STEMMING THE TIDE OF AIDS

What do young black South Africans think about AIDS?

Dr Barry Kistnasamy, a member of the IDRC-funded Centre for Health and Social Studies (CHESS) in the University of Natal’s medical faculty, said that, surrounded as they are by violence, young black youth often have a fatalistic attitude toward preventive measures against the disease. What he and his colleagues heard from them in AIDS seminars was: “Why should I use a condom tonight if I’m going to die tomorrow at the hands of the hit squad?”

Dr Kistnasamy also said a number of critical factors besides violence lead to transmission of the human immunodeficiency virus (HIV) in South Africa.

One is the migrant labour system. There are approximately three million black men living in single-sex hostels — with a micro-economy of sex-trade workers surrounding them. The risk of AIDS spreading there is high because many workers have multiple sexual partners and do not frequently practice safe sex.

Another is the vulnerable status of black women, who cannot insist on condom usage because they suffer a triple oppression of culture, race, and class. If they tell a prospective sexual partner, “If you do not wear a condom, I will not sleep with you,” they are likely to receive the reply, “Well, I’ll go to another woman.”

Dr Noddy Jinabhai, the director of CHESS, gave yet another reason for South Africans’ negative attitudes toward condoms: “They’re not popular because condoms have been promoted by the government as a form of birth control to curtail the black population.”

For the Medical Research Council of South Africa, CHESS has been conducting a survey of black adolescent high school students’ attitudes to sexuality and condom use in urban black South African townships. The project looks at condom availability and use as the major factors in AIDS prevention. “It’s been a fascinating study,” said Dr Jinabhai. For example:

“We thought that we should do the survey among the 14 to 17-year-olds because they have a better grasp of English and they are less likely to be sexually active. We were astounded that the majority of that group were long ago sexually active. We found that we needed to start at ages 11, 12, and 13 to find those who are not sexually active. This included both boys and girls.”

Dr Kistnasamy, who is a physician and specialist in community medicine, predicted that when added to the socio-economic problems of poor South African communities, “AIDS is going to have a devastating impact.”

But Dr Jinabhai found one reassuring aspect: “We are very fortunate that we have not reached epidemic proportions of AIDS in South Africa. It’s been spreading down from Central Africa, down truck routes from Zambia and Zimbabwe and Mozambique, and it’s obviously in South Africa. But from the few surveys that have been done we can say that it hasn’t reached epidemic proportions yet. The number of people infected doubles in about nine months. If in the next six months to a year or two we can go in for a massive intervention program, we could actually blunt the epidemic.”

AIDS PROJECTS

This urgency helps explain IDRC’s interest in AIDS prevention in South Africa, which it is furthering through its support of CHESS (see sidebar).

One IDRC-funded project originally involved South African refugees in camps in Zambia, Uganda, and Tanzania, but has been re-located to Natal because many of the exiles have returned to South Africa. The collaborating institutions in the project are the Health and Refugee Trust (HEART), a British charity, and the health department of the African National Congress.

The goal is to develop an information base about the attitudes of South African refugees to AIDS and other sexually-transmitted diseases. Project researchers hope to introduce educational materials for prevention programs in three areas: hostels, squatter settlements, and rural communities. Another project, aimed at preventing HIV spread within organized labour in South Africa,
concentrates on long-distance truck drivers. They are members of the Transport and General Workers Union, who, with the Workplace Information Group, are administering the project. These truckers are considered to be at special risk of HIV infection. Away from home at least six days out of seven, they frequently have multiple sexual partners and travel in countries where HIV prevalence is higher than in South Africa. In one small sample tested in 1989, for example, 13 of 26 such drivers were found to be HIV positive.

The first two cases of AIDS in South Africa were confirmed in 1982. As of July 1991, there had been 818 cases and 374 deaths. The best available data indicated that 445,000 people were infected with HIV at the end of 1991.

The main spread of the virus in the black community occurs heterosexually, the other major route being from mother to child. Intravenous drug use and contaminated blood products are rarely found to spread the virus. In the white population, the principal spread is within the homosexual community. Some 50% of the African population is under the age of 21 — another factor that promotes the spread of AIDS. Attitudes of South African whites vary according to their place in society, Dr Jinabhai said.

"Among the more educated, affluent section of the white community, there's a very high level of awareness and a very high level of concern, and I would suspect a certain measure of practice of safe sex. Among a large section of the white working class, I would suspect again their knowledge and awareness would be fairly high. But the practice of safe sex would be probably low, as would be the case with, say, urbanized African males."

COMMON PROBLEMS

Dr Jinabhai is himself a native of South Africa, and is a physician, community health specialist, and epidemiologist. He noted that despite great differences between his country and others, some aspects of the AIDS situation are similar globally. For example, a number of studies have shown that AIDS awareness is not a problem among black people in many parts of the world, including South Africa. Many people have heard about the disease and are aware that it is deadly, but still do not practice safe sex.

