.\footnote{13}

Violence involved two categories: 1) “Assaults were known to subordinate black
men as a group.\footnote{14} Beatings were constitutive of two enduring categories of men – whites
and blacks. They were racist, also, because they drew upon the old forms of social and
cultural hierarchy, derived from slavery and conquest, to subordinate black workers to
their white supervisors. Even where black men beat each other, the force of the conflict
was usually the racial hierarchy” (Moodie, 1994:57, also as cited in Breckinridge,
1998:673); and 2) The other determining factor was the connection between white
identity and state power. Black workers were aware of the relationship between mine supervisors and mine management and were cognizant that the magistrates would always align themselves to white assailants (Breckinridge, 1998).

The absence of women in the mines created a propagation of violence as well as a phemonology of male sexual experience known as mine marriages. Mine marriages were described thus:

“On the mines there were compounds which consisted of houses, each of which had a xibonda or husband inside. Each of these xibondas would find a boy for himself, not only for the sake of washing his dishes, because in the evening the boy would have to go and join the xibonda on his bed. In that way he had become a wife. The husband would double his join (his length of time) on the mines because of this boy. He would make love with him. The husband would penetrate his manhood between the boy’s thighs” (Moodie, 1988:230).

Miners were said to engage in these relationships because they were not allowed to go into town to meet women. Additionally, men professed a loneliness and boredom which was alleviated by their relationships with young boys. In the relationship the wifely sexual behavior was passive and was described as subordinate both sexually and socially. “As the boy became old enough he might wish to start his own family on the mine or to become the senior partner. According to Tsonga tradition that was his right” (Moodie, 1988:235). Men who held the position of mine wife were able to double their wages and reduce their mine contract. The (male) wives would be able to “pay bridewealth and build their own umzi” (Moodie, 1988:230). As land was appropriated for the Afrikaner less land was available for the South African workers. Since many men worked in order to supplement their income from farming there was no longer any incentive to remain in the
mining system. Many men opted to remain in the urban areas on a full time basis. This system produced a breakdown in the rural homestead, as men sought out town women and ceased sending remittances to their wives at home. In order to control the influx of South Africans into town the Afrikaners created a system of laws to solidify a racialized and segregated state. Laws which foreshadowed the apartheid legislation had been passed as early as the 18th century. However, the genesis of apartheid has been ascribed to 1948 when two momentous events occurred. The first event included the publication of the Report of the Color-Question Commission chaired by Paul Sauer. All proposals outlined in this report were subsequently embodied in apartheid legislation (Welsh, 2009). The second event that took place was the election of the National Party. The following discussion will present the unfolding of the apartheid legacy during the period from 1948 to 1994. Although history does not take place in a vacuum it is possible to outline the rise and decline of the apartheid in three phases. The first phase comprises the period from 1948 to 1959 when the National Party consolidated its power base. The second phase encompasses the period from 1960 to 1966. During this period the Republic of South African government encountered hostility from the global community due to its handling of the Sharpeville massacre. In this phase the Republic of South African government tried to placate the global community by informing them that setting up homelands or reserves was part of a decolonization measure. Lastly, the third phase, which took place from 1966 to 1994, may be described as the decline of Afrikaner nationalism and the rise of democracy (Welsh, 2009). The National Party led by Daniel Francois Malan narrowly defeated the Boer general, JC Smuts of the United Party on
Friday, May 28, 1948. Smuts’ loss was attributed to his absence from his duties as Prime Minister. These absences became more frequent as he began to place more attention on the creation of the United Nations. Not surprisingly, he did not have a strong focus on implementing a segregation policy in the RSA. Historians point out two reasons for the National Party’s victory. One observation was made by the historian Van Wyk who wrote that, “the call from the platform and pulpit, in classroom and editor’s office, was for the Afrikaner to be Christian, anti-English and anti-black, all rolled into one. That, at any rate, was how it was broadly understood, if not openly advocated” (Van Wyk, 1991:61 as cited in Welsh, 2009:25). Secondly, Piet Cillie wrote that “the strategy of the Nationalist opposition was to win back the Nationalist component of the United Party and the weapons were Afrikaner rights, republicanism and the color question, concerning which every sign of laxity and laissez-faire on the part of the authorities was mercilessly attacked” (Cillië, 1980:67). Whatever the reason for the National Party’s narrow victory it exposed the National Party’s electoral vulnerability (Welsh, 2009). They would have to “entrench the National Party power and expand discriminatory practices” (Welsh, 2009) in order to maintain party rule. Under the leadership of DF Malan, the Prime Minister, and HF Verwoerd, the Minister of Native Affairs, the party passed the Population Registration Act on May 16, 1950. This act, which is considered the cornerstone of apartheid legislation, provided the underlying determination that the “legislation is the generic act structuring racial privilege over a wide range of activities of which sexual intercourse and marriage across the color lines happen to be the sensational exceptions. It is in the competition for jobs, land, schools,
houses, that the real sense of racial deprivation and discrimination is kept alive, and a source of explosive political, economic and social conflict as well. Nothing competes with the Population Registration act in drawing the racial lines of this conflict” (Slabbert, 1985:51). Another so-called linchpin of apartheid legislation was the passage of the Group Areas Act on July 7, 1950. The act “provided the government with the legal framework to segregate the country by assigning separate areas to the different races and by allowing forced removals and resettlements, government expropriation of property and the establishment of racial reserves” (Riley, 1991:21). Black South Africans were the most frequently dislocated group. More often Black South Africans were moved to townships located on the periphery of the city limits. On June 21st, in 1951 the legislative branch made another step towards emphasizing “tribal identities at the expense of a national African identity” with the passage of the Bantu Authorities Act of 1951. The Act gave all executive, administrative and judicial functions to tribal chiefs. Verwoerd stated that “it is clear that the key to the true progress of the Bantu community as a whole and to the avoidance of a struggle for equality in a joint territory or in common political living areas lies in the recognition of the tribal system as the springboard from which the Bantu in a natural way, by enlisting the help of the dynamic elements in it, can increasingly rise to a higher level of culture and self-government on a foundation suitable to his own inherent character” (Pelzer, 1966:40). In 1952 two important acts of legislation were passed. The Natives (Abolition of Passes and Co-ordination of Documents) Act was published on April 28th. The RSA government required that all male Black South Africans between the ages of 16 and 65 carry a reference book which
contained the individual’s photograph and blank pages for employers’ signatures (Riley, 1991). The reference book documented all movement, indeed every aspect of the life of Black South Africans and was to be carried at all times and presented to members of the police force at will. The ferociousness with which the South African Police service enforced the pass laws was detailed in Mark Mathabane’s *Kaffir Boy: The True Story of a Black Youth’s Coming of Age in Apartheid South Africa*. Mathabane wrote that:

> “Toward the end of 1966 my father was temporarily laid off his job as a menial labourer for a white farm in Germiston, a white city an hour’s bus ride southeast of Johannesburg. He had been told by his baas (boss) that he would be recalled as soon as the reorganization of the firm was complete: it was coming under new ownership….My father had been arrested that morning at the bus stop-for being unemployed…The man’s story was as follows, as he and my father waited for the bus several police vans suddenly swooped upon the bus stop. People fled in all directions. My father was nabbed as he tried to leap a fence. His pass was scanned and found to contain an out-of-work stamp; he was taken in. His crime, unemployment, was one of the worst a black man could commit. What would happen to him now? I asked my mother. She told me not to worry, that my father would come back home after serving the customary four weeks’ sentence for being unemployed” (Mathabane, 1986:35).

The passage of the Native Laws Amendment Act made holding the reference book compulsory for women. Additionally, the Native Laws Amendment Act extended influx controls. The amendment to the Urban Areas Act was said “to control employment, residence and presence in urban areas” (Hindson, 1987:61). The Minister of Native Affairs described it in the following manner: “What will happen, is that the Native will only be allowed to go from certain areas, which we call non-prescribed areas (and these are mainly non-urban areas) to a prescribed area (which will be mainly urban areas) if he
can receive the necessary permission” (House of Assembly Debates, February 4, 1952, as cited in Hindson, 1987:63). The African National Congress\(^{16}\) (ANC) mounted the Defiance Campaign in 1952 and asked that the RSA government repeal the pass laws.

In the autobiography of Albert Luthuli, the president of the ANC, describes June 26\(^{th}\) as a day of open disobedience. Luthuli stated, “to put it simply, while they celebrated three hundred years of white domination, we looked back over three hundred years of black subjection. While the whites were jubilant over what they said God had given them, we contemplated what they had taken from us, and the land which they refuse to share with us though they cannot work it without us” (Luthuli, 1962:115). Although the campaign was unsuccessful it marked the first mass movement of the ANC. Verwoerd’s view of the inherent character of the Black South African as ‘native’ and ‘tribal’ also had a profound influence on the framework for the Bantu Education Act of 1953. In an oft cited speech Verwoerd stated that:

“It is the policy of my department that education should have its roots entirely in the Native areas and in the and in the Native environment and Native community. There Bantu education must be able to give itself complete expression and there it will have to perform its real service. The Bantu must be guided to serve his own community in all respects. There is no place for him in the European community above the level of certain forms of labor. Within his own community, however, all doors are open. For that reason, it is of no avail for him to receive a training which has its aim absorption in the European community while he cannot and will not be absorbed there. Up till now he has been subjected to a school system which drew him away from his own community and partially misled him by showing him the green pastures of the European but still did not allow him to graze there” (Pelzer, 1966:83-84).
Meanwhile in 1953 the ANC began its collaboration with the Congress of Democrats, the Indian Congress movement and the South African Colored People’s Organization in order to create the National Congress of the People (Worden, 2007). “The list of grievances and demands formed the Freedom Charter. This document was endorsed unanimously by 2,844 delegates who attended the meeting at Kliptown near Johannesburg in June 1955” (Worden, 2007:116). The document was loosely based upon the UN Universal Declaration of Human Rights. The charter stated that South Africa belongs to all who live in it and no Government can justly claim authority unless it is based on the will of all the people (Riley, 1991). The South African government was always mindful of the growing insurgencies and used the South African Police force to squelch potential protests. Additionally, they used existing legislation to detain and arrest the most prominent members of the anti-apartheid groups. On December 5th, 1955 the South African government levied a charge of high treason upon 156 people involved in the Congressional meeting and in the composition of the Freedom Charter. Albert Luthuli recalled that, “We expected the Government to do something. Although for some months the Minister of Justice and the Chief of Police had separately accused Congress of “seditious and traitorous activity the charge of high treason was unexpected” (Luthuli, 1962:163). Luthuli recalled that ”It was not until we had been drafted through various formalities into the cells that we realized just how extensive the arrests were. In the cells we met not just a few friends, but men from every corner of the land-professionals and laborers, priests and laymen, Muslims, Christians, Hindus, infidels, Africans, Indians, Coloreds. Again, as at the Congress of the People, one thing
stood out: the resistance has long since ceased to be a matter of race—it is not the dark skin versus the light, but a loose confederation of people of all classes, creeds and colors, lined up against adherents of the Master Race and the injustice which it lives by” (Luthuli, 1962:165). “Charterism became the foundation of ANC ideology and remained a benchmark of opposition to apartheid into the 1990s” (Worden, 2007:116). On December 6, 1955 the United Nations General Assembly adopted a resolution expressing “concern over South Africa’s racial policies” (Riley, 1991:49). Women were also involved in protests. On August 9, 1956 South African women presented a petition to the Prime Minister in protest of the pass laws. The women pointed out that pass laws would adversely affect the entire family for the following reasons: “1) Homes would be broken up when women were arrested under pass laws; 2) Children would be left uncared for, helpless and mothers would be torn from their babies for failure to produce a pass; 3) Women and young girls would be exposed to humiliation and degradation at the hands of pass-searching policemen; and 4) Women would lose their right to move freely from one place to another” (www.anc.org.za/ancdocx/history). In 1959 the South African government instituted the Promotion of Bantu Self-government and created eight Bantu homelands which were to be self-governed by the local chiefs. With the passage of the Urban Areas Act, which created artificial homelands, the government sought to entrench ethnic divisions in order to prevent African nationalism. The homelands policy resulted in mass removals and dispossession. Prime Minister Hendrik Verwoerd18 instituted these measures because he believed that the reserves must not be economically self-sufficient. In fact he refused the development of industries within the homelands in order to lessen
the possibility that they may become stable and political independent. He envisaged the homelands as a place of separate development that was driven by economic interdependence and political independence (Worden, 2007, Welsh, 2009). Residents of the homelands did not accept the substandard living conditions willingly. One of the first skirmishes occurred in 1959 when rioting broke out between South African Blacks and police in Durban due to the destruction of beer stills owned by South African women and the prohibition of all alcohol except for beer purchased at municipal beer halls. Other protests included riots against the Bantustan policy. These riots marked the beginning of mass protests against the apartheid policy conducted by South African blacks as well as Whites and an increase in the South African government’s coercive powers. Increasingly, the global community condemned the racist policies as well. British Prime Minister Harold Macmillan gave the famous winds of change speech in which he indicated that Britain would no longer tolerate the racist policies. Macmillan remarked that: “The most striking of all the impressions I have formed since I left London a month ago is the strength of the African National consciousness. The wind of change is blowing through the continent. Whether we like it or not, this growth of political consciousness is a political fact. Our national policies must take account of it” (Riley, 1991:67). But rather than relax some of its apartheid policies, the South African government responded more vehemently especially after the occasion of the Sharpeville massacre.

On March 18, 1960, Mangaliso Sobukwe, the president of the Pan Africanist Congress announced the unfolding of the first stage in its fight to liberate black South
Africans from the tyranny of apartheid. On March 21th PAC called upon all African men to leave their passes at home. Sobukwe recognized that this campaign might not be entirely successful and he commented that: “But we know clearly that our struggle is an unfolding one, one campaign leading to another in a never ending stream – until independence is won” (The Sharpeville Massacre Notes, March 18, 1960). Sobukwe also pointed out that the government would not accept their attempt to redress apartheid willingly. He stated: “The Government will be ruthless. They will probably cut us off from one another, censor the press, use their propaganda machinery to malign the leaders, mislead the people and spread falsehood about the Campaign” (The Sharpeville Massacre Notes, March 18, 1960).

On March 21, 1960 in the township of Sharpeville South African Blacks protested against the pass laws. In following the instruction from PAC 10,000 men, women and children walked to the police station chanting freedom songs and using the campaign slogans “Izwe Lethu (Our land), I Africa, Awapele ampasti (Down with passes), Sobukwe Sikhokle (Lead us Sobukwe). The marchers proceeded to the Sharpeville police station where policemen were lined up around armored cars. The PAC were allowed to enter the police station to surrender themselves to the police department. However, shortly thereafter the police opened fire (The Sharpeville Massacre Notes, March 21, 1960). In this event, which is known as the Sharpeville massacre, 69 people were killed and approximately 180 people were injured when the South African police opened fire on the crowd. Three more blacks were killed at the Langa location near Cape Town. The global community reacted by condemning the act. However, the South African
government responded by declaring a state of emergency on March 30, 1960 which was not lifted until August 31, 1960. Sobukwe was arrested on a charge of incitement. The journalist Mr. Stanley Motjuwadi commented on the deportment of Mr. Sobukwe stating that “A day after the Sharpeville shootings I had an interview in Johannesburg’s Fort prison with Mangaliso Robert Sobukwe. He was awaiting trial on a charge of incitement and seemed to have aged overnight. He was depressed and almost at the point of tears – the Sharpeville tragedy had really hit him hard” (The Sharpeville Massacre, March 21, 1960). Additionally the South African government detained 18,000 black strikers and on April 8, 1960 the South African government passed the Unlawful Organizations Act which made both the ANC and PAC unlawful organizations under the South African statute. In protesting the government’s measures on April 9th, David Pratt, a disillusioned farmer, attempted to assassinate Prime Minister Dr. Hendrik Verwoerd. On March 29, 1961, the anti-apartheid activists who had been tried for high treason were not acquitted until March 29, 1969. Several months later the South African police department began a series of extensive raids in which between 8,000 and 10,000 people were arrested. The raids and the banning of the ANC and PAC prompted the leaders Walter Sisulu and Nelson Mandela to form the military wing of the ANC called Umkhonto we Sizwe or Spear of the Nation while in hiding on a farm in Rivonia. Meanwhile, the UN General Assembly condemned the South African government for its apartheid policy including the refusal to reverse its racist policies. The Rivonia farm was raided in 1963 and ANC leaders Walter Sisulu and Nelson Mandela were arrested under the General Law Act. The Rivonia trial, considered one of the most important trials in
history, began in Pretoria on October 29, 1963. Charges were leveled at six black South Africans, four white South Africans and one Indian. The end of the trial occurred on June 2nd when Walter Sisulu and Nelson Mandela gave testimony in which they admitted that they had “recruited people for training in the preparation, manufacture, and use of explosives in both South Africa and abroad for a campaign of sabotage against the South African government” (Riley 1991:88). On June 8, 1964 Nelson Mandela, ANC Secretary General Walter Sisulu, Elias Matoaledi, Govan Mbeki, Raymond Mhlaaba, Andrew Mlangeni Denis Goldberg and Ahmed Kathrada were given sentences of life imprisonment. The sentence was widely condemned by the United Nations. In 1966 two events occurred which marked the beginning of a period of further turmoil in South Africa and continued condemnation of the racist principles espoused by those who promoted the apartheid regime: 1) The assassination of PM Verwoerd on September 6, 1966 by a parliamentary member who resented the Prime Minister’s work with the Colored community; and 2) The United Nation’s formal observance of those who had been killed during the Sharpeville Massacre. The years between 1966 and 1994 marked one of the most turbulent and violent in the “apartheid period”. This period is characterized by several important events: 1) The uprising of the Black Consciousness movement; 2) The emergence of Steven Biko, one of the leaders of the Black Consciousness movement and his subsequent death during his incarceration; 3) The massacre at Soweto on June 16, 1976; and 4) The increasing upheavals during the 1980s and finally the Republic of South African government’s acceptance of joint rule among
white and black South Africans and the recognition of majority rule led by the African National Congress and the adoption of a democratic government.

From 1968 to 1972 there was “explosive discontent” (Welsh, 2009: 143) which spawned the Black Consciousness movement. The ideology of this organization was not unlike the Black Panther movement in the United States which supported black exclusivity and black empowerment. Although the leaders of the movement recognized that all white South Africans did not subscribe to racist principles they did not envisage non-whites as collaborators in the movement. Steven Biko suggested that liberal white South Africans “fight for injustice within their own white society” (Arnold, 1987:77). Mandela was disappointed in these views on the grounds that it appeared to be a mirror image of white racism. Biko retorted that there was a need for Blacks to overcome a colonization of the mind. He wrote that:

“All in all the Black man has become a shell, a shadow of man, completely Defeated, drowning in his own misery, a slave, an ox bearing the yoke of Oppression with sheepish timidity…The first step therefore is to make the Black man come to himself; to pump back life into his empty shell; to infuse him with pride and dignity, to remind him of his complicity in the crime of allowing himself to be misused and therefore letting evil reign supreme in the country of his birth” (Stubbs, 1978:48-49).

The Black Consciousness movement flourished among Black South African students who attended the black universities. These students formed the South African Student Organization (SASO) and grew to more than 6,000 members. The organization of students decided to mount a protest against the Bantu education system24 and other racist policies. The University students were not the only protestors of the Bantu education policy. The South African Student movement comprised high school students and other
youth groups. The list of grievances and recommendations for improvements included a removal of the Bantu education label because it meant inferior academic instruction, no access to equal pay for equal work, and it impeded individuals from taking other work. The students suggested that the government implement “free and compulsory education, permanent residence in urban areas; freedom of movement; abolishment of the pass system; equality before the eyes of the law; equal rights; the release of detainees and the end of apartheid” (Brooks and Brickhill, 1980:55). At the heart of the demonstration proposed by the students was the deplorable living situations in which most black South Africans lived. It was said that it was not surprising that they selected Soweto as the site of the mass movement. Soweto, was the largest township in the country and was described as a gigantic slum. “The majority of houses in Soweto were of the standard three room variety which comprised two bedrooms, a living room and a kitchen. They had no internal lavatory or bathroom, many lacked running water and most lacked electricity. Into Soweto had been dumped tens of thousands of families from other parts of the Witwatersrand. It had no industry at all, and commerce was barely sufficient to meet the needs of the inhabitants” (Brooks and Brickhill, 1980:181). At 7:00 am on June 16, 1976 thousands of students began gathering at the dozen or so assembly points selected for the march. Students marched through Soweto carrying placards which read: “Down with Afrikaans, Blacks are not Dustbins-Afrikaans Stinks, Afrikaans is tribal language, Bantu Education – To hell with it” (Brooks and Brickhill, 1980:8). Orlando was the first site of the violence. In Orlando fifty policemen emerged from a vehicle and made an arc formation in front of the students. The students remained calm and yet
the policemen proceeded to throw a tear gas canister at the crowd. The students retreated but retained their stance in front of the policemen. Suddenly, one policeman fired his revolver into the crowd. A black journalist recalled: “I remember looking at the children in their school uniforms and wondering how long they would stand up to the police. Suddenly a small boy dropped to the ground next to me…They were shooting into the crowd. More children fell. There seemed to be no plan. The police were merely blasting away…” (The Observer, June 20, 1976). Amidst the pandemonium some young girls picked up rocks and bricks and began throwing them toward the police. Black journalist remarked that one young thirteen year old boy, Hector Petersen, was covered with blood. The photograph of Hector Petersen’s limp body in the arms of one of the demonstrators became the image of the Soweto massacre. In protest of the shootings students set fire to the administration buildings: an observer stated that “all administrative offices, post offices, beer halls and bottle stores were destroyed. The rioting kids were quite clear of where to spend their fury which was quite inflamed by the presence of the police and their shooting and killing of black kids” (Solidarity Mission to South Africa, 1976:5). The police reported that by 8:00 pm they had reports that twenty buildings had been “set ablaze” (Brooks and Brickhill, 1980:12). On June 17th the violence continued. The Rand Daily Mail wrote that the only structures undamaged during the protest were the police stations (Brooks and Brickhill, 1980:16). During a press conference the West Rand Administration Board reported that 21 offices had been burned down, ten offices had been plundered and three schools were burned down. Additionally countless beerhalls, community halls and other buildings had been burned
down (Rand Daily Mail, June 18, 1976). Black and white University students condemned the police shootings and called for a referendum. The deputy secretary general of the African National Congress, who was living in London, pointed out that the conflict in Soweto occurred because it was “the area of greatest expression of wealth in our country and the poorest sections of people who produce it” (Morning Star, June 18, 1976).

Initially, members of the South African Police System claimed that only 95 individuals had been killed during the riots. They were forced to recant this statement when the number was found to be closer to 500 individuals. Many white South Africans aligned themselves with the South African Police system and attributed the discontent and violence in Soweto to instigators. But many humanitarian agencies viewed the riots as acts against humanity and offered material assistance and support to inhabitants of Soweto. The Soweto Parent Association also mobilized and offered practical assistance in arranging mass burials and providing money to those who could not afford to bury their children. On the other hand several members of the South African Cabinet were aghast at the Soweto event if only because it was inconvenient especially in considering the impending meeting in Switzerland between Prime Minister Vorster and Secretary of State Henry Kissinger on June 24th (Rand Daily Mail, June 18, 1976). The meeting held between Prime Minister Vorster and Secretary of State Henry Kissinger led to a discussion between Zimbabwean (then Rhodesian) Prime Minister Ian Smith and Secretary of State Henry Kissinger to install a government of Black majority rule and white minority rights (Riley, 1991)26. On November 17th of 1976 the United, Progressive Reform and Democratic Parties met to discuss possible power sharing with
Black South Africans and to eliminate discrimination (Riley, 1991). In 1977 the Soweto schools re-opened amidst anti-apartheid protests. In order to appease some of the population Prime Minister Vorster proposed giving more power to the Asian and Colored populations. However, this proposal was not extended to black South Africans. Increasingly, South Africa found itself isolated from the West and PM Vorster appealed directly to the United States populace to reject the policy of President Jimmy Carter towards South Africa. In 1977 riots broke out again after the death of Steven Biko, the leader of the Black Consciousness Movement, while he was in custody in a prison in Port Elizabeth.

Biko had been arrested for inciting unrest and was held naked in prison so that he might not commit suicide. During his imprisonment his health deteriorated and he was moved to a prison in Pretoria. He died in his jail cell having never received medical treatment for his injuries. An inquest determined that he died from extensive brain injuries, which were blamed on a scuffle between Biko and the police. After an autopsy it was determined that he had incurred head injuries eight days prior to his death. His funeral was attended by thirteen diplomats from the West and by 10,000 South Africans (Riley, 1991). The violence that occurred as a result of Biko’s death represents another sign of unrest that took place during Vorster’s position as prime minister. Prime Minister Vorster resigned after an ineffectual turn in office due to ill health. However, it was believed that he left the position due to a scandal involving members of his cabinet and $460,000 in unauthorized expenditures. Vorster’s policies had been characterized by a commitment to the pass laws and essentially to the philosophy of separate development.
P.W. Botha took the office of Prime Minister on September 28, 1978.

As Vorster sought to maintain the status quo, P.W. Botha looked to make changes which he felt might convince the global community of the importance of maintaining the apartheid policy. In accomplishing this feat Botha had to convince South African businessmen of the necessity of economic reform and persuading them that this reform would not undermine the basic tenets of white supremacy. Botha called for increased independence in the homelands through “dynamic leadership, good organization, territorial consolidation, additional land and greater economic development” (Deegan, 2001: 51). Alas, Botha’s program was unsuccessful as the homelands remained “sites of corruption, inefficient bureaucracies, unbridled unemployment and continued population growth” (Deegan, 2001:52). Additionally, Botha made the changes because he viewed himself as a reformer. However, any policies that he made were viewed through the prism of the principles of the National Party. (Welsh, 2009). He stated: “Do not ask me to say that I stand for a Christian nationalism and then come and tell me that I must neglect the interests of the black man and the brown man, because then I shall not be a Christian and I shall not be a Nationalist (Scholtz, 1988:16 as cited in Welsh, 2009:209).

