"At First Blush"
Examining Adolescent-Centred HIV/AIDS Preventative Education in South Africa

By

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Abstract

The search by most individuals in South Africa for a healthy sexuality comes with recognizing that HIV/AIDS is now the leading cause of death. As such, their lives, the relationships that they establish and their efforts to maintain a healthy balance have changed dramatically. Disappointingly, the epidemiological trends, policy developments and social realities surrounding these efforts have not addressed sufficiently the structural deficiencies inherent within gender relationships, equal opportunity and the right to be healthy. Nowhere is this more the case than among adolescent and female populations.

This thesis argues that preventative education is one of the most important means of ensuring successful reduction in future infection patterns and that it must be participatory in nature. It is also argued that there is a need for expanding the role of education in disease prevention with the goal of ensuring gender equality and the meaningful inclusion of marginalized groups (such as adolescents) in future programming. At issue here is the need to consider the individualized nature of sexual choice making rather than through over-arching and over-generalized themes.

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Chapter 1

Introduction

1.0 Posing the Problem

What comes to mind for many people whenever the HIV/AIDS epidemic is discussed is the picture of some emaciated ghost of a human being, riddled by and dying from disease. Having said that, there are many people (particularly in the West) who have no idea what the face of this disease *really* looks like—just that it somehow encompasses the 'horror' of all things that could possibly go wrong with life, with sickness and with the need to face the inevitability of death. On a global scale, it represents probably the greatest humanitarian crisis in the history of the world not to mention the greatest example of socio-economic imbalance and international ambivalence. Given that seventy percent of all HIV-positive people in the world today live in sub-Saharan Africa (where an estimated 9 percent of its overall population is infected as compared to 0.6 percent of adults in the United States) and, where of the world's total 28 million AIDS deaths to date, roughly 26 million have been concentrated in sub-Saharan Africa, it becomes incomprehensible to think of what a continued trend in infection rates entails (Hunter, 2003: 45). No matter how one examines this epidemic,

the conclusion remains the same: the challenges presented as a result of increasing HIV infection and AIDS-related deaths are nothing short of tremendous. Furthermore, they incorporate directly a multitude of issues with respect to inequity, resource distribution and basic human rights.

On a personal and community level, the problem of HIV and AIDS intersects all aspects of how we understand human and gender relationships, our abilities to engage and interact with one another and to find meaningful connection in that interaction. Interestingly, when it comes to studying adolescents, the sexual engagement trends of both girls and boys are part of a worldwide pattern. Irrespective of where one lives globally, North America, Europe, Asia or in Africa, young individuals appear to be having sex at increasingly younger ages and have more partners by the time they reach twenty than their parents ever dreamed of (Hunter: 2003).

South Africa is currently experiencing one of the most severe examples of HIV/AIDS—concentrated primarily among the disadvantaged sectors of its population, although not limited exclusively to them. The Medical Research Council of South Africa has declared that HIV/AIDS is now the leading cause of death among South Africans and estimates that:

> About 40% of all adult deaths aged 15-49 that occurred in the year 2000 were due to HIV/AIDS and that about 20% of all adult deaths that year were due to AIDS. When this is combined with the excess deaths in childhood [they estimate] AIDS accounted for 25% of all deaths in the year 2000 and has become the single biggest cause of death. (Dorrington et al: 2001)

Despite some fluctuation between numbers, these projections clearly show that

without treatment to deal with the manifestations of AIDS and unless major behavioural change occurs, the number of AIDS deaths can be expected to grow and, within the next 10 years, to more than double the number of deaths due to other causes, resulting in 5-7 million cumulative AIDS deaths in South Africa by 2010 (Dorrington et al: 2001). Other projections, such as those put forward by Love Life (a consortium of leading South African non-governmental organizations which offer and implement a range of high-powered media, sexual health services, outreach and HIV support programmes) not only support these findings but are also estimating that there may be between 5.3 - 6.1 million infected by 2005; and between 6 - 7.5 million by 2010 (Love Life and Abt. Associates: 2001).

So what now? We understand HIV/AIDS in today's context to be a structural problem. In other words, by 'structural', the relationship between the health and HIV seroprevalence status of individuals—as affected by the socio-economic structures and constraints which surround them. According to authors Essex, Mboup, Kanki, Marlink and Tlou, there are four major types of structural barriers that need to be considered, and which will be explored throughout this thesis—as they affect not only the propensity for engaging in risk-taking behaviours but also in terms of encouraging behavioral change. They are: economic, political, socio-cultural and organizational barriers (AIDS in Africa, 2nd ed.: 517).

1.1.1 Economic Barriers

This category is perhaps one of the most widely discussed with respect to the history of the exploitation of developing nations by the West, the legacy of colonialism in Africa, who is responsible for the spread of disease in developing nations, the reluctance of drug companies to provide affordable medications and vaccines and who is now most responsible for fighting the AIDS pandemic. By economic barriers, particularly in the case of many African countries such as South Africa, this thesis refers to economic (under)-development, poverty, migration, seasonal work, social disruption as well as those economic trends brought about and facilitated by gender inequalities.

As far as economic barriers are concerned, M. Ankrah, in "Socioeconomic Decline and Health; A Double Crisis for the African Woman" (1996) argues that not only is the AIDS pandemic felt most acutely by women (because they are the most economically vulnerable) but that within the past 30 years, in which many African nations gained their independence, the African woman has experienced not one but two major crises. The first Ankrah argues, has been inherently socioeconomic in nature wherein women have had to deal with a reversal in their overall status not only through a loss in material well-being, but also as their expected advancement through national structures (into legitimate positions of authority and power) continues to be denied (Ankrah, 1996: 100). Severe gender disparities in Africa, particularly on an individual and community level, leave women poor and dependent on men for cash (especially when state structures do not exist to provide much needed social support) and create incentives for exchange of sex for money. The second crisis facing African women, she

argues, is that of AIDS. While socioeconomic setbacks obviously jeopardize the overall well-being of individuals, of women, and their families, AIDS is indiscriminate in its ability to infect and affect–therefore providing one of the most critical links between over half of the population, regarding health status, socio-economic development and the capacity of regions and communities to overcome decline in productivity levels and social stability (Ankrah: 101).

While immediate socio-economic consequences relate to morbidity and mortality, along with losses from the most economically productive age groups (those 15-50 years), long terms costs will not simply be felt in expenditures to health, education and preventative services but also in the loss of generative revenue, through shortages in labour supply and in the rural areas–where a majority of South Africans still live (Ankrah: 103). Since the role of women as breadwinners and as head of households has often been downplayed both within political and developmental spheres, policy makers, researchers and AIDS organizations need to begin focusing more attention as Frank (1989) points out, to the fact that while the African father and husband tends to be recognized as the head of the household, the principal economic support for the family–especially for subsistence–is borne and more often provided by the mother. Finally, as can be found in South Africa, this situation of female-breadwinners and economic supporters of the family is being significantly affected by the shortage of men in rural areas due to mobility and economic hardship and the ability of either group to monitor or seek treatment for the spectrum of associated illnesses suffered by those affected by HIV/AIDS.

1.1.2 Socio-Cultural Barriers

Since the naming of this disease in the 1980's, there have emerged some radically different understandings as to how HIV/AIDS came about, who was primarily responsible for the proliferation of its spread–with much of the research focusing on specific sexual, drug-using and risk-related behaviours (Klein, Easton and Parker: 18). Accordingly, HIV/AIDS prevention work has moved from targeting specific populations (such as sex workers, truckers, miners, drug users and gays) towards understanding HIV/AIDS within a much larger and more complex set of socio cultural structures (Aggleton 1996; Parker 1994; Parker, Barbosa and Aggleton, 2000). Much of this has to do with the fact that based on several decades of research information on its own *hasn't* proven enough to produce automatic risk-reduction and behavioural changes. There needs not only to be a greater degree of accessible prevention work, but more effective programs which uniquely and appropriately incorporate the needs of target populations—particularly if real reductions in infection rates are to occur. As such, there has been movement towards considering that political, economic and gender-based factors also play a central role in not only facilitating the continued spread of HIV/AIDS but in creating multiple barriers to effective HIV/AIDS programming (Sherr, Hankins and Bennett, 1996; O'Leary, 2002).

1.1.3 The Politics of AIDS Policy Making

The first major area of research to center around the politics of AIDS-related policy making relates to the impact of development as well as public health policies and

costs on governments. In the case of South Africa, extensive debate has surrounded the links between policies, structural adjustment programs and the socio-economic instabilities that contribute to and foster HIV transmission (Essex et. al.,; Bloom and Glied, 1993; Elmendorf and Roseberry, 1993; Sweat and Denison, 1995; Turshen, 1998; Quam, 1994). These will be explored throughout the course of this thesis but merit attention in that they play a significant role in either facilitating or hindering behavioural change in individuals and among communities.

For example, the two African countries that have successfully controlled AIDS, Senegal and Uganda, have done so, this thesis argues, because of the firm commitment and support from the highest levels of political leadership. In resource-poor environments, funds devoted to HIV prevention inevitably mean fewer resources allocated for more popular programs. Widespread misinformation, denial and the stigma associated with this disease also contributes to ambivalence about developing additional HIV prevention policies—particularly when or if in creating these policies, parties run the risk of stirring up controversy or losing political support (AIDS In Africa: 518). Finally, broad policy changes (such as alleviating poverty, increasing access to education or motivating health-seeking behaviour) are difficult, by their general nature, to achieve consensus on and, more importantly, to be implemented at ground levels.

1.1.4 Organizational Barriers

This final category seems to intersect with all others—particularly with respect to competition over scarce resources, cost-effectiveness and inter-level collaboration. Based

on recommendations put forward by SADC (The Southern African Development Community), the hope in terms of HIV prevention has been to delay the onset of activity among populations not yet sexually active, to increase condom use, to support and emphasize peer-based training and education and to increase the availability of mobile clinics plus educational and community mobilization programmes (AIDS In Africa: 519).

Based on the afore mentioned success of Uganda in reducing its new HIV infection rates, the key appears to be addressing organizational barriers from a holistic approach—in other words, focusing on young people primarily, on abstinence, faithfulness (such as their "zero grazing" campaign) on condom promotion but above all, demonstrating a *visible* commitment from the President in his call for widespread societal involvement (AIDS In Africa: 520).

1.2 Thesis Statement

While there are many ways of approaching the problem of HIV/AIDS in South Africa, and while all are important in one way or another, this thesis will focus primarily on the role of preventative education and its ability to effectively target and encourage behavioural change among adolescent populations. In particular, it argues that current policies and programming are *not* sufficiently meeting the needs of adolescents, and that evidence in support of this claim can be found in the fact that infection patterns among this age group continue to rise at alarming rates. Furthermore, these policies and preventative programmes appear to be failing in their ability to not only combat

pervasive ignorance—one of the major causes for the spread of AIDS—but also in providing consistent, sufficiently detailed and appropriately accurate information. This is particularly important for individuals and adolescents who have not yet engaged in sexual activity in that such information provides alternatives for protecting individuals from diseases and increases the chances that they will make (and continue to make) healthy choices throughout their sexually active lives.

Aside from the problems associated with socio-economic barriers, insufficient resource allocation, a lack of skilled personnel, insufficient research, flawed institutional structures and a legacy of racial and gender imbalances, you appear to have above all in South Africa, an enormous problem of policy implementation, inter-departmental cohesion, as well as follow up assessments and recommendations for innovative (yet realistic) improvements (Marias: 2000; Schneider and Stein, 2001). This thesis will focus on those areas in which the greatest gaps appear to exist, what key factors seem to contribute to them, as well as on what can be done in order to bridge some of these imbalances.

1.3 Targeting Adolescents

In order to understand the need for more effective adolescent sexual health education and interventions, it is necessary to review why adolescents are such an important target group and to investigate what some of the general and historical objectives have typically been emphasized in this area. One of the most important reasons for this is because not all preventative programs aimed at individuals

(particularly youth) have been related specifically to behavioural change but have instead taken on other prevailing social and medical concerns when dealing with adolescent sexuality.

