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South Africa Is Seen to Lag in H.I.V. Fight

By CELIA W. DUGGER

ORANGE FARM, South Africa — Young men have flocked by the thousands to this clinic for circumcisions, the only one of its kind in South Africa. Each of them lies down on one of seven closely spaced surgical tables, his privacy shielded only by a green curtain.

“I’ve done 53 in a seven-hour day, me, myself, personally,” said Dr. Dino Rech, who helped design the highly efficient surgical assembly line at this French-financed clinic for cutting off foreskins.

Circumcision has been proven to reduce a man’s risk of contracting H.I.V. by more than half. Yet two years after the World Health Organization recommended the surgery, the government here still does not provide it to help fight the disease or educate the public about its benefits.

Some other African nations are championing the procedure and bringing it to thousands. But in South Africa, the powerhouse country at the heart of the epidemic, the government has been notably silent, despite the withering international criticism the country has endured for its previous foot-dragging in fighting and treating AIDS.

“Countries around us with fewer resources, both human and financial, are able to achieve more,” said Dr. Quarraisha Abdool Karim, the first director of South Africa’s national AIDS program in the mid-1990s under President Nelson Mandela. “I wish I understood why South Africa, which has an enviable amount of resources, is not able to respond to the epidemic the way Botswana and Kenya have.”

Even without government involvement, demand for the surgery, performed free under local anesthetic, has surged over the last year here at the Orange Farm clinic. The men are counseled to continue using condoms since circumcision provides partial, though substantial protection.

Men waited nervously one recent chilly morning for their turn. Most were hoping the procedure would help them stay healthy here in the nation with more H.I.V.-positive people than any other.

But some said they were also drawn by a surprising, if powerful, motivation: They had heard from recently circumcised friends that it makes for better sex. You last longer, they said. Your lovers think you’re cleaner and more exciting in bed.

“My girlfriend was nagging me about this,” said Shane Koapeng, 24. “So I was like, ‘O.K., let me do it.’ ”

As new H.I.V. infections have continued to outpace efforts to treat the sick in Africa, there is growing concern about the ballooning costs of treatment for an ever-expanding number of patients who need medicines for the rest of their lives. Almost two million people were newly infected in 2007 in sub-Saharan Africa, bringing the total of those living with H.I.V. in the region to 22 million, according to United Nations estimates.

The major international donors to AIDS programs, including the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria, are ready to pour money into male circumcision, but the countries have to be ready to accept the help.

“You can’t impose it from the outside, particularly such a sensitive intervention,” said the Global Fund’s executive director, Dr. Michel Kazatchkine.

Public health doctors agree that circumcising millions of men will be no simple task. Africa has a severe shortage of doctors and nurses, and circumcision is potentially a political and cultural minefield in countries where some ethnic groups practice it but others do not.

Still, some countries are showing it can be done. In Botswana, circumcision was largely stopped in the late 19th and early 20th centuries by British colonial-era administrators and Christian missionaries.

But Festus Mogae, who was president from 1998 to 2008, provided a critical endorsement of male circumcision just before he stepped down.

Over the past year, the government has trained medical teams to do circumcisions in all its public hospitals and aims by 2016 to have circumcised 470,000 males from infancy to age 49, which is 80 percent of the total number in that group.

Public awareness is being raised through advertisements on radio and television. Billboards have sprouted across the country featuring a star of the national youth soccer team.

“Men have started to flock to the hospitals,” said Dr. Khumo Seipone, director of H.I.V./AIDS prevention and care in Botswana’s Ministry of Health.

In Kenya, where the Luo do not generally practice circumcision, Prime Minister Raila Odinga, himself a Luo, encouraged the procedure and lobbied elders. The H.I.V. infection rate among Luo men is more than triple that of Kenyan men generally — 17.5 percent versus 5.6 percent.

“Anything that could help save lives needs to be tried,” Mr. Odinga said, adding that he had been circumcised.

So far, more than 20,000 men in Kenya have been circumcised in hospitals, dispensaries, village schools, social halls and tents. Teams of doctors, nurses and counselors have even taken boats to islands in Lake Victoria to circumcise Luo fishermen.

"If the Luo Council of Elders and local politicians had been against it, the government would not have dared endorse circumcision," said Robert Bailey, the principal investigator on the Kenya male circumcision clinical trial.

In sharp contrast, male circumcision has no political champion here in South Africa, where the largest ethnic group, the Zulus, have generally not practiced it since the early 19th century, when it was abandoned due to protracted warfare, according to Daniel Halperin, an epidemiologist and medical anthropologist at Harvard University.

Thabo Masebe, a spokesman for President Jacob Zuma, said the Health Ministry must first set a policy on circumcision before Mr. Zuma, who took office in April, can take a position. Mr. Zuma is Zulu. The province of KwaZulu-Natal, the Zulu heartland, has the highest adult H.I.V. prevalence rate in the country, 39 percent, according to Unaids.

"The president gets involved when decisions are made," Mr. Masebe said. "If the president spoke now, and when the time comes to make a policy, a different decision is taken, it wouldn't sound good."

The new health minister, Aaron Motsoaledi, spoke at length about AIDS in a recent speech to Parliament but made no mention of male circumcision. Dr. Yogan Pillay, a senior official at the National Department of Health, said a policy was being drafted and would be put forward for discussion by the end of the month.

In March 2007, the World Health Organization concluded from rigorous clinical trials in Kenya, Uganda and here in Orange Farm township that male circumcision reduced female-to-male H.I.V. transmission by about 60 percent.

"This is an important landmark in the history of H.I.V. prevention," the W.H.O. said at the time.

That same year, a committee of scientists, advocates and others advising the South African government recommended offering circumcisions as quickly as possible, perhaps by contracting with private doctors while public health workers were trained. Instead, the government set up a task force to study the issue, said Dr. Abdool Karim, a committee member.

The surgical methods developed in Orange Farm are now being copied in the region. Population Services International, which provides counseling at the Orange Farm clinic, is putting them into practice in Zimbabwe in collaboration with the Health Ministry there. It also received $50 million from the Bill and Melinda Gates Foundation to work with the governments of Zambia and Swaziland in the hope of circumcising some 650,000 men in those two countries.

South Africa has made strides in recent years, and now provides antiretroviral therapy to more people with AIDS than any other developing country.

But this is not the first time its policies have lagged behind. The country delayed for years providing antiretroviral medicines to treat AIDS under its former president, Thabo Mbeki, who denied the

scientific consensus about the viral cause of the disease. Harvard researchers estimated that the government would have prevented the premature deaths of 330,000 South Africans earlier in the decade if it had provided the drugs.

“South Africa has no shortage of scientists,” said Olive Shisana, chief executive officer of South Africa’s government-financed Human Sciences Research Council. “We have a shortage of people willing to take the evidence that exists and use it for public health.”

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Women and AIDS in South Africa
A Conflicted History Leads to a Dispiriting

By Alexandra Suich

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Article

Ten years ago, when Prudence Mabele discovered she had HIV, she was told to abandon her studies. She was working towards her degree in analytical chemistry at a time when HIV was neither understood nor tolerated in South Africa. "There were a lot of problems then", she said. "They didn't understand a lot about AIDS, so they told me to leave what I was doing because I was going to infect staff and students. They thought if I was at the laboratory I would infect people."

In a decade when there was a dearth of knowledge about HIV transmission, there proved an abundance of opportunity for