The reforms that transpired included the funding of the Black Foundation to improve housing and facilities in the township and the abolition of the pass laws. The appeal included anti-squatting and slum clearance laws. Another reform included the reorganization of parliament. Botha designed a tricameral parliament that comprised a House of Assembly for Whites, a House of Representatives for Coloreds and a House of Delegates for Asians. The electoral college consisted of fifty White chamber members,
twenty-five Colored members and thirteen Asians. Not surprisingly the reforms were welcomed by the business class because they felt that they would be helpful for the economic system and by the White working class who favored the continued subjugation of Black workers. The Whites feared that by allowing Blacks to gain more skills White workers would no longer have a place in industry (Deegan, 2001). These reforms failed to quell the incidence in violence. As the following chart indicates violence continued to surge in the townships:

<table>
<thead>
<tr>
<th>Year</th>
<th>Cause of Death</th>
<th>Number of Deaths</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td></td>
<td></td>
<td>175</td>
</tr>
<tr>
<td>1985</td>
<td></td>
<td></td>
<td>879</td>
</tr>
<tr>
<td>1986</td>
<td>Shot by Police</td>
<td>412</td>
<td>1298</td>
</tr>
<tr>
<td></td>
<td>Killed by other blacks</td>
<td>265</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Burned bodies found</td>
<td>231</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>390</td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td></td>
<td></td>
<td>661</td>
</tr>
<tr>
<td>1988</td>
<td>Shot by police</td>
<td>34</td>
<td>1149</td>
</tr>
<tr>
<td></td>
<td>Burned bodies found</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Killed by other blacks outside</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Natal</td>
<td>912</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Killed in Natal conflict</td>
<td>183</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Botha put into place several measures giving members of the police department the authority to conduct punitive actions against groups or individuals inciting riots against the government. The members of the police department were given the power to conduct these measures without fear of censure by the government. From 1985 to 1989 the
following “low-intensity warfare tactics” were granted to the South African police:
“Divisional police commissioners were given the power to govern black areas by decree;
Community leaders were detained, and vigilante groups and assassins were used to
disrupt popular organizations; Potential troublemakers were ‘surgically removed’, i.e.,
assassinated; Local groups were influenced to support the government through financial
incentives. The government began a national program to introduce black municipal
guards and auxiliary police, so-called kitskonstables. The municipal guards were armed
and placed at the government’s service (Dugard, et al. 19002:80). Additionally, police
were given the “power to arrest and detain without trial, divisional police commissioners
were given the power to govern black areas by decree; judicial supervision of police
powers was curtailed; and members of the security forces had an indemnity against the
consequences of their unlawful actions” (Dugard et al, 1992:74-5). Although Botha
introduced reforms for the Colored and Asian populations his policies were still steeped
in a white supremacy power structure. Since “white rule was still upheld” (Deegan,
2001:64) under Botha’s rule the country subsisted in a situation of “violent stability”
(Deegan, 2001:66). During Botha’s term “forty nine activists were assassinated, the
homes of anti-apartheid campaigners were ransacked or fire-bombed, the Congress of
South African Trade Union (COSATU), the headquarters of the South African Council of
Churches and the Southern African Catholic Bishops Conference were all demolished by
bombs” (Deegan, 2001:66). Botha’s stint as prime minister ended abruptly in 1989 when
he resigned after having had several strokes. F.W. de Klerk took office as prime
De Klerk proposed five areas which needed to be addressed in order to quell the violence. These areas included: “1) Bridging the gap of distrust; 2) Initiating the process of negotiation; 3) Opening the door to economic prosperity; 4) Setting up a new political dispensation to accommodate everyone in the country; and 5) Dealing firmly with violence” (De Villiers, 1994:15). De Klerk, unlike Botha, sought a political solution to the disenfranchisement of the Black South Africans. In his opening address to Parliament on February 2, 1990 he showed that it was the government’s intention to normalize the political process in the country and negotiate “a just constitutional dispensation in which every inhabitant would enjoy equal rights, treatment and opportunity in every sphere of endeavor – constitutional, social and economic” (De Villiers, 1994:34). His address included the following conditions: “1) The prohibition of the African National Congress, the Pan Africanist Congress, the South African Communist Party and a number of subsidiary organizations was rescinded; 2) People serving prison sentences merely because they were members of one of these organizations or because they committed some other offense which was merely an offense because a prohibition on one of the organizations was in force were identified and released; and 3) The period of detention in terms of security emergency regulations were limited to six months. Detainees acquired the legal right to legal representation and a medical practitioner of their choosing” (De Klerk, 1991, Address to Parliament, February 2, 1990). Many South Africans expressed surprise at the contents of the speech. However, in fact the government had initiated contact with the exiled members of the African National Congress and Nelson Mandela since the 1980s during which time
Frederik van Zyl Slabbert met with the opposition in 1986, Nelson Mandela had entered into a letter writing campaign calling for negotiation between members of the ANC and the South African government and Botha himself had met with Nelson Mandela in 1989” (Deegan, 2001:71). Although de Klerk had received support for his mandate to lift South Africa from its apartheid past, the document prepared and issued by the Organization of Africa Unity on August 21, 1989 showed that the African National Congress was interested in negotiation and in the construction of a non-racial society. The Declaration’s premise was to discuss a way to end apartheid and create a non-racial democracy (Ebrahim, 1998). Nelson Mandela was released from prison on February 11, 1990. His speech to the South Africans was delivered at a mass rally and was televised globally. After Mandela’s release the negotiations between the South African government and the African National Congress took place in several steps. In 1991 the first phase involved the return of political exiles and the release of political prisoners. The second phase took place in September of 1991 and resulted in the National Peace Accord (Deegan, 2001). In December, 1991, the Convention for a Democratic South Africa met to negotiate the process of democracy. Negotiations took place intermittently as both sides worked through the power sharing arrangement. Finally, in November, 1992, de Klerk suggested a timeline for the transition to a democratic government: 1) Bilateral talks and multi-party conventions – March, 1993; 2) Establishment of an electoral commission – June, 1993; 3) The adoption of an interim constitution – September, 1993; 4) General election – March/April, 1994; and 5) The institution of a new government in 1994 (Guelke, 1999).
In 1993 the negotiating council decided to hold elections on April 27, 1994. The following chart outlines the breakdown among voters in all of the provinces:

<table>
<thead>
<tr>
<th>Party Affiliation</th>
<th>EC</th>
<th>GAU</th>
<th>KZN</th>
<th>MPU</th>
<th>NC</th>
<th>NP</th>
<th>NW</th>
<th>OFS</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Christian Democratic Party</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African National Congress</td>
<td>84.4</td>
<td>57.6</td>
<td>32.2</td>
<td>80.7</td>
<td>49.7</td>
<td>91.6</td>
<td>83.3</td>
<td>76.6</td>
<td>33.0</td>
</tr>
<tr>
<td>Democratic Party</td>
<td>2.1</td>
<td>5.3</td>
<td>2.2</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freedom Front</td>
<td>6.2</td>
<td>5.7</td>
<td>6.0</td>
<td>2.2</td>
<td>4.6</td>
<td>6.0</td>
<td>2.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inkatha Freedom Party</td>
<td>3.7</td>
<td>50.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Minority Front</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>National Party</td>
<td>9.8</td>
<td>23.9</td>
<td>11.2</td>
<td>9.0</td>
<td>40.5</td>
<td>3.3</td>
<td>8.8</td>
<td>12.6</td>
<td>53.3</td>
</tr>
<tr>
<td>Pan Africanist Congress</td>
<td>2.0</td>
<td>1.5</td>
<td>0.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.7</td>
<td>1.2</td>
<td>2.1</td>
<td>4.6</td>
<td>1.9</td>
<td>2.9</td>
<td>3.3</td>
<td>4.8</td>
<td>3.8</td>
</tr>
</tbody>
</table>


Table 2.2 shows that the African National Congress garnered, overwhelmingly, the largest percentage of votes in all of the provinces with the exceptions of KwaZulu-Natal and Western Cape. The Inkatha Freedom Party and the National Party respectively acquired the largest percentage of votes in these provinces. President Nelson Mandela, the leader of the African National Congress was elected to be the first president of the
democratic Republic of South Africa. As the following chapters show the legacy of apartheid has left an indelible mark of poverty, violence and inequity on the country which inflames an already burgeoning HIV/AIDS epidemic.

2.4 HIV Surveillance. HIV sentinel surveillance was started in the early 1980s. Approximately 70% of the countries (Burundi, Guinea, Mali, Niger, Sierra Leone, Zambia, Zimbabwe) use this system. Although pregnant women make up the largest segment of the sentinel population there are participants from (Sexually Transmitted Infections) STI clinics as well as (Tuberculosis) TB patients. It is less challenging to collect data from pregnant women because they are active sexually, definable, amenable and a stable population. Also, they are likely to be representative of the general population (United States Centers for Disease Control and Prevention and Ministries of Health, WHO African Region, 2001). The surveillance system is donor-funded exclusively. Therefore, when donor funding is withdrawn data collection is curtailed. Challenges involve inadequate training for the staff, problems in the field including laboratory control mechanisms and little involvement with community in the dissemination of the data results (CDCP and WHO, 2001).

South Africa began its sentinel surveillance program in 1990. The testing of specimens occurs simultaneously in all nine provinces for four weeks. The WHO monitors procedures at individual sites. South Africa’s protocol differs in that the country monitors testing at the provincial and national levels. Additionally South Africa allows generalization of HIV prevalence rates from sentinel surveillance system to the ante natal clinic (ANTE) attendees. At the clinics women receive pre- and post-test counseling. The
counselors inform them that when they collect blood for HIV testing they use a voluntary unlinked anonymous procedures. At that time the attendee has the option of: 1) participating without receiving test results; 2) participating and receiving test results; or 3) participating only in STI screening.

2.5 Utilization of Prevalence Rates. The prevalence rate is a cumulative figure which reveals the sum of past incidence rates. With respect to HIV/AIDS the incidence rate may be determined by the number of new diagnoses for a particular year. The prevalence rate is useful because it speaks to the number and identity of the population living at present with HIV/AIDS. High prevalence rates may suggest that there have been an increase in the number of individuals who are receiving ARV. In this sense the prevalence rate is higher because individuals may simply be living longer. On the other hand if the incidence rate is high the existence of low prevalence rates may suggest that there have been an increase in the number of deaths due to an opportunistic infection or there may be changes in the population, or previously, there may have been errors in reporting. For this reason, the incidence and prevalence rates should be considered concurrently.

2.6 Data Sources. Historically, data obtained from the Joint United Nations Program on HIV/AIDS (UNAIDS), United Nations International Children's Emergency Fund (UNICEF), United Nations Development Program (UNDP) and International Labor Organization (ILO) are more desirable because the collection methods employed by these agencies are transparent and verifiable. However, political upheaval and poor epidemiological infrastructure in South Africa produced an environment that was
unfavorable to many agencies to extract data consistently from South Africa. Increasingly, researchers may look to the Human Sciences Research Council, a non-partisan, public-purposes organization in South Africa, to provide appropriate data for the biological and social sciences.

2.7 United Nations Development Program. The UNDP was created on January 1, 1966. In the forty one years since its inception the organization has been a leader in promoting new approaches in development. The organization has worked closely with World Health Organization (WHO) in developing programs to alleviate diseases such as malaria, leprosy and schistosomiasis and has worked closely with the World Bank and Food and Agriculture Organization (FAO) in “agricultural output” in developing countries (UNDP, 1985).

Over the past twenty years, the World Bank, as the “world’s preeminent development institution” (Zwi, 1994) has become the most influential donor in the international health policy arena effectively usurping the role of the WHO and UNICEF. As the single largest external financier of health projects for developing countries, the World Bank (hereafter cited as the Bank) has proposed policy changes to improve the quality of health care and the efficiency with which it is disseminated to the population (Buse and Walt, 1992). However, not surprisingly, the Bank is most concerned with “securing sustainable health care financing by seeking to control public and private expenditure” (Zwi, 1994).

The efforts of the Bank to transform the landscape of international health policy have resulted in increased attention to financing and systemic reforms and have increased
the awareness of projects within both the international and domestic health sector as well as in promoting the need for more purposeful guidelines in their implementation of specific policies.

In the years preceding the publication of the World Development Report of 1993, the Bank expanded its activities and more clearly it began to take on the role of a leader in international health sector. For example, in June, 1996, the Economic Development Institute (EDI) of the World Bank organized an EDI Health Policy Seminar, which was held in Johannesburg, South Africa. This five-day seminar on sustainable health care financing was the catalyst for bringing together policymakers from 10 countries in the region of southern Africa. As an added measure the seminar was organized by the Economic Development Institute of the World Bank, the Regional Office for Africa of the World Health Organization, and the Center for Health Policy of the University of Witwatersrand in Johannesburg. Those countries, which participated in the seminar, included Angola, Botswana, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. Those organizers of the seminar identified several objectives.

The objectives included: 1) reviewing options, initiatives and models for sustaining financial resources; 2) Effective implementation of sustainable financing initiatives; 3) Examining the equity and poverty implications of different strategies; 4) Identifying research priorities, policy analysis, and training needs in order to improve national capacities to mobilize sustainable resources for health (Beattie, et al., 1997).
At the close of the seminar participants concluded that they would not achieve success without careful strategic planning. They discerned that they had to maintain ample communication among and within national health and finance departments. The ministers had to work in tandem during the planning and implementation of new reforms. In planning reform they acknowledged that it was important to share their experiences and lessons with other countries. Also, they recognized the necessity of collaborating with the private voluntary and private for profit sectors. Lastly, they noted that individuals who plan active and make decisions daily might benefit from more-in-depth training in the implementation of health financing options (Beattie, et al, 1997).

2.8 **UNAIDS (the Joint United Nations Program on HIV/AIDS).** The UN Economic and Social Council created the UNAIDS governance in 1994. However, the program was not fully operational until 1996. The program now operates under the auspices of the Program Conduct Board and is represented by 22 governors from Eastern and Southern Africa, West and Central Africa, Asia and Pacific, Caribbean, Eastern Europe and Central Asia, Latin America, Middle East and North Africa.

2.9 **World Health Organization.** WHO operates under the direction of the World Health Assembly, which comprises 193 member states. The Assembly has supervisory functions which consist of appointing the Director-General and revising and approving the program budget. The core functions of WHO include:

1. “Providing leadership on matters critical to health and engaging in partnerships when applicable”

(http://www.who.int/about/role/en/index.html).
2. Promotion of ethical guidelines and standards for a wide range of global topics including organ and tissue transplantation, developments in genomics;


Unfortunately, due to political instability in the 1990s (Surveyors were unable to conduct surveys in some of the provinces. For example, in 1995 there were a number of political killings in KwaZulu Natal.) and limited access to vulnerable populations many well-known agencies have been unable to collect data in South Africa. Therefore, the South African government has attempted to address the challenges in data collection with the creation of StatsSA and exercise greater adherence to sound epidemiological practices in disseminating the results of its own National HIV and Syphilis Prevalence Survey. Accordingly, while Western researchers may consider agencies such as World Bank and WHO the more desirable sources, the surveys from the South African researchers offer continuity and consistency in its diffusion of data.
In the preceding chapter I stated that inequities in gender power, as reflected in a nation state’s interpretation and adherence to ethical principles which apportion access to fundamental freedoms and as exercised through its social and cultural mores, economic and political infrastructures and policies, may limit women’s access to health choices that enable them to reduce their vulnerability in contracting HIV/AIDS (UNAIDS, 2004).

This chapter examines how social and cultural mores hinder girls and women from determining “the conditions under which sexual encounters take place” (Dixon-Mueller, 1993:269). Additionally I will consider the role historically constructed social and cultural patterns of gender relations play in women’s disproportionate contraction of HIV/AIDS (Shishana, 2004; Pettifor, 2004; Tlou, 2002; Gupta and Weiss, 2002).

The literature on gender examines women’s powerlessness in negotiating safer sex practices, such as the use of the male condom, and their concomitant vulnerability in contracting the virus. Given the fact that the consistent use and proper application of the condom may reduce the risk transmission of contracting HIV and/or STDs by 80-95% women’s inability to control condom usage may place them at an increased risk of contracting HIV. This problem exists because few men will consent to use condoms during sexual encounters. This action places both parties at an increased risk of contracting HIV (Weeks, et al. 1999; Cornell, 1987). In a focus group discussion in rural South Africa women expressed frustration concerning their partner’s unwillingness to use condoms. Many women stated that it was a “waste of time” to speak of condom
use with their husbands (Shishana, 2004). One woman stated that: “There is no way of avoiding AIDS except for the finding of a cure - a man does not want to wear a condom because [he gives a reason that] he needs children - you can never trust a man…He leaves for work. I do not know what he is doing there - something wrong may occur within a minute” (Shishana, 2004:8). The women advocated the use of preventive methods which they could employ without the knowledge of their partner. L.L. Heise and C. Elias point out that women’s vulnerability is reflected in both public and private spheres in that in their intimate relationships women don’t hold the power to insist upon condom usage and economically the have too little power outside of their relationships to leave partnerships that put them at risk [for contracting HIV/AIDS] (Heise and Elias, 1995).

Jacques du Guerny and Elisabeth Sjöberg (1999) argue that inequities in the gender roles assigned to men and women keep women in subservient positions where they will most likely be economically dependent upon men. This dependency reflects a lack of power and lower status where they may not negotiate the use of condoms or other prophylactics in sexual relationships even when their husband/partner may be HIV seropositive. Thus this study is guided by the hypothesis that: As the use of condoms increases, a woman’s vulnerability in contracting HIV decreases. This analysis is meaningful because while there is an abundance of literature which examines the correlation between gender power inequities and a decrease or increase in women’s vulnerability in contracting HIV/AIDS there are limited studies which analyze how condom usage, which is an important indicator of relational power, may influence the incidence of HIV and, by extension, the disproportionate rate of HIV among women.
This chapter is divided into four parts. Part one examines how gender may be defined. Part two is a historical discussion of the period from 1930 to 1940 when some South African women took advantage of the White Customary Law courts in order to escape abusive or neglectful husbands, their participation in the military arm of the African National Congress in the 1960s, the growth of the women’s movement in South Africa in the 1980s, and their representation in the South African parliament in 1994. Part three reviews how cultural and social mores in the private arena constrain women’s sexual and reproductive rights and their ability to prevent the contraction of sexually transmitted diseases. In part four the chapter examines a possible connection between condom usage during last sex act and increased incidence of HIV.

3.1 Defining Gender. Gender may be described as “a constructed and contingent set of assumptions about female and male roles” (Charlesworth, 1999:394). Article 7(3) of the Rome Statute refers to “gender simply as two sexes, male and female, within the context of society” (Rome Statute, Article 7(3)).

In *The Effect of Power in Sexual Relationships and Reproductive Health* Ann Blanc contends that a gender analysis is useful because gender inequities support a “universal sexual double standard that gives men greater sexual freedom and rights of sexual self-determination than women enjoy” (Blanc 2001:190). Blanc, whose remarks are not culturally specific to South Africa alone, argues that gender based power originates from the biological differences between men and women and is determined by the norms and expectations within society which control and restrict both male and female behavior and characteristics.
In Ann Blanc’s estimation the balance of power within relationships affects sexual and reproductive health in three principle areas: 1) Status; 2) Violence; and 3) Access to health services.

The power differentials in sexual relationships influence attitudes toward spousal communication and those concerned with sexual and reproductive health issues. Communication between men and women is difficult because of fears surrounding sexual fidelity. For women discussions about sex are especially difficult because they profess to have little knowledge about sex and are conditioned to behave demurely and passively about sexual encounters. This characteristic is reflected in a woman’s inability to negotiate the use of condoms and other forms of contraceptives as well. Blanc writes that men consider the control of a woman’s sexuality important in their role as head of the family. She points out that although men profess to “approve of family planning” in fact they do not want to relinquish this control to women. They fear that in giving up this control their wives or partners will become promiscuous or unfaithful. Also, husbands or partners were said to believe that an oral contraceptive would damage their wife’s reproductive organs or that an Intrauterine Device would cause them pain during intercourse. But, as Blanc maintains, even when an appropriate contraceptive method was identified, the husband or partner placed the full burden of contraception upon women. These mixed signals have left women confused and fearful that by opposing their husband or partner, to whom they were often dependent economically, they placed themselves in danger of assault, separation or divorce.
Ann Blanc’s definition of gender is appropriate for this study because, like Ms. Blanc, I, investigate the gender power schism and its relationship to the proliferation of HIV/AIDS among women using a western hegemonic construction. Nevertheless, however relevant Ann Blanc’s definition may be to this study, her definition does not address the complex nature of the gender power struggle between South African men and women. I believe that the intricacies of the gender faction among South African women and men are best illuminated by comparing them to other models. In the following section I discuss gender as it is defined by two prominent Nigerian feminists: Chikwenye Ogunyemi and Molara Ogundipe. Susan Arendt asserts that African women do not identify with White Western feminism (or Black Western feminism) because White Western feminism only focus on the relationship between men and women. She points out that African women define gender relationships in the “context of other political, economic, cultural as well as mechanisms of oppressions such as racism, neocolonialism, religious fundamentalism, and corrupt systems” (Arendt, 2000:711).

Ogunyemi (1996) and the African-American feminist, Alice Walker, developed the term Womanism, independently of one another, to describe the feminist perspective in the context of the African and African-American women’s worldview.

According to Ogunyemi, there is a large difference between the African-American woman praxis, as outlined by Alice Walker, and African Womanism as defined by Africans. Ogunyemi states that,

“It is necessary to reiterate that African women have never totally identified with the original Walkerian precepts. An important point of departure is the African obsession to have children” (Ogunyemi,
“When I was thinking about womanism, I was thinking about those areas that are relevant for Africans but not for Black women in America – issues like extreme poverty and in-law problems, older women oppressing young women, women were oppressing their co-wives or men oppressing their wives. These are problems that are not covered from an African American-womanist perspective. So, I thought it was necessary to develop a theory to accommodate these differences” (Ogunyemi, 1996:133).

Ogunyemi spoke of the importance of working with men in order to change the gender power structure. Lastly, Ogunyemi advised women to be independent economically. She pointed out that men would have more respect for a woman who was self-sufficient.

Molara Ogundipe also distances herself from European and African American feminism. She describes the challenges of African women as mountains which represent areas of oppression. The areas of oppression include imperialism, traditionalism, illiteracy, patriarchy, racism and self. Also, in her writings on African feminism she identifies herself as a Stiwanist. The term derives from STIVA, an acronym for Social Transformation in Africa including woman. Both writers maintain that inequality calls upon women and men to reduce inequality by increasing their participation in the political community and economic development and growth of their country.

Cheryl McEwan is one of a growing number of South African feminists who argue that “the struggle for South African women lies in the (im)possibilities of translating de jure equality into de facto equality, and of translating state level commitment to gender equality into tangible outcomes at the local and individual levels” (McEwan, 2005:177). Cheryl McEwan’s statement is an example of how South
African scholarship on citizenship is beginning to challenge Anglo and African-American feminist theories (Gouws, 2005). It is the belief of McEwan and other scholars that South African women are denied full and equal citizenship because they are passive participants in the social, economic and political structures from which power is derived. Women’s subordinate position is attributed to customary law which “entrenches women’s economic insecurity” and which makes it “very difficult” or impossible for women to enter the public sphere and realm of political decision-making (Fourie, 2006:44). McEwan proposes that South Africans look to the private patriarchies in effecting institutional change.

3.2 Patriarchal System and Customary Law in South Africa, 1930-1940.

Pre-colonization African societies were defined in terms of kinship bonds. In South Africa, the term *Ubuntu*, which has its origins in the Bantu language, best described the kinship bonds between an individual and his/her family and friends (Swanson, 2009; Samkange, 1980; Ramose, 2006). Desmond Tutu (1999) affirmed that a “person with *Ubuntu* is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed” (Tutu, 1999:126). In *Ubuntu, An African Assessment of the Religious Other* (1998) Dirk Louw wrote that in the Zulu language the term *umuntu ngumuntu ngabantu* ("a person is a person through (other) persons") implies that one must always strive to behave in a manner that is
respectful of one’s ancestors while being cognizant of the future role as an elder and ancestor to whom others will seek guidance.

In “the idiom of kinship,” the African rulers of the Swazi, Sotho, Zulu and Xhosa peoples were described as parents who were charged to look after the people, “judge disputes fairly, govern the nation wisely and provide for the needy” (Bennett, 1999:67; Gluckman, 1958, Schapera, 1956). A chief was said to rule in consideration of the benefit of his people many of whom were senior kinsmen and prominent leaders in the community. The leader acted in accordance with a common saying kgosi ke kgosi ka batho (a chief is a chief through his people) in rendering decisions about the welfare of the people (Schapera, 1955). In *African Societies in South African*, Hammond-Tooke writes that “the rights and duties of a chief are not immutably fixed: the chief and his subjects are thought to be involved in a perpetual transactional process in which the former discharges obligations and, in return, receives the accepted right to influence policy and command people. The degree to which his performance is evaluated as being satisfactory is held to determine the extent of his legitimacy” (Hammond-Tooke in Thompson, 1969:248). At the center of this socio-political order is the belief that family is of paramount concern while an individual’s interests are secondary. The ‘family was regarded as a corporate entity’ (Woodman, 1974) and “customary law was the name of the legal relationship that arose out of a family’s dealings with other families, not those flowing from one person’s relations with another” (Bennett, 1999:5).