For example, during the 1970's and up until the early and mid 1980's, most preventative programmes aimed themselves, rightly or wrongly, primarily at preventing teenage pregnancy (Fisher and Fisher, 2000). While the yolk of responsibility tended to be (and continues to be) placed upon the female, many preventative programs tended to reflect a "just don't do it" attitude or used general slogans like "Love Carefully" (Hunter: 2003).

With the introduction of HIV in South Africa by 1982, and as the AIDS epidemic grew alarmingly, educational and preventative program priorities changed drastically. Interestingly, although surveys conducted all over the world indicate that the vast majority approve of, and support the idea of teaching sex education and other associated life skills in schools, there remain considerable differences in opinion with regard to the nature, content and method for implementation of these preventative programs (Alexander, 1984; Gallup Poll, 1978; Fisher and Fisher, 2000 and Love Life, 2000).

Regardless of what view one holds regarding adolescent sexual education, research consistently shows that reaching early adolescents (before the age of sexual engagement) is one of *the* most critical juncture points in terms of both instilling and maintaining long-term appropriate and risk-free behaviours (Ford and Bowie, 1988; Flora and Thoreson, 1989; Jansen, 1995, Klein and Easton, 2002). Addressing this adolescent target group is critical primarily because it is the stage at which enduring patterns of

healthy behaviours are first established, and because establishing healthy patterns from the start is considered to be significantly easier to establish than changing risky behaviours once they have already been entrenched (Orenstein, 1994; Rosenthal, 1997; McKay and Holowaty, 1997; Fisher and Fisher, 1998 and 2000; Morrel, Unterhalter, Moletsane and Epstein 2001; O'Leary, 2002).

By targeting schools and by working towards ensuring the full involvement of young people (as part of their own solution), this thesis argues that not only can a larger number of the population be encouraged to affect responsible behaviours but it can also lead to an increase in general awareness, community-involvement, the provision of informed care and support and in challenging the current problems associated with stigma, vulnerability, power imbalances or outright forms of exploitation.

Well-meaning and even detailed policies are important in order to address one facet of the HIV/AIDS problem (that being a future course of action) but they are little more than that if they do not actively incorporate the collaborative potential and efforts of front-line communities and grassroots organizations. This is where the greatest gap appears to exist in terms of adolescent preventative programming in South Africa and where an important opportunity for change can, and should occur.

1.4 Theoretical Framework and Definition of Concepts

It is difficult to approach the subject of HIV/AIDS, preventative education and the disproportionate vulnerability of women with detachment. There are simply too many deep-seated questions about human values, sex-based differences in infection rates,

and about the profound differences between the underlying causes and consequences of HIV/AIDS infections in males versus females. These differences strongly reflect differences in biology, sexual behaviour, social attitudes and pressures, economic power and vulnerability. Furthermore, in so many ways, the inequities that women and girls suffer as a result of HIV/AIDS serves as a barometer for their general status in society and for the discrimination that they encounter in all fields—including health, education and employment.

Despite a rich multiplicity of views and diversity in experiences, generally, feminists share a recognition that women are oppressed in society, that this oppression takes on many forms and that it is often compounded further by other forms of oppression based on features such as race, ethnicity, age, sexual orientation and economic class. Because feminism considers oppression to be objectionable on both moral and political grounds, it seeks to transform society in ways that can ensure the elimination of such oppression in all its forms (Young: 1990).

HIV/AIDS is, for these and many additional reasons, inherently a gender-based issue and needs to be seen in this light if it is to be addressed and dealt with in the most effective way possible. In other words, gender analysis is crucial to understanding HIV/AIDS transmission, policy formation and the role of preventative programming so that appropriate programmes of action can be implemented in the future—for *all* individuals, visible or not. Key to this is an understanding of the socially constructed aspects of male-female relationships—which underpin individual behaviour, as well as the gender-based rules, norms, and laws governing the broader social and institutional

context. Good gender analysis does not imply that we treat women and men symmetrically, for just as class analysis can be used to understand and address the problems of the poor, so too can gender analysis be used in order to understand the nature and problems of women's subordination.

In South Africa, host to overwhelmingly high HIV/AIDS prevalence rates, large numbers of teachers, administrators and other educational employees are becoming infected themselves with the virus. This has a substantial impact upon the overall supply and quality of education; it has consequences for the planning administration and management of education; as well as on funding levels and strategies for future organization of the educational and health sectors. Overall, the available evidence appears to indicate that HIV/AIDS is exacerbating the gender-based disparities that not only already exist in educational and preventative sectors, but which, in most cases, disadvantages adolescent girls in their access to quality education, in preventing transmission and in influencing the social attitudes and cultural norms acquired by young people (UNAIDS, 1997, 1999 and 2000; Weiss and Rao Gupta, 1998; Weiss, Whelan, Rao Gupta, 1996, 2000).

In all of these areas, gender is a critical factor for it raises the flag that distinctly different approaches to both policy formation and preventative education are required in order to better address the separate needs of adolescent girls and boys. It also highlights the need to make available provisions which enable these same adolescents to adopt the beliefs, attitudes and behaviours that will not only safeguard their immediate situations but also contribute to a long-term social re-orientation which promotes and seeks to

secure gender equality.

1.5 Methodology

The methodological objective was first, to examine the extent to which HIV/AIDS interventions (both preventative and educational) have aimed themselves at and have been able to reach their anticipated targets. The general assumption at the beginning of this research process was that preventative programmes had not been reaching the mark—particularly given the rise in the numbers of new infections among adolescents in South Africa. Preliminary research and statistical data also indicated that young girls ranging from 15-24 years of age and young women between 25-29 years represented the greatest risk group and most noticeable rise in HIV infection levels (MRC Annual Report 2000-2001: 24).

In addition to the numerous books, journals and statistical reports that were reviewed, a large number of South African newspapers, government health and educational documents and non-governmental/civil service publications were collected and their content used in the formation of this paper. While these materials comprise the majority of this thesis' research and argument base, it should also be noted that four months were spent in South Africa collecting information, engaging in many conversations, meeting with a multitude of AIDS-related organizations, health practitioners, school administrators and municipal officials in the cities of Pietermaritzburg, Durban, Pretoria and Johannesburg.

Finally, perhaps the most important impact upon the scope and views of this

thesis arose from the day-to-day experiences of running workshops for roughly 3,000 adolescents (ranging from 12-20 years of age). This particular stage of research took place during the months of September and October (2001) and was generously funded through a CIDA Research Award for Young Canadians. Even though much of the material was anecdotal in nature (due to the requirements of this thesis could not therefore be included) it *did* fundamentally change the arguments, focus and views that are now being presented to you, the reader. The vibrancy, generosity, commitment and hard work of those working, learning and living in the reality of high seroprevalence is something that simply cannot be articulated—it must be experienced. It is the hope of this document then, that despite the enormity of information being provided, despite the differences in views, approaches and histories in addressing this issue, that the human element be maintained and at all times remembered.

1.6 Structure of Thesis Argument

Chapter two provides some theoretical exploration surrounding the topic of HIV/AIDS and takes a look at how notions of individual responsibility and the nature of human relationships have tended to be defined socially, politically and institutionally. In particular, it seeks to argue that, whatever one's culture and whatever one's gender, individuals are entitled to have at least two basic needs met. The first and most immediate need is to survive and be physically healthy. Physical health on its own however, is not enough. Both men and women will be prevented from realizing their potential when their need for mental health and equality of opportunity is also left

unsatisfied. Thus, inequalities in health between social groups are not simply inequalities in desired states of 'well-being' but rather represent objective inequalities in the capacity of individuals to play an active part in social and community life, to realize their fullest human potential and to help others do the same. Since this chapter wishes (through its argument) for the improvement in the situation of women as well as in physical and mental health (particularly as related to HIV/AIDS), it sees these two categories as strategic issues. The reason is simply that they provide the key to women's effective participation in and the overall possibility for a fairer and healthier society. In order for both women and men to flourish they must interact with one another. It is primarily through social participation therefore, that people learn what they are capable of and how these capabilities may best be used (Sen: 1985).

It is often in the everyday practices (or through everyday inaction) that the actual effectiveness of policies are reflected, as well as their ability to influence the capacity of either the state or other organizations to achieve their policy objectives. When it comes to challenging counter-cultural and sometimes unpopular notions of gender-equity, the routines and attitudes of ground-level educators can, and do have a significant impact upon the ways in which gender inequalities are experienced within the context of adolescent health education. Their practices further affect the self-interpretations and capacity of participant learners to adopt safe preventative behaviours. This happens through both the symbolic and actual mediation of so-called 'realities', as well as through contextual interpretations (particularly regarding 'appropriate' forms of behaviour) and by either assigning or withholding resources or information that might alter or

compromise the ability and willingness of individuals to inject views, to develop practices of their own, or to adjust programming to their own needs. Very often, ground-level educators are asked to implement a series of unclear recommendations or policy objectives, sometimes with little or no training (particularly in the case of many teachers) and are thereby required to selectively adopt ad-hoc methods of awareness-raising. They must also use their discretion to develop labels, coherent conceptions of health and sexuality and rationalize or modify their own understandings of the purpose of their work.

This chapter, finally, examines how, when it comes to the issue of HIV/AIDS, sexual health and individual choice-making, representations of gender difference and interpretations of women's versus men's needs very often come out in patterned simplifications as well as in the day-to-day routines and rationalizations of individual responses. That in turn, contributes and is connected to an entire cultural system which justifies asymmetrical rights, access to resources and value between women and men—on the grounds that women are not as significant as men.

Chapter three provides some of the history behind and evolution surrounding HIV/AIDS in South Africa, and will review some of the policy approaches towards preventative education through various governmental levels. Following the transition from an apartheid state in 1994, the South African government was required to shift from a predominantly centralized form of government towards a transitional local council form of administration. The practical implications of this shift were nothing short of enormous and have had a direct relationship with the tug-of-war politics that have surrounded the

issue of HIV/AIDS policy-making. In particular, many challenges remain with respect to who holds central responsibility for the funding, organizing and executing of AIDS-related treatment, care and preventative education and these challenges further serve to highlight the importance of incorporating community-level organizations and youth in addressing and participating in programme planning, implementation, monitoring and evaluation.

The concluding chapter of this thesis contains a summary of the main debates, issues and problems surrounding HIV preventative education and programming and also presents some suggestions for future improvement. Since individuals are not without some ability to choose and act on their own behalf, alternative approaches must begin by promoting good communication, flexibility and respect for changing inter-personal and social dynamics. Finally, it will reiterate one short but very central point: that ways of knowing and ways of doing are inseparable.

Finally, while this thesis cannot hope to address all of the issues surrounding adolescent preventative education, it can start by focusing on a few. Educating youth on the realities of HIV/AIDS requires addressing the relentless succession of stressful conditions that many of these young people face daily, as well as the continued and very real possibility of being asked to navigate through tremendously confusing and often-distorted structures. For example, where there exists a high reality of crime or violence (particularly towards women), where there exists the practice of continued disregard for their rights as individuals and where there is economic insecurity, a lack of community health or social services and high population turnovers, it becomes increasingly more

difficult to sustain and maintain stable and healthy inter-personal relationships.

These sorts of external pressures are often times the seemingly insignificant but compounding realities which prevent, in some cases, a full understanding on the part of youth of the associated risks for HIV infection. Schools, and the commute to and from them, are not the safe places that many assume or would like them to be. As mentioned earlier, given the higher concentration of HIV among young women (a significant proportion of whom are school age) and given the continued rise in new infection numbers, it seems appropriate to suggest that schools are a key site for intervention in order to address the topics surrounding HIV/AIDS, gender relations and the need to both make and support healthy choices.