"A major problem in South Africa — as with most parts of the world — is that the practice of safe sex is extremely low," he said. "We feel it's absolutely imperative that we change attitudes. We are going to have to find innovative ways of doing research (to accomplish this)."

CHESS:
Examining Health Issues

Millions of South Africans may one day be served by a health service resulting from research undertaken by an organization known as CHESS, which is supported by IDRC.

The Centre for Health and Social Studies (CHESS), established in 1988 by an anti-apartheid group of doctors and dentists (the National Medical and Dental Association), was set up to make possible health research, policy formulation, education, and training for South Africans.

In July 1991, CHESS received an IDRC grant for institutional support, which constitutes its principal funding. CHESS is based in the pediatric department of the University of Natal. Its board of management includes representatives from both universities in Durban, the British charity HEART (Health and Refuge Trust), and the Mass Democratic Movement.

Dr Noddy Jinabhai, the director, said that CHESS has recently completed a major study of a squatter settlement outside Durban to determine the impact of urbanization on health. The objective is to develop housing and health services based on community participation models.

"We are hoping this particular study will provide a framework for a district health service or a regional health delivery system to emerge, based on the research just completed," he said. Some nine million people live in the region.

Within its major programs, CHESS has projects dealing with a wide variety of subjects, including a food and nutrition delivery scheme, a computer-based health resources information system for policy planning, monitoring and evaluation, an analysis of children's diseases, and an educational and training program.

During the past year and a half, CHESS has attempted to create a critical mass of researchers and policy analysts in the Natal region. "We have deliberately chosen a fairly narrow regional focus, but we hope that this will have some implications at the national level," said Dr Jinabhai.
The most important disease in South Africa is tuberculosis, with 85,000 new cases per annum. By comparison, the total number of new AIDS cases was only 175 in 1989, 302 in 1990, and 165 in 1991.

"But given the nature of HIV infection and the mortality and the potential to devastate the working class, it's a very serious problem we have to tackle," said Dr Jinabhai.

Drs Jinabhai and Kistnasamy pointed to the weakness of the public health system in South Africa as a limiting factor in efforts to slow the spread of AIDS. The United States and South Africa are the only two countries in the Western world that do not have a national health system, said Dr Kistnasamy.

Eighty per cent of whites have pre-paid health insurance and are served by a highly-entrenched private sector that provides services such as heart transplants and hi-tech equipment. Yet only 7% of blacks have pre-paid health insurance, and most must use over-crowded, under-funded black hospitals. There are 195 multinational drug companies and a medical equipment industry in the country, but there is little in the way of community health services for the majority of the population. The health system, with its 14 ministries, is currently being re-structured.

Dr Kistnasamy is keenly aware of the shortcomings of the public health system in South Africa but he is nevertheless optimistic that things can change, especially in knowledge about AIDS. He hopes through the efforts being made by such groups as CHESS that "we'll be able to move forward in terms of a brighter future for the children of our country."

David Spurgeon in Ottawa

The origins of Kimberley, 470 kilometres southwest of Johannesburg, date back to the discovery of diamonds there more than a century ago. Its affluent heritage is reflected in the areas that are home to the city's 30,000 whites, where paved roads, electricity, and toilets are taken for granted as basic amenities.

Kimberley's remaining population — 120,000 people — live in six surrounding townships, themselves divided along racial lines. Greenpoint is one of the poorest; the average monthly wage is CAD $115. It has 6 communal water taps to serve its 5,000 residents. There is no water-borne sewage system and toilet facilities consist of 18 buckets placed under chairs with holes. Waste is disposed of once a day.

These racial and economic divisions have been institutionalized by apartheid laws in cities throughout South Africa. But just as political reforms are being discussed at the national level, so are less publicized negotiations taking place aimed at the integration of cities fragmented by apartheid. Many see these local negotiations as the first step toward the creation of non-racial democratic structures in South Africa.

PLANACT, a local, non-profit service organization, is examining the problems and mechanisms relating to the integration process. IDRC and OXFAM-Canada are helping to fund its research. Formed in 1985, PLANACT works in the areas of housing and urban development policy, primarily on behalf of black community and civic associations and trade unions. In addition to working with groups at the local level, PLANACT is involved with other research organizations in developing national policy alternatives on a range of local government issues.

OVERCOME LEGACY

In trying to create non-racial local governments, black organizations must overcome a legacy of urban development under apartheid. Townships, where most urban blacks live, were originally created as temporary residences for migrant labourers far from white metropolitan areas. Despite the government's intention that blacks return to the "homeland" areas, most people remained in the townships. Infrastructures were neglected and today, townships suffer from over-crowding and inadequate