Under customary law Lobola (*ukulobola*) or bride wealth solidified the bonds between two families. In patrilineal societies the payment of bridewealth transferred
genetrical and uxorial\textsuperscript{15} rights from the family of the bride to the family of her prospective husband. In exchange for providing these rights the family of the bride was given cattle, livestock and/or money by the prospective bridegroom or his family. Those who defend bridewealth maintain that the practice should be preserved because it is a unique aspect of African culture. Moreover, it is believed that because the custom is a contract between two families neither husband nor wife was in favor of dissolving the union out of fear of disappointing their family. Women were said to support bridewealth because they felt that it was a demonstration of a man’s love and commitment (Chigwedere, 1982). The critics of bridewealth point out that, often, in circumstances of spousal abuse, the parents of the bride are complicit in the maltreatment of their daughter. In this sense the practice of bride wealth is said to bind women to an abusive marriage. Additionally, opponents state that if a divorce is sought either the parents or guardian of the bride or groom will have to return the bride wealth. This procedure suggests that, bridewealth operates on the fault principle that, “the person deemed to have been the cause of the breakdown forfeits the bridewealth” (Banda, 2006:112).

In 1806 the British authorities considered bridewealth to be a practice which treated women as property wherein they were subjugated under men’s control (Mathabane, 1994; Kisaakye, 2002; Chigwedere, 1982). They deemed customary law uncivilized and subjected inhabitants to rule under Roman-Dutch law.\textsuperscript{16} This system appeared to work nominally in the Cape colony. However, in Natal (later KwaZulu Natal) the colonial authorities realized that customary law was more effective than the
Roman-Dutch system. In 1840 the British inhabited an area on the southern tip of the Zulu kingdom. The Zulus and other chiefdoms had, through warfare, assumed control of an area that was not demarcated beginning in the eighteenth century (Duminy and Guest, 1989). Theophilus Shepstone, who became the first secretary for Native Affairs in the Republic of South Africa in 1845, designed a system whereby Africans were relegated to reserves on land and were ruled by “native customary law” that was “administered by chiefs and by white magistrates who were assisted by native assessors” (McClendon, 2002:531). The administration of customary law by colonialists was said to harden the patriarchal customs that existed before colonization. It was thought that although the status of women had always been entrenched in a patriarchal structure, formerly, “they exercised control over the production of staple foodstuffs and their fertility” (Guy, 1983:9). In light of these benefits women were said to have status and some measure of independence. However, under the colonial system “the rights and authority of chiefs and elders, as well as the white colonial officials” were more vigorously enforced (McClendon, 2002:531). Under the legal system, and in the context of customary law, women lost three powers that were deemed essential for their autonomy: contractual, proprietary capacity, and by extension locus standi in judicio. R. Hirschon writes that the access to property is a cornerstone of social empowerment. In this vein women lacked social standing because, in their status as minors who were under the control of their husband or father, they were denied the control of property. Yet, Bennett in Human Rights and Customary Law states that women’s proprietary incapacity was unclear because it could refer to the absence of one or several of the
following rights: 1) The power to acquire property; and 2) The freedom to use and dispose of property (Bennett, 1999: 87). Of course, the rights were predicated upon the fact that as minors women would not understand the intricacies of law and were thus denied contractual capacity as well.

Finally, since it was assumed that women were unable to argue persuasively, and to participate credibly in the forensic arts they were denied access to locus standi in judicio (Bennett, 1999).

In 1870 the British authorities made the decision to exercise more control over the ‘native’ population of South Africa by codifying customary law. The authorities established the first Natal Code in 1878 and signed the second code into law in 1891. Vast changes in the African homestead economy accompanied the passage of the Natal codes. Jeffrey Guy points out that the society was “no longer organized around the control of the labor power of women” (Guy, 1990:34-35). Now there was the “expectation that women should labor outside as well as inside the home …now they operated in a changed situation, in which cash and commodities provided a source of value independent of the women-cattle-labor power cycle. The economic and social dynamic was, therefore, different, drawing on changed, external productive forces” (Guy, 1990:34-35). Concurrently the government put in place a segregationist policy which unified two former Boer republics: Transvaal and the Orange Free State and two former British colonies: the Cape and Natal, and which included territorial, social, political and legal separation by race (Dubow, 1989). The policy was the catalyst for the Native Land Acts of 1913 and 1936 and the Native Administration Act of 1927.41
All of these laws gave appointed chiefs and white native commissioners the legal authority to govern Africans according to the statutes of the colonialists.42

The African chiefs and elders were said to approve of the Native Affairs Department’s acknowledgement and respect of their customs and traditions.43 However, they were less pleased with their increasing loss of authority over wives and daughters. They complained that the white courts and appointed chiefs undermined their influence and made it difficult to control their wives and daughters (Booth, 1992). They condemned the laws because it was felt that wives and daughters took their requests for divorces to white customary law courts for arbitration. Chief Matole of South Africa, who was appointed by the Native Affairs Department, made the following comments concerning the changes in customs and traditions:

“It has grieved the people to lose their old laws and customs; the women are flocking to the towns and are being exploited and despoiled by foreign people, and the people cannot understand why the government does not do something about this. Some of these girls go to the towns to escape the harsh treatment they receive from European farmers. It is a time-honored custom that no women should leave their husbands or guardians, but now if they have any cause for complaint they get a divorce and go to the towns” (Natal Archives, 31 July 1939 as cited in McClendon, 1995:539).

The chiefs’ concerns were taken to the colonial government and an alliance was formed to prevent women’s immigration into town. But the government’s acquiescence to the entreaties of the chiefs was far from altruistic. It is believed that their agreement had more to do with their interest in enforcing their segregationist policy. Shula Marks’ article, *Patriotism, Patriarchy and Purity: Natal and the Politics of Zulu Ethnic Consciousness* explored two reasons why the government had such an interest in
maintaining women in the rural setting. First, women’s role in agricultural production “lowered the cost of reproducing the urban workforce; Secondly, “by aiding the hold of patriarchal structures over women, the state could control the return of the young men to the reserves and white farms which still needed their season labor” (Marks, 1991:42).

While on the one hand the government controlled African women by allowing patriarchal practices to flourish, on the other hand, they allowed women and “juniors” access to the court system. As the following cases illustrate the white customary court system did not always offer women relief from an abusive relationship. It was not true that women who sought divorce were always successful in achieving them.44

In the 1930 case of Mkize vs. Ngqalanga, Nompepe Mkize, the second wife of Hlupizwe Ngqalanga requested a divorce from her husband on the grounds of desertion and physical abuse. In one incident Ngqalanga assaulted his wife after determining that she did not honor his request to assist his first wife in making sorghum beer. Hlupizwe accused Nompepe of visiting her people too frequently. “New” wives were still outsiders to the husband and his family. It was believed that women who traveled between their father’s kraal and their husband’s house may obtain the soil to perform witchcraft on the husband. In fact the disharmony between husband and wife was considered proof that witchcraft was afoot. But in fact Nompepe claimed that usually, she only left after receiving permission from her husband. Furthermore, she accused her husband of leaving for three months to work in the urban area without providing sufficient food to feed herself and their baby. Hlupizwe pointed out that each wife had the same amount of grain.
He maintained that his first wife had more children and was able to subsist on the grain which he provided. In accordance with the Natal Code of Law her brother served as her legal guardian. The court discharged her petition and Nompepe had to remain with her husband (McClendon, 2002).

Another more virulent case involved the 1929 case of Ngubana vs. Langa. Ngubana initiated divorce proceedings against his wife Langa. He complained that his wife made frequent visits to her people. It was his fear that his wife might acquire medicines which she could use to harm him. His wife did not dispute that she left their home for her father’s umzi on several occasions. However, she claimed that her husband was violent and had even tried to kill her. But on all of the occasions Langa was either returned to her husband by her father or her husband physically forced her return to their home. Finally, owing to her frequent beatings Langa told the court system (at the prodding of her husband) that her husband no longer loved her. Ngubana received his divorce and Langa’s father was ordered to return all ten heads of cattle (McClendon, 2002).

As men began to spend more time in the urban centers women were obliged to assume control of households. Since many women lacked technical skills to acquire positions in the formal sector they had to rely upon work in the informal job market. In becoming more self-reliant women acknowledged the importance of improving their position outside of the boundaries of their home.

Women’s insertion into the public sphere between 1954 and 1963 was predicated upon two factors: 1) Under the banner of Motherism in the multiracial Federation of
South African Women and 2) Women formed this organization out of a realization that men would not acknowledge, nor would they provide, for their needs.

3.3 Examining the Public Sphere. Gisela Geisler points out that women inserted themselves into the public political discourse out of a sense of duty to their children. Motherhood was the catalyst for their involvement and was a unifying factor across rural-urban, class and race boundaries. The Federation of South African women (FSAW) advanced the concept of Motherism because the organization “wanted to expand the scope of women’s work within a nationalist liberation movement” (Geisler, 1999:608) and was a “real and serious attempt to incorporate women into the political program of the national liberation movement on an equal footing with men” (Geisler, 1999:608). Additionally, South African women’s entrance in the public arena was based upon the acknowledgement that men did not invest the same attention in the equality status for women. The FSAW observed that women in Zimbabwe and Namibia had not progressed in their struggle for women’s liberation. Zimbabwean and Namibian women agreed to suppress their own political interest for women’s freedom in order to join men in the fight against racial discrimination only to be met with continued acts of subordination (Ranchod-Nilsson, 1994; Geisler, 1995).

The repression and exile of ANC leaders in 1963 forced the liberation movement to go underground. During the ANC’s suspension the women’s division of the ANC was disbanded. In 1969 women in the ANC organization created a separate sector that was led by the Women’s secretariat. Although the Women’s Section of the ANC was principally designed to re-invigorate the movement politically and internationally its de
**facto** objective was to serve as a support network for its male and female members. The Women’s Section provided organized childcare facilities, and clothed and fed its members. The women were also charged with providing education for the children of the exiled members. Although these tasks were considered mundane by the military members of the organization the women fulfilled a necessary role for the organization. Women who were members of *Umkhonto we Sizwe* (MK), the military arm of the ANC, recognized that the organization of the women’s section made it possible for them to participate in revolutionary work because they had confidence in their children’s caretakers (Klugman, 1994, Goetz, 1998). As one woman stated, “I didn’t have to choose between motherhood and politics because the Women’s section made it possible for me to do both. I knew I could leave my child in good hands” (Issel, 1991:45).

The women had the added duty of serving as mediators in the relationships between men and women. This problem was especially virulent in the MK because although women were better sharp shooters and exhibited a greater degree of commitment to the military cause of the movement they were often questioned about their motives for pursuing this active military sector rather than serving in clerical or secretarial positions. Additionally, men refused to take orders from women who held higher positions of authority than themselves. Women were considered sexual fodder for men and were forced to engage in sexual relationships in order to garner consideration for promotions (Terborg-Penn, 1990).

After the September 1981 conference of the Women’s Section of the African National Congress (ANC) women requested full citizenship in the African National
Congress. Younger women, who had been exposed to women’s movements during exile in Morogoro, Tanzania, proposed that women should take a more active participation in the affairs of the ANC. They argued that there should be a focus on women’s political education and their insertion in the political process. The quest for women emancipation was not well received within the organization. Some women reacted to what they perceived as the inappropriateness of introducing gender inequality into the agenda citing the difficulty of mobilizing two revolutions; one against apartheid and the other against gender inequality (Eades, 1999; Deegan, 2001).

The leaders of the African National Congress believed that there should be a battle against the common exploitation and oppression of men and women on the basis of color instead of a battle against men for women’s rights (Ellis, 1992; Morrow, 2004; Feinstein, 2009). Women pointed out that in this regard the ANC was no different than most of the world; National liberation had taken precedence over women’s emancipation (Ellis, 1992).

At the Nairobi Conference of the United Nations Decade for Women in July 1985 women learned how to integrate their desire for emancipation with democracy in South Africa. ANC women learned more about the importance of articulating their concerns for emancipation and gender equality. At the Nairobi conference women learned that women’s emancipation was not just a social issue but required political and economic power (Saunder, 1992).

In 1985 the ANC held a regional seminar which spoke to the concerns of women. During the discussion the women reacted against the ANC and called the organization...
traditional, conservative, and primitive with constraints imposed upon women by a man-dominated structure. In their address to men of the ANC they spoke against a male chauvinism, domination in the home, village, town, factory workshop, in politics, economics and within the organization as well. However, again the men railed against the pursuit of emancipation and criticized the feminist leaning because they considered it irrelevant to the South African anti-apartheid movement (Ellis, 1992).

The women’s organization received the support for which they had been searching, when, in September, 1985, the ANC President Oliver Tambo remarked that South Africa could not be seen as free as long as women were oppressed. Oliver Tambo argued that there was a need for women to take up the debate of emancipation. Tambo called on the Women’s Section “to liberate us men from antique concepts and attitudes about the place and the role of women in society” (Tambo, 1985:41). He added that freedom had to be embraced by both women and the entire movement. He made the plea that the ANC would not consider its objectives achieved, nor its task completed, or its struggle at an end, until the women of Namibia and South Africa were fully liberated (Tambo, 1985).

Initially, the Constitutional guidelines for a Democratic South Africa addressed only the “protection of the family unit.” However, due to the protestation of the Women’s Section the ANC declared that it would reconsider the feminists’ suggestions. In 1989 the ANC drafted a document which addressed the emancipation of women in the Republic of South Africa. The document was important because it showed a commitment to redress gender inequality (Guy, 1980; Lovenduskin, 1993). The members of the ANC
recognized that gender equality affected not just women but men as well. Jacklyn Cock, a feminist, noted that the discussion on gender equality was important because “it means we are not some marginalized group working for an eccentric goal. We have the support of a mass-based movement which not only shares our goals but which provides us with the space to formulate demands” (Cock, 1989:4). In 1990 the South African women in attendance at the Malibongwe conference in Amsterdam were buoyed by the realization that they had a right to participate in all areas of decision making in gender equality. The women directed the ANC to include a quota of 30% in the parliament and to include women and gender equality in its constitution (ANC, 1990).

3.4 The Road to Gender Equality. On January 29, 1993, the South African government demonstrated its commitment in eliminating gender/sex inequalities by signing the international Convention on Elimination of All Forms of Discrimination against Women (CEDAW). The government followed this act by incorporating in its interim Constitution language which proposed to uphold equality between men and women…so that all citizens would be able to enjoy and exercise their fundamental rights and freedom (Constitutional Principle III, Schedule 4).

In his inaugural address on May 10, 1994 Nelson Mandela asserted that South Africa would not be completely free “until women have been emancipated from all forms of oppression” (Deegan, 2000:). Under the leadership of Nelson Mandela a new state emerged which guaranteed legal and policy advances for women and men as well as the redistribution of resources and benefits to all people. In this commitment to a democratic South African government, as it was reflected in the interim Constitution, the Republic of
South Africa gained a reputation as one of the most liberal democracies in the world (ANC, 1995).

3.5 Admittance into Parliament. Both new men and women Members of Parliament (MP) were confronted with problems of legalese and heavy workload including the review of large numbers of reports. But women’s problems were more extensive. Women had to cope with a lack of domestic support whereas men could depend upon their wives to take care of home and hearth. Women criticized the late hours because they had a difficult time balancing their lives with their children and/or spouses. Additionally, many husbands/partners expressed resentment of the long hours working in the parliament (Erlank, 2005).

The new Parliament convened in May, 1994 and included 111 women who represented 26.5 percent of the total representatives. Parliamentarians were at first pragmatic and women asked that they construct day care centers and women’s rooms. Other women expressed caution and concern that their gender issues would be subsumed under the rubric of domesticity and women’s place in the household. They pointed out that worldwide efforts to address gender concerns was relegated to course offerings in child care and handicrafts rather than a discussion of gender inequality (Feris, 1999; Hassim, 1999). Women proposed creating gender focus desks which would monitor programs and their impact upon gender equity. For example Albertyn pointed out that the gender focus desk in the land reform ministry would make land available to women as well as men. Employment creation programs would provide positions for men as well as women. In institutionalizing the policy measures, the female Members of
Parliament believed that the state would understand how to make more equitable decisions for all of its citizens (Albertyn, 2002). Both the Departments of Land Reform and Intelligence utilized this system to effect policy reform. The most significant measure was the passage of the Commission on Gender Equality in 1996. In the formulation of this policy it was believed that gender issues would not be marginalized (Geisler, 2000). But, as Natasha Erlank (2000) points out, and as is the case with many political officials, in fact, women’s positions in parliament isolated them from the very constituents whose interests they wished to represent. Secondly, due to mounting demands for their time there was little opportunity for gender activism. Even so, women did make an effort to drive the gender debate. Nevertheless, while the pursuit of gender equality was touted as an important objective in the restructuring of the government, by 1999, the growing incidence of gender-based violence and high levels of poverty led individuals to believe that the pursuit of gender equality was again relegated to an ancillary status. Women who initially did not want to follow the same post-liberation record observed in other women’s movements, were disappointed to find the system return to status quo. Although originally their efforts drew women into the movement after liberation the previous pattern of subordination resumed (Erlank, 2005).

3.6 **Social and Cultural Mores.** Women’s reduced status echoed observations made previously that men’s disproportionate possession of power limits women’s ability to act in their own agency. In sexual relationships women may not dictate where, when, and how, sexual relationships will take place. It is believed that these patterns of adult sexual activity are created during adolescence. In South Africa this complex system of
mores in which individuals must adhere to rules of *ukuhlonipha* conduct, and status, places both young men and women at an increased vulnerability of contracting HIV/AIDS. The following studies elucidate how the “incongruent expectations in behavior among young men and women propel gender based power imbalances that impact negatively their sexual and reproductive health” (Varga, 2003:161). Christine Varga’s study examined the concepts of masculinity and femininity formed among rural and urban adolescents in KwaZulu/Natal. The overall objectives of the study were two-fold: 1) To show the correlation between gender ideology or gender roles and the social impact of childbearing upon the adolescents who reside in rural and urban KwaZulu/Natal Province; and 2) To illustrate how gender roles influence the sexual dynamics that lead to pregnancy and increase women’s vulnerability in contracting HIV. Dr. Varga conducted the study in a rural site located 130 kilometers south of Durban and in the former black township in metro-Durban. The data comprised sexual and fertility decision-making and negotiation among adolescents ranging from 11 to 24 years old and included four research approaches: 1) Focus-group discussion; 2) Workshop role playing; 3) Questionnaires; and 4) In-depth interviews. Her findings revealed that the gender roles and behavior were guided by the Zulu concept of *ukuhlonipha*, meaning, respect or dignity. The term has significance in all aspects of society and as such varies according to the context of the relationship. In an individual’s relationships with the elder members of the community the term connotes deference. In romantic relationships the word takes the meaning of esteem, mutual respect and love. When one speaks of self the term refers to self-respect, maintaining a good reputation and the ideological belief
that respectful behavior leads to personal success. For young women, in the context of sexual dynamics, Ukuhlonipha means relinquishing all sexual control to one’s partner. A young woman must acquiesce to sexual advances, but she must avoid pregnancy. Also, she must be coy, soft spoken and “lady-like” in her demeanor. Respectability means not having more than one boyfriend at a time. In spite of the fact that having many lovers compromised their respectability young women felt pressured to maintain more than one lover as a form of social security and to gain respect among female peers. Additionally, even though women stated that avoidance of pregnancy was important in maintaining respectability contraceptive measures were rarely discussed or openly negotiated among partners. 53% of those interviewed considered the responsibility for contraceptive devices the domain of the female; 33% felt that it was the responsibility of the male; 9% of those interviewed stated that both were responsible for contraceptive devices; and 6% were undecided. In general, contraceptive measures included tactics such as encouraging withdrawal, “allowing the male partner to suggest condom use,” monogamy or “simply being lucky” (Varga, 2003:164). Girls expressed confusion about the topic of female contraceptives. Female contraception, though supported by both young women and men, created a disagreeable outcome for women. Women spoke of the undesirable effects of weight gain due to the pill or increased risk of sterility if one used an intrauterine device (IUD). They also spoke of the possibility that they would be chastised if parents or elders discovered their contraceptive use. Women who used contraceptive measures were said to be promiscuous and were treated with disdain by the community.
On the other hand, in Zulu culture, sexuality defines young men. The concept of *isoka* involves a colloquial usage which has strong sexual connotations. A young man who has *isoka* status is one who is highly sexually active and has multiple sexual partners. Culturally, *isoka* status confers the rights to “decision-making power” within a relationship. *Isoka* status is acceptable because it is believed that men engage in sexual activity out of a biological need. This belief may be shared by women as well. Statistics show that as many as 53% of men and women stated that sex is more important for men; 4% of women stated that it was more important for women and 32% stated that it was equally as important for women and 11% were undecided. In group discussions men maintained that contracting recurring sexually transmitted infections was the best indicator that the male was *uyisoka* or *isoka*.48

Paternity disputes may also bestow the concept of *isoka* upon men. However, interestingly, many men do not have to accept paternity in order to receive this status. In fact, when faced with a paternity decision many men will not accept paternity when a girlfriend discovers the pregnancy (Varga, 2003). Many cite the fact that one’s parents may not want them to accept responsibility. They maintain that if one is still a student and is receiving pressure from their parents to remain in school it is easy to refuse paternity. Men also view paternity as a threat because of the financial obligations to both the child and the young woman. Whereas young men may walk away from the sexual exploit relatively unscathed young women may not only lose their social standing in society but their ability to attend school as well. Again, in this instance, the decision making power of young men affects not only the young woman’s societal status but
of the child as well. One of the study participants stated that “[the boy’s] acceptance of paternity would maintain the girl’s dignity. If he refuses, everyone will say she is an isifebe because her child has no father” (Varga 2003:166).

Christine Varga’s study examined the impact of societal and cultural mores on the sexual habits of young women and men. Her study suggests that the Zulu social and cultural mores promote high risk behavior, i.e. failure to use a condom (using the pill or an IUD will not protect women against the virus that causes HIV), engaging in sexual relations with multiple partners and/or contraction of STIs by young men. Similarly, Catherine MacPhail and Catherine Campbell conducted a study which examined the influences of high risk behavior on adolescent sexuality. These writers conducted their survey in the South African township of Khutsong, which is located approximately one hour southwest of Johannesburg.

Figures 3.1 and 3.2 respectively illustrate the rates of HIV infection and the percentage of sexually active young men and women in Khutsong. The researchers divided the data into four age bands. The age bands are: 13-16, 17-20, 20-21 and 21-25. The rates of HIV infection in the 13-16, 17-20 and 21-25 age bands are highest among young women. This data is consistent with other studies which suggest that young women are infected disproportionately with HIV/AIDS. For example, in the 13-16 age band the rate of infection among females is six times that of young men. In the 17-20 age band the rate of HIV infection among women is nine times that of young men. Also, for women in the 17-20 age category, the rate of HIV infection represents an increase that is four times that of young women in the 13-16 age band. For young men in the 17-20
age category the rate of infection is two times that of young men in the 13-16 age band. For young men the greatest increase in the rate of infection is observed in the 17-20 and the 20-21 age bands. The rate of HIV infection has increased almost seven-fold. There is no data for women in the 20-21 age band. However, at the 17-20 age band the rate of infection was 29.9. In the age category of 21-25, the rate of HIV infection for women had almost doubled to 58. Figure 3.2 shows an increase in the percentage of sexually active adolescents. The greatest increase is observed in the progression from the 13-16 year age band to the 17-20 year age band. Interestingly enough, for both age bands, women are observed to be slightly more active sexually than men. This fact may be less remarkable when we consider that young women in the 13-25 age range may exchange sexual favors for material goods and/or school fees. They profess to see nothing wrong with this relationship. Many may consider the exchange of sexual favors a business transaction which is a means to an end.49 A comparison of the biological data and the responses to the survey suggest that there may be a myriad of reasons why condoms are not used on a consistent basis by young men and women.

The researchers interviewed 22 males and 22 females between 13 and 25 years of age. The data collected was derived from eight focus groups and contained six to eight adolescents in each group. The researchers divided the groups into four age bands characterized by gender. During the focus group the researchers asked four questions:

1. Why do people have relationships and are there different reasons for males and for females? Why do people therefore have sex and are there differences in males’ and females’ reasons?
2. Why do some people use condoms and some people do not?

3. Is AIDS a problem in this community? Among whom? Do others see that it is a problem?

4. Are there people who go against the norms of masculinity and femininity? What is the community’s reaction to them?

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**Rates of HIV Infection among young people in Khutsong**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-16</td>
<td>1.2</td>
<td>7.6</td>
</tr>
<tr>
<td>17-20</td>
<td>3.3</td>
<td>29.9</td>
</tr>
<tr>
<td>20-21</td>
<td>22.4</td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>58</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3.1 Rates of HIV Infection among young people in Khutsong [Adapted from Table 1 (MacPhail and Cambell, 2001).]

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**Sexually active adolescents in Khutsong**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-16</td>
<td>18.3</td>
<td>19.1</td>
</tr>
<tr>
<td>17-20</td>
<td>81.4</td>
<td>87.4</td>
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<tr>
<td>20-21</td>
<td>98.8</td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3.2 Adapted from Table 2 (MacPhail and Campbell, 2001)
The researchers analyzed discussions using a two-stage interpretive thematic analysis. Stage one involved organizing information into broad categories. Stage Two involved discerning factors which contributed to low condom uses. The research revealed that there were seven factors which determined low condom usage.

1. Perceived risk of HIV infection

The focus groups had high levels of knowledge about HIV. Students in the 13-16 age bands did not think HIV/AIDS was a common problem. Students in the 17-20 age range had knowledge of others with HIV and knew it was a problem. Young women more readily admitted that HIV was a problem. However, the knowledge was predicated by lower feeling of vulnerability. The students viewed HIV as a disease of others. There was conflicting information about HIV prevalence in the community. Also, the perception was that HIV was spreading because of prostitutes: “HIV was a function of ‘abnormal’ sexual encounters” (2001:1620).

2. Peer Factors

Among both men and women there was a general consensus that condoms were unnecessary “within a steady relationship.” They believed that its use was limited to out-of-relationship sexual encounters. Young men were particularly vulnerable to the opinions of their friends. Men who identified condom use were chastised by friends. Women were unable to bring up condom use because they thought that men might think they had been unfaithful.
Women were upset when men suggested using condoms because it indicated that men believed them to be promiscuous.

3. Condom availability

Procuring condoms were problematic for women. Women recounted situations in which clinic and hospital staff were reluctant to give condoms to women. Many women claimed that the staff threatened to contact their parents concerning their condom use. Again, there was fear of being labeled promiscuous if one carried condoms.