Since preventative education entails much more than sets of rules concerning what to do and what to avoid, it requires acknowledging, from the onset, that human beings behave differently in different contexts, and that more work needs to be done in terms of understanding how and under what conditions people might be prepared to change particular behaviours and sexual patterns. Because changing learned sexual behaviour is extremely difficult, the best hope for success in preventing the future spread of HIV lies in empowering children and youth with the knowledge, attitudes, values and lifeskills that they need in order to feel confident about making good choices. Good policies therefore, need to work less at describing society and content and instead towards *understanding* it. In order to do this, policies, as some have suggested, need to begin confronting and critiquing the ways in which notions of cultural traits and community values have colluded with the epidemic and have sabotaged effective

interventions (Marias: 2000).

What this means in practical terms, is that AIDS needs to be seen less as a reflection of the status quo, fueled by certain contributing variables and factors (such as poverty, discrimination, powerlessness and so forth) and more as an opportunity for compassion, leadership and human understanding.

Chapter 2

Creating Space; A Gendered Approach to Understanding HIV/AIDS and Adolescent Preventative Education

Society does not conceive of men in terms of gender; it conceives of them gender-neutrally, as persons. Thus, men's identity and experiences serve, in effect, as the characterization or standard of what it is to be a person. This is true only of men's identity and experience; it is not true of women's. (Debra DeBruin, 1994)

There are obvious differences between male and female patterns of sickness and health. Not surprisingly, many of these stem, in part, from biological differences between the sexes. But as we shall see the situation of health, development and HIV/AIDS is more complex than might at first appear. As such, gender differences surrounding health are especially important to pay attention to since they flag other areas of inequality and discrimination which continue to exist in societies the world over. Though female subordination can take many forms, it is an extremely pervasive phenomenon and demonstrates "both endless variety and monotonous similarity" (Rubin: 1975). This does not however, mean that as an exclusive result of subordination, *all* women are worse off in every way than all men. What this point suggests rather, is that in most societies, the male is, and continues to be more highly valued than the female. This in turn, transfers itself to health and socio-economic spheres when men are placed in

dominant positions with respect to the allocation of scarce resources, the privilege of disclosing (or not) one's health status, maintaining positions of power, decision making as well as the status associated with being the head of the household.

As argued by Susan Hunter in her book Black Death, since in many parts of Sub Saharan and Southern Africa, women tend to be much less informed than men with respect to HIV/AIDS, the virus is spreading much more rapidly among females than their male counterparts (2003). Furthermore, even if women are aware, she argues, their right to refuse sex is often limited and, when or if they demand condom use, they run the additional risk of partner violence. According to UNAIDS 2002 "AIDS Epidemic Update" women with HIV are much more likely to have a physically violent partner, and almost half believe that they could not deny their husbands sex after a beating or if they feared HIV infection (29). Women also routinely have more illnesses but are less likely to receive medical treatment, and girls, not boys, are the ones taken out of school to replace lost labor from AIDS deaths in families or to care for sick family members (29).

But while HIV/AIDS can be argued as an epidemic that affects women disproportionately more than men, it is also, as pointed out by a 2002 World Bank study, a loss that is everyone's to be felt. In Sub-Saharan Africa, gender discrimination has reduced per capita economic growth in the region by 0.8 percent each year since 1960, roughly the same annual loss that the Bank's experts attribute to AIDS. Given that almost 70 percent of the world's 1.2 billion extremely poor people are women makes this not only a gender issue but a global issue (World Bank: 2002).

Though theorists have posited many reasons for the discrepancies between levels

of awareness and the subsequent behaviours required to prevent risk for HIV infection, as we have seen, the numbers continue to rise. As such, this thesis argues that a gendered perspective, both theoretically and in terms of practical application, is not only relevant but *imperative* if, what one is aiming at, are interventions which seek to improve the socio-cultural obstacles to women's empowerment and to help curb HIV/AIDS.

Because the decision-making process lies at the heart of so many of the issues surrounding this epidemic, the gender dimensions of HIV infection and AIDS has become an important area for preventative education to focus upon. For example, it is a well-known fact that women are particularly vulnerable to HIV infection because of the interplay between biological, cultural and socio-economic factors. Furthermore, the inequity that women and girls suffer as a result of HIV/AIDS serves as a barometer of their general status in society and of the discrimination that they encounter in all fields, including health, education and employment. It is for these reasons, that HIV/AIDS is inherently a gender-based issue and why it needs to be seen in this light if it is to be addressed effectively in terms of preventative efforts.

Key to conducting a sufficient gender analysis of HIV/AIDS therefore, is an understanding of the multiple social constructions and aspects of male-female relationships that underpin individual behaviours and choice-making processes. Fundamentally, these gender-based rules, norms, and laws govern the broader social and institutional contexts in which HIV/AIDS has emerged and which affects the basis of and opportunity for prevention and change.

2.1 A Strategic Perspective

Adopting a strategic feminist perspective (Moser, 1993 and Doyal, 1995) is an important starting point when addressing the need to reduce the unique vulnerability of women and adolescents to HIV/AIDS. It acknowledges for example, the need to change those environmental and structural factors that typically render women more vulnerable than men, and which reinforce the perpetual subordination of women's power to men. The trusty feminist adage 'the person is political' remains as true today as it ever was primarily because it draws attention to the lived politics of gendered policy.

This is particularly important in the areas of health and preventative education for it shows us how the macro-political policy process (from design to implementation and back again) is constructed by the on-going struggles and experiences of individual people in their respective communities. Very often, the discourse surrounding HIV infection and AIDS as an epidemic—in international development theory, educational programming and practice—finds itself guilty of universalising concepts, trivializing the issues and problems around gender and of distorting conservative perceptions about gender and ways to prevent infection—thereby maintaining the subordinate position of women in society and in individual relationships (Payne: 1991, Doyal: 1995, Koblinsky, Timyan and Gay: 1993).

As such, when it comes to the idea of mainstreaming gender, it is important to start with a strategic set of goals in mind but also to look closely at local and individual decision-making levels (Moser, 1993). The reason for this is that local arenas are arguably the closest to the home and private sphere and therefore have the greatest

capacity to deliver both positive and tangible improvements in women's day-to-day lives. Since discrimination generally, but particularly against those living with or affected by AIDS, is able to layer itself upon other already existing forms of discrimination, and since it most deeply impacts upon marginalized groups in society, it remains incredibly difficult to measure the full impact of this disease as a gender issue. As such, it requires careful and deliberate attention.

2.1.1 Are Women Really the Weaker Sex?

According to Herbert Daniel, "like every other epidemic, AIDS develops in the cracks and crevasses of societies inequalities [therefore] we cannot face the epidemic fully if we try to hide those contradictions and conflicts which it exposes" (1989: 38). Feminism seeks, as diverse a theory as it may be, to factor into consideration not only the current dynamics of the HIV/AIDS crisis but also the structural history of gender, sexuality, imperialization and the unhelpful polarization of the body and culture by arguing that women have not only fallen into the cracks of marginalization, but have, in some cases, been relegated there deliberately. In this era of global epidemics, it further alerts us to the cultural constructions of material life—but without arguing that cultural discourse is all that there is. In other words, it highlights the fundamental need to develop new and more inclusive theories surrounding the body, of the interchanges between relationships and how, as a society, we understand the disproportionate exclusion and targeting of women.

Because gender analysis helps us to understand why such exclusion has

contributed to women's higher risk for infection not only biologically, but also in terms of social and cultural history, it provides an excellent planning tool for preventative and educational programming. It also forms the basis for this thesis' incorporation of both the Gender and Development (GAD) approach, but also for considering other critical feminist approaches when analyzing HIV/AIDS preventative programming in South Africa. At the heart and purpose of this approach, is the need to "effectively aid the goal of the emancipation of women, through strategies to challenge and overcome oppressive roles and relationships" (Moser, 1993: 83).

2.2 The Makings Of A 'Good Girl'

Traditionally in education, many of the so-called 'life skills' that young girls were expected to develop were those which would secure their cooperation as mothers, wives and generally, good women. They were expected to acquire good household management, child and health care skills. Some 'consciousness raising' was also promoted, with the purpose of emancipating women, of improving their social position and/or by 'modifying' their way of looking at life. In other words, education aimed at carving for many women, a reality that was based on the expectations of others—notably men (Waylen: 1996). There occurred because of this, the convergence between state and educational services with the goal of advancing and incorporating the 'native race' generally, but women and girls particularly—through education—and as a means for upward mobility. As illustrated by Elizabeth Schmidt's article, "Missionary Education for Women and Girls: The Domestication of African Women", with their domestic

training, women could become nannies, servants and seamstresses, helping to build independent economic bases but not to the extent that they challenged traditionally male domains. Those with higher levels of education, she argues, could become teachers and nurses, the professions par excellence of the emerging African female middle class (1992). What is important about her article on the instillation of educational structures, and why it continues to pertain to the issues surrounding HIV/AIDS prevention work, is that despite attempts to reinforce a certain sense of 'duty', despite presenting the idea of 'values' as a means of upward mobility or avenue for advancement, African women's opportunities continued to remain limited.

Other academics (Walker, 1997 and Ranger, 1997) also argue that there is a clear disjuncture between what women experience and articulate as their needs, on the basis of which they challenge domestic gender relations in a particularly immediate way, and what they say about 'tradition' more generally. Women, both authors argue, seem more likely to uphold tradition in relation to community affairs, which they experience as somewhat more distant. Terrance Ranger, in his piece "The Invention of Tradition in Colonial Africa", illustrates that the legacy of colonialism has brought out two very important things with respect to how women have been systematically relegated into the margins of society. The first, he argues, was the practical breakdown "of many customary institutions regulating the relations between the sexes, a breakdown almost always disadvantagious economically to women" while the second was "the constant appeal by men to 'tradition'" (1997: 609). In fact, Ranger also reminds us that the collection of colonial records on African 'tradition', on which so many of today's

conventions and customs are based, were exclusively derived from male informants—to the point that indigenous female beliefs remained unrecorded. Thus, he argues, men's dominance in society, that is, their control over religious and social beliefs and political organization, was often validated through a process whereby the authenticity of 'custom' could clearly be questioned.

The dissonance between ideology and practice may not however, even be self-conscious in women's accounts, but nonetheless poses a challenge to patriarchal power. Here, the extent to which women are organized and brought into contact with new discourses around gender is likely to play an important part in making their articulation and power to demand equality a more overt process. By putting on the policy agenda, issues that include women's representation within community structures, and by creating space for legitimating women's claims for greater participation in community affairs, there is opportunity to improve thinking about how priorities and needs are conceptually constructed. There is also occasion to express and better understand the relationship between interests, prescribed gender roles, and what individuals believe are both possible and desirable. Very often, the perceptions of these individuals are shaped (to varied levels) by the economic reality of low or non-existent returns as well as by their community's historically determined dependence on urban or informal-sector jobs and wages.

In order to more effectively promote HIV/AIDS programming—particularly programs aimed at adolescents and women—policy planners and educators need to better develop identification criteria so that they do not trap individuals underneath processes

which prioritize gender over other social divisions and which represent all women as members of the same oppressed group, unified by their experience of male domination and their uniquely female emotionality (Doyal: 1995). According to numerous researchers (Barret and Phillips, 1992; Braidotti *et al.,* 1994; Mohanty *et al.,* 1991 and Nicholson, 1991) this is not only inaccurate and inappropriate, but negates the importance of hearing the 'many voices' that make up the title of 'woman'. Instead, they argue, greater emphasis needs to be placed on the differences between women; working-class women, lesbians, black women, women with disabilities and women from third world countries. These differences in turn, should be seen as contributions to the process whereby social constructions of health and sickness offer important examples of how such links are forged in concrete historical circumstances. As can be seen, there are very marked inequalities in the health status of women from different classes and racial backgrounds. Having said this, the greatest disparities are those that divide the majority of women in the developed countries from the majority of those living in what is often called the 'third world'.

The preventative framework needs to incorporate, alongside the ideals of gender equality, practical steps for promoting infrastructural and social development, including clinics, schools, adult education and re-training programs, affordable transportation and communication networks. The reason is that without access to such services and facilities, many women and their families are simply unable to access the educational programs that promote their awareness and empowerment and are unable to access health care sufficient enough to allow them to live their day to day lives to the fullest potential.

As stated earlier, it is their basic and fundamental human *right*. The challenge therefore, in responding to any pandemic lies in addressing not just the infection itself but also the conditions that make infection possible. As such we must not only understand but incorporate how diseases such HIV/AIDS affect the multiple aspects of an individual's life and offer visible support for the improvement and accessibility of services for those most marginalized by society. So often, these are the poor, the non-white, the young, the old, the rural and the women.

As per preventative planning and policy work, the household also represents an important unit which needs to be disaggregated, so that the power relations and inequalities inherent within it are fully recognized. However, planning and policy development must do so without abandoning larger planning goals on the basis of the household—as is often done when 'responsibility' is reduced to and designated as the problem of small groups or individuals. It is not. Responsibility not only changes from person to person but represents a multiplicity of different understandings between communities, countries and international regions. By assuming that the responsibility for adopting safe behaviours is 'purely' an individual problem, one runs the risk of undermining those other social and familial networks that are so essential for daily survival.

As stated, these household and social forms are not only variable but need to be incorporated into flexible structures rather than into the top-down bureaucratic approaches that have been favored in the past. At macro-levels, the principle of gender equality in the South African constitution needs to be given greater substance on the

ground, if truly participatory HIV/AIDS preventative programs are to succeed in the face of strongly entrenched patriarchal attitudes and institutions. This will require commitment (at all levels of civil-service, private and non-governmental organizations) to the principle of gender equality—as well as the difficult task of applying such commitment to practice. Thus, education and training for gender equality (and how in turn, it relates to the health and well being of society as a whole) are *essential* components to working towards the goal of HIV reduction in South Africa.

2.3 Categorical Assessments

There are three main categories that must be considered when strategically assessing HIV/AIDS prevention programs and policies. Falling under the first category are those programs which concern themselves with the reproductive rights of women exclusively. The second category pertains to areas where the exercise of power exists between women and men while the third category deals with those programs that promote gender-neutrality and which stress gender equality—even when acknowledging that the affects for men and women are felt differently (Moser, 1993 and Kabeer, 1994). It is the category of power distribution that is not only the most problematic, but with respect to the topic of this thesis, the most relevant. This is because the formulation and distribution of power dynamics entails at its core, the reshaping of constructions and understandings of gender and gendered roles and which also sit at the base of interpersonal communication, negotiation and healthy choice-making between males and females.

So what does this mean for preventative programming? Theoretically, it means that academics and ground-level advocates must recognize that the social consequences of promoting 'new' understandings of gender often is, and will likely continue to be met with considerable resistance from both men and women alike. This presents challenges not only in terms of policy formation, but for attempts to implement truly inclusive and accessible programming at ground levels.

Creating opportunities for both women and adolescents to fully participate in the reconstruction of their right to be healthy comes with the need, therefore, to resist the presence of those socio-cultural values which work against them and to acknowledge that women's participation is often prevented or even openly denied by the burdens and extra responsibilities assigned to them through private spheres. In this case, age is not a factor except to acknowledge that the younger the female, the more difficult it can be to exercise options, to have or find access to resources and programs, or to maintain long-term support within both familial and peer-based structures.

Another important strategic goal for preventative health programming is to begin acknowledging and creating opportunities which teach individuals how best to react to oppressions suffered in everyday life (both in public and private spheres). This provides the chance for young adolescents and women to learn and begin understanding the value of their right to be assertive and the value of becoming comfortable with exercising that right.

Many of the policies promoted under the Women In Development (WID) framework have not been able to sufficiently incorporate these elements, particularly as

they have tended to operate from a top-down approach. It is also because they have, in their design, tended to address and serve groups (notably teens and women) in uniformity. This fails to appreciate (structurally speaking) the full impact of HIV/AIDS on the lives of single individuals—as well as the biological and social sexism that facilitates its spread disproportionately higher among women than among men (Doyal: 1995). Furthermore, when examining the economics of HIV transmission, the cultural domination of heterosexism both within South Africa and the African region at large, one must not forget that it is also reinforced by broader gender inequalities in income and wealth. For many women then, economic security and sometimes their very survival, remains dependent upon the support of their male partner. Sexual intercourse is thereby done in a way that he desires and may well be the price that these women pay for that support. As Ugandan MP Miria Matembe reports:

> The women tell us they see their husbands with the wives of men who have died of AIDS. And they ask 'What can we do? If we say no, they'll say pack up and go. But if we do where do we go to?' They are dependent on the men and they have nowhere to go. What advice can you give these women? (Panos Institute, 1990, p. vi)

Overall, an analysis of gender inequality within health, development and educational processes has far-reaching implications. As pointed out by Naila Kabeer, it goes beyond the questions of male prejudice and beyond the preconceptions highlighted by earlier approaches to health and social development by looking instead at the institutionalized basis of male power and privilege. (1994) In other words, it goes beyond looking at male power and privilege within the domestic domain of families and

households—to uncovering in this case, its operations within those purportedly neutral institutions within which polices are both made and implemented (Kabeer: 43). Finally, just as class analysis can be used to understand and address the problems of the poor, so too can gender analysis be used to understand and address the problems of women's subordination.

2.4 Taking a Critical View

While WID scholarship and advocacy has become the established voice of feminism within many of the official agencies of health education and development, critical approaches to understanding the problem of HIV's continued spread not only exists, but appears to be gaining momentum. At the heart of such an approach is the argument that society's current status quo—is in conflict, not harmony. Arguing that societal conflict remains rooted both in class and group struggles, this approach seeks to illustrate (through competition for both power and scarce resources) how domination and oppression are structurally maintained (Kabeer, 1994 and Maguire, 1984). The reason that change is seen as so deeply threatening both Kabeer and Maguire argue, is because it represents an attempt to challenge structural inequities. The HIV/AIDS epidemic not only illustrates many of the outward manifestations of sexual inequality (engendered through economic and structural processes but often dismissed as a social phenomenon) but also needs to be understood for its ability to further marginalize those least able to negotiate their issues with oppression.

Critical feminists claim that in order to better understand sexual inequality,

structurally and dialectically as it relates to social class, we must go beyond traditional theoretical approaches and frameworks of analysis because, on their own, they cannot fully provide a satisfactory analysis of gender inequality. While many traditional approaches provide good explanations for historical changes in the divisions of labour, class opposition, and subsistence, and while many show how these changes coincide with the development of the antagonism between men and women in monogamous marriage and patrilineal inheritance (Engles, 1972: 129) they remain either too narrow or too vague when it comes to the multiple complications surrounding HIV/AIDS. Critical feminism is a useful alternative in that it allows one to take, use and subvert some of the traditional theoretical categories—so as to point to the aspects of women's subordination (such as with class analysis) and to provide explanation for the gendered composition of institutional hierarchies. This applies not only to all political levels and structures but to the nature and composition of educational policies and preventative programming. Furthermore, it provides the essential flexibility with which to maintain the point that there is no *one* issue concerning HIV's rampant spread throughout South Africa—but rather there are many. As such, focusing solely on the production of things or exclusively on the inequitable distribution of resources (while both useful and important) does not always correlate dependently on the production of people. In other words, the 'exchange value' or, the value of people versus *things*, cannot always be determined as equal in all things and among all people (Nicholson, 1987). Consequently, large areas of human activity (which in this case, relates to the likeliness of and realities for infection) are overlooked along with the distinctive relationships that men and women have to the

various spheres of both production and reproduction. The problem with this is that in neglecting these individual differences, we also fail to address the engendered social treatment of the human body, of sexuality, communication and disease.

Chapter 3

From Drawing Board to Delivery System; Policy Approaches to HIV/AIDS

South Africa is one of the countries worst affected by HIV/AIDS. It has been estimated that roughly 4.2 million people are currently HIV positive, representing nearly one quarter of the country's overall population (22.4% using 1999 estimates) (AIDS Foundation, 2001; Whiteside and Sunter, 2000). According to data taken from a 2000 national Metropolitan Life study, which estimates infection rates by age and race, amongst 15-19 year olds, 15.64% of African females are likely to be HIV positive as compared to 2.58% of African males. These numbers are in keeping with arguments which suggest that adolescent females are engaging in sexual activity at fairly young ages and with much older men (particularly those in the age category above 30 years of age and which have highest concentration average for infection). Males on the other hand, tend to have sex with females of their same age or younger (Chris Desmond of HEARD, University of Natal, Durban, found in *INDICATOR SA,* Vol. 18, No. 2: 51). Also significant is the fact that these figures were found to be equivalently representative for both white and Indian males versus females. This indicates great need for effective and well-organized preventative programming targeting adolescents, as well as programming that addresses the existence of enormous gender disparities in rates of infection between boys and girls regardless of racial or socio-economic background.

As it currently appears, the Education Department in South Africa has done little more than mention gender differences and has equally failed to provide clear mention of how it proposes to incorporate gender politics in its future strategies for HIV/AIDS programming targeting adolescents. For the last ten years, there have been a host of initiatives launched—aiming to address the reach of this epidemic into the field of education. In particular, they have tended to focus either on the declining number of learners (due to increased rates of infant mortality as well as learners having to take up the responsibility of caring for affected family members) or the decline in the number of available teachers (also on account of AIDS mortality). Despite these initiatives, the situation has worsened and infection rates have continued to go up. That raises the question as to whether or not the problem is with respect to policy *design* or if rather, it is a problem of ineffective implementation.

3.1 The Current Reality

Defined as a middle-income country, with a population base of roughly 44 million people, South Africa is not dependent upon donor aid to fund its health and social services, although a considerable amount of foreign aid money flows into its National AIDS Programme (UNICEF, UNAIDS and WHO, 2002). With the exception of Botswana, South Africa has an income level far above its African neighbours and is similar in this respect to certain Latin American and Asian countries. Despite its relative wealth however, South Africa has faired quite poorly on almost every indicator of social access and outcome. This can be attributed to the problems and historical legacy of white

settler and apartheid government, the unequal distributions of wealth and resources, a lack of consistent political and financial support as well as a highly concentrated sense of social disruption.

Overall, the 1980's in South Africa were characterised by immense internal mobilization affecting every facet of life, which, in turn, spearheaded the apartheid regime's political and economic isolation from the rest of the world. By the early 1990's, as is widely known, due to the consequences of multiple pressures, the apartheid government was inevitably forced to allow liberation movements back in to South Africa and to incorporate them into what many anticipated becoming a more open and responsive style of political leadership. The period between 1990-1994 represents a timeframe in which a whole series of discussions (at all levels) were held and which led to a negotiated settlement in terms of how the 'new' administration would implement social policies. Ultimately the first democratic elections were held in 1994 resulting in an ANC majority government, and with Nelson Mandela as its head.

South Africa's quasi-federal system now consists of one national and nine provincial governments and holds responsibility for the implementation of most public functions, including provincial level AIDS programmes. Apart from certain functions (such as military, penal and tertiary education) the role of the national government is to collect and distribute all revenue in an equitable way between the provinces, to set broad policy frameworks, and to define norms and standards for service provision. As of 1997, a new programme of fiscal federalism was introduced (Marias, 2000) which meant that provinces began receiving global budgets for implementing social programming rather

than defined allocations per sector. This not only created a system of tug-of-war politics (between provincial and federal levels) but it also came to characterize a substantial proportion of the infighting of province against province. For example, with the exception of the housing sector, the national government began allocating to the provinces, lump sum budgets that provincial governments were then responsible for dividing up among different departments. Since, as Marias points out, national governments could not decree the amount of funding any provincial government had to spend on for example, health, let alone the amount it wished to see destined for HIV/AIDS work (2000). As such, subsequent decisions about actual spending on the part of the provinces remained at the discretion of each province as did the task of implementing the health policies and programmes devised at the national level. In some provinces, where there was unhappiness over budget allocations (the range in divergent funding for the 1998/1999 financial year ranged from R2.5 million in one province to R55 million in another), materials and joint-programs put forward by the National Directorate were rejected citing claims that 'proper consultation' had not occurred or that there were 'unrealistic directives' on the part of the national government (Figures cited in Schneider, 1998: 9:4 and Marias, 2000).