4. Adult views on sex and condoms

Students did not use condoms because of parents’ disapproval. They lived at home and had little opportunity to engage in sex. They felt that there was not enough time to use condoms because one had limited amount of time to engage in sexual relations.

5. Rape and Assault

Women were forced into having sexual relationship with their male partner and his group of friends. There is no information on the degree of incidence from the study. However, reportedly, women did not consider this situation extraordinary and found attempts to prevent this assault futile.

6. Economic context of adolescent sexuality

Women engaged in sex in exchange for school fees, clothing and other items.
Women’s economic dependence upon men impeded their ability to negotiate safer sex with their partners.

7. Growing Empowerment for Women

There was a marked difference in male and female views concerning sex within the 21-25 age bands. Women in this age group professed that they were no longer concerned with society’s perception about them. They maintained that they were more concerned with their sexual health. Consequently, they were less willing to engage in sexual relationships without the use of a condom. Men, on the other hand, still believed that they needed sex and that women who carried condoms should be considered sexually promiscuous.

3.7 Data Analysis. Thus far, this discussion has suggested why gender power inequities and men’s risky behavior have made women more vulnerable in contracting sexually transmitted diseases including HIV. The results of these studies were not inconsistent with the data compiled and presented by researchers of the 2005 South African National HIV household survey conducted by a group of independent researchers: Thomas Rehle, Olive Shisana, Victoria Pillay, Khangelani Zuma, of the Human Sciences Research Council, Adrian Puren, National Institute for Communicable Diseases, Johannesburg and Warren Parker, Center for AIDS Development, Research and Evaluation, Johannesburg and the staff of the Human Research Sciences Council. The staff of the Human Research Sciences Council presented compelling data and findings on the biological and socio-behavioral factors that may drive the disproportionate incidence and prevalence of HIV among women. The discussion examines the National HIV...
incidence measures and profiles of the 2005 South African national household survey.\(^5\)

While this study does not inform us about how women are affected by the absence of condom usage it does reveal some important information about the nature of self-reporting of risky behavioral practice and the complexity of variables which may be attributable to the epidemic’s proliferation.

![Figure 3.3](image)

**HIV Incidence**

<table>
<thead>
<tr>
<th></th>
<th>Black</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Series1</td>
<td>1.8</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Figure 3.3 - Chart created from data obtained in Thomas Rehle et. al. study, 2007

![Figure 3.4](image)

**Estimated number of new infections**

<table>
<thead>
<tr>
<th></th>
<th>Black</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Series1</td>
<td>557,000</td>
<td>14,000</td>
</tr>
</tbody>
</table>

Figure 3.4 – Chart/Graph created from data in Thomas Rehle, et al. study, 2007
Figures 3.3 and 3.4 show the incidence rate and the number of new infections of HIV for individuals of Black and Other\textsuperscript{51} ethnicities. The incidence rate of Blacks is nine times that of the individuals in the Others category. The researchers estimated that Blacks may contract HIV at a rate that was thirty-nine times that of individuals in the Others category. The estimated number of new infections among Blacks is disproportionately large in comparison to the figures listed in the Other category. An examination of the incidence rate combined with the knowledge of the demographics of each province enables us to understand why the figures may be disparate.

The researchers compiled the incidence rates of all nine provinces of the Republic of South Africa. KwaZuluNatal had the largest number of participants in the study followed by Gauteng (both populous provinces), Eastern Cape and Limpopo. Figure 3.5 indicates that Mpumalanga had an incidence rate of 2.4\% and the Orange Free State and Gauteng followed closely behind at 1.9\%. There is little surprise that the incidence rates in Mpumalanga and Orange Free State are the highest among the provinces. Both Mpumalanga and the Orange Free State are provinces in which mining is an important industry. In 2006, one year before the results of the South African household survey were published, the World Bank Group wrote that mining communities were particularly vulnerable to HIV and AIDS. Their data revealed that 20\% of coal miners and 30\% of gold miners were HIV positive. The article pointed out that miners had prevalence rates that were “17\% higher than the base population” (World Bank Group, 2005:1). Gauteng comprises three municipalities which include the city of Johannesburg and Tshwane. The province may have the distinction of possessing the third highest incidence
rate because of sheer population density some of which is attributable to its position as an economic leader in southern Africa.

Figure 3.5 – Compiled from data outlined by Thomas Rehle et al., 2007

Figure 3.6 – Data adapted from study by Thomas Rehle et al (2006)
Thomas Rehle et al. acknowledge the importance of condom usage in mitigating the contraction of HIV/AIDS. However, as Figures 3.6, 3.7, 3.8 and 3.9 reveal, the data outlining the biological status and self-reported vulnerable behavior may be incongruent. The researchers presented four variables that may contribute to the proliferation. The variables are: marital status, sexual history, number of sexual partners and condom use.

Figure 3.6 represents the incidence and prevalence rates of four classifications of marital status. At the face value the prevalence and incidence rates are highest among those who are single and widowed. It is interesting to note that the prevalence and incidence rates among the married and divorced are discordant. These measurements may indicate two situations. The number of new infections among the sample divorced individuals may be lower than the sample married individuals. A natural question would be to ask what would account for the higher prevalence rate. Since the prevalence rate is a compilation of all cases and does account for mortality rates and is a measure of those living with the syndrome, we may surmise that the number of individuals living with the syndrome and who may be receiving ART treatment may be higher. Since the incidence rate among the divorced is lower we may also assume that there are few new cases of HIV detected among those in the sample. The data may be consistent with empirical evidence that points out that the divorced may be using condoms because they have more casual sexual relationships (hence the reduced number of new infections. We may also come to this conclusion when we observe the actual number of individuals affected in both categories. For example, among the single individuals, the HIV prevalence is 16.6% of 5,306 which represents 881 people and 318 new cases of
HIV (3.0%). For the married category, 14.3% of 3,240 represents 625 people in the prevalence rate and 42 (1.3) new cases. Among the widowed, the prevalence rate is 34% of 227 which represents 77 people who have been infected with HIV and 12 new cases of infection.

Lastly, among the Divorced, 48 or 4.0% of the people have been infected with HIV and 2 new cases of infection. Interestingly enough, these figures suggest that those who are widowed may be less inclined to use condoms during sexual encounters.

As noted, the prevalence rate among those who reported that they never had sex was 75. Although in relationship to the sample number (1747) the cases are small this may be an indication that individuals who take the survey may not feel comfortable in disclosing their true sexual history. This information may have profound ramifications in other studies which rely upon self-reported sexual behavior. For obvious reasons the only accurate sexual history may be obtained from pregnant women. This is considered one of the main reasons why data from antenatal clinics is used so frequently. The prevalence rates of those who reportedly have had more than one partner within the last twelve months is higher than the those who reportedly have had only one partner within the last twelve months.

Again, there may be problems in self-reporting. It is true that engaging in sexual intercourse without a prophylactic even once places an individual at risk for contracting HIV. However, the odds may be greater with individuals who have had several partners. These individuals have had more opportunities to be exposed to the virus.
Figure 3.7 - Chart created from data acquired from Rehle et al. 2005

Figure 3.8 - Chart created from data acquired from Rehle et al. 2005

Figure 3.9 represents condom usage for those in the 15 to 24 and 25 to 49 age bands. Among those in the 15 to 24 age band the data suggests that condom use may drive contraction of HIV. The correlation between condom use and contraction of HIV among those in the 25 to 49 age band is less clear. Researchers point to other causal
factors. Since the relationship between condom usage and contraction of HIV (as reflected in the incidence rate) is more accurate among individuals in the 15 to 20 age band the following section examines the relationship between condom usage and incidence of HIV.

Figure 3.9 - Chart created from data acquired from Rehle, et al. 2005

3.8 Reported Condom Usage and HIV Incidence Rates. The incidence rate is the most accurate measure of the success of a prevention strategy. It is likely that a society that shows a consistent decline in the number of new infections may attribute this phenomenon to prevention campaigns. Unfortunately, the data which speaks to the incidence rate is sparse in all agencies. The Human Sciences Research Council provides the incidence rate. However, the indirect incidence estimates have been derived mathematically from HIV prevalence rates.
They use this method on younger age categories because “the effect of AIDS-related mortality on HIV prevalence rates is minimal” (HSRC, 2008:37).

As illustrated in Figure 3.10 for individuals in all age groups the incidence rate peaked in 2005. However, in 2008, there was a sharp decline in the number of new infections reported. The greatest drop in the incidence of HIV is noted among individuals in the 17 to 18 year old age band. For 17 and 18 year old men and women the incidence rate in 2008 decreased by more than half of the reported rate in 2005. The peak in the incidence rate mirrors that of the prevalence rate. This occurrence is not surprising given the fact that the estimation is derived from the prevalence rate. Also, the largest reduction in the incidence rate would most likely be reflected after several years of consistent condom usage. Therefore, lower rates would be revealed in the 17 to 18 year old age band.

As revealed in Figure 3.11 there is a gradual increase in the condom usage for individuals between 15 and 20 years of age. Although one may not make a direct comparison among variables, the estimation of incidence does suggest that there is a downward trend in the incidence for 2002, 2005 and 2008 that corresponds with an upsurge in the condom usage. This trend may suggest that the prevention campaign is successful in limiting the number of new infections among the youngest and most impressionable members of the society.
Figure 3.12 reflects the condom usage for both men and women in the 25 to 49 age group. The reported condom usage is substantially less than the reported condom usage in the 15 to 24 age group. For example, in 2002 and 2005 the data for men in the
25-49 age group reveals condom usage that is half that of men in the 15-24 age group. However by 2008 the differential in the reported condom usage among men had decreased slightly. For women in the 25-49 age group and for the same time period the point differential though slightly less prominent is still significant. The difference in reported condom usage for both men and women may speak to the importance South African women place on fertility and motherhood.

![Condom Usage at last sex act](Image)

Figure 3.12 – Source – Data from Human Sciences Research Council, 2008:45

In the article “Conceptualizing Motherhood in Twentieth Century South Africa,” Cheryl Walker writes that fertility and motherhood continue to be “very highly valued by women and to inform their choices around motherhood” (Walker, 1995:431). Walker stated that:

“In the language of PHCNs, the terms ‘women’ and ‘motherhood’ are almost synonymous. The way in which they represent women revolves primarily around
women’s experience of mothering, and their roles and responsibilities as mothers. For the PHCNs, the relationship between being a woman and being a mother is automatic. The biological ability to bear children, in other words, a woman’s fertility, lies at the root of a mother’s status and identity… To be a woman then is to bear children. Women who do not want children are denying their roles as mothers, their dignity and rejecting their identity as women” (E. Walker, 1993:77-78 as cited in C. Walker, 1995:431).

In considering this statement there is a reduction in condom usage reduced because this age group (25-32) reflects women who are at the peak of their reproductive life. The difference in the point differential between males and females of the 25 to 49 age group is not substantial. For example, in 2002, there is a point differential of 10 points. For 2005, the differential has shrunken to 6. However, in 2008, more women reported condom usage than men. Although the point differential is only 1.7 the number may suggest that there are other factors which may account for this anomaly. A change in mortality rate and burden of disease may explain the reduction in condom usage by men and women >50 years of age.

As illustrated in Figure 3.13 for 2002 and 2005 the number of individuals who report condom usage has dropped precipitously by two-thirds. However for 2008 there is a big surge in the number of reported condom usage. The number of individuals who report condom usage has increased almost 4.5 fold.

The decrease in the life expectancy rate as presented in Figure 3.14 is driven by a surge in the infant mortality rate and an increase in the death rates due to opportunistic infection associated with the HIV and AIDS epidemic. Certainly, the differential in
reported condom usage among the 25-49 age group and those 50 years of age and older may well reflect the fact that by the age of 55 a significant portion of the population is deceased.

Figure 3.13 – 50 years and older – Data, Human Sciences Research Council, 2008

Figure 3.14 - Source: World Health Statistics, World Health Organization, 2009
3.9 Gender Redux. Researchers express optimism that the dramatic increase in the reported condom usage will reduce a woman’s vulnerability in contracting HIV/AIDS. The data does suggest that males and females within the 15-24 age band are utilizing condoms at least for some of their sexual encounters. Researchers may be buoyed by this knowledge because it may indicate that educational programs and peer groups have been successful. On the other hand, while reportedly, the prevalence rates have peaked, there is still an indication that males and females in the 25-49 age band fail to use condoms on a consistent basis. Although this age band represents women’s child-bearing years there is not always an indication that women (and men) neglect to use condoms because they wish to become pregnant. I would suggest that this is an important opportunity to work with both men and women to determine women’s reproductive interests, discuss family planning and discuss the importance of monogamy in keeping both partners HIV seropositive free. Research may also address the growing incidence of former prisoners, many who may have contracted HIV while in prison and who, while incarcerated, conducted sex with other men.

Once this population is liberated they may continue to engage in sexual relationships with other men while also maintaining a sexual relationship with their wives or partners. It is in the interests of healthcare providers to provide proper treatment and counseling to prevent a new outbreak before it has the opportunity to take hold.
CHAPTER FOUR

Dying of Sadness\textsuperscript{53}: Gendered Based Violence as a Vector of HIV/AIDS

Men use physical assault to force sexual contact, beating their female partners if they refuse to have sex, or if they are found to be using contraceptives. Women often get infected with HIV because of the culture of gang rape - yet health officials in SA 'refuse to acknowledge sexual encounters such as these as rape'.

K. Wood and Rachel Jewkes, 2009 (Stuijt, January 10, 2009)

Last week one guy was telling his friends that he was going to rape all those girls who denied him [before] when he was clean. Now he was going to give them his AIDS and show them something.


Today's violence is rooted in history – it is the ghost of apartheid come back to haunt its creators. One must look at that legacy to understand this upsurge in violence. It has bred social deprivation, fostering frustration and the potential for violence. This does not always take the form of political violence, but permeates society through increased crime rates, murder, rape, wife battery and child abuse.


These quotations highlight three vectors through which gender partner violence may amplify a woman’s vulnerability in contracting HIV. These vectors include, but are not limited to, disclosure of HIV seropositive status, a perversion of the South African philosophical principle of \textit{Ubuntu} and barriers in the use of condoms. For example, the CDC and WHO have identified disclosure as an important factor in preventing mother-to-child transmission, reducing risky-behavior among couples and in increasing HIV testing and counseling. As early as 1993 the CDC observed that women who revealed their HIV seropositive status to boyfriends or husbands (who were also HIV seropositive) were at an increased risk of experiencing additional violence. However, the sexual assault of women
who were HIV seropositive increased their risk of exposure to a more virulent strain of HIV that was resistant to the latest antiretroviral drugs (CDC, 2001; WHO, 2004).

Second, the South African principle of *Ubuntu* speaks to one’s interconnectedness with the community and generosity toward ones neighbors. In a perversion of this principle some HIV seropositive individuals engage in sexual relations without using a condom and disclosing their HIV seropositive status to their partners. These individuals propose to share their HIV infection with others so that they do not have to live with HIV outside of the community.

Third, and as mentioned in chapter three, acts and/or threats of violence may inhibit a woman’s ability to negotiate the use of condoms. Rachel Jewkes, the president of the Gender and Health Research Unit at the South African Medical Research Council, states that often violence is used by men who may feel their position, status, and identities threatened. Violence is seen as a way of re-asserting their masculinity and control (Jewkes, 2004). The norms of femininity and masculinity govern interpersonal relationships, joint decision-making and negotiation of safe sex practices between partners. Stereotypes which bestow virtues of independence, decisiveness and strength upon men and by contrast passivity, inferiority and weakness upon women legitimize wife battering and make acceptable domestic violence within marriage or common law partnership. This reasoning holds true for both the proportion of those who are not comfortable using violence but who employ it nevertheless and those who “haven’t really given thought to right or wrong” (Long, 2004:13).
In this sense it is understood that abusive men’s propensity to engage in risky behavioral practices may augment the exposure to HIV for both men and women.54

For this reason Kistner proposes that the term gender-based violence be used more commonly because “the same mechanisms that are oppressive and abusive of girls and women keep men and boys welded to [negative] masculine identification” (Kistner, 2003:12). The authors of the Declaration of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) describe gender-based violence as discrimination against women which impairs or nullifies women’s enjoyment of their human rights including life and to the highest attainable standard of physical and mental health” (United Nations Development Fund for Women, 2001:11). In the following discussion violence against women is described as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such act, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (WHO, 2009:3).

In consideration of these findings this chapter proposes the hypothesis that as a woman’s exposure to violence increases, her vulnerability in contracting HIV increases. The hypothesis would appear to be commonsensical and yet few studies seek to measure the impact of rape, which in this chapter translates as the risk of acquiring HIV after rape, upon prevalence rates and/or to examine the cost of providing anti-retroviral therapy to women who have tested positive for HIV. Lastly, the chapter concludes with a discussion of the passage of legislation enacted to redress the epidemic of violence in South Africa.
Institutional and Micropolitical Violence in South Africa. Violence has always been considered important to the “legitimation, foundation and the operation of the Western property regime” (Blomley, 2004:1). The most recent offerings on the relationship between state and violence derive from H. Lefebvre and Nicholas Blomley. H. Lefebvre states that “every state is born of violence, and…state power endures only by virtue of violence directed towards a space” (Henri Lefebvre (1998: 280-281)). Nicholas Blomley opines in *Law, Property and the Geography of Violence: The Frontier, the Survey and the Grid* that there has always been a relationship between state law and violence. His article maintains that enforcing the law, whether by physical violence be it realized or implied, is the cornerstone and the legitimizing force of property regime. Property is enforced in violent means and may involve the act of expulsion from the property for the squatter or the indigenous person as meted out by the state. Laws involving property “defined where people could and could not go as well as their rights to land use, and it backed these rights as need be, with sovereign power” (Harris, 1993:67 as cited in Blomley, 2004). Violence has been considered an acceptable strategy for resolving disputes and conflicts that occur in the work place and in intimate settings. In RSA violence has persisted unabated for so long that it has created a climate where women, who hold subservient positions in the country, are “undervalued, disrespected and prone to violence by their male counterparts” (UNIFEM, 2003:8). However, additionally in RSA it is believed that through the ordinances of apartheid, violence has become institutionalized “in that its success could only be achieved by repressive means of law enforcement” (Jenkins, 1996:14 as cited in Abrahams, 2004:4). The tacit cultural
acceptance of violence has extended to sexual relationships and, it is believed, may account for the epidemic of sexual violence experienced by women. Scholars and scientists suggest that gender-based violence is linked to a “culture of violence” borne out of patterns of a patriarchal society which maintain women in a subservient position, “social consequences of the migrant labor force”, the legacy of apartheid and subsequent breakdown of the family unit, the lack of respect for others and a tendency to settle disputes violently and the lack of political will “to prevent violence or to prosecute the perpetrator of the crime” (R. Jewkes, et al., 2001:5).

Increasingly, in the context of laws which propagate violence, attention has been drawn to the mining environment and racial ordinances such as the Pass Laws Act of 1952. Although the 1952 legislation is described “as a means of enforcing temporary migration “ (Hindson, 1987:62), “this law criminalized Africans and Coloreds and exposed vast numbers of men to prison and prison gangs and produced a culture of violence” (Kynoch, 2008:629). The pass book, which was also known as a dompas, resembled a passport, but comprised more extensive information than a normal passport. The document contained the “individual’s fingerprints, photograph, personal details of employment, permission from the government to be in a particular part of the country, an employer’s reports on worker performance and behavior and qualifications to work or seek work in the area” (http://home.snu.edu/~dwilliam/f97projects/apartheid?laws.htm). Transporting the document was compulsory for all South Africans over the age of 16. The police exercised tight controls of the Pass Laws and routinely conducted sweeps in the early morning hours in all households of the townships and at transportation points as
well. Any irregularities or infractions might result in a fine, imprisonment or hard labor on white farms. In Witwatersrand 16,000 men were convicted in 1930. By the mid-1950s the police averaged 275,000 arrests per year. Researchers estimate that between “1916 and 1981 17,250,000 South Africans were arrested for pass law violations” (Kynoch, 2008:642). Clearly the majority of the offenders were sent to prison where they were exposed to a prison population that contained prolific gang organizations which recruited and victimized new members. The Ninevites, led by Jan Note (Nongoloza), dominated the gang activity in the mine compounds and the prison system during the first decade of the twentieth century. Note’s criminal empire included at least ten generals who assaulted, robbed and murdered miners and residents in the neighboring township of Johannesburg as well as coerced teenage males who were sexually exploited. While Note attacked the migrant miners and location inhabitants there was little reaction to the criminal activity. However, when whites and blacks agents of the state were attacked the government created a special policy squad to eradicate the gangs (Kynoch, 2008). The government officials forced Note to disband the gang in 1912.

The Isitshozi was another mine-based criminal gang. The Isitshozi were principally established to protect its members within the Rand mines. However, gradually, they became known as “the people who kill people on the mines” (Kynoch, 2008:632). They, too, enlarged their criminal portfolio to include “rape and sexual coercion” on the mines (Kynoch, 2008). Again, this criminal activity was said to flourish because it occurred among the migrant miners, location inhabitants and the black
township. Additionally, enforcement of apartheid legislation was said to prevent police authorities from prosecuting “real crime” (Kynoch, 2008; Hindson, 1987).

The high percentage of rapes committed in a victim’s home is consistent with the observation that women have a greater risk of sexual violence from an intimate partner, spouse, or even an acquaintance. For example, in the 1980s and 1990s in Soweto, gangs of young men would break into homes and gang-rape young girls. *Jackrolling* or “raping in front of others” was also committed in public places such as taverns, schools and in the streets. The gangs were said to *dla abantwana* (eat the girls or children). Additionally, for young men, *jackrolling* was considered a game or sport and a method of increasing one’s self-esteem among their colleagues. Although *jackrolling* diminished in 1994, gangs known as *bhepa span*, (which in isiZulu means “crude sex”), have surfaced in KwaZulu-Natal. Members of the gang have been known to rape high school teachers as well as young girls (Wojcicki, 2002).

The first studies linking gender based violence and HIV/AIDS, which took place in 1991 and were conducted in the United States, looked to the relationship between early sexual abuse and increased vulnerability in contracting HIV. Zierler, Feingold, Laufer, Velentgas, Kantrowitz-Gordon and Mayer designed a study which involved 186 adults who provided the researchers with information of occurrences of abuse and exposure to sexual and drug networks. Their findings showed that 50% of women and 20% of men had been raped during childhood or adulthood. Women who had experienced childhood rape were far more likely to be working as a prostitute. Additionally women who had a history of sexual abuse had a prevalence rate which was twice that of women who had
experienced no abuse. In an addition to verifying that childhood exposure to rape may drive the incidence of risky behavior this study was one of the first analyses which suggested that the contraction of HIV may be a health outcome of sexual violence.

In 2004 a team of researchers from the United States and South Africa (Rachel Jewkes, Kristin Dunkle, Heather Brown, Sioban D. Harlow, James McIntyre and Glenda George) published the results of a cross sectional study which considered the link between gender-based violence and HIV/AIDS in South Africa. The team hypothesized that past experience of intimate partner violence, child sexual assault, forced first intercourse, adult sexual assault by non-partners, or current involvement with a controlling partner was associated with newly diagnosed HIV infection. Between November 2001 and April, 2002 the researchers selected four difference health centers in Soweto, South Africa where they interviewed 1,366 women aged 16 years or older. Utilizing the WHO ethical and safety recommendations and a South African adaptation of the Sexual Relationship Power Scale (SRPS) for research on domestic violence against women, the team members questioned the women’s experiences concerning physical violence, defined as having been pushed, shoved, slapped, hit with a fist, kicked, dragged, beaten up, choked, burned, hurt/threatened with a weapon or having something thrown at them and sexual violence, defined as having been forced to have sex, and/or being forced to perform an act they found humiliating. Their findings revealed that, “adjusting for age and current relationship status and women’s risk behavior” women who had violent or controlling male partners were at an increased risk of contracting the HIV infection. They attributed the increased risk to the fact that abusive men were prone to have
multiple sexual partners from whom they contracted HIV. Abusive men were more likely to coerce their partner(s) to take part in risky sexual practices which placed them at an increased risk of contracting HIV. Additionally, their findings revealed that Intimate Partner Violence (IPV) was associated with an increased likelihood of HIV risky behavior. However, they maintained that the statistical interaction between partner, violence and SRPS score in a multivariate analysis revealed underlying constructs which were not associated with their questions on abuse or violence. So that while Intimate Partner Violence may lead to risky behavior which may increase an individual’s vulnerability in contracting HIV infection their study did not explain the association. While there was no association between Intimate Partner Violence and HIV seropositivity the researchers did affirm that women who had experienced Intimate Partner Violence or who were involved with controlling male partners were at an increased risk of contracting HIV even after one accounted for their own risky behavior. At the study’s conclusion the researchers point out the necessity of conducting additional studies which would also show the connection between violence, sexual risk taking, condom refusal and HIV risk in men.

In another study, Rachel K. Jewkes, Johanthan B. Levin and Lovday A. Penn-Kekana presented their findings from a cross-sectional study that was undertaken in three of South Africa’s nine provinces: the Eastern Cape, Mpumalanga and the Northern Province. Two thousand two hundred and thirty two households were selected for interviews. Women between the ages of 18-49 years were selected randomly from each household. The surveys were divided accordingly: 725 in the Eastern Cape, 748 in
Mpumalanga, and 756 in the Northern Province. 1447 women were selected for the study. The researchers used a questionnaire to collect information concerning women’s experiences in the past year of different forms of physical violence. Acts of violence were defined as being slapped, punched, beaten, kicked, bitten, choked, burnt or threatened by an intimate partner. The researchers reported that although sexual violence by the intimate partner was measured inefficiently “fairly high levels of violence and experiences of IPV were reflective of gender inequalities” (Jewkes, et al, 2004:8). As in the previous study, the researchers alluded to the need to conduct additional in-depth studies which looked to verify the link and the cause of the relationship between Intimate Partner Violence (IPV) and vulnerability in contracting HIV/AIDS among South African women. The following analysis considers the numerical impact that the incidence of rape may have on the prevalence rates.

4.2 Violence Analysis. In determining a woman’s vulnerability or risk of contracting HIV on account of gender partner violence or rape Rachel Jewkes draws attention to the following factors: 1) The probability of the rapist having HIV; 2) the probability of a woman being uninfected at rape; 3) The number of rapists; 4) the degree of trauma; and 5) The transmission risk per sex act of the given degree of trauma (Jewkes: 2000:6). Jewkes points out that the probability of a rapist having HIV is approximately 21%; the probability of a woman being uninfected at rape is approximately 20% for adults and 4% for women less than 18 years of age. Jewkes calculates that the age-adjusted transmission or risk per sex act at 0.012.
Given this information I have created a simple formula for estimating the number of transmissions that may occur per year because of rape (and in the absence of anti-retroviral prophylaxis) and for estimating the numerical effect that rape may have on the prevalence rate:

Number of rapes reported to the RSA police = $R$

Estimated number of HIV transmissions due to rape ($0.012 \times R$) = $T$

Prevalence Rate ($N_1$) = (Percentage rate $\times N_2$)

Number of individuals who are HIV seropositive = $N_2$

Estimated Numerical effect (ENE) that rape may have on the prevalence rate = $N_1 - T = ENE$

The data used in the following discussion is derived from the twentieth National Antenatal Sentinel HIV and Syphilis Prevalence Survey in RSA. The researchers conducted the studies in all nine provinces and used the standard methodological system developed by the World Health Organization and UNAIDS. A total of 32,861 pregnant women ranging from 15 to 49 years of age and who attended ante natal studies in public health sectors participated in the study in 2009. The survey reveals information concerning the HIV status of the general population and also speaks to the prevalence and incidence of pediatric HIV as well as “potential maternal-to-child transmission” (2.2.1). It must be noted that due to the fact that the majority of women who attend public health facilities are African, accordingly, they are disproportionately represented in the surveys.

4.3 Eastern Cape Province. Appendix D illustrates the prevalence rate for Eastern Cape Province. The chart shows an increase from 0.4% in 1990 to 29.5% in 2009. The greatest spike in the prevalence rate occurred in the following years: a notable
spike occurred between 1994 and 1995 when the prevalence rate increased from 1.9% to
4.5%. The prevalence rate represents an increase that was two times that of the previous
year. There was another spike between 1997 and 1998 when the prevalence rate increased
from 8.1% to 12.6%. This prevalence rate represents an increase of 4.5%. The rate
reached a plateau in 2005 with a prevalence rate of 29.5%. Thereafter it appears to level
off and even decreased slightly in 2007 where one observed a prevalence rate of 27.6%.
Chart 4.2 represents a composite of HIV prevalence rates for the whole of the Eastern
Cape. However, the following chart shows how the HIV prevalence rate varies among
districts.

![Eastern Cape](image)

Figure 4.1 –Figure created from Statistics, South Africa Police System, 2007-2009

The largest decrease in HIV prevalence rate occurred for the districts Alfred Nzo,
Cacadu and Ukhahlamba. As the analysis in the survey points out the largest changes
are observed in districts where the sample sizes were smallest. For example, in 2007,
Alfred Nzo district recorded a sample size of 187 with a prevalence rate of 24.8%. By 2008 the sample size had increased slightly to 201. However, the prevalence rate had increased by 5% and was recorded to be 29.8%. By 2009 the sample size had decreased slightly to 186 as had the prevalence rate which was now 23.7%. The sample size for Cacadu district increased from 269 in 2007 to 281 in 2008. By 2009 the sample size had decreased to 255. The district showed a steady increase of the HIV prevalence rate 20% points in 2007, 23.8% points in 2008 and lastly 24.3% points in 2009. The sample size in Kuhahlamba district decreased from 224 in 2007 to 219 in 2008 and 200 in 2009. The prevalence rate increased from a high of 29.4% in 2007, 21.9% in 2008 and lastly 23.5% in 2009. Among all districts the largest prevalence rate was recorded in 2009 in Nelson Mandela Metropole which had a prevalence rate of 30.7%.

Thus far one has observed a prevalence rate which spanned from 20% to 30.7%. The following section of the chapter considers the impact of rape on the HIV prevalence rate. Since the South African Police Service works with numbers of individuals rather than percentages I calculated the number of individuals who presented as HIV seropositive by multiplying the prevalence percentage rate by the sample number for the years 2007, 2008 and 2009 for all of the provinces. The following table represents the information for the Eastern Cape province.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>N₁</td>
<td>4118 (28.8%)</td>
<td>4216 (27.6%)</td>
<td>4225 (28.1%)</td>
</tr>
<tr>
<td>N₂</td>
<td>1186</td>
<td>1163</td>
<td>1186</td>
</tr>
</tbody>
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Table 4.1 – Percentage of HIV Seropositive – Eastern Cape
Due to the fact that the South African Police Service does not record the crime data in a normal calendar year I have taken an average for each time period and have arrived at an estimation of the sexual crimes committed during a normal calendar year (January 1 to December 31). For example, from April 2006 to March 2007 the number of sexual crimes recorded was 9,117. I divided 9,117 by 12 and arrived at a total of 759 sexual crimes committed per month. I added 2277 [759 x 3 (representing the months of January, February and March for 2007)] to the sum of 6813[9,087/12 = 757 ; 757 x 9 (representing the months of April to December, 2007)] and arrived at the figure of 9,090 sexual crimes committed in 2007. Utilizing Rachel Jewkes’ figures for risk of acquiring rape (average of .012) I computed the estimated number of HIV cases due to rape and arrived at 109 new cases of HIV due to rape. I subtracted this number from 1,186, which was the number of cases of HIV seropositive women as recorded in antenatal clinics in 2007 in Eastern Cape. Therefore, without the cases of sexual crimes the HIV prevalence might be 1,076 for the year 2007. For the year 2008 I arrived at the following figures: 2277 (759 x 3) + 7092 (788 x 9) = 9,369. The estimated number of HIV cases due to rape may be 112 new cases of HIV. I subtracted this number from 1,163, which was the number of cases of HIV seropositive women as recorded in 2008. Therefore, without the cases of sexual crimes the HIV prevalence may be 1,051. Lastly, for the year 2009, I arrived at the following figures: 2,364 (788 x 3) + 6,777 (753 x 9) = 9,141. The estimated number of HIV cases due to rape may be 110. Therefore, without the cases of sexual crimes the number of women who present as HIV seropositive are 1,076.
4.4  *Gauteng Province.* Appendix E shows the HIV prevalence rate for Gauteng province and points to a range from 0.7 to 33.1%. There is a steady increase in the percentage rate until 2003 when there is a slight decrease in percentage rates. Thereafter, the HIV prevalence rate increased by 3.5 points after which the HIV prevalence rate decreased gradually until 2009 when the percentage rates reached 29.8%. The largest peaks occurred from 1994 to 1995 when the percentage rates increased by 5.6 from 6.4 to 12.0. The largest peaks occurred between 1997 and 1998 and 2000 and 2001 when the percentage rates increased respectively 5.4 percentage points and 5.6 percentage points. There are seven districts represented in the province of Gauteng. In 2009, the district of Ekurhuleni holds the largest prevalence rate at 34.0% and the second largest number of participants at 1791 in 2007, 2,006 in 2008 and 1,896 participants in 2009. The districts Ekurhuleni, Metsweding and West Rand represent districts wherein there is a decrease in the percentage points between 2007 and 2008 followed by an

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage rate (ostensibly rate of rape included)</th>
<th>Percentage rate minus rape transmission rape</th>
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<tbody>
<tr>
<td>2007</td>
<td>1186</td>
<td>1076</td>
</tr>
<tr>
<td>2008</td>
<td>1163</td>
<td>1051</td>
</tr>
<tr>
<td>2009</td>
<td>1186</td>
<td>1076</td>
</tr>
</tbody>
</table>

Table 4.2 –Percentage of Sexual Crimes – Eastern Cape
increase between 2008 and 2009. The district Ekurhuleni shows a decrease of 1.8 from 2007 to 2008. The district then shows an increase of 2.5 in percentage points from 31.5 to 34.0. The district of Metsweding shows the largest decrease in percentage points of 7.7 in the years between 2007 and 2008. There is an increase in percentage points of 8.2 between the years of 2008 and 2009. West Rand shows a decrease of 4.6 between the years of 2007 and 2008 and then an increase of 2.3 percentage points between 2008 and 2009.

Figure 4.2 – Created from Statistics, South Africa Police System, 2007-2009

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<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>7018 (30.5%)</td>
<td>7497 (29.9%)</td>
<td>7187 (29.8%)</td>
</tr>
<tr>
<td>N2</td>
<td>2140</td>
<td>2241</td>
<td>2141</td>
</tr>
</tbody>
</table>

Table 4.3 – Percentage of HIV Seropositive, Gauteng
Utilizing the formula outlined in the section on the Eastern Cape my computation revealed that there were 15,327 sexual crimes committed in 2007. I arrived at 184 new cases of HIV due to rape. I subtracted this number from 2140 which was the number of cases of HIV seropositive women as recorded in antenatal clinics in 2007. Therefore, without the cases of sexual crimes the HIV prevalence might be 1957 for the year 2007.

For the year 2008 I computed that there would be 17475 sexual crimes. The estimated number of HIV cases due to rape may be 210 new cases of HIV. I subtracted this number from 2241, which was the number of cases of HIV seropositive women as recorded in 2008. Therefore, without the cases of sexual crimes the HIV prevalence may be 2031.

Table 4.4 – Percentage of Sexual Crimes – Gauteng

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage rate (ostensibly rate of rape included)</td>
<td>2140</td>
<td>2241</td>
<td>2101</td>
</tr>
<tr>
<td>Percentage rate minus rape transmission rape</td>
<td>1957</td>
<td>2031</td>
<td>1946</td>
</tr>
</tbody>
</table>
Lastly, for the year 2009, I arrived at 16,269 sexual crimes. The estimated number of HIV cases due to rape may be 195. Therefore, without the cases of sexual crimes the number of women who present as HIV seropositive are 1,946.

4.5 KwaZulu Natal Province. Appendix F shows that the percentage points for KwaZulu Natal province range from 1.6 to 40.7 for the years from 1990 to 2009. The first peak occurs from 1992 to 1993 when the percentage rate increases by 5 percentage points. The second peak occurs from 1993 to 1994 when the percentage rate increases by 4.9 percentage points. The third spike was shown from 1994 to 1995 when the percentage rate increased by 4 percentage points. The largest increase was noted between 1996 and 1997 when the percentage rate increased by 7 points. This district shows the highest prevalence rate among all of the districts. The rates ranged from 1.6 to 40.7 percentage points. The highest prevalence rate was 46.4 and was recorded in 2009 in the district Uthukela.

Umgungundlovu showed a prevalence rate of 45.7 and was recorded in 2008. The districts of eThekwini, Ilembi and Umgungundlovu consistently documented percentage rates that surpassed 40 percentile rate.

For 2007 I concluded that 14,265 sexual crimes had been committed. I calculated 171 new cases of HIV due to rape. I subtracted this number from the 2677, which was the number of cases of HIV seropositive women as recorded in antenatal clinics in 2007 in KwaZulu Natal. Therefore, without the cases of sexual crimes the HIV prevalence might be 2506 for the year 2007. For the year 2008 I computed 12,792. The estimated number of HIV cases due to rape may be 154 new cases of HIV. I subtracted this
number from 2695, which was the number of cases of HIV seropositive women as recorded in 2008. Therefore, without the cases of sexual crimes the HIV prevalence may be 2541. Lastly, for the year 2009, I computed 13,263 sexual crimes. The estimated number of HIV cases due to rape may be 159. Therefore, without the cases of sexual crimes the number of women who present as HIV seropositive are 2506.

Figure 4.3 – Created from data from South Africa Police System, 2007-2009

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N₁</td>
<td>N₂</td>
<td>N₁</td>
</tr>
<tr>
<td>----</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>6918 (38.7)</td>
<td>2677</td>
<td>6963 (38.7)</td>
</tr>
</tbody>
</table>

Table 4.5 – Percentage of HIV Seropositive – KwaZulu Natal
4.6 Limpopo Province. Appendix G outlines the prevalence rates for Limpopo province. The percentage points range from 0.3 to 21.5. The largest peaks were observed from 1995 to 1996 and 1997 and 1998. Between 1995 and 1996 there was an increase of 3.1 percentage points and between 1997 and 1998 there was an increase of 3.3 percentage points. There was a peak in the percentage rate of 21.5%. Thereafter, the percentage rates decreased until 2009 when there was an increase in the percentage rate.

HIV prevalence epidemic curve, Limpopo. In the context of the districts in the Limpopo province the highest prevalence rate was observed to be 28.8 in the Waterberg region in 2009. There was steady decrease in the percentage rate for the districts of Sekhukhune and Vhembe. For the regions of Capricorn and Mopani there was a gradual increase in the prevalence rate.
I arrived at 4587 sexual crimes committed in 2007 and computed 55 new cases of HIV due to rape. I subtracted this number from 865 which was the number of cases of HIV seropositive women as recorded in antenatal clinics in 2007. Therefore, without the cases of sexual crimes the HIV prevalence might be 810 for the year 2007. For the year 2008 I computed 4,524 sexual crimes. The estimated number of HIV cases due to rape may be 54 new cases of HIV. I subtracted this number from 793, which was the number of cases of HIV infected women as recorded in 2008. Therefore, without the cases of sexual crimes the HIV prevalence may be 738. Lastly, for the year 2009, I computed 4,839 sexual crimes. The estimated number of HIV cases due to rape may be 58.
Therefore, without the cases of sexual crimes the number of women who present as HIV seropositive are 674.

Table 4.8 – Percentage of Sexual Crimes – Limpopo

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage rate minus rape transmission rate</th>
<th>Percentage rate (ostensibly including rate of rape figures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>810</td>
<td>865</td>
</tr>
<tr>
<td>2008</td>
<td>738</td>
<td>793</td>
</tr>
<tr>
<td>2009</td>
<td>674</td>
<td>729</td>
</tr>
</tbody>
</table>

4.7  *Mpumalanga Province*. Appendix H shows that the HIV prevalence epidemic curve extends from 0.4 to 35.5%. The largest spike occurred between 1993 and 1994 where the rate increased by 9.8 percentage points. The next largest increase occurred between 1997 and 1998 where the percentage rate increased 7.4 percentage points. There are three districts that are represented in the Mpumalanga province. The Gert Sibande district recorded the highest prevalence rate respectively in 2007 at 40.6 and in 2008 at 40.5. The region also reports the largest decline in prevalence rate. Yet, the
Ehlanzeni district does report a gradual decline in the prevalence rate. The Nkangala region was the only district which reported a gradual increase in the HIV prevalence rate.

I computed 4587 sexual crimes committed in 2007 and computed 55 new cases of HIV due to rape. I subtracted this number from the 865, which was the number of cases of HIV seropositive women as recorded in antenatal clinics in 2007. Therefore, without the cases of sexual crimes the HIV prevalence might be 810 for the year 2007. For the year 2008 I computed 4, 524 sexual crimes. The estimated number of HIV cases due to rape may be 54 new cases of HIV. I subtracted this number from 793, which was the number of cases of HIV infected women as recorded in 2008. Therefore, without the cases of sexual crimes the HIV prevalence may be 738. Lastly, for the year 2009, I computed 4,839 sexual crimes. The estimated number of HIV cases due to rape may be 58. Therefore, without the cases of sexual crimes the number of women who present as HIV seropositive are 674.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th></th>
<th>2008</th>
<th></th>
<th>2009</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N_1</td>
<td>3748 (20.4)</td>
<td>865</td>
<td>3833 (20.7)</td>
<td>793</td>
<td>3412 (21.4)</td>
<td>729</td>
</tr>
</tbody>
</table>

Table 4.9 – Percentage of HIV Seropositive - Mpumalanga
Figure 4.5, Created from Statistics, South Africa Police System (SAPS), 2007-2009

Table 4.10 – Percentage of Sexual Crimes – Mpumalanga
4.8 *Northern Cape Province.* Appendix I shows a prevalence rate for the Northern Cape province that ranges between 0.2 and 18.5 percentage points. There have been two prominent gradations. The first prominent gradation occurred from 1994 to 1995 where there was a percentage point increase of 3.5. The second prominent gradation occurred from 2001 to 2002 where there was a percentage point increase of 4.7. There are five districts represented in the province. F. Baard represents the highest sample number as well as the highest prevalence rate. The most interesting district is that of Namaqua which observed a prevalence rate of 7.3 percentage points in 2007. In 2008 the prevalence rate had dropped 5.1 points to 2.2. Then, in 2009 the prevalence rate dropped to 0.0. Overall, the rates were lower than other districts.

![Figure 4.6, Created from Statistics, South Africa Police System, 2007-2009](image)

I computed 1794 sexual crimes committed in 2007 and arrived at 22 new cases of HIV due to rape. I subtracted this number from 515 which was the number of cases of HIV
infected women as recorded in antenatal clinics in 2007 in Northern Cape. Therefore, without the cases of sexual crimes the HIV prevalence might be 493 for the year 2007. For the year 2008 I computed 1,848 sexual crimes. The estimated number of HIV cases due to rape may be 22 new cases of HIV. I subtracted this number from 547, which was the number of cases of HIV seropositive women and arrived at 22 new cases. Therefore, without the cases of sexual crimes the HIV prevalence was 525. Lastly, for 2009, I computed 1,854 sexual crimes and 22 possible cases or HIV or an incidence of 541.

Table 4.11 – Percentage of HIV Seropositive – Northern Cape

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage rate minus rape transmission rate</th>
<th>Percentage rate (ostensibly rate of rape included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>493</td>
<td>515</td>
</tr>
<tr>
<td>2008</td>
<td>525</td>
<td>547</td>
</tr>
<tr>
<td>2009</td>
<td>541</td>
<td>563</td>
</tr>
</tbody>
</table>

4.9 **North West Province.** The North West has the unique, albeit, unfortunate distinction of having the earliest and highest spikes in the prevalence rates among the
provinces. The percentage rates range from 0.2 to 31.8. Appendix J indicates that the earliest spike and one of the highest percentage points recorded in the 1990s occurred from 1990 to 1991 when there was a percentage difference of 5.4. Another interesting drop occurred from 1991 to 1992 when the curve dropped 5.8 points and reads at 0.9. This precipitous drop would be of concern and may be grounds for disputing additional data from this province. However, there is another substantial spike in the epidemiological curve, from 1995 to 1996 which, suggests, that the deep ebbs and flows are characteristic of the prevalence rate in the province. Four districts are represented in the province. Three out of the four districts (Dr. R. S. Mpmpati, Ngaka M. Molema and Dr. K. Kaunda) show a slight increase in the prevalence rate from 2007 to 2008. However, these three districts also show a decrease in percentage rates of at least 2.5 points. Bojanala is the only district which shows an increase in the prevalence rate in the year 2009.

As outlined in Figure 4.7 for the year 2007 I computed 4,530 sexual crimes committed in 2007 and computed 54 new cases of HIV due to rape. I subtracted this number from 778 which was the number of cases of HIV seropositive women as recorded in antenatal clinics in 2007 in Northern Cape. Therefore, without the cases of sexual crimes the HIV prevalence might be 724 for the year 2007. For the year 2008 I computed 4,512 sexual crimes. The estimated number of HIV cases due to rape may be 54 new cases of HIV. I subtracted this number from 654, which was the number of cases of HIV seropositive women and arrived at 600 new cases.
Lastly, in 2009, there were 4,890 cases reported of sexual crimes which translates to 59 new cases of HIV or 608 cases.

Figure 4.7, Created from Statistics, South Africa Police System (SAPS), 2007-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Bojanala</th>
<th>Dr. R.S. Mompati</th>
<th>Ngaka M Molema</th>
<th>Dr K. Kaunda</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>33.3</td>
<td>26.8</td>
<td>27</td>
<td>32.4</td>
</tr>
<tr>
<td>2008</td>
<td>31.8</td>
<td>28.1</td>
<td>28.2</td>
<td>35.2</td>
</tr>
<tr>
<td>2009</td>
<td>34.9</td>
<td>25.7</td>
<td>25.1</td>
<td>29.2</td>
</tr>
</tbody>
</table>

Table 4.12 – Percentage of HIV Seropositive – North West
From 1990 to 2009 the HIV prevalence rate ranged from 0.6% to 32.9%. The greatest spikes in the prevalence rates occurred from 1993 and 1994, which showed an increase of 5.1 percentage points (from 4.1 to 9.2); 1996 and 1997 where one observed an increase of 6.5 percentage points (from 11.0 to 17.5) and 1998 and 1999 which indicates a percentage increase of 4.9 (from 22.8 to 27.9). From 1999 to 2009 the percentage rates vary little with the largest range occurring from 2001 to 2002 which registers a decrease of 1.3 percentage points (from 30.1 to 28.3) from 2002 to 2003 which demonstrates an increase of 1.3 percentage points (from 28.8 to 30.1). Lastly, there was a decrease of 2.8 percentage points from 2008 to 2009 where the percentage rates were 32.9 and 30.1.

The HIV prevalence rates are represented below in the following chart.

4.10 Orange Free State Province. From 1990 to 2009 the HIV prevalence rate ranged from 0.6% to 32.9%. Appendix K shows that the greatest spikes in the prevalence rates occurred from 1993 and 1994, which showed an increase of 5.1 percentage points (from 4.1 to 9.2); 1996 and 1997 where one observed an increase of 6.5 percentage points (from 11.0 to 17.5) and 1998 and 1999 which indicates a percentage increase of 4.9 (from 22.8 to 27.9). From 1999 to 2009 the percentage rates vary little with the largest range occurring from 2001 to 2002 which registers a decrease of 1.3 percentage points (from 30.1 to 28.3) from 2002 to 2003 which demonstrates an increase of 1.3 percentage points (from 28.8 to 30.1). Lastly, there was a decrease of 2.8 percentage points from 2008 to 2009 where the percentage rates were 32.9 and 30.1. The HIV prevalence rates are represented below in the following chart.
There are five districts represented in the Orange Free State Province. In 2007 the district of Lejweleputswa showed the largest percentage rate at 37% as well as the largest sample number of 578. Thereafter the percentage rate dropped 3.2 percentage points to 33.8. The sample number of 611 was larger in 2009 than in the subsequent years. The district Motheo had the second largest sample number at 565, but interestingly enough, it boasted the second lowest prevalence rate of 27.4. By 2008, the number of participants had decreased and the prevalence rate had increased by 4.2 percentage points to 31.6. In 2009 the number of participants had increased by 114 and numbered 601 individuals. However, the prevalence rate had decreased 3.8 percentage points to 27.8. In the analysis all districts, except Lejweleputswa, showed an increase in the prevalence rate in the year 2008. The increase was followed by a decrease in the prevalence rate which
ranged from .4 percentage points in the case of the Lejweleputswa district to 6.6 percentage points in the example of the district Fezile Dabi.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>N2</td>
<td>N1</td>
<td>N2</td>
</tr>
<tr>
<td>2167 (31.5%)</td>
<td>682</td>
<td>2,016 (32.9%)</td>
<td>663</td>
</tr>
</tbody>
</table>

Table 4.13 – Percentage of HIV Seropositive – Orange Free State

I computed 4,392 sexual crimes committed in 2007 and computed 52 new cases of HIV due to rape. I subtracted this number from 682 which was the number of cases of HIV infected women as recorded in antenatal clinics in 2007. Therefore, without the cases of sexual crimes the HIV prevalence might be 630 for the year 2007. For the year 2008 I computed 4,482 sexual crimes. The estimated number of HIV cases due to rape may be 54 new cases of HIV. I subtracted this number from 663, which was the number of cases of HIV seropositive women as recorded in 2008. Therefore, without the cases of sexual crimes the HIV prevalence may be 609. Lastly, for the year 2009, I computed 4,557 sexual crimes. The estimated number of HIV cases due to rape may be 55. Therefore, without the cases of sexual crimes the number of women who present as HIV seropositive are 648.
Table 4.14 – Percentage of Sexual Crimes – Orange Free State

4.11 Western Cape Province. The prevalence rates in the Western Cape range from 0.1 to 15.7. Western Cape is one of the few provinces where the increase in the HIV prevalence rate is measured and in fact reflects RSA’s HIV epidemiological curve. The largest spikes occur much later in the epidemic’s life span and are observed from 1996 to 1997, which shows an increase of 3.2 points and from 2001 to 2002 which reveals an increase of 3.8 points. Women were tested in six districts in the Western province. Cape Metropole consistently showed the largest sample of antenatal women and largest prevalence and not surprisingly carried the largest number of women who tested HIV seropositive. The district of Overberg showed the highest prevalence rate.
However, the sample number was one of the lowest in the province and reflected the fact that in 2009 27 women had contracted HIV.

In 2007, the South African Police System (SAPS) documented 8,703 cases of sexual crimes. This number reflected 105 possible new cases of HIV due to rape. In 2008, the SAPS documented 9,183 cases of sexual crimes. This number reflected 110 possible new cases of HIV due to rape. In 2009 the SAPS documented 9,447 cases of sexual crimes. This last number reflected 113 possible new cases of HIV due to rape.
Table 4.15 – Percentage of Sexual Crimes – Western Cape

<table>
<thead>
<tr>
<th>Prevalence rates without SCAW</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence rates with sexual crimes against women</td>
<td>585</td>
<td>611</td>
<td>621</td>
</tr>
</tbody>
</table>

4.12 Strategies and Practices in Mitigating Domestic Violence. After apartheid the state passed several works of legislation to redress the incidence of sexual violence perpetrated against women. The first of these ordinances was the Domestic Prevention Act of (no. 133) of 1993. In 1998 the Domestic Violence Act was passed and was ratified in December 15, 1999. On May 22, 2007, the lower house of parliament expanded the “common law definition of rape” so that it now included all forms of sexual penetration without consent, irrespective of gender”. The term replaces the much milder phrase of “indecent assault” (Reuters, May 22, 2007). The Criminal Law Amendment no. 32 was passed on December 17, 2007. The Criminal Law (Sexual and Related
Matters) Amendment Act also gives an individual who has been exposed to HIV, access to post exposure prophylactics (PEP).