The important point here is that with respect to the growing problem of HIV/AIDS, these struggles for legitimacy, influence and power served to erode provincial department's efforts to carry out their mandates properly. Because of this, the implementation of social policy (post-1994) has come to reflect as was mentioned, huge discrepancies in the AIDS budgets between provinces (but also the differing ability of

South Africa's citizens to pay for services, to access programs or to be aware of their rights of entitlement to such access (Schneider, 1998).

3.1.2 "The Plan"

The South African Strategy and Implementation Plan or "The Plan" represents an attempt on the part of the national government to organize and address an assortment of issues surrounding the problem of HIV/AIDS and its continued spread. Developed in the early 1990's, it consisted of a series of networks and consultative forums between NGO sectors, progressive health care workers and sections of the mass democratic movement. These networks and forums both insisted and argued for a new policy framework that would further support movements towards a democratic government. They clearly understood and deliberately emphasized the failings of the National Party to sufficiently address ever-growing concerns over the spread of HIV in South Africa.

In October 1992, the ANC and the Department of Health jointly convened a national conference carrying the theme "South Africa United Against AIDS". Not only was this an attempt to raise awareness about a rapidly growing epidemic, but it was also seen as an attempt to show unity at a time of complex and sensitive political negotiations. Also at this conference, the National AIDS Coordination Committee of South Africa was launched (now referred to as NACOSA). Its main objective was to set about formulating a comprehensive and effective AIDS policy plan. Attending the conference were representatives from all political parties, HIV/AIDS, health care, education, human rights and religious organizations.

The AIDS Plan not only drew heavily on differing perspectives (in terms of drawing up its goals and objectives) but it also assigned the central role to government to act as leader, funder and implementor of a comprehensive response to AIDS. As such, the language and scope of its final draft proposals reflects not only the debates of that time (such as the need to embrace and establish the sexual rights of women under cross-cutting themes) but also the need to accord people living with HIV/AIDS a key role in AIDS policy development and implementation. One such debate focused on the fact that the "Plan" went further than the WHO inspired AIDS plans of that period as well as on the need to embrace the sexual rights of women and to establish those rights underneath a cross-cutting theme. It drew on research conducted in the early 1980's to the early 1990's in both industrialized nations as well as from other African countries and proposed to be multisectoral by developing implementing units in key ministries (notably in this case, Health, Education, Welfare and Defence). Final authority however, was to rest with a coordinating structure in the President's office nationally, and the Prime Ministers' offices at the provincial level (NACOSA, 1994).

In terms of policy implementation, the basic structure and goal of the Plan was to be able to respond to HIV/AIDS through the following six key elements: education and prevention, counseling services, health care, human rights and law reform, welfare and research. It was felt that this would be the most appropriate, "effective and democratic way of developing a representative and united response to the HIV and AIDS epidemic [and was supposed to be] a mechanism for the people to signal to the government how they wished the HIV/AIDS epidemic to be tackled and the services and programmes they

wished to be involved in and provided" (NACOSA/National AIDS Plan, Appendix 43 in *The South African STD/HIV/AIDS Review*: 43).

Outlined clearly in its objectives were the need to: prevent the transmission of HIV, provide care for those infected and affected by HIV/AIDS, alleviate the impact of HIV/AIDS on communities, offer support for those not necessarily infected, but required to care for someone that was, provide a forum in which all South Africans could become involved in efforts to combat the spread of the virus, identify resources that could be used in the fight against HIV/AIDS and ensure the involvement of communities in all stages of development, planning and implementation of the Plan. This implementation of the Plan was to be further guided by the pursuit of three overriding objectives: preventing the spread of HIV, reducing the personal and social impact of HIV/AIDS and by mobilizing and unifying national provincial, international and local resources (National AIDS Plan: 43).

The Plan emphasized as its main focus, education and prevention, and was set to comprise roughly 53% of the available HIV/AIDS budget (Marias, 2000: 14). While this was suitable for the first few post-election years, concerns began to mount that the degree of political and community-based commitment would only begin to be tested 5 to 10 years down the road (Gevisser, 1994). These predictions have indeed proven true—but sadly, represents many of the worst fears rather than greatest hopes. In short,

> the Plan had laid emphasis on co-operation and inclusion while a vibrant synergy was envisaged between state and civil society. Crucially, implementation of the Plan was envisaged as multisectoral, with its management apex located in the President's Office. This, it was hoped, would provide the authority and prominence needed to propel

> implementation horizontally across various governmental departments and vertically through tiers of government. (Marias, 2000)

The Plan ultimately hinged its success on the ability of government and AIDS-interested organizations to persuade South Africans of the need to make certain behavioural choices, despite the constraints previously created by socio-economic status and racial discrimination (Marias, 2000; Trengove Jones, 2001; Kisoon, Caesar and Jithoo, 2002). Emphasis was placed, as Marias points out, on biomedical and behaviourist models of health intervention, and as such, policy makers tended to assume that a rationalist approach could suitably address behavioural trends by simply promoting abstinence, condom use and faithfulness as both rational and safe alternatives (2000: 15). It was also hoped, he argues, that these models would reflect in their design, the transparent, predictable and consistent decision-making abilities of policy planners and those responsible for implementation (2000: 15)

HIV/AIDS as a disease however, seems to defy (actively) this model of rationality and thereby continued to exacerbate the differences between the Plan's objectives as well as the tendency of many individuals to ignore the threats of 'impending doom' or warnings regarding the likeliness of becoming infected if safe sex practices, such as condom use, were not adhered to.

The final AIDS programme was based, according to both Schneider (1998) and Marias (2000) on the following foundations:

- A national programme (the National HIV/AIDS and STD Directorate) that was set up in 1994 and located in the National Department of Health. By 1998 it consisted of 18 staff members and 7 short-term consultants.

- Nine provincial programmes, which were linked specifically to communicable disease control. Also noteworthy was that the bulk of the responsibility (for policy implementation) was invested into this level.

- An emerging and coordinated district level for AIDS and communicable disease response. At the district level, staff and resources remained very low and depending on the province, many individuals had to also juggle other (often time or resource consuming) tasks.

- Fifteen AIDS Training, Information and Counseling Services (ATICC's) situated in eight out of the nine provinces. Although these were created prior to 1994, because of their predominantly urban locations, and because of their long-established relationship with local government authorities, they remained.

Some argue that South Africa's good fortune (that being a peaceful transition to democracy) has also, in some respects, been its direct misfortune (Marias, 2000). As has been mentioned, the ANC government found itself (post-transition) in the difficult position of having to restructure an entire public-sector and in having to both amalgamate and rationalize the bringing together of old apartheid-based administrations with new ones. At the same time, the government also found itself needing to overhaul the planning and management systems of each department and needing to develop new operating guidelines and staffing profiles. Confusion was inevitable over and around the location of responsibility and continues to represent a problem today—particularly at local levels.

Within the AIDS Directorate for example, staffing structures were not finalized until late 1997 despite having used short-term and contract staff to help ease some of the immediate transitional difficulties. Even so, there were enormous insecurities and deep levels of resentment to bridge (between staff from the old bureaucracy and the

new one) resulting in the tendency to associate regulatory and procedural systems with the illegitimate 'apartheid state rules' (Marias, 2000: 15). Delays became an endemic problem, checks and balances were sometimes openly disregarded, and a structural gridlock occurred. The 'old' administrators were accused of using their knowledge and expertise to humiliate the newcomers, and pride, fused with disdain prevented the 'new' staff from asking for their help. The Directorate, along with many other administrative departments, found itself caught in a bureaucratic maze with no guiding thread to help lead them out.

In terms of advancing the arguments of this thesis, both the historical context and timeline in which HIV/AIDS has emerged in South Africa (along with its links to the policy responses of state structures) can, and should be used to illustrate the structural inability on the part of the South African government to provide its citizens with full opportunities to receive sufficient health care, suitable social service delivery and to benefit from consistent and effective preventative programming. Furthermore, it further questions whether or not, and to what extent, the South African government has truly understood its obligations when it comes to serving people, or if in fact, it has been more concerned with serving its *own* interests through the maintenance of the status quo.

3.2 Understanding 'Health' In Development

Writer Naila Kabeer puts forward an interesting re-examination of the concept of development, which can be used, in this case, to focus on arguments concerning the

need for better preventative health programming and policy development. For starters, she points out that by its most narrow meaning, 'development' refers to the *planned* process by which resources, techniques and expertise are brought together in order to bring about improved rates of economic growth in an area variously designated as the periphery. This view holds, she argues, the assumption that development reflects "the processes of social transformation unleashed by attempts of diverse development agencies at local, national and international levels, both within the official domain and outside it, to achieve various and often conflicting goals" (1994: 69-71). As such, depending upon who is looking at a particular issue, the term 'development' holds either positive or negative connotations and either comes from a gender-based perspective or it does not. Nowhere has this been truer than with the conflicting goals of governments, between organizations, and among individuals when it comes to how best to address and deal with the rising HIV infection rates.

Statistical data unquestionably shows that in South Africa, those who have been most marginalized by HIV/AIDS have also been those traditionally with the least access to power, and who have generally tended to be poor and non-white (UNAIDS, 1997, 1999, 2002). Women either affected or infected by HIV have not only fallen under these categories, but also tend to bear an extra burden given the asymmetrical nature of gender relations in education, health and development fields. Social transformation has also come slowly to South Africa, especially with respect to HIV/AIDS and continues to be paid for by each individual who must suffer the

indignity of infection, the social stigma associated with being HIV positive and by those who understand just how casually this world can dismiss the lives of some in order to promote the comfort of others.

3.3 From Drawing Board to Delivery System: A Right to Be Healthy

Following from the goals and aims set out by the Plan, this section tracks the other main legislative areas from which HIV/AIDS programming has either been developed, or into which it has been incorporated. In particular, focus is placed on the ministries of health and education, as well as on other forces which have shaped existing responses and which continue to demarcate the growing gap between what is being promised versus what has been done.

According to Sections 27 and 28 of the South African Constitution, everyone has the right of access to health care services (including reproductive health care) and it is the state who is responsible for taking 'reasonable' legislative and 'other' measures in order to achieve the realization of those rights (1996). What this states, on paper anyway, is that for the South Africa government, there are clear directives and guidelines by which its citizens are to be provided basic and primary forms of health care.

Internationally speaking, the *Universal Declaration of Human Rights* under Article 25 states that, "everyone has the right to a standard of living adequate for the health and well-being" not only for themselves, but also for their family (1948). The International Covenant on Economic, Social and Cultural Rights also recognizes

under Article 12 that any state party to the present Covenant (which includes South Africa) "must recognize the right of everyone to the enjoyment of the *highest attainable* standard of physical and mental health" (U.N.T.S., No. 1453, vol. 993, 1976: 3).

Finally, Article 16 of the *African Charter on Human and People's Rights* equally states that "every individual shall have the right to enjoy the *best attainable* state of physical and mental health [and that] state parties [to the Charter] shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

The reason for highlighting items such as 'highest attainable' and 'best attainable' is because it is here, where the otherwise clear guidelines blur, where political posturing most often occurs, where the struggle for scarce and limited resources is most recognized and where unfortunately, the poorest and the HIV positive individuals are denied not only equal but even fair access to health care. It is therefore within this 'grey-zone' that one must pay closest attention for it is the place within which the continued subordination of women occurs, where state-run hospitals are not adequately staffed or provided with sufficient enough resources to care for their patients and where those same (and typically poorest) patients are told to go home with their disease for at least there, they stand a chance of receiving more sustainable care. It is also here where politicians, civil servants and preventative educators find themselves between the rock and a hard place. There is only so much money to go around, there any number of competing priorities and each priority has a

list of urgent and legitimate needs. Because of this, there comes to be great fluctuation between spending priorities, the offering of programs as well as ensuring the effective completion and realization of each program's potential.