Through the passage of the new law the government demonstrates political will in reducing the incidence of gender based violence. However, the decentralization of the specialist units of the South African Police System and of the Family Violence, Child Protection and Sexual Offense Unit (FCS) has left many policemen without adequate support to enforce the laws and without safe and comfortable facilities to interview victims of rape. A number of complaints have been leveled against the SAPS for their failure to obtain protection orders, seize firearms or other dangerous weapons and in general execute all due diligence in protecting the lives of women threatened by clients or partners (Amnesty International, 2008). The results of procedural analyses conducted by Amnesty International reveal that “members of the SAPS do not understand their legal responsibilities nor do they feel under sufficient pressure to fulfill them” (Amnesty International, 2008:31). The health care workers have also been guilty of poor service to victims of rape. Accounts have been written of workers who exhibit “unsympathetic, judgmental and impatient attitudes” to survivors of rape (Amnesty International, 2008:38).

In a study of the attrition of rape cases which pass through the criminal justice system, conducted by Vetten et al. they indicate that rape is a difficult crime to prosecute. In their exploration of the processing of rape cases in the Gauteng province they noted that 50.5% of the cases resulted in arrests. However, only 42.8% of the perpetrators were charged in court. Convictions only occurred in 1 out of 20 cases. However, the
perpetrators were convicted for lesser charges so the real conviction rate was only 4.1%. 15.6% of those convicted received less than the 10 year minimum sentence for rape (Vetten et al., 2008).

On account of the flaws in the system it has been necessary for several agencies to create clinics which address the needs of survivors of rape. In February 2000, *Médecins sans Frontières* and the Health Department of the province of Western Cape created the Simelela Clinic in Khayelitsha Clinic, Western Cape. Initially, the center was launched as an acute care facility for rape victims. However, in August, 2005 the center was designed as an acute care one stop center for rape survivors. The center provides emergency medical care and follow-up, psychological and social support, forensic medical examination as well as the opportunity to make a formal complaint to the SAPS. Additionally, the center offers a 28-day course of post-exposure prophylactics (PEP) antiretrovirals to individuals who come to the clinic within 72 hours of the rape. Individuals who are already HIV infected are provided ongoing treatment as well as access to ARV if needed (AI, 2008).

The Thuthuzela care center is another example of a facility which offers an integrated approach to care for the rape survivor. Thuthuzela, which is a *Xhosa* word which means comfort, is said to be “a critical part of South Africa’s anti-rape strategy and aims to reduce secondary trauma for the victim, improve the perpetrator conviction rate and reduce the lead time in finalizing cases” (www.unicef.org/southafrica/hiv_aids_729.html).
4.13  *A Review of the Impact of Violence upon the Epidemic.* The data presented in this chapter indicates that in spite of the Republic of South Africa’s constitution which clearly states that “everyone has the right to be free from all forms of violence from either public or private sources” (Bill of Rights, Constitution of the Republic of South Africa, Section 12, c) and several other acts of legislation enacted to redress gender-based violence, there is still a disproportionate number of sexual crimes perpetrated against women. Moreover, as the data suggests the sexual crimes may be linked to an increase in the HIV incidence and prevalence rates. As outlined in the Section 4.1 in large measure the violence may be linked to the legacy of Apartheid. However, the government of the Republic of South Africa may be culpable as well. Former President Thabo Mbeki expressed reticence in accepting the assertion that the Republic of South Africa was crime ridden. Mbeki proclaimed that, “A massive propaganda campaign has been conducted on the issue of crime, in many instances without any regard and respect for the truth. We will ourselves discuss this matter because of our own serious concern radically to bring down the levels of crime. However, what is necessary is that anybody genuinely committed to this goal should make an objective study of this problem and avoid the serious distortions which result from this exploitation of this issue for partisan political purposes” (ANC Today, vol. 7, no. 10, 16-22 March 2007, accessed 5/23/2007).

On another occasion President Mbeki stated that the perception of rampant crime was much greater than the reality. He claimed, “It’s not as if someone will walk here to the TV studio in [CNN, Johannesburg] and get shot. That doesn’t happen and it won’t happen.” However, in fact, weeks after this statement, the CNN correspondent, Jeff
Koinange and his pregnant wife were robbed at the station at gunpoint; the robbers stole broadcast gear worth tens of thousands of dollars (The Globe and Mail, March 31, 2007). Mbeiki’s defensive style was consistent with his insistence that HIV was not the causative agent of AIDS. Since Mbeki’s departure, President Jacob Zuma has condemned the violence and has offered some hope that the sexual violence against women will lessen.

Thus far, the government has been ineffectual in enforcing the acts of legislation. They must design a viable treatment system to support women who have been victims of sexual crimes. The failure to provide the resources for women will result in continued violence in the townships and continued proliferation of HIV/AIDS among women. This period would be an optimal time to work with researchers in the United States who have had to grapple with a surge in HIV/AIDS among the population of North Americans of African ancestry and increased crime in the inner cities. However, whether or not the government decides to work with international agencies, it must be more diligent in providing the resources to support survivors of rape.
CHAPTER FIVE
Shadow over the Republic of South Africa – How Challenges in the Economic and Education Sectors may drive the Pandemic

…”In socio-economic terms the legacy of apartheid remains entrenched and, with the massive loss of jobs in the past decade, even appears to be worsening. Wealth is still concentrated in a white minority. The nature of capital remains largely the same – concentrated in the mining-finance complex, which continue to dominate the commanding heights of the South African economy. Serious inequalities persist, with signs of worsening particularly among the formerly oppressed. The number of people living in poverty is staggering. Almost half of the population lives in poverty, including many of the employed- the “working poor.” Unemployment and underemployment are on the rise as more jobs are shed and people rely on survivalist activities to make ends meet. The complex nature of the transition emerged in deeply contradictory government policies.” COSATU policy statement, July 2001

The September, 2008 report released by the World Health Organization claimed that economic forces, may be important in determining morbidity rates and ones propensity in contracting certain diseases. Since wealthier countries and wealthier individuals enjoy greater health and higher income, there was every expectation that there would be a strong association between AIDS, a highly infectious disease and poverty.

Dr. Paul Farmer expressed these sentiments over a decade ago. Dr. Farmer maintained that poor women were at a greater risk of contracting HIV because their choices were constrained. He stated, “We can describe a political economy of risk that this exercise helps to explain where the AIDS pandemic is moving and how quickly – we begin to see why similar stories are legion in sub-Saharan Africa and India…these women have been rendered vulnerable to AIDS through social processes – that is, through the economic, political and cultural forces that can be shown to shape the dynamics of HIV transmission” (Farmer, 1998:121). Brooke Schoepf maintained that the virus was fueled by women’s need to survive economically. Women are forced to
engage in unprotected transactional sex which may increase their vulnerability in contracting HIV (Schoepf, 1998). Women in South Africa are considered vulnerable because they are largely absent from the “formulation of financial and monetary policies and tax systems. Women hold a majority of lower paid jobs and maintain little powerful administrative posts” (Schoepf, 1998:24). Moreover, “discrimination in education and training, hiring and pay promotion inflexible working conditions, barriers in the workplace and limited childcare services constrain women in the pursuit of promotion and higher salaries” (Schoepf, 1998:24). Deborah Posel pointed to the link between Apartheid and poverty as a contributing factor to the HIV/AIDS crisis in South Africa. She maintained that the apartheid policy facilitated the severance of family ties and the creation of new patterns of sexual behavior which placed both men and women at increased risk for contracting STDs and HIV/AIDS. The government’s influx control system placed women in the position of caring for their families single-handedly. However, since women were largely unskilled and poorly educated this situation limited the range of positions open to them. Women learned that they could earn more from part time domestic work and/or petty entrepreneurial activities such as the brewing and sale of sorghum beer and commercial sexual work than from full-time wage labor (Posel 1991). Although both activities yielded a more substantial income than formal employment, commercial sexual work placed women at a more vulnerable position for contracting STDS and/or HIV/AIDS. Peter Piot, the former director of UNAIDS, pointed out that since HIV in sub-Saharan Africa is transmitted principally by sex it may be economic transition that influences women’s vulnerability in contracting the virus.
In light of these statements this suggests that as a woman’s socio-economic status decreases her vulnerability in contracting HIV increases.

The socio-economic status is defined as a composite measure that typically incorporates economic status which is measured by income, social status, which is measured by education and work status, which is measured by occupation. Historically, the socio-economic status has been associated with the decline or amelioration of health outcomes. The following study argues that the economic degradation in the townships forces women to resort to survival/transactional sex in order to provide for their families.

It is important to note that there are two systems which continue to drive the informal labor force. During apartheid the system was driven by the influx control policy. The system forced men to leave the rural sector for mining work in the urban areas. Meanwhile remained behind and either waited for remittances from their husbands, worked illegally in the urban sector or worked in informal labor selling sorghum beer. The second wave of is said to be a result of the shift from the Keynesian economic strategy adopted under research and development policy to a neoliberal policy erected under the Growth Employment and Readjustment (GEAR) policy designed at the impetus of the World Bank. Activists and advocates blame this policy for the continued social and economic inequalities that plague RSA. They suggest that the increase in wage competition under trade liberalization has caused factory closings and has contributed to an unemployment rate which in 2007 was 26.7% for women. I fashion this chapter in three parts. In part one I examine the influx control system and the shift from the Redistribution and Development (RDP) program to the Growth, Employment and
Redistribution policy (GEAR). In part two I discuss how both the apartheid legacy and present economic policy serve as the catalyst for a phenomenon of truck stop prostitution that has fueled the HIV pandemic. Lastly, I discuss the paradox in the education system in which one observes that young women in the secondary and tertiary levels of the education are vulnerable in contracting HIV because they engage in sexual relations with older men (sugar-daddies) in exchange for amenities.

5.1 The Influx Control System. In the years between 1920 and 1948 both Black and White farmers in the rural areas were displaced due to the drought. The first wave of rural to urban migration found both poor Whites and Blacks flocking to the urban areas for unskilled positions. However, the Depression reduced the amount of available jobs for both groups and brought to the forefront white job protectionist policies which resulted in less job competition for Whites (Hindson, 1987, Elder, 2003). During 1923 to 1937 the government enforced a national influx control policy which removed Black women, children and “surplus” Blacks from the urban areas and relegated them to the rural reserves. The policy dictated that only family members who were “gainfully employed” in the formal labor market may work in the urban area. Both the farming and mining industries benefited from this policy in which extremely low wages were paid to the workers. The influx policy created a system in which African women were required to perform domestic duties in their homes as well as pursue (domestic) employment in rural or urban white households. African men, on the other hand, lived in hostels in the urban areas and worked in the mining sector where the wages barely provided them with the means to live in the hostels (Harris, 1987, Elder, 2003). When the pass laws were
relaxed in 1942 a large number of Blacks migrated to the urban areas where they had the opportunity to live as nuclear families in family housing for Black workers. Yard communities in Sophiatown allowed Black and White Bohemian South Africans to live side by side in a community which was described as New York Harlem in South Africa (Elder, 2003).

In 1952 the apartheid state enacted stricter legislation (The Native Laws Amendments Act of 1952 and amendments to the Urban Areas Act) to define the individuals allowed to live and work in the urban areas and who might be considered permanent residents. A black woman might only receive this status if she or her husband could prove that they had ten years of uninterrupted urban work. A rural woman might only come into the urban areas to seek work if she was accompanied by a male relative. Additionally she was only allowed 48 hours to acquire a position. The influx control was said to be “highly threatening for Black women. The implementation came at a time when new employment opportunities were opening up for women in urban areas…More importantly, influx control measures forced women into rural subsistence or the low-paying agricultural labor market…severely reducing women’s income-generating abilities” (Elder, 2003:62). After the African National Congress took control of the RSA government the population assumed that all economic policies would erase the poverty and degradation under which they lived during the apartheid regime. However, as the following section illustrates, the RSA government were soon forced to follow the same structural adjustment program that the World Bank and the IMF had suggested for other African countries.
5.2 The Shift from the Redistribution Development Program to the Growth, Employment and Redistribution Program. The African National Congress (ANC) outlined the principles of its new economic policy in the Discussion Document on Economic Policy, in the DEP Workshop in Harare, during September 20-23, 1990. The document proposed to: 1) Provide relief of poverty; 2) Reduce existing social conflict over unequal distribution of material resources; 3) Respond to the expressed expectations and demands of communities; 4) Correct existing biases and inequalities in resource allocation relating to race and gender and socio-economic divisions within the black urban communities.

After years of planning President Nelson Mandela selected Jay Naidoo to serve as the administrator of the Redistribution Development Program (RDP). Minister Naidoo controlled a special RDP fund which comprised several billions of Rand annually. The final proposal included the following goals:

<table>
<thead>
<tr>
<th>Housing</th>
<th>Affordable. 1 million houses in five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water</td>
<td>Within two years provide 20 to 30 liters of potable water each day to every person. Within five years provide 60 liters of potable water each day to every person. Potable water should be no more than 200 meters from their dwelling.</td>
</tr>
<tr>
<td>Electricity</td>
<td>Provide 2.5 million more households and all schools and clinics with electricity.</td>
</tr>
<tr>
<td>Healthcare</td>
<td>Children under six years of age may receive free medical care and improve maternity care for women.</td>
</tr>
<tr>
<td>Land Reform</td>
<td>Restitution to those who lost farm land during apartheid; Redistribution of land to those who need it.</td>
</tr>
<tr>
<td>Education and Training</td>
<td>Provide free education for everyone, small class sizes (no more than 40 students per class), and train new workers for technical positions to meet the burgeoning global economy.</td>
</tr>
</tbody>
</table>

Table 5.1 – Basic Services and Needs, Redistribution Development Program
One year after the adoption of RDP the ANC began to rethink its original economic policy. At the prompting of the Republic of South Africa’s domestic business sector, the IMF and the World Bank, the African National Congress agreed to shift its economic policy and to implement a program of privatization. Accordingly in 1996 under the authority of then Deputy President Thabo Mbeki, the Office of RDP was disbanded. Minister Jay Naidoo was assigned to other duties and DP Thabo Mbeki controlled the funds. Although the government proclaimed that RDP maintained was still of importance much of the objectives as espoused in the original plan were not realized.

Between 1994 and 2001 the following objectives were met.

<table>
<thead>
<tr>
<th>Key Programs</th>
<th>Governments’ Statement</th>
<th>Criticism and Backlash</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>1.1 million inexpensive homes</td>
<td>Only 30% of the housing complied with building regulation. Researchers pointed out that housing resembled structures implemented under the Apartheid regime. Housing was small, poorly constructed and dank.</td>
</tr>
<tr>
<td>Electricity</td>
<td>1.75 million homes connected to the grid</td>
<td>Infrastructure was inadequate to provide electricity for entire communities. As a result there were vast overloads which resulted in a great deal of blackouts.</td>
</tr>
<tr>
<td>Healthcare</td>
<td>Erected 500 additional clinics. 5 million people will have access to healthcare.</td>
<td>Individuals with access to healthcare increased only by 1.67%. Advancements overshadowed by AIDS pandemic as well as TB and Malaria epidemics. The life expectancy rate declined from 64.1 to 53.2.</td>
</tr>
</tbody>
</table>

Table 5.2 – Redistribution Program, Adapted from RDP, 2000

5.3 *Restructuring of the Reconstruction Development Program.* The government began preparing state companies such as ESKOM, the electricity provider, TELKOM the telecommunications provider, the arms industry and the transport sector for privatization. The costs involved in privatization resulted in an increase in the price
of electricity for domestic users. The government rationalized that in order to attract investors to buy ESKOM, the electricity company needed to make a return on its investment.

In all provinces the government tried to ensure that households paid for the electricity. In the poorest townships people who were unable to pay for electricity were denied electricity for years. Some individuals resorted to illegal acquisition of electricity whereas others resorted to the use of wood from the forest. In Soweto, the biggest black working class township in South Africa, cutoffs of electricity were made as part of recouping debt and making sure people paid for their use of electricity. At one point about 70% of the population owed money on their electricity bills. At this time the community formed the Soweto Electricity Crisis Committee to compel the electric company to offer electricity to everyone. The advocacy group mobilized the population around the popular slogan: Electricity is neither a right nor a privilege.

In order to enforce their demands the residents began reconnecting the electricity illegally when ESKOM disconnected one resident house. The campaign enlisted the assistance of youth, women and unemployed men and trained them to reconnect the electricity. The campaign was so popular that it caused the government to stop the procedures of cutoffs in Soweto (Bond, 2004).

In 1996 the government announced the implementation of GEAR. The objective of the plan was to support a tight fiscal and disciplined monetary policy toward increased foreign and domestic investment and priority public expenditures.
Unfortunately, the implementation of the program, at the urging of the World Bank has been said to “inflict hardships on the most vulnerable members of society, especially women and those with HIV seropositive family members susceptible to water-borne diseases and opportunistic AIDS infections” (Bond, 2004).

Eventually, RSA experienced growth although amidst unemployment rates that in 2007 were 27.6% for women. The unemployment rates in RSA have persisted for so long that there is reason to suggest that the income and expenditures of households in the majority of families income may be supplemented by women’s secondary employment in “survival sexual work” in canteens or bars. As is noted in the following study, increasingly, a large number of women in KwaZulu-Natal provide sexual services for the men who frequent the truck stops along the highway in KwaZulu-Natal.

5.4 Commercial Sex Work and Survival Sex. In the article “She Drank his Money” Janet Wojcicki interviewed women who exchanged sex for money or alcohol in shebeens or stokvels (taverns) in Soweto and the Hammanskraal town. Dr. Wojcicki performed her study in Soweto in 1999-2000 and in the Hammanskraal area in 1999. In Soweto, the field researchers interviewed 29 women and in Hammanskraal they interviewed 24 women who discussed the practice of survival sex and argued that violence is normative for women and in fact, is to be expected, especially for those who refuse to acquiesce to a man’s demands for sex after accepting drinks from him. Dr. Wojcicki pointed out that women emphasized the distinction between survival sex and commercial sex work. Survival sex work may involve performing domestic chores such as laundry, preparing food, et al.; there was the sense that survival sex was conducted
among more respectable women. Many perceive that commercial sex workers wear short skirts revealing their thighs, which increase the likelihood that South African men may rape them. One of the participants stated:

“Sometimes when they see you with a short [skirt], they see automatically your thighs are big and then they say, oh maybe…let me put it this way, maybe sometimes you are not fit, you are just in normal size of the body, I can say men they are stupid; whenever they see thighs, they turn on. However, additionally, commercial sexual work is considered un-African and “Western phenomenon” (Wojcicki, 2002:277).

One of the participants remarked:

“If they are doing it here [prostitution] and wearing short skirts, then they are going to be raped. If you are wearing short skirts, they go inside your home and rape you inside your home. Here [Soweto] is not safe because of their [prostitutes’] clothes. They are wearing short things and transparent things, they are not going to be safe, they are going to be raped…they are not going to get that money…people who know you are going to rape you” (Wojcicki, 2002:273)

Another reason why survival sex is unlike commercial sex work is in the type of financial transaction incurred; in the case of survival sex the financial transaction is not fixed and varies according to the partner. The subject revealed:

“You see, when it is his first time, I ask for a lot of money. It depends on how much money he has, but I want money. If he comes for the second time, I accept any money, like R20 or R50, because I’m assured that he is mine. The other one maybe he has got no money and he gives me R30, the other one R10, and the other R50 just like that. The transaction may also involve other items: They buy me beer, and as we are busy drinking, I ask him not to buy me anymore because I know the right time will come—so then comes the time when I have to go with him to his place. Along the way, I’ll explain to him my situation. Like I’ll tell him my financial problems and all that I want. Then he’ll give me money to buy the things that I want. At the taverns? This is how I get money. When I see some young man, I go to him and say, “Look, I have lost money for electricity units. So how about you giving me some money to buy those electricity units?” I know he is going to give me that money to buy electricity units” (Wojcicki, 2002:274).
On the other hand women who accept beers or other refreshments and refuse to engage in sexual activity are at an increased risk not only of rape but of physical assault as well. Culturally, the action is not even considered rape; there is an implicit agreement that the woman has consented to sex when she accepted the drink. In the isiZulu dialect, individuals use the phrase: Umuntu wondl’ ihashi akaligibelayo of whose translation is: If you don’t feed a horse, you can’t ride it. In another article addressing sexual workers in the Hillbrow/Berea/Joubert Park area of Johannesburg Wojcicki states that sexual workers have HIV prevalence rates of 50%. Sexual workers, who provide sex to truckers along the trucking route in KwaZulu-Natal also place themselves at an increased risk of contracting HIV.

In a field study conducted by Karim et al in 1991 and 1992, the authors revealed that women who work at truck stops are at the “upper end of the scale for risk of HIV infection” (Karim et al., 1995:1521). During the study ten in-depth interviews and twelve questionnaires were completed. The researchers discovered that the respondents had a total of 266 clients per week. The women only performed peno-vaginal sex because they found oral and anal sex were unacceptable. Although the women were able to obtain condoms they were rarely used. The women recalled that most of the clients refused to use the condoms and those who relented would refuse to pay them or would resort to physical abuse citing their dissatisfaction. As the authors pointed out the fact that the women could insist upon peno-vaginal sex only suggests they have some control of the situation. However, as the sexual workers pointed out their decision to forego the use of condoms is predicated upon the amount of money that they bring in
when they don’t use them. They state that they know the risk of HIV infection but they are worried about how they may feed their family and dependents in the present. They profess that they will worry about HIV/AIDS if or when they contract it (Karim, et al. 1995).

5.5 Education. Pettifor, Measham, Rees and Padian revealed that for “young women money is the prevailing force behind the formation of transactional sexual relationships (relationships in which women exchange sex for money or other goods) in South Africa and the proliferation of HIV/AIDS. Increasingly, transactional sex is considered common place and frankly essential.

Increasingly, transitional sex is considered essential for survival resources. Their hypothesis observed that a woman’s power to negotiate the use of condoms was compromised in transactional sex relationships and increased their vulnerability in contracting HIV (Pettifor, 2004).

The researchers collected data on sexual power, HIV risk behaviors and HIV serostatus from 11,904 interviews of men and women between the ages of 15 and 24 years of age. Although their primary interest in variables was HIV serostatus and condom use consistency, a subject which has been addressed in chapter three, this analysis is of interest because of its discussion of the relationship among money, education and sexual power. The researchers’ study revealed the following information: 1) Young women were more likely to have low condom use self-efficacy; 2) Older partner relationships were more common during which time condom usage was not discussed and/or practiced with their partner; and 3) Reduced education (no high school) (Pettifor et al. 2004:1998).
Although the researchers did not find a linkage between sexual power and HIV seropositive status the study did affirm a correlation between “two measures of sexual power, relationship control and forced sex and condom use consistency” (Pettifor, 2004:2000).

In another study Kalichman et al. worked with 499 individuals in impoverished African townships; 995 in racially integrated townships and 678 in non-impoverished neighborhoods. The researchers asked the participants to rate their experience with ten stressors: 1) housing; 2) transportation; 3) sanitation; 4) insufficient food; 5) HIV/AIDS 6) unemployment; 7) discrimination; 8) poor education; 9) violence and 10) crime on a three-point scale: 1-Not a problem; 2-somewhat of a problem and 3 - serious problem. In general, their results revealed that individuals living in the impoverished areas were more likely to have tested seropositive for HIV than individuals dwelling in urban residential areas. The researchers maintained that poverty-related stressors, such as violence, crime, lower access to education and unemployment were a strong risk factor for HIV. The writers reached the conclusion maintained that in order to alleviate the threat of AIDS it was important to eliminate the personal threats such as unemployment and reduced access to education (Kalichman, et al. 2004).

The aforementioned studies are important because they reveal how unemployment and reduced access to education have been identified as two determinants which may propel the disproportionate increase of HIV/AIDS among women. However, increasingly, some data show that young women’s enrollment in secondary and tertiary institutions matches or surpasses the enrollment of young men. Studies have
suggested that higher levels of education among women result in lower HIV prevalence rates. In RSA, there is a paradox between higher education levels and higher rates of HIV prevalence. Empirical evidence would suggest that the payment of school fees places a heavy burden upon the families of young women. In order to pay for food and other accommodations in order to continue their education women must often look to relationships with older men. Unfortunately, this action may increase their propensity in contracting HIV/AIDS.

In a direct repudiation of the Bantu Education Act of 1952 enacted during apartheid the RSA created the South African Schools Act. The Act dictates that the country redress past injustices in educational provision, provide an education of progressively high quality for all learners and in so doing lay a strong foundation for the development of all our people's talents and capabilities, advance the democratic transformation of society, combat racism and sexism and all other forms of unfair discrimination and intolerance, contribute to the eradication of poverty and the economic well-being of society, protect and advance our diverse cultures and languages, uphold the rights of all learners, parents and educators, and promote their acceptance of responsibility for the organization, governance and funding of schools in partnership with the State (South African Schools Act, 1996, No. 84).

The Education system in RSA is divided into three broad bands of education: General Education and Training, Further Education and Training, and Higher Education and Training. Education is compulsory for all South Africans from the ages of seven to fifteen and the school life is said to span 13 years or grades.
As the charts reveal, women’s enrollment in the secondary institution began to exceed that of young men in 1975. This trend continues among men and women between the ages of 20 and 24. In the context of secondary enrollment women have a substantial edge over 20 and 24 years of age. By the time men and women reach tertiary levels, women’s enrollment greatly surpasses the enrollment of males. In analyzing this observation we must ask why HIV prevalence rates surge among the population of “higher educated” young women. The statistics would suggest that intergenerational sex is an important indicator of transactional sexual relationships in which sex is exchanged for goods (more often) or currency.
In Figure 5.4 overwhelmingly young women between the ages of 15 and 19 engaged in sexual transactions with men who were at least five years their senior.