3.3.1 Health Authorities and Statutory Bodies In South Africa

Assuming then, the South African government's 'committed' approach to providing basic health care as a fundamental right, one can argue that it is obligated to not only coordinate but regulate and include free primary health services at public facilities such as clinics, community health-care centers and throughout municipalities. The aim in doing this is to steer patients away from large hospitals and to instead offer a 'more efficient' and decentralized combination of services—all with an alleged focus on primary health care. The White Paper on the Transformation of the South African Health System (16 April, 1997 and tabled in 1997) also openly claims that "the strategic approach guiding us in this endeavor is that of comprehensive primary health care" and promises to South Africans, the provision of free health services to all children under the age of six, to pregnant women and, the provision of free primary health care services at the point of delivery to any of those who are not members of a medical aid scheme.

The services that are to be included under this primary health model focus on the following areas:

- Immunization, communicable and endemic disease prevention, maternity care, screening of children, health promotion and youth health services.

- Counseling services, support for chronic diseases, disease of older persons, rehabilitation, accident and emergency services, family planning and oral health services.

As mentioned, any persons that are members of a medical aid scheme are excluded from free services and as patients (or potential patients) of a private health clinic (PHC) they are to be treated by PHC-trained nurses or, at some clinics, by doctors. If for whatever reason, complications occur, they are then to be referred to a higher level of care such as can be found in hospitals.

Provincial governments are responsible for determining which medicines are applicable to each level of care and for determining which facilities are to be stocked with certain combinations of medicines. This is 'determined' using WHO guidelines and is to be revised on a two-year basis in order to include new developments in medical and pharmaceutical fields.

Unfortunately, as prevalence rates show, HIV/AIDS is spreading unevenly throughout South Africa and as such, the variance between infection rates also reflects the different obligations and responsibilities that each provincial department must consider in order to deal with their individualized problems not only in terms of prevention work, treatment and care, but also in differing levels of funding for greatly differing infection prevalence rates. For example, infection rates among women attending antenatal clinics in KwaZulu Natal had reached 32.5% in 1998 (which by the way, was a 20.8% increase over 1997), while the Northern Province experienced a rise in their infection rate of 40.2%. On the other hand, the lowest infection rate (of 5.2%) was

recorded in the Western Cape (Marias, 2000; UNDP/UNDAIDS, 1998: Department of Health, South Africa, 1999/2000).

3.3.2 Growing Pains and the Politics of Transition" Going Local

The multiple functions of both national and provincial health administrations are, as mentioned, to provide and manage comprehensive health services at *all* levels of care—wherever deemed appropriate. The basis of these services, have emerged out of a district-based PHC model and have been demarcated nationally into 42 health regions and 162 health districts. Major emphasis has further been placed on the shift from curative hospital-based care towards an integrated community-based one. This is particularly the case when it comes to the network of mobile clinics—run by government—and which forms the backbone of primary and preventative health care in South Africa.

Local government is recognized in South Africa as a separate sphere of government, thereby endorsing its unique constitutional status. Some of the services rendered by local governments include: preventative and promotion of health, with some municipalities rendering curative care, environmental health services including the supply of safe drinking water, sewage disposal and refuse removal as well as regulation, licensing and so forth.

3.4 Education and Preventative Programming for HIV/AIDS

According to Act 108 of the South African Bill of Rights, everyone has the right

to receive an education. (1996) But what does this right mean on the ground—particularly in light of the many changing realities, stresses and constraints that besiege the average young learner today? It hard enough to get through the period of adolescence and yet young people in South Africa must also face the relentless succession of increasing infection rates, multiple socio-economic constraints, familial obligations, high unemployment, gender discrimination, racism and even ageism. They are old enough to know what they think, old enough to act, old enough even, to be supporting families in some cases, but too young to fit fully into adult society.

On July 27, 1999, Minister of Education, Prof. Kader Asmal, launched an education mobilization campaign titled "Tirisano". This Setswana name when translated means "working together", and addresses, as its fundamental priority, to connect all those within, around and outside of the educational sphere regarding the multiple issues of today as they affect those representing the hopes for tomorrow.

Pertaining to HIV/AIDS, in September 1999, the Department of Education launched a specific set of policies on HIV/AIDS which were to include the following key elements: that no discrimination would be tolerated, that no teacher or pupil be excluded or denied the chance to attend school, that no medical testing would occur (thereby respecting and protecting the right to privacy) and that no pupil, student or teacher would be required to disclose their HIV status. In the event that an individual was known to be HIV positive, special provisions were to be made in order to eliminate the risk of transmission.

This policy was developed in cooperation with the Ministry of Health and was

launched to coincide with the start of "HIV/AIDS School Week" (which is the first week of September, beginning in September 1999).

Underneath both the Tirisano Plan and the Department of Education's 'Life Skills' programming, a host of initiatives were launched as an attempt to address the epidemic and its anticipated reach into education. Citing HIV/AIDS as the first of its nine priorities, the department of Education also included: child safety and rights, teacher development and training programs (around professionalism and implementation of the Plan's objectives), institutional renewal, implementation of curriculum, whole-school development, good citizenship and values, rural and urban development, further education and training in higher education as well as the organizational effectiveness of national and provincial departments (2002: 11-13).

The following chart, taken from the Department of Education's "Strategic Plan for 2002-2004" (2002: 13) helps to highlight some of the objectives and performance areas pertaining to HIV/AIDS which the Ministry intends to address over the next few years of its mandate:

KEY PERFORMANCE AREAS (2002-2004)

STRATEGIC OBJECTIVE AND PERFORMANCE MEASURES

STRATEGIC OBJECTIVE	PERFORMANCE MEASURES		
	2002	2003	2004
HIV/AIDS			
To strengthen the capacity to implement HIV/AIDS strategy and all related policies	HIV/AIDS Units set up in provinces	Integrated and effective response to HIV/AIDS at school level	Implementation occurring in a coherent manner
To ensure that policy and legislation frameworks respond appropriately to HIV/AIDS	Ensure continued adherence to EEA Section 16 and other policies related to sexual abuse	Policies respond appropriately to people and realities of HIV/AIDS	All areas of the system adhere to legislation requirements
To continuously improve the understanding of the effects of HIV/AIDS across the system	Research reports on impact of HIV/AIDS done	Improved data base and reporting	Departmental response based on research findings
Ensure multi-partner response to pandemic	Education stakeholders working together	All programmes reflect maximum co-operation with partners	Identifiable sector response
Addressing gender issues as they relate to HIV/AIDS	Continual support for the educators trained on gender equity and its relationship to HIV/AIDS	Peer group clubs formed and implementation of peer education on gender relations and against gender violence as impacting on HIV/AIDS	Gender issues addressed in a professional manner
To ensure the integration of life skills and HIV/AIDS into the curriculum	Educators trained and materials developed	Life skills integrated into the curriculum	Quality Learning Support Materials developed
To ensure competent management and governance of HIV/AIDS in schools and at district level	Senior Management Teams (SMTs) and governing bodies trained in the management issues of HIV/AIDS	District management plans for the pandemic in place	Schools manage the pandemic effectively

In addition to commissioning ongoing research, data collection, tracking trends, developing indicators and conducting special surveys regarding the impact of HIV/AIDS on the different aspects of the education system, the Tirisano Plan has also set out further guidelines for approaching and dealing with HIV/AIDS.

3.4.1 Systemic Provisions

During the time frame of March – December 2002, the Tirisano Plan set about identifying and addressing the capacity needs between both provincial and national

departments of Education. The goal was to ensure a comprehensive and integrated level of planning for HIV/AIDS (across all educational sectors) and to develop appropriate guidelines related to the problems associated with this epidemic's continued spread as well as regarding sexual abuse in terms of ensuring that appropriate disciplinary procedures were in place. It also aimed to provide sufficient training of staff, parents and administrators by providing them with the materials required to implement Life Skills Programming.

In May 2002, a multi-partnered conference was held on HIV/AIDS and the education sector and where an advocacy strategy was set up in order to bring together key partners from the educational community. In particular, focus was placed on the role of parents, teachers, traditional leaders and staff from the Departments of Education. The goal was to not only strengthen and maintain strategic partnerships between governmental departments and non-governmental organizations but also to promote the 'social clustering' of departments—especially with regard to information sharing, efficiency of response and the provision of services. (Department of Education, Programme 1 on HIV/AIDS, 2002: 25)

3.4.2 HIV/AIDS And Curriculum

By November 2002, the Department of Education's programme on HIV/AIDS aimed to ensure that Life Skills and HIV/AIDS education was integrated into the curriculum across all levels of the educational system—including specialized sites for learners with special needs, that a 'learning area program' which includes HIV/AIDS and

related issues was set in place and to ensure that the provision of learner support materials were not only provided but being *used* inclusively in teaching.

3.4.3 HIV/AIDS And Gender Issues

Pertaining to HIV/AIDS as a gender issue, the Department of Education continues to highlight the need for gender components in its Life Skills programming. Whether or not this is actually occurring on the ground is a different story, but on paper, it exists. The areas it most notably speaks out against are those, once again, related to sexual abuse and the problems of violence towards women. It also, and importantly, advocates the need to train educators on gender issues and on ensuring that gender equity be realized in classrooms as well as the need for supporting peer-based education on gender issues—once again, against gender violence, inter-generational sex and the pervasiveness of HIV/AIDS across the educational system.

3.4.4 Practical Considerations

The implementation plans for integrating democratic values into the fabric of South African education appear sound and thoughtful. But they also promise to be time consuming, expensive and labour intensive. Creating separate directorates, governing bodies and administrations focused specifically on the issues of Life Skills and HIV/AIDS enlarges the bureaucracy of educational administration and has the potential to marginalize the original initiatives and goals set forward. While the Tirisano Plan is a rich report that combines in its language participation, personal action and commissioned

research with policy implementation, critics such as Crewe (1997) and Snyder (2000) have argued that it fails to consider the diverse experiences and needs of schools, administrative staff and individual learners and instead approaches these issues in a vague and even authoritarian manner. Crewe and Snyder further argue some of their main concerns to be a lack of time, resources and training available for teachers and school staff. According to these individuals, such areas of concern not only affect curriculum-based education but also opportunities for counseling and peer-education.

Retraining educators is a costly, time consuming and expensive process. At the moment, a brief survey of the curricula of educator training in South Africa shows a marked absence in course offerings either in moral development, life skills and HIV/AIDS training or citizenship education (Shwartz, 2002). By moral development, Shwartz refers to the training of and development in pupils of values and beliefs about what is right or wrong; about how to make actions consistent with those beliefs; the ability to think and reason as well as to have and foster a sense of empathy. In other words, moral development is seen in developmental psychology and education as a life long process—especially as individuals encounter new and more complex ethical dilemmas in relation with peers, at the workplace and in intimate relationships (Shwartz, 2002).

While this is slowly improving, and even if one educator from every school was trained in South Africa, the attrition rate of educators and the notoriety or failure of 'trickle-down' approaches in institutionalizing new approaches to teaching and learning remain discouraging. Perhaps then, it is worth suggesting that bigger gains could be had

if restructuring were to occur around the pre-service training of new educators as well as focusing efforts on school principals, counselors and key administrators. More importantly however, the current educator training curriculum needs an overhaul at ground levels. This was reflected in the School Based Research Report commissioned by the South African government and directly relates to Life Skills and preventative programming:

> Several parents put forward a critique of the government in respect to the link between access to basic social services, and the facilitation of values in young people. They suggest that if the government were achieving its more basic mandates, with particular reference to the provision of housing, jobs and a quality education for all, then 'values' could be more successfully navigated in the home environment (Research, 2001: 2).