Women who engage in sexual relations with older partners increase their vulnerability in
contracting HIV because older men are part of a higher prevalence HIV group. Women who engage in transactional sexual relationships also maintain boyfriends among their own age group. Again, the multiple sexual partnerships increase their propensity to contract HIV. The results of the 2008 South African National HIV Survey bear witness to the fact that the prevalence rates for women between the ages of 15 and 29 remain high in the ages groups from 15 to 24 when women may be actively enrolled in secondary or tertiary school system.

![Partner is 5+ years older](image)

**Figure 5.4 – Reproduced from Nelson Mandel/HSRC Study of AIDS, 2010**

A review of the data in Figures 5.1, 5.2 and 5.3 juxtaposed against the HIV rates outlined in Figure 5.5 gives credence to the observation that rates may be high for young women who attend school because they engage in transactional sex for school supplies or for recreational or academic fees.
The revelation does indicate the need to revise previous assumptions about the relationship between access to higher education and HIV/AIDS prevalence rates and to conduct more rigorous fieldwork.

![South African National HIV Survey](image)

**Figure 5.5 – Reproduced from Nelson Mandela/HSRC Study of HIV/AIDS, 2010**

### 5.6 An Analysis of Poverty and Society in the Epidemic

The studies presented in this chapter clearly reveal that both the influx control policy enacted during the apartheid regime and the GEAR policy enacted under the watch of the African National Congress have contributed to poverty in the townships. Moreover, women’s attempts to provide for their families have made them more vulnerable in contract HIV/AIDS. It is apparent that the government has failed to provide for a population which, for many, keeps them mired in poverty. In the context of education the government’s promise to waive the education fees for students in the most impoverished townships is welcome news to their
parents. However, unfortunately, young women who attend institutions in the secondary and tertiary levels are being forced to engage in transactional sex by both their “sugar daddies” and their parents who see an opportunity to acquire items for their households as well. In this instance the government must be more proactive in providing jobs for their parents so that they may go about the business of caring for their own children.
CHAPTER SIX
CONCLUSION

When I began this dissertation I argued that a multidimensional analysis, which considers how socio-economic, cultural and political factors underlie sexual behavior, is important in reducing the incidence and prevalence rates of HIV/AIDS among women in the Republic of South Africa. Accordingly, in chapters three, four and five I explored how the role of gender power inequities, violence and socio-economic status propels the disproportionate proliferation of HIV/AIDS among women. These chapters also examined the specific legislative acts that the Republic of South Africa has enacted to enforce the adherence to bylaws of the Constitution of the Republic of South Africa. In the passage of these acts of legislation, the government demonstrates, albeit indirectly, that it possesses the political will to ameliorate the HIV incidence and prevalence rates. This action is important because the demonstration of political will, as reflected in the implementation and design of AIDS treatment and prevention programs, has proven to be an effective means of reducing the prevalence and incidence rates of HIV/AIDS in a country. The governments in Thailand, Kenya and Uganda illustrate successful models of prevention and treatment programs and are discussed in the following passages.59

In Thailand the first AIDS case was reported in 1984, but sources maintain that the widespread epidemic did not begin until 1988 during the so-called first and second waves of the epidemic, which spread among IV drug users and commercial sex workers (Porapakkham et al., 1995). The government’s response60 to the epidemic was slow until 1991, when the new Prime Minister, Anand Panarachun was installed. Prime
Minister Panyarachun made two decisions which marked the beginning of its new prevention and treatment program. The Prime Minister transferred the AIDS prevention and treatment program to the jurisdiction of his office and increased the HIV/AIDS budget from two million to forty-four million US dollars. In addition, the Thailand AIDS activist Mechai Viravaidya, mobilized a massive public campaign in which Anti-AIDS messages aired every hour on the country’s 488 state-owned radio stations. During this time discriminatory policies, such as the law requiring physicians to furnish the names and addresses of HIV/AIDS-infected individuals was repealed (UNDP, 2007). Between 1996 and 1997, the government provided AZT to pregnant women in order to reduce the incidence of vertical transmission of HIV. In summary, the government earmarked five strategies in mitigating the spread of HIV/AIDS. The strategies included: 1) The involvement of the community and family in prevention; 2) The establishment of health and social welfare services for the prevention of the virus; 3) The development of knowledge and research; 4) International cooperation; and 5) The management of systems to integrate all of the services (Phanuphak, 1985).

In Kenya, researchers discovered “the first AIDS cases in early 1982 among commercial sexual workers” (International Programs Center, HIV/AIDS Profiles, 2008:8). Although the government declared the epidemic a national disaster in 1995, it did not present a policy until 1999 during which time the government of Kenya transferred the National AIDS Control Council to the office of the President (The World Bank, Staff Appraisal Report, Kenya, 1995).
As in Thailand, the government asked that the HIV/AIDS policy be perceived as an expression of its commitment in reducing the spread of the virus (*The World Bank, Project Performance Assessment Report, Kenya, 2002*).

In Uganda some researchers suggest that HIV had begun to appear in Lake Victoria in the late 1970s. However, the first HIV/AIDS cases were not cited until 1982 (*Hogle, et al. 2002*). The sitting president of Uganda, Yoweri Museveni, established the first AIDS control program in 1986. The objective of the program was to educate the population about the risks of acquiring the virus (*Hogle, et al., 2002*). By 1992, the government had created a multi-sectoral approach which included the participation of several governmental agencies (*World Bank: Uganda-The Sexually Transmitted Infections Project, 2002*). In 1995, researchers noted that the prevalence rates appeared to be declining and the government proclaimed the program a success. In 1998 the government requested reduced prices for antiretroviral drugs and in 2001 the World Bank agreed to fund the program in the amount of 47.5 million US dollars (*Document of House of Parliament, Kampala, Uganda, March 21, 2001*). In the decades following the design of these model programs the incidence and prevalence rates ebbed or surged in accordance with the mission of the country’s leaders.

The government of the Republic of South Africa did not participate in a national HIV/AIDS plan until 2004, when it reversed its previous AIDS denialist policy and began offering ARV to its population of HIV infected women. Presently, one million individuals receive ARV through the international agencies President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund. Unfortunately, the program is not
sustainable under its present policy. Mark Heywood of the AIDS Law Project, stated that only forty percent of HIV infected individuals “who require treatment are receiving it” (Rabita Aziz, Growth and Challenges: South Africa’s fight against HIV/AIDS, ScienceSpeaks: HIV and TB News, August 30, 2010). Heywood ascribed the problems to “poor budgeting decisions, financial mismanagement and a lack of monitoring evaluation of HIV programs” (PlusNews, September 22, 2009). In 2009 alone the national minister of Health, Aaron Motsoaledi, admitted that there was a shortfall of R1-billion (US$123 million) to provide ARVs. Heywood also explained that the healthcare system is now more unequal than it was during apartheid. Additionally, the health care workers are poorly supervised and at a salary of US$100 they are poorly paid as well (PlusNews, September 22, 2009).

The Republic of South Africa’s failure to enforce laws which may reduce the disproportionate proliferation of HIV among women may be described as part of a “larger system of discrimination against women” (Cook, 1993:73) and is perceived as a violation of women’s basic human rights. This chapter suggests that the government may consider an agenda which raises the status of women by addressing the development of reproductive and sexual health services which advance health and rights to education, gainful and safe employment, and the right to live free of sexual coercion, discrimination and violence (Germain et al., 1994; WHO, 1997).

In the Republic of South Africa the mandates may alleviate surges in violence, especially in economically depressed townships as well as rural areas, redress the high unemployment rate and remove financial barriers to education through the elimination of
school fees and hidden costs of books and uniforms. This discussion considers the possible directives in improving women’s status, chapter summaries and future research agenda. Part one is a summary of the findings from the data analyses of chapters three through five. The second section describes the mandates that may be effective in increasing women’s empowerment and their ability to provide sustenance for their households. In part three an agenda is presented for future research which considers the ethical challenges in the microbicide and vaccine trials in South Africa.

6.1 Summary of Chapters. Although the government sought to redress the high incidence of sexual crimes with the passage of the Domestic Violence Act and to provide greater access to primary education by the cessation of school fees, it has been unsuccessful in enforcing these mandates. The more successful programs in the Republic of South Africa rely upon individual efficacy and grass roots organizations to mitigate the spread of the virus. For example, in chapter three the data revealed that during the course of six years (from 2002 to 2008) there was an increase in the reported condom usage among young women between 13 and 19 years of age. This finding suggests that young women are aware that consistent condom use is an effective preventive measure against contracting HIV and STIs. More importantly, the increase in condom use at last sex act may indicate an increase in women’s level of self-esteem which is reflected in a reduction in less risky behavioral practices. The HIV incidence rate has decreased in accordance with this perceived change in behavior. In this instance we observe that young women are taking an active role in reducing their vulnerability in contracting HIV/AIDS. But, surprisingly, the data on condom usage
and the results from questionnaires on the knowledge of HIV transmission are incongruent. In spite of the fact that young men and women between 13 and 19 years of age regularly receive educational talks on sexual and reproductive health only 40% of those surveyed reported the correct responses to a test on their knowledge of HIV/AIDS transmission. This discordance suggests that there is a need for additional research which addresses the reasons why young women have begun to increase their efficacy concerning condom usage. But as young women may be making strides towards reducing their vulnerability in contracting HIV, the government’s efforts in reducing the vulnerability have been less rigorous.

In chapter four the propagation of sexual crimes and the contraction in the number of prosecutions against rapists show that the government has been ineffective in reducing women’s exposure to violence. The South Africa Police System and the court system have summarily failed to react quickly to threats of violence. As a result of their inaction many women still find their lives threatened even after protective orders are filed against their perpetrators. The risk factor modeling showed that for every act of rape committed there is at least a .012 risk that the woman may contract HIV/AIDS.

Lastly, the South African economy has grown at least 5% a year and has experienced 32 consecutive quarters of positive growth. Although unemployment rates have dropped slightly and several hundreds of jobs have been created, the lives of women (and children) who are the most vulnerable members of the society are still mired in poverty (The Economist, October 10, 2010). Due to the effects of the influx policy of the Apartheid and the post-apartheid structural adjustment program, reflected in its GEAR
policy, many women must resort to transactional sex in order to provide sustenance for their families. The South African government has demonstrated the political will to increase the literacy of the entire population and the attendance of primary, secondary and tertiary. The government recognized that the payment of school fees prevented many students from attending school. As a result of this knowledge the government has waived the payment for primary school students in the poorest provinces (KwaZulu Natal and Eastern Cape) in South Africa. Unfortunately, these efforts do not apply to students at the secondary and tertiary levels. Therefore, young women who have acquired the funds to pay for tuition at the University level often do not have the means to pay for food and other necessities and must resort to transactional sexual encounters in exchange for these amenities. The failure to actively enforce any of the legislative acts and/or programs suggests poor planning on the part of the government and does not inspire confidence within the population. The government’s failures are perplexing because, unlike many countries in Africa, the Republic of South Africa has one of the most progressive constitutions and is said to have one of “the most integrated national gender machineries in the world to promote women’s equality” (Gouws, 2008:25). The machinery consists of an Office on the Status of Women, a Women’s Empowerment Unit, a Women’s Caucus in parliament, the Joint Monitoring Committee on the Quality of Life and the Status of women, gender desks in every state department at the national level with duplicate desks at the provincial level, and an autonomous Commission on Gender Equality (Gouws, 2008:25). Again, the machinery has been ineffective due to “overlapping mandates, poor communication, personalized politics, the lack of a feminist
agenda and the reluctance to make the government accountable for infractions against women” (Gouws, 2008:25-26). The following section proposes the adoption of several mandates first proposed by Adrienne Germain, the Vice-President of the International Women’s Health Coalition (IWHC) in New York, and colleagues Sia Nowrojee, formerly of the IWHC and Hnin Hnin Pyne, an AIDS specialist in the ASIA technical department of the World Bank, that addresses both development and human rights concerns and sexual and reproductive rights.

6.2 Mandates to redress the Violation of Women’s Human Rights. The first mandate will help to integrate women into the development process and would seek to “work with ministries of finance to increase investments in human development (health, education, water, sanitation, housing and social services)” (Germain et al. 1994:136). This effort would call for a restructuring of the economic policy in the Republic of South Africa. Presently, many South African women are unable to participate in the neoliberal macroeconomic framework. The market solutions have increased women’s vulnerability to poverty and their responsibilities in caring for members of the household. The infrastructure for social services is limited and is only available “for single women who are mothers, individuals who care for disabled relatives or those entitled to an old age pension” (Gouws, 2008:25).

The second mandate will promote primary health care and will require the design and development of a stronger infrastructure (Germain et al, 1994). When apartheid was dismantled the Republic of South Africa suffered the emigration of a large portion of its professional sector included members of the health profession. This “brain drain”
has left the country with a shortage of nurses and physicians to care for its population. The HIV/AIDS pandemic and re-emergence of other infectious diseases has resulted in a system in which many of the professionals are overworked and underpaid. The country may well benefit from the temporary immigration of nurses and physicians from other countries to train young women and men.

The third mandate may include programs to empower women in social and political affairs and to enforce laws on inheritance and demand that men be responsible for their own sexual behavior and agree to care for their progeny (Germain et al, 1994). It is important to request that the education ministries eliminate the gender gap in education and foster equitable gender relations (Germain et al, 1994). The ministries should enact and enforce laws which call for the prosecution of teachers who coerce young women and/or men into engaging in sexual relations in order to receive a favorable grade or in order to secure funding for school or recreational pursuits. The appropriate ministries may develop training programs for women in order to prepare them for vocational or technical quests so that they may obtain positions in the formal economic sector to provide sufficient funds to care for their children.

Lastly, it is appropriate to design programs to empower women to take responsibility for their healthcare and to work with men in accept accountability for their own sexual behavior. These mandates are not original or new to the literature. Clearly, given the Republic of South Africa’s inability to enforce laws or directives due to a poor infrastructure, insufficient resources and training programs it is important that its officials
reach out to other countries for assistance in training its population in order to meet the demands of the 21st century.

6.3 *Future Research Agenda.* As I stated in chapter one, the first HIV/AIDS cases were cited in the Mortality and Morbidity Weekly Report in 1982 and addressed the presence of decreased immune functions and the subsequent deaths principally among the homosexual community in the United States. As some members of the homosexual community maintained influential positions in the advertising arena as well as large amounts of disposable income, they influenced advertising companies to address the importance of limiting one’s sexual partners and to use condoms when engaging in oral and anal intercourse. Among homosexual communities in San Francisco and New York City a reduction in risky sexual behavior resulted in the closure of bath houses which produced a decrease in the incidence of HIV/AIDS. The homosexual community also mobilized to convince pharmaceutical companies to commit more research dollars to the development of a vaccine as well as the first generation of antiretroviral drugs. But, as we enter the third decade of the HIV pandemic studies suggest that the incidence of HIV/AIDS is on the rise among young homosexual and heterosexual adults. Some attribute the increase in HIV/AIDS rates to complacency. Due to the efficacy of antiretroviral drugs in the United States few young adults have (will) witnessed (witness) the deterioration of someone who is dying from PCP or wasting away due to fungal infection. They are aware that HIV/AIDS is now considered a chronic illness which may be controlled by total adherence to antiretroviral drug therapy. Also, their behavior may be attributed to their youth and perceptions of invincibility or the belief that the
contraction of HIV/AIDS occurs to other people. Accordingly, due to any one of these factors, the HIV/AIDS epidemic is surging within the community of young women (defined as women between 15 and 24 years of age) of African descent who were born in the United States. The incidence rates among young women of African ancestry who reside in Brazil, Jamaica and Trinidad and Tobago remains high. However, in South Africa, the data shows (and the incidence rates suggest) that young women between 13 and 19 years of age are utilizing condoms during sexual intercourse. Additional research may comprise an examination of the factors which contribute to the rise of HIV/AIDS among young women in these four regions. Additionally, for many women a microbicide is the only prophylactic that will enable them to protect themselves against contracting HIV. There is a need for research which reviews the ethical challenges confronting researchers when setting up trials. Some trials assess efficacy by using surrogate markers that test for CD4 cell count and viral loads. However, some researchers must use a placebo-control arm and they must wait to see becomes infected. The use of the placebo-control arm is troubling to the community which views it as another measure which increases a woman’s propensity in contracting HIV/AIDS. Nevertheless all topics present interesting topics in a future research agenda.

6.4 The Significance of Parental Monitoring, Self-Esteem and Socio-Economic Status. Risk-taking behaviors often share similar psychological, environmental, and/or biological antecedents. The hypotheses are: 1) As self esteem decreases, risk sexual behavior increases. According to Coopersmith, individuals “with low self-esteem are self-critical and note their shortcomings and deficiencies” (Bednar, et al. 1989:47).
Young women are much more willing to look to the external world and increasingly, to members of the opposite sex for a sense of self-worth. On the other hand, the young woman who has high self-esteem will be mindful of ways in which she may improve but she will not respond to them in ways that are self-denigrating; 2) As parental monitoring decreases, risky sexual behavior increases. Subjects who perceive that their actions are being monitored are less likely to engage in risky sexual behavior; 3) As the socio-economic status decreases, risky sexual behavior increases. In this qualitative study I will conduct five in depth interviews with each subject. Also, I will ask that the subjects complete a questionnaire. The study will culminate in a HIV/AIDS conference of young women of African ancestry from Brazil, the United States, South Africa, Jamaica and Trinidad and Tobago. A book will be generated from the presentations and discussions. The conference will make known young women’s thoughts on the pandemic’s impact upon their lives. As future wage earners they will certainly bear the economic burden imposed by the syndrome.

6.5  *Ethical Challenges in Microbicide Clinical Trials*. Since the South African government is not fully engaged in meeting its obligations in reducing the disproportionate proliferation of HIV among women it is essential to “widen the field of actors” (Mapping the Standards of Care at Microbicide Clinical Trials Sites, UNAIDS, 2009:16) in order to provide a higher level of care that is sustainable for its HIV infected population (USAID, 2009). It is clear that a collaborative effort among the South African government, donor organizations and pharmaceutical companies must be put in place in order to “fund massive research programs, to develop new diagnostics and
preventive measures such as vaccines and microbicides” in addition to providing ARV
drugs to its HIV infected population (UNAIDS Standards of Care, USAIDS, 2009:2).
The field of Bioethics, which is defined as “the systematic study of the moral
dimensions-including moral visions, decisions, conduct and policies-of the life sciences
and health care employ a variety of ethical methodologies in an interdisciplinary setting”
(Warren T. Reich, 1998:xxi as cited in Jousen, 1998:vii) is appropriate in guiding the
South African government and donors in answering key questions of ‘HIV related care’
(USAIDS, 2009:3) as well as addressing the range of full services and health care to
which participants may be entitled during clinical trials. Bioethics’ “concern
preeminently with the protection of vulnerable patients and research subjects”(Wolf,
1996:10) engages us in resolving moral problems that encompass “what constitutes a
reasonable package of care, and the competing demands on research funds” (USAIDS,
2009:4). In South Africa, the HIV/AIDS pandemic, the focus on human rights, brought
about by the death of Steven Biko\textsuperscript{62}, the transition to democracy as well as the HIV
dissident policy of Mbeki have led to a desire to increase the dialogue on bioethics.
Within the context of HIV, microbicides provide protection that women may have
without the active cooperation of a male client or patron (UNAIDS, 2009:3). Bioethics
may guide researchers to conduct ethically sound clinical trials for women of African and
European descent in South Africa.

Since microbicides provide a chemical barrier to HIV transmission and do not
interfere with physical intimacy and conception they may be used covertly by women
who otherwise have little control over prophylactic use and are considered the best line of
defense in the prevention of contracting HIV. “Microbicides are designed to block HIV infection by directly inactivating the virus or interrupting its attachment, entry, or replication” (Coplan, Mitchnick and Rosenberg, 2004:1911). In July, 2010 the director of the World Health Organization (WHO) Margaret Chan, congratulated scientists on the success of the microbicide trial of the anti-retroviral drug called Tenofovir. The study, called Caprisa 004, was conducted among 889 women between the ages of 18 and 40 at the Center for the AIDS Program of Research at the University of KwaZulu-Natal in South Africa. All of the participants were women who were HIV-negative, sexually active and considered at risk of becoming infected. “Half of the women were given vaginal applicators filled with gel containing 1% tenofovir. The other half of the women received a placebo. All of the women were given counseling on avoiding HIV infection and received a free supply of condoms” (S. Karim et al, 2010) The study revealed that the consistent use of the gel offered women 54% protection. However, even when women used the gel inconsistently they were afforded 39% protection. In 2011 the study known as MTN-001 made a head-to-head comparison between tenofovir gel and tenofovir oral tablets. The researchers discovered that the daily use of the gel had a 100-times higher concentration of active drug in the vaginal tissue than did the oral tablet. Interestingly enough 87% of Americans preferred the oral tablet. Whereas, 100% of the African participants said that they would use either product if it became available.

The Health Minister of the South African government, Aaron Motsoaledi stated that it would “fast track” the anti-HIV gel. Henry Gabelnick, the executive director of
Conrad, the US-based agency that created the gel, stated that “moves are already under way to smooth its path from concept to clinic” (Parker, 2010). Gabelnick revealed that the science and technology department’s technology innovation agency will set up a public-private partnership with a pharmaceutical company in South Africa. In an effort to push through collaboration Gabelnick has promised to bring in the top ten research units in the Republic of South Africa. Salim Abdool Karim, who is an HIV researcher, has agreed to set up a meeting that will be hosted by the South African government, the World Health Organization in addition to policymakers and ethicists. The implementation of the public-private partnerships will further RSA’s goals to reduce women’s vulnerability in contracting HIV. Moreover, Conrad, the US-based agency will have the resources, both in materials and in personnel to enforce the dissemination of the microbicides.

Although it would appear that efforts to collaborate are being met researchers are still challenged to secure and retain in their clinical trials a sufficient number of women of African descent of the Americas and the Caribbean in order to determine the efficacy of the microbicide for individuals of African ancestry. Additional research may comprise field work studies which consider why the number of Black participants remains low. The research may also address how pharmaceutical companies or agencies may provide participants with the access to successful treatment regime after the clinical trial has ended. These topics show the need to conduct additional studies that illuminate the factors that drive the proliferation of HIV/AIDS and determine the design of chemotherapeutic measures that will prevent women from contracting HIV/AIDS.
All studies are warranted in order to thwart the reduction in life expectancy rates among South African men and women, the disintegration of economic viability and reverse the pattern of degradation that continues to permeate the South African society.
Most people have been exposed to the microorganism that causes PCP. However, those who succumb to the illness are often severely immunosuppressed due to organ transplantation or chemotherapy. The medical history of these patients revealed no such presentation. Before the onset of this phenomenon scientists estimated that the non-African, non-AIDS KS affected primarily men of Eastern European or Italian ancestry in their sixth or seventh decade of life. The disease, which affects .02% of the population, was characterized as “idiopathic multiple projected sarcomas of the skin” and rarely proved fatal. In contrast the men who contracted the more virulent form of AIDS KS were predominantly Caucasian males in their late 30s. The illness attacked the gastrointestinal tract and lymph nodes and often involved lesions in the lungs, liver, pancreas, adrenal glands and spleen. Scientists noted that the populations affected by both illnesses were overwhelmingly Caucasian homosexual male (Annals New York Academy of Sciences, 1982:373-382).

This group was blamed by the heterosexual community for introducing HIV into The Republic of South Africa through what one specialist stated was “the perverted practices of promiscuous homosexuality” (Kaufman, 2004).

As stated in the article Freeing South Africa: The “Modernization “of Male-Male Sexuality in Soweto, South Africa, “gay people have always been present in South Africa black cultures. African traditional cultures dealt with things differently: I asked my grandmother and great-grandmother (she died at the age of 102). Within the family, the moment they realized that you were gay, in order to keep outside people from knowing, they organized someone who was gay to go out with you, and they arranged with another family to whom they explained the whole situation: “Okay, fine, you’ve got a daughter, we have three sons, this one is gay, and then there are the other two. Your daughter is not married. What if, in public, your daughter marries our gay son, but they are not going to have sex. She will have sex with the younger brother or the leder brother, and by so doing, the family will expand, you know” And at the end of the day, even if the next person realizes that I am gay, they wouldn’t say anything because I am married. That is the secret that used to be kept in the black community” (Donham, 1998:14-15).

The word Khoikhoi derived from the Namaqua dialect of indigenous Cape inhabitants. It is said that the cultural group Khoikhoi figures prominently in the history of South Africa for two reasons. They were, in fact, the first indigenous inhabitants to maintain a substantial amount of contact with the Dutch. Secondly, the Khoikhoi were said to be the descendants of the Cape Colored ethnic group. However, the historian Richard Elphick noted another salient point. Dr. Elphick maintained that the history of the Cape Khokhoi differed from other southern African peoples because their subordination was both structural and cultural. The descendants of the Khokhoi adopted the language, the religion and many of the cultural traits of the Europeans (Elphick, 1985).


799 heterosexual individuals at high risk for contracting HIV were enrolled in the study in South Africa. The study was simply “paused” in South Africa because it was not yet evident that the participants had the same reaction as the volunteers in the United States.

I use the terms as defined in epidemiology. Prevalence rates are defined as the total number of cases divided by the total population. The incidence rates are defined as the total number of new cases in a given time divided by the number of those individuals at risk for contracting a disease.
I refer to internationally recognized human rights such as women’s rights to health care and social services, education, equal protection under the law and special protection for children. I suggest that the government’s negligence in providing these rights for all of its citizens may be cited as a factor in the disproportionate increase of HIV and AIDS among women.

Dr. Clair Apodaca first proposed the use of process tracing to me in an e-mail dated April 7, 2007.

In 2008 Zimbabwe had the largest prevalence rate in sub-Saharan Africa.

Cases are “described as units of analysis. What constitutes a case, or unit analysis, is usually determined during the design stage and becomes the basis for purposeful sampling in qualitative inquiry (Patton, 2002:447). In this dissertation documents constitute the unit of analysis. Document analysis may comprise the study of “excerpts, quotations, clinical or program records, official publications or reports (Patton, 2002: 4).