When little to no training is provided for teachers, and when their average workload consists of over-crowed classrooms, examination-driven curriculum and low staff morale, it becomes fairly clear to see how teachers can come to lack the commitment to not only teach these topics once, but to persist in teaching them over the long-run. Schools are further hindered in their ability to provide support for children and adolescents affected by HIV/AIDS when there exists high absenteeism rates, insufficient guidance from education ministries and a lack of resources to carry out proposed support programmes. Therefore, until more effective referral and monitoring programmes are not only designed, but consistently and suitably implemented, and until Ministries of Education make HIV/AIDS their top priority (both on paper *and* in practice) South Africa will likely continue to be flagged by increasing HIV infection rates and the associated effects felt within its educational system. Finally, unless, as Morrell (et. all)

points out, policies and initiatives such as the Tirisano Plan take into consideration the complex understandings that are exhibited differently by boys and girls, and unless they work towards a better *understanding* of the complexities inherent within school contexts (rather than just assuming them), they run the risk of talking past realities and becoming "disarticulated from [meaningful] engagement with the epidemic and with efforts to ameliorate its tragic effects" (*Indicator SA*, Vol. 18, No. 2: 2001).

3.5 The Policy Framework for Gender, Education and Health Issues

There are a number of ways in which health becomes a gendered process and there are a number of reasons why, therefore, preventative health policies and education must also take a gendered approach when tackling issues of life-skills, healthy choice-making, cross-gender communication and HIV/AIDS. Research has shown that not only is there a division of labour in health care, particularly in terms of who provides care for family members affected by AIDS, and that not only does this division affect adolescents, but that there are also discrepancies in access to basic resources and social services as well as in the tendency of some medical staff to regard concerns over ill-health differently among adolescents and women (Wolf, 1996, Ndati and Kiai, 1997, May 2000 and Klein, Easton and Parker (Ed.) in O'Leary 2002). This in turn, feeds into the general failure on the part of many individuals and structures to consider the social origins of many female and youth-specific illnesses which routinely operate under the radar of larger issues and to incorporate them into those processes which hold the potential to provide opportunities for real change and empowerment.

It would also appear that when it comes to respect for good governance, the rule of law and in particular, the promotion, protection and fulfillment of human rights obligations, the response in South Africa, at many levels (as well as elsewhere in the world), has been largely rhetorical. When one incorporates an epidemic as overwhelming as HIV/AIDS, structural and institutional weaknesses are often exacerbated because of how they display the gap between promises made and the lack of enabling legislation to operationalize those promises. In essence, as Geraldine Terry of Oxfam observes, "although basic services such as education are provided, there are problems of apathy, disaffection, and low self-esteem which prevent marginalized people from taking advantage of them" (Terry, 1998).

So, while the idea of 'learner-centered' and 'participatory' strategies sound terrifically appealing on paper, there remain enormous differences between how they are ideologically prepared versus their ability to function through state and institutional structures—so as to operate as an effective service provider (which in this case, concerns providing good quality and substantive preventative programming).

The most important challenge then, facing both the creation of preventative policies and their required implementation, is the need to work towards increasing access to high quality sexual health education programs for youth across the country. Rather than spending resources and time surveying, researching and collecting endless amounts of data on that which we already have a solid awareness of (that being the steady increase in infection rates among adolescents and that schools are an excellent avenue for implementing preventative programming), perhaps we are better served to concentrate on

increasing efforts towards the *consistent* implementation of programs. Gender issues can, and should be implemented in all preventative programming (targeting both males and females) and should be used within current ABC (Abstain, Be Faithful, Condomise) approaches. There also needs to be greater emphasis and attention given to the lack of meaningful discussion about sex as a natural process and about healthy choice making and the options available to youth with respect to HIV/AIDS—particularly among family members and within schools. If the purpose of preventative programming and the promotion of gender awareness should be to develop the sexual personalities of youth (by encouraging safe sexual behavior and equal responsibility for both boys and girls) then it needs to address, proactively and openly, those social factors that put adolescents most at risk. One of the greatest of those risks (particularly for adolescent females but extending to adolescents generally) surrounds their lack of power to negotiate and ensure that condoms are used *every time*. That is why, as Klein, Easton and Parker point out in O'Leary's publication Beyond Condoms (2002) prevention work must move beyond targeting traditionally 'high risk' populations in the general ways it has in the past and instead appropriately incorporate the unique and often changing needs of specific populations. This is where the need for effectively trained prevention educators, teachers is so important and where the support of principles and key administrators can either make or break the success of incorporating life skills programming—not just in the short term but over the long haul. The best results can only be reached by developing space for context-specific interventions and by promoting their implementation as imperative to long-term successful reduction in infection rates. This means taking a look at other

alternatives, in Life Skills programming, to simply promoting condom use and abstinence—such as self-esteem, inter-personal negotiation and communication skills. Above all, however, it means providing long-term support that is not only visible to adolescents, but accessible.

Although there are many reasons why sexual health programming (as it currently exists) is less than optimal in South Africa, several priority mechanisms for change are apparent and need to be better supported. Firstly, policy makers in positions to effect change must be reminded of the health, social and economic costs associated with continuing the status quo with respect to HIV prevention and the currently inconsistent provision of 'life skills' programming in schools. Equally important, advocacy must work at motivating these policy makers (by stressing that "an ounce of prevention is worth a pound of cure") to further improve program evaluation research conducted in school settings and to work at making parents understand the need for their support for the provision of broadly based sexual health programming in schools. There must, at the very least, be equal cooperation on the part of the policy makers, school administrators, medical officers of health and provincial ministers of education and health who can, and will both clarify and expand existing priorities, program objectives and standards.

Another important priority area is teacher training. Most associate teachers assigned to teach sexual health education, learn the skills to do so on the job, either through in-service training or through self-education. It would appear that despite the Tirisano Plan, and despite the mention of the need to address the issues of HIV/AIDS and gender-based inequities within schools, many faculties of education are not preparing

teachers with sufficient training or in many cases, providing them with sufficient resources to enable them to provide high quality sexual health education to their students. While some of the problems and issues surrounding this lack of implementation are discussed differently throughout this thesis, at this stage they serve to highlight that even when partnerships (such as with sexual health specialists from local departments of public health) are available, and although they are invaluable, they do not eliminate the clear need to raise existing standards for school-based preventative programming. It is strongly argued therefore, that a combined commitment by policy makers, program planners and teacher training programs *must* occur if there is to be better quality sexual health and life skills programming made available to *all* South African youth—on a consistent basis.

Very often, it is difficult to see beyond the language chosen for and used in policy development—primarily because they use seductive terms such as 'self-help', 'holism' and 'capacitated transparency'. Although initially this offers an attractive opportunity to focus on individual agency without having to understand its relationship to structural change, breakdown and decay, individuals Gujit and Kaul Shaw (1998: 1) call this dynamic the 'myth of community'. They argue that these kinds of terms tend to hide internal differences, practical barriers and power dynamics from the average individual thereby making opportunities for 'self help' increasingly more difficult to attain. This sort of language is further problematic because it claims that the responsibility for change rests on the individual—yet it subtly discourages and prevents that same individual from feeling welcomed to participate in the processes for change.

This happens through the creation of an administrative maze, highly technical language and the suggestion that only appropriately specialized individuals truly understand what adolescent needs exist at the ground levels in terms of curriculum and programming. Exclusion therefore, occurs through many barriers such as; class, education, race and age, and is typically based on who has access to the appropriate positions of authority versus who does not. If, within a given community, some schools support the implementation of preventative programming while other schools do not, then it becomes the responsibility of the department of education to follow up on this and to ensure that equal training and access to programming is being made available to all. Furthermore, policies need to work harder at providing opportunities for schools to share and access expertise by encouraging multiple departments and health specialists to come together, to coordinate knowledge and resources and to work at distributing them to schools irrespective of district and irrespective of school size or access to available funds.

Since the earliest days of feminist struggles, feminists have been involved in the development and critique of governmental and local policy, with the explicitly political intention of rectifying inequalities and injustices (Correa and Reichman, 1993; Doyal, 1996; Moser, 1993; Young, 1990 and Wolf, 1996). This is particularly so in areas which have traditionally been the concern of local and national governments, such as education, health, social welfare and human rights. These are fields that touch people closely and so policy decisions that relate to these fields can affect change in profound—and sometimes unexpected—ways. In South Africa, despite the existence of gender machinery, and despite the fact that it represents (at least on paper) a model for the African region as a

whole, there remain significant silences in terms of tackling women's participation and role in the political sphere as well as around their ability to engage with policies and state institutions. In other words, South Africa's national machinery for the advancement of women refers to a set of co-ordinated structures within and outside of government, which aim to achieve equality for women in all spheres of life (*Gender Update,* UNDP, 2000). This national machinery in South Africa was established after the 1995 World Conference on Women, held in Beijing. It is composed of three specific and supporting pillars:

- Parliamentary structures of the Women's Caucus and the Parliamentary Committee on the Quality of Life and Status of Women
- The Office of the Status of Women, based in the Office of the Presidency and working closely with the gender desks in line ministries
- The Commission for Gender Equality, which is an independent advisory, consultative and research body, but which is directly accountable to parliament

While the Commission on Gender Equality is the most visible arm of South Africa's gender machinery, the composition, powers and functions of the CGE are set out in the South African Constitution (South African Constitution, 1996). So, while the CGE is responsible for taking the constitutional mandate of gender equality to the broader public and to uphold its commitment to promote a more gender-sensitive representation of women (particularly through the media), to develop an updateable media directory and database with gender contacts, and to ensure its implementation at all levels of government, the participation of women in local government and the integration of gender analysis in programming as well as service delivery remains low. In short, the

difficulties of 'effective service delivery' by implication means that it is failing to include the needs of those whom it is set up for and designed to serve (*Gender Update*, UNDP, 2000).

According to many feminists but particularly Moser, women's involvement in the political and community-based processes that affect their daily existence, are a pre-requisite for the overall and strategic empowerment of women (1993: 76). Effective gender policy, (in this case, within the field of education and preventative health programming) requires first confronting such social, political and ideological barriers to women's participation and then working again, at promoting "independent access for women to key resources, services and facilities" (May, 1997: 76).

When state structures (at whatever level) fail to recognize how their policies are affected, and often constructed by the ongoing struggles and experiences of people in their local, rural or urban communities, they run the risk of becoming largely ineffective. Such contradictions between legislative language and practice contribute further, in the case of HIV/AIDS, to the widening gap between who is getting infected and how that operates underneath the broader umbrella of socio-economic inequality and human power dynamics.

Chapter Four

Conclusion and Recommendations

The purpose of this thesis was to examine some of the problems and dynamics surrounding HIV/AIDS in South Africa as well as to assess some of the multiple processes that affect the search by individuals for a healthy sexuality. The focus therefore, was on the role of preventative education—its attempts and successes in encouraging behavioural change among adolescent populations. The hypothesis was that due to current epidemiological trends, policy developments, social and biological realities, adolescents (particularly female adolescents) represent one of the most vulnerable groups for HIV infection. As such, preventative education provides one of the most critical components towards ensuring long-term successful reductions in infection patterns.

Given that current policies and programming are *not* sufficiently meeting the needs of these adolescents, and although there are many reasons why sexual health education is less than optimal, this thesis argues that several mechanisms for change are available and need to be explored more seriously. The starting point however, needs to

be a willingness to develop more effective, gender-oriented, and participatory-based programs—which place the concerns and realities of adolescents at the forefront of policy development and implementation. Quite clearly, top-down approaches have not been the most effective when it comes to targeting behavioural change among youth particularly given that these same youth make up the fastest growing infection demographic.

So where do we go from here? Unfortunately, there is no easy answer. While we wait for an HIV vaccine or a cure for AIDS, HIV is gaining vital time building up a huge reservoir of infections and in the creation of resistant strains with higher virulence levels. Even if a vaccine or a cure is found, it is likely to be a long time in coming and who is to say that it doesn't change form—thereby managing to stay ahead, once again, in the race with immuno-mutation. As such, the outcomes of protection through vaccination might only become obvious after an extended time scale has passed. After all, we still have no cure for the common cold.