This sentence was taken from a March 11, 2011 e-mail from Dr. Edmund Abaka.

The author points out that Frantz Fanon envisages violence as a “source of liberation for the subjugated masculinity of the black South African. Violence speaks to “ a cleansing force that frees the native from his inferiority complex and his despair and inaction” (Fanon, 1963:73).

It is important to note Sogoni’s account that violence in the mines was individualized. One could not be assured that other mine workers would help each other (Breckinridge,1998).

The report proposed: “1) The maintenance of the white population of South Africa as a pure white race by the complete elimination of any miscegenation between white and non-white; its (the white population’s) permanence as an independent political community and its further development on a Christian-national basis by the necessary protection in all spheres, and the drawing of a clear dividing line between white and non-white, thereby removing all possible causes of clashes of interest between white and non-white; 2) The maintenance of the indigenous non-white racial groups of South Africa as separate volk-communities (volksgemeenskappe) by combating all influences that undermine their respective identities, and the establishment of possibilities for them to develop separately, in a natural way, their own volk-character (volkstaard), capabilities and calling, complemented and fertilized by Christian civilization until becoming self-sufficient volks-units (volkseenhede); and 3) The maintenance of the traditional trusteeship principle. The cultivation of national pride and self-respect by each group and the encouragement of mutual esteem and respect among the different race and racial groups in the country” (DeVilliers, 1977:85).

The African National Congress was founded in 1912 under the name of South African Natives’ National Congress. The organization was comprised of professional men, intellectuals and chiefs who sought to “open a dialogue with the South African government in the hope of improving the African’s lot” (Feit, 1972). The government ignored their entreaties. It was the youth division that called upon the ANC “to [use] boycotts, strikes, civil disobedience and non-cooperation as weapons in the fight for liberation” (Feit, 1972:184).

The detained included Albert Luthuli, ANC President, Oliver Tambo, ANC Secretary and the former ANC Secretary, Walter Sisulu.. On December 17, 1957, the South African government withdrew the charges against 61 out of the 156 arrested due to the lack of evidence (Riley, 1991).

Native Affairs Minister Hendrik Verwoerd was elected Prime Minister leader of the National Party after the death of Prime Minister Strydom (Riley, 1991).
The production of beer was considered an informal economic activity which afforded women a second or third income from which they could run their household. Women accused the government of changing the law in order to make it more difficult for them to produce beer and generate an income. Also, beer purchased at the municipal hall was sold at a higher rate.

On March 16, 1960, the Pan Africanist Congress president, Robert Mongaliso Sobukwe informed the commissioner of the police, Major General Rademeyer, that they would be holding a five-day, non-violent, disciplined and sustained protest campaign. On March 18th he stated that “I have appealed to the African people to make sure that this campaign is conducted in a spirit of absolute non-violence” (Currey, 1999:259).

Welsh writes that the “fuse was lit when Geelbooi, a petty criminal who had been harshly interrogated by the police some months before, arrived on the scene, drunk, and on seeing the man he took to be his interrogator, fired two shots in to the air with a pistol. This episode coincided virtually to the second with a scuffle involving Spengler who, according to the police account, had opened the gate of the fence surrounding the police station to admit an African who said that he wished to surrender. The shots fired by Geelbooi and the stones being thrown, combined with Spengler’s fall, evidently panicked the police, who, without any order having been given by the officer in command, opened fire on the crowd and continued firing for some twenty seconds until order to cease” (Welsh, 2009:121).

The president of the PAC, Robert M. Sobukwe was sentenced to three years in prison for his part in the campaign against RSA’s pass laws. He spent an additional six years in prison under the Sobukwe Clause which gave the government the authority to imprison an individual indefinitely. He wasn’t released from Robben Island until 1969. After his release he practiced law in Kimberley, South Africa (Riley, 1991).

The General Amendment Law Act was “aimed at suppressing Black Nationalists (Riley 1991:83).

There was a large disparity in education as only ten percent of teachers in the Black South African system possessed professional teaching qualifications. It was noted that “Pupils found themselves in large classes, often in temporary accommodations at a distance from the main school building, under teachers who were dealing with secondary school work for the first time, and at the same time trying to cope with a strict application of the dual medium rule. Conditions were ripe for revolt, and the language issue added to the numbers explosion was to prove a powerful mix” (Hartshone, 1992:76 and as cited in Welsh, 2009:155).

The name was derived from South Western Township.

The policy of “one man, one vote, a Black majority government was approved under Rhodesian Prime Minister Ian Smith on November 24, 1977 (Welsh, 2009).

In fact it was remarked that more detainees died in custody between June, 1976 and October, 1977 than in the previous thirteen years. On June 25th, William Tshwane was buried before his family could view his body. On August 5th, Mapetla Mohapi was said to have hanged himself. On September 2nd Luke Mazwembe was said to have hanged himself with pieces of a blanket. On September 25th Dumisani Issac Mbatha died after becoming ill in prison (African National Congress, 1977).

The meeting between Botha and Mandela was said to create dissension and suspicion among members of the African National Congress and the Mass Democratic Movement (Welsh, 2009:377).

The Organization of African Unity (OAU) was instrumental in fostering the total abolition of apartheid. In a statement known as the Harare Declaration, the ad hoc committee called for the adoption of a new
constitution which comprised the following principles: 1) South Africa as a united, democratic and non-racial state; 2) A state where all people shall enjoy common and equal citizenship and nationality regardless of race, color, sex or creed; 3) A state where all its people shall have the right to participate in the government on the basis of universal suffrage, exercised through the one-person, one-vote system; and 4) A state where all people shall have the right to form and join any political party of their choice, provided that this is not a furtherance of racism (Declaration on the Question of South Africa, Organization of African Unity, August 21, 1989).

At the onset of the pandemic, the scientific community looked to the anatomical and histological differences between female and male organs in explaining women’s increased vulnerability in contracting HIV. There are several reasons why the physiological causal argument proved so pervasive. The female reproductive tract is vast. It comprises the vagina, uterus and extends to the fallopian tubes and ovaries. Spermatozoa remains inside the reproductive tract until it is absorbed. Spermatozoa infected with HIV encounters “a wealth of lymphocytes, mastocytes and plasmocytes which make the female reproductive tract extremely hospitable to the attachment of HIV” (Nicolosi, et al. 1994:574). Heterosexual women (and bisexual men) who engage in penile-vaginal or penile-anal intercourse are vulnerable to the HIV virus because semen contains a higher concentration of the virus than does vaginal fluid and poorly lubricated vaginal and anal areas may result in abrasions which increase ones risk of exposure to HIV. Within the last decade researchers have acknowledged that women’s physiological disposition may not fully explain the disproportionate prevalence of HIV among women.

In Human Rights and African Customary Law, T.W. Bennett points out that these women were the exception. Most women were willing to forego the promises of legal independence promised by the White colonial authorities. Women elected to remain under the patriarchal support of their father, brother or husband. (Bennett, 1999).

According to Valerie Oosterveld, the term “gender was first used and defined in an international criminal law treat, the Rome Statute of the International Criminal Court (ICC)” (Oosterveld, 2005:55).

Patricia Collins and Clenora Hudson-Weems believe that many North American women of African descent do not subscribe to “the Walkerian precept.” These authors coined the term Africana Womanism in acknowledging the cultural identity of North American women of Black Africa ancestry and in bringing to the forefront their relationship to Africa. Contrary to Ogunyemi’s statement the characteristics of the concept of Africana womanism are in fact aligned with an African praxis. Brenda Verner describes the concept thus: “We love men. We like being women. We love children. We like being mothers. We value life. We have faith in God and the Bible. We want families and harmonious relationships. We are not at war with our men seeking money, power and influence through confrontation. Our history is unique. We are the inheritors of African-American women's history, and as such we shall not redefine ourselves nor that history to meet some politically correct image of a popular culture movement, which demands the right to speak for and redefine the morals and mores of all racial, cultural and ethnic groups” (Verner, 1994:35).

“Genetical rights refer to the group character of marriage in patrilineal societies. The term infers that issue from the marriage become part of the father’s kin group. In circumstances of divorce the father’s family retains the children. Under uxorial rights the husband expects that “he will enjoy exclusive sexual rights to the woman” (Banda, 2005:109). If the woman commits adultery and bears a child that is not sired by her husband the husband may claim the adulterine child as his own or he may sue the adulterer for damages (Banda, 2005).
The laws were deemed ‘repugnant to the general principles of humanity recognized throughout the whole civilized world’. Later, in Natal, authorities acknowledged the necessity of recognizing customary law.

In this section I consulted the pivotal article, *Tradition and Domestic Struggle in the Courtroom* by Thomas V. McClendon which looked to a discussion of law and historiography. Of course in the literature on society and customs I consulted the standard Evans-Pritchard. However, for an overview of the “upheaval and change in Southeastern Africa” or the notion of the Mfecane I consulted Andrew Duminy and Bill Guest, eds, *Natal and Zululand From Earliest Times to 1910: A New History* (Pietermaritzburg, 1989) and *Sources of Conflict in Southern Africa, ca. 1800-30: The Mfecane Reconsidered*, *Journal of African History*, 33, 1 (1992), 1-36. Both of these sources were cited from McClendon’s article.

Shepstone’s policies included “the allocation of reserved lands for African tribal occupation; the recognition of customary law; administration through acceptable traditional authorities; the exemption of Christian Africans from customary law; and the attempt to prevent permanent African urbanization through the institution of a tort labour system” (Marks, 1978:174).

Jeffrey Guy in *Cheryl Walker’s Women and Gender in South African to 1945* stated that “On marriage women were given access to productive land, which they worked themselves. They were in control of the process of agricultural production and retained for their own use a substantial proportion of the product of that land and their labor. Work was heavy but it took place in a community which provided substantial security” (Guy in Walker, 1990:46).

Locus standi in judicio refers to one’s right to bring their case to trial and secure legal representation on their behalf.

For a more extensive discussion of the Native Land Acts of 1913 and 1936 and the Native Administration Act of 1927 please see Chapter Five. This chapter examines the relationship between land procurement and migrant labor practices and its affect upon women and children.

Shula Marks considers George Heaton Nicholls, who was a member of Parliament for Zululand and President of the South African Planters’ Union, an underestimated figure in the formulation of segregation policies. Marks’ article included quotations from private letters and memorandum in which Nicholls proposed “the maintenance of chieftain-dom. [For] the institution is the necessary pivot around which all tribal evolution must take place” (Ms. Nic. 2.081/Folder 3, pencil draft, nd/KCM 3323 as cited in Marks, ). Nicholls recognized that the magistrates would not use members of the Zulu royal family to serve as subordinate chiefs on the reserves. Instead Nicholls “co-opted” the Natal kholwa (African Christian) and other prominent African leaders ‘which set out the principle of creating reserves’ in which Natives would be enabled to attain a high standard of economic production under a system of local self-government” (Ms. Nic.2.08.1KCM 3350 as cited in Marks,).

Not all of the chiefs and/or elders accepted the laws being proposed by the Natal magistrates. Albert Luthuli attended the conference of chiefs and expressed dismay at the blatant acceptance of the policies concerning the land reserves. “Natal Africans appeared completely indifferent to the fate of their disenfranchised brothers in the Cape and the conference appeared to accept without criticism the proposals relating to land…We younger men were shocked and taken aback, but we did not see how to make an issue of it with a politically entrenched older man” (Luthuli, 1962:95-96).

The Natal Code formalized divorce by making it a “legal event” that took place before the Native
Commissioner’s Court. The plaintiff and defendant tried to show who was at fault. Wives (and their legal guardians) attempted to show that it was the fault of the husband so that their family would not have to return the cattle. Husbands tried to show that the woman was at fault so that the cattle had to be returned to them (so that they might remarry) or in order that the woman had to remain in his household (McClendon, 1995).

45 The ANC set up a Women’s Section in Tanzania. Also, for younger women while they were in exile they had the opportunity to pursue their education in academic centers in Tanzania. Some women were exiled in London and the United States (Ellis, 1992; Morrow, 2004).

46 In 1993 South Africa had not yet ratified the Convention, but article 18 of the Vienne Convention on the Law of Treaties 1969 (which codified customary international law) provided that a signature was sufficient “to impose upon it a general obligation to uphold the principles underlying the treaty” (Bennett, 1995:82).

47 The term Ukuhlonipha means Respect in Zulu language.

48 Having multiple partners and sexually transmitted infections (STI) are risk factors for HIV/AIDS. Since STIs increase one’s vulnerability in contracting HIV/AIDS, it is believed that STI levels of prevalence are a predictor of HIV/AIDS prevalence as well.

49 For additional information please see Chapter Five. This chapter outlines how low socioeconomic status may contribute to an increase in a woman’s vulnerability in contracting HIV/AIDS.

50 For a discussion of the methodology used in collecting data for these incidence studies please refer back to the section on Incidence as the Gold standard in HIV measurement in Chapter Two.

51 The researchers of the study do not specify the ethnicities of individuals comprised in the “Others” category. Because few White South Africans and East Indians attend public ante natal clinics one may probably assume that the majority of the individuals who are classified as Colored comprise the ‘Other’ category.

52 For additional information on ante natal clinics and data collection refer back to Chapter Two, Sentinel Data Collection.

53 The title is adopted from the paper, Dying of Sadness: Gender, Sexual Violence and HIV Epidemic, written by Peter Gordon and Kate Crehan and published by the United Nations Development Program. The paper cites the culpability of gender, the HIV epidemic and sexual violence in fueling the HIV/AIDS epidemic. During the Rwandan Genocide women who had been raped begged to be killed. Their tormentors refused and told them ‘you will die of sadness’. Women who became pregnant as a result of the rape have been shunned by their families. These women live outside of their community and care for children who were the product of an act of violence.

54 In the article Refugee Women, Violence and HIV, Lynellyn D. Long wrote that both women and men and boys and girls of all ages were at risk of sexual violation. She stated that the rape of men and their sexual mutilation were very common but vastly underreported (Long, 2004).

55 Also, he mentions that gendered violence is a function of the grid as well. He quotes Sanchez who states that “Historically, women have suffered first as victims of violence within spaces constructed as the private sphere, and second as victims of the law’s privatization of the violence they experience” (Sanchez, 1998;551 as quoted in Blomley, 2004). She maintains that the laws provide a space for women in the commercial sex trade. Periodic forceful displacement forces women in private or concealed spaces which
increases their vulnerability in the exposure to the sexual violence of men (Blomely, 2004).

56 In The Politics of Violence in Democratization Jacqueline M. Klopp and Elke Zuern state agree that violence “can be an intrinsic part of bargaining over political change” (Klopp and Zuern, 2007:140).

57 Researchers (Foss et al.) who modeled predictions of HIV due to rape have considered the transmission probability may be .001, .08 or .16. For the purposes of this chapter I used the more conservative rate.

58 The ‘paradox” has been used by Sir George Alleyne, the Secretary-General Special Envoy for HIV/AIDS in the Caribbean to describe this same phenomenon. Sir Alleyne maintains that the higher HIV prevalence rates are attributed to the fact that although education is supposed to help women develop higher levels of esteem/self-worth these young women are unable to serve as advocates for themselves in relationships.

59 In The Coming Plague, Laurie Garrett notes that the Zairian government was one of the first to accept the position that HIV/AIDS was a heterosexual epidemic. The government also has the distinction of being one of the first countries to work collaboratively to form a project which “focused on the scope of the epidemic and heterosexual transmission” (Garrett, 1994:350). Project SIDA was led by Jonathan Mann and included Zairian scientists Drs. Nzila Nzilambi, Ngaly Bosenge, Kalisa Ruti as well as Drs. Henry Francis and Tom Quinn of the National Institute of Allergy and Infectious Diseases. The HIV prevalence studies performed by the team revealed that having multiple partners, medical injections with nonsterile needles and foreign travel were the key risk factors in contracting HIV/AIDS (Garrett, 1994:351).

60 Thailand’s revenue from the sex and prostitution trade “equaled a quarter of its revenue from all rice trade income” (Garrett, 1994:468). Therefore, when the WHO Director-General Mahler expressed deep concern concerning the epidemic in mid-1987 the Thailand government tried to “repress or ignore the virus” (Garrett, 1994:468). The Thailand government responded to the concerns of the WHO by imprisoning HIV+ foreigners and by publishing and disseminating HIV/AIDS free certificates to prostitutes who serviced the tourist industry.

61 The adult prevalence rate is 1.4%. However, among the most at risk populations, the prevalence rate is: 1) 50% for female sex workers; 2) 30-40% for injecting drug users and 3) 24.7% for Men who have sex with Men (http://www.usaid.gov/our_work/global_health/aids/Countries/asia/thailand_profile.pdf). 76% of the HIV infected population receives antiretroviral therapy.

62 The South African Medical and Dental Council failed to acknowledge the unethical behavior of its medical practitioners who refused to treat Steve Biko after he suffered a severe beating at the hands of a Pretorian officer. Mr. Biko later died in prison of brain injury as a result of that beating (Benatar, 2006).
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“UNAIDS promotes Female Condoms in Developing Countries.” *AIDS Weekly Plus.* July 28, pp. 10-1.

“AIDS Chief says Nonoxynol-9 not effective against HIV.” *AIDS Weekly.* July 10-17, pp. 2-3.


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Feinstein, Andrew. 2000. *After the Party: Corruption, the ANC and South Africa’s Uncertain Future*.


Internet:
http://www.avert.org/safricastats.htm
http://www.reuters.com/article/2007/05/22/idUSL22578136
Appendix A

Etiologic Agent of HIV and AIDS

**Robert Gallo**, M.D. (1937-) Gallo and his lab were the first scientists to identify a retrovirus as the etiologic agent for naturally occurring leukemias, lymphomas and sarcomas in humans. Dr. Gallo received international acclaim for his discovery that HIV was the cause of AIDS and for the development of a blood test which detected HIV antibodies. For additional information please see: Bernard J. Poiesz, rancis W. Ruscetti, marvin S. Reitz, V.S. Kalyanaraman & Robert Gallo, *Isolation of a new type C Retrovirus (HTLV) in primary unclultured cells of a pateient with Sezary T-cell leukaemia*, Nature, vol. 294, 19 November 1981 and Popovic M, Sarnagadharan MG, Read E, Gallo RC (1984) *Detection, isolation, and continuous production of cytopathic retroviruses (HTLV-III) from patients with AIDS and pre-AIDS*, Science 224 (4648): 497–500.

**Luc Montagnier**, M.D. (1932-) and *Françoise Barré-Sinoussi*, Ph.D. (1947-)
Both scientists were the recipients of the 2008 Nobel Prize in Physiology/Medicine for isolating the human immunodeficiency virus from the lymph nodes of a French patient. [After performing a lymph node biopsy the scientists found traces of reverse transcriptase in the lymphocyte culture. The presence of RT indicated that the infectious agent was a retrovirus. The confirmation that the retrovirus was the cause of AIDS in the fall of 1983 and the winter of 1984 was based upon new evidence which looked to the high frequency of antibodies against the virus in the lymphadenopathy patients (Montagnier, 2002). For additional information please see: Barré-Sinoussi F, Chermann JC, Rey F, Nugeyre MT, Chamaret S, Gruest J, Dauguet C, Axler-Blin C, Vézinet-Brun F, Rouzioux C, Rozenbaum W, Montagnier L (1983), *Isolation of a T-lymphotropic retrovirus from a patient at risk for acquired immune deficiency syndrome (AIDS).* Science 220 (4599), pp. 868–871. In 1985 there was a dispute between Luc Montagnier and Robert Gallo concerning the issuance of patents for the HIV blood test. In 1987 President Reagan and Prime Minister Jacques Chirac reached an agreement that both countries should share in the patent royalties.

**Individuals prominent in the origins of HIV/AIDS**

**David Carr.** Reported to be earliest documented case of AIDS. Carr presented to the physician with purplish lesions, rapid weight loss, night sweat and general malaise. An autopsy performed after his death in 1959 revealed the presence of PCP and cytomegalovirus. Physicians reserved tissue samples to be used in follow-up experiments. [G. Williams, Tb Stretton and Jc Leonard, Cytomegalic inclusion disease and Pneumocystis carinii infection in an adult. *Lancet ii* (1960), pp. 951–55]. Subsequent studies revealed that the samples had been contaminated. There was no way of confirming that the gentleman died as a result of AIDS.
Gaëtan Dugas (Canadian flight attendant theory) During the 1980s North Americans apportioned blame for the spread of HIV to Gaetan Dugas. In an early AIDS study conducted by Dr. William Darrow of the Centers for Disease Control and Prevention Mr. Dugas was referred to as Patient O. It was believed that Dugas was Patient Zero because he was known to be a frequent visitor of gay bathhouses in New York and in 1983 had had sexual intercourse with at least 40 individuals out of the 248 known AIDS cases. (Jaffe HW, Darrow WW, Echenberg DF, O'Malley PM, Getchell JP, Kalyanaraman VS, Byers RH, Drennan DP, Braff EH, Curran JW, et al. (1985). The acquired immunodeficiency syndrome in a cohort of homosexual men. A six-year follow-up study, Annals of Internal Medicine 103 (2), pp. 210–4.

Arvid Noe. Mr. Noe and his wife and daughter, all of whom died from opportunistic infection as a result of their contraction of AIDS, died in 1976. Mr. Noe, a Norwegian sailor, traveled frequently to Africa, where it is believed he contracted HIV. This belief is based upon the knowledge that Mr. Noe had contracted gonorrhea and was active sexually outside of his marriage. (Frøland SS, Jenum P, Lindboe CF, Wefring KW, Linnestad PJ, Böhmer T (June 1988). HIV-1 infection in Norwegian family before 1970, Lancet 1 (8598), pp. 1344–5).
STAGES (Source: AIDSMEDS, The HIV Life Cycle)

Stage One: Fusion (Arrow 1 on the diagram)
HIV attaches itself to the human cell membrane of the lymphocyte T-cell or CD4. When HIV binds to CD4 proteins are released allowing fusion of HIV genetic information. A class of fusion inhibitors blocks the attachment.

Stage Two: Reverse Transcription (Arrow 2 on the diagram)
If fusion takes place HIV genetic material enters cell on two strands of RNA. The viral enzyme or reverse transcriptase makes a DNA copy of the RNA. The new DNA is called
proviral DNA. Reverse transcriptase may be blocked by class of drugs known as Nucleoside Reverse Transcriptase Inhibitors (NRTIs) and Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs).

**Stage Three: Integration (Arrow 3 on the diagram)**
The viral enzyme known as integrase enables the HIV DNA to hide undetected in the nucleus of the cell. HIV DNA is made when the cell attempts to make new protein. This process may be blocked by integrase inhibitors. This leg of the cycle may be blocked by integrase inhibitors.

**Stage Four: Transcription (Arrow 4 on the diagram)**
Viral DNA produces mRNA which contain the genetic material of the virus. This stage may be blocked by antisense anti virals or transcription inhibitors.

**Stage Five: Translation (Arrow 5 on the diagram)**
mRNA carries directions for making new proteins. Once the strands have been translated new viral proteins are made.

**Stage Six: Viral Assembly and Maturation (Arrow 6 on the diagram)**
Viral enzyme (protease) cut long strands of protein into smaller proteins. Some parts of the protein become structural elements of a new HIV or others become enzymes such as reverse transcriptase. This assembly may be blocked by protease inhibitors.
Anti-retroviral therapy

Treatment used (at least three antiretroviral drugs) “to maximally suppress the progression of HIV” (WHO, 2010). There are five classes of inhibitors: Fusion, Integrase, Non-nucleotide, Nucleotide and Protease.

Fusion or Entry Inhibitors

This class of ARV drugs prevents the “fusion” or “entry” of gp41 protein on HIV’s surface and CD4 cell. In March of 2003, the FDA approved Fuzeon, (Roche) a drug which targets the gp41 protein. In August, 2007 the FDA approved the fusion inhibitor Selzentry or Celsentri.

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Adverse reactions:
Hypersensitivity reactions have occurred in < 1% of patients and have included combinations of rash, fever, nausea and vomiting, chills, rigors, hypotension and elevated serum liver transaminases (Fuzeon, Patient product Information: Roche, 2010)

Integrase Inhibitors

This class of ARV drugs blocks integration or the inscription of HIV’s DNA onto CD4’s DNA. In October, 2007 the USFDA approved Merck and Company’s pharmaceutical Isentress. According to 48 week studies when taken in combination with other anti-HIV medications this ARV may reduce viral load to undetectable (less than 400 copies/mL, or less than 50 copies/mL) and may increase CD4 (T) cell counts (Isentress patient product information, 2010). Adverse reactions: Abdominal pain, gastritis, dizziness, genital herpes, herpes roster, hepatitis.

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Non-nucleoside Reverse Transcriptase Inhibitors (NNRTIs-non nucleosides or non-nukes)

This class of ARV drugs prevents the RT enzyme from converting RNA to DNA. HIV genetic material will not be transferred to the genetic material of the healthy cell.
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**Adverse reactions:**
Efavirenz – Dizziness, poor concentration, confusion, abnormal dreams, depression, drowsiness and skin rash.  
Nevirapine (Viramune®) – Skin rash  
Delavirdine (Rescriptor – Skin rash  
Sustiva – Nausea and skin rash

**Nucleoside Reverse Transcriptase Inhibitors (NRTIs) or nukes**
This class of ARV prevents HIVs RT enzyme from making a viable viral DNA. The drug structure resembles the human cell’s DNA. The HIV’s RNA uses the faulty DNA to convert to proviral DNA.
Adverse reactions: Mitochondrial toxicity which may lead to lactic acidosis. Symptoms include nausea, weakness, difficulty breathing, weakening of the leg muscles (Cichocki, 2008).

Protease Inhibitors
This ARV blocks the protease enzyme and prevents HIV from making new particles.

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Adverse reactions: Diabetes (This ARV may increase sugar levels); liver toxicity and lipodystrophy (AIDS Treatment Data Network, 2006).
Appendix D
Eastern Cape Province

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Source: South Africa Police System Statistics
Appendix L
Western Cape Province

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Source: South Africa Police System Statistics