4.1 Summary of Findings

Given the associated costs (both in terms of time and expense) of Life Skills and preventative programming as well as of the Ministry of Education's Tirisano Plan, there are a few areas where this thesis suggests focus should be placed. Within the educational sphere (perhaps one of the most effective avenues through which to reach a high proportion of adolescents and young adults) it is critical that training on the multiple issues surrounding HIV/AIDS and gender-sensitivity be given to teachers, school

principles, counselors and key administrators. That is not to say however, that just by creating training programs which address HIV/AIDS progress will necessarily occur with respect to youth and gender issues. In order to make real inroads, there must also be the desire to implement what has been learned and a firm commitment on the part of school administrators to ensure its promotion at ground levels, to routinely assess and to provide feedback on ways in which improvements can be made. Furthermore, and perhaps of greatest importance, adolescents themselves, need to be included in the development of those socio-health and educational strategies which affect and address them. Peer-based education, the incorporation of drama and roll-playing, the provision of situational exercises as well as opportunities for accessible, on-going discussion with trained adults and most importantly, access to resources and services are critical components and specific examples of where expansion can, and should occur.

At community levels, and as has already been highlighted in governmental documents such as the Tirisano Plan as well as in other educational and health documents, inter-collaborative relationships need to be strengthened among traditional leaders and healers as well as among non-governmental organizations (NGO's), civil-service organizations (CSO's) and municipal departments. The reason, quite simply, is that there does appear to be a willingness and growing commitment on the part of individuals in all areas to do *something* to help curb this epidemic, but when it becomes a matter of operating within the context of few resources, limited people-power or influence, it becomes increasingly more difficult to sustain programming over the long-run.

Finally, the role of South Africa's place within the global community must

also be discussed and cannot, if this issue of HIV/AIDS and increasing infection rates is to be properly addressed, be ignored. In particular, how South Africa operates in proportion to its global partners directly affects its decisions about the allocation of resources and funding to health and education. According to Susan Hunter, an uncountable number of atrocities have been perpetuated over the course of history, in the name of medicine and health by those "high minded people such as the public health experts behind the Tuskegee Study in the United States, colonial medicine's experiments in segregation and social control, and testing of vaccines and medicines in Africa that are never provided there once they are developed" (2003: 209). Key to her argument is that cloaked in economic arguments or in arguments for the protection of intellectual property rights (as was displayed during the recent court case of South African's fighting against international drug companies for the availability of affordable and even generic anti-retroviral medication), those who maintain control over a disproportionate level of wealth perpetuate the continued exploitation of those who are too poor to pay the exorbitant prices that the global economy demands for its drugs. She goes so far as to argue that to deny drugs that keep westerners alive for up to ten to fifteen years is nothing short of post-colonial racism writ large and to others, nothing short of deliberate genocide (Hunter: 209 and Steven Lewis: 2002). Brazilian AIDS activist Richard Parker also argues that, "vulnerability to HIV and AIDS has increasingly come to be understood as fundamentally linked to questions of social and economic inequality and injustice" (Parker in Whiteford and Manderson, 2001: 40).

Even the World Bank, through its public health policy of delivering antiretroviral care, the availability of condoms, as well as the combined need for

preventative education and awareness, has been building the links between poverty and AIDS since 1990 (Parker, 2001, World Bank, 2002). It has chosen to define the HIV/AIDS pandemic in economic terms arguing for example, that poor countries should not consider providing treatment to the afflicted and that prevention programs should come first even if people were dying in absolute agony (Hunter, 2003). Interestingly, these same Bank policy makers did not argue that the means to provide care and treatment should be given to countries with large numbers of sufferers, that drug companies should be called to task for letting people die at the same time that they earn astronomical profits, or that the debts of poor countries should be forgiven so that they could 'afford' to pay for treatment (Hunter, 2003).

The views put forward by the World Bank, and routinely upheld by the various neo-liberal policies of governments around the world (including South Africa's) are not only fundamentally flawed but unacceptable because, as Parker points out "public policy must ultimately stem from discussion and debate of the nature of a good society...not solely what makes economic sense" (2001: 40). Given that AIDS is an exceptionally expensive condition to care for—for any government, not just an emerging middle-income one such as in South Africa—and given the multitude of political landmines surrounding any type of response to it, one may reach the crude conclusion that the more rapidly those people living with HIV become sick and die, the more 'cost-effective' governments see the epidemic as being. It is a horrible suggestion to make and yet, just like syphilis or the plague in the fourteenth century, there are people who do argue, sometimes privately but even publicly, that AIDS is a way to clear the deck and start the development process all over again (Hunter, 2003).

Since the poor in South Africa are as short of water as they are of food, since adequate housing remains a significant concern, as does basic infrastructural service-provision (particularly in rural areas) and not to mention equal and fair access to primary health care and education, it becomes easy to see how AIDS can become drowned beneath the many competing priorities. Columbia University economist Jeffery Sachs, who has also been a leading global activist when it comes to assisting the poor in AIDS-inflicted countries, particularly Africa, points out not merely that the poorest of the poor might as well be invisible, but that as far as the role of the international community is concerned with respect to exacerbating this pandemic, the world's richest countries (in other words, G8 countries) have been unconscientious, irresponsible and insensitive. "The failure of the United States to pay its UN dues," Sachs says, "is surely the world's most significant default on international obligations [and] far more egregious than any defaults by impoverished 'Highly Indebted Poor Countries' (HIPC's)" (Sachs, *Economist*: 17).

On a positive note, there are some hopeful developments in the war against AIDS, the most notable being that this pandemic has turned into a rallying ground for the rights of the poor, the marginalized, or traditionally exploited—to have what is their fair share of the world's resources. Countries such as Canada, the United States, the World Trade Organization (WTO), World Bank and other policy makers are under ever-increasing pressure and influence to stop the control of world debate and to admit that AIDS is taking bigger and bigger bites out of the economic backbones of so many countries in sub-Saharan Africa that the entire global economy is suffering as a result (Hunter, 2003). Even the United States, under the Bush administration, and to the

surprise of many, has recently pledged $15 billion to combat AIDS in developing nations.

Additionally, human rights activists and humanitarians are making inroads in the fight to level policymaking playing fields through innovations in communication, linking up with one another around the globe (especially to insist on the rights of the poor to medicine), to facilitate ongoing and direct partnerships among churches, charitable organizations, healthcare providers, educators and individuals committed to the idea that AIDS as a disease is not the 'fault' of anyone but rather a predetermined outcome—particularly for the poor. Allowing its spread to continue unchecked is not only irresponsible but morally irreprehensible and no longer a suitable option.

Linked to good institutional arrangements, national, provincial and community-level plans regarding HIV/AIDS and its affects on society, is inevitably the issue of leadership. South Africa requires special mention in respect to leadership particularly surrounding what have been considered controversial and damaging debates (questioning the causal link between HIV and AIDS) as well as for its resistance to and delays in providing universal access to treatment to prevent vertical transmission. These roadblocks have led many AIDS activists, educators and health care professionals in South Africa to conclude that leadership has been misguided (Kisoon, Caesar and Jithoo, 2002). South Africa, for example, is the only country in the region where non-governmental organizations (such as the Treatment Action Campaign, Community Law Center at the University of the Western Cape, the Institute for Democracy in South Africa), as well as the province of Kwa-Zulu Natal, have instituted litigation against the national government on issues related to AIDS programming (64). On paper however, South Africa might otherwise indicate that the response to the pandemic enjoys a very

high level of political support. As was noted earlier, presidents and Cabinet ministers are all involved in one way or another in the national AIDS councils or co-ordinating bodies, governments have committed themselves to spending a portion of their domestic resources on AIDS-related activities and HIV/AIDS has been identified as a national priority—across all departments and levels of government.

Good leadership should include the following key components: the pledging of domestic resources, mobilizing these same pledged resources for access to education and treatment, initiating programmes that promote the rights of women, managing national AIDS institutions efficiently, ensuring governmental effectiveness and accountability, recognizing the roles of civil society, religious and traditional leaders as well as committing to and engaging in activities in relation to development and economic planning. Perhaps then, South Africa faces not so much a problem of commitment to intervention and response but rather has been falling short when it comes to the actual implementation of programs.

In terms of the arguments put forward by this thesis, chapter two has outlined the need for strategic gender-based planning—particularly given the contextual history of HIV's proliferation in South Africa and given the unequal share of power distribution in gender relationships. Since political and social contexts determine the contextual and structural merit of gender issues in health, as well as in regards to adolescent sexual education, policies must cease leaving the problem of full implementation to the discretion of community-level education authorities. Instead there *must* be greater coordination and shared information among all levels (both within health and education as well as outside of it) as well as strong leadership that provides clear directives and

practical opportunities for programme implementation.

Chapter three raises questions about the role of polices and institutional structures when it comes to providing adolescents and women the level of access and support that they require in order to fully realize their right to be healthy and HIV-free. Despite the importance of South Africa's oppressive political and social history, it remains too easy to place full blame for the current problem and prevalence of HIV/AIDS on legacies of the past. While significant in terms of facilitating the spread of the epidemic, how ideas are generated *today*, how the use of tradition and custom is incorporated *today* and how the growing numbers of HIV positive individuals are incorporated in communities, policy development, gender-planning and activism, will greatly determine the direction of prevention and response for the future. Therefore, it is not enough to simply raise questions but instead, solutions must be sought out in terms of how better to incorporate adolescent populations and women in the various types of organizations that deal with and address HIV/AIDS. Politicians and policy makers as well, must commit to the topic of AIDS beyond making public speeches and the wearing of AIDS pins for photo opportunities. They must make implementing programming their own personal project—and thereby work actively at utilizing all the resources, power and influence provided to them through the auspices of their office. Projects could include: developing both global and local business coalitions on HIV/AIDS; organizing concerts, raising money for research and care programs; facilitating a system of in-kind contribution; harmonizing funding efforts as well as further integrating business solutions (through networks of subsidiary companies). The perfect example of an individual who has best utilized his leadership status would be Nelson Mandela's with his Global AIDS

Fund and in particular, his recent "46664" Campaign.

As individuals, no matter where in the world one resides, it is important to urge against complacency which, as time and statistics have revealed, only serve to deepen the AIDS crisis. Instead, advocates need to increasingly mobilize their support for the integration of understanding with respect to gender relations, epidemiological awareness, capacity-building and resource distribution with respect to basic health services, access to affordable and/or free drugs and preventative programming.

Since the way in which men and women relate to one another is at the heart of socio-gender relationships, it must be the primary priority for not only prevention and treatment of this disease but also for meaningful feminist engagement with the state (particularly from within structures). Given current macro-economic policy frameworks, poverty alleviation—as it disproportionately affects women—represents one of the greatest challenges. Instead, significant investments must be made not only in terms of providing funding but also in ensuring that said funding is distributed fairly, that sufficient training is provided in how best to distribute it and that follow up, transparency and accountability occurs across all levels.

Finally, as has been mentioned throughout this entire thesis, there is no one issue with respect to HIV/AIDS but rather there are many. The best piece of advice that was found in terms of where next to turn in terms of this epidemic is contained in an appropriate Africa proverb, "the best time to plant a tree is twenty years ago [and] the next best time is now."

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Certificate of Ethical Acceptability of Research Involving Human Subjects

This is to certify that the Research Ethics Board has examined the research proposal or other type of study submitted by:

Principal Investigator:	Carla Fundak
Name of Research Project:	At first blush: An assessment framework of HIV/AIDA as a gender issue in South Africa
REB File Number:	2001-054

and concludes that in all respects the proposed project meets appropriate standards of ethical acceptability and is in accordance with the Tri-Council Policy Statement on the Conduct of Research Involving Humans.

Date:

Signature of REB Chair:

Dr. Eric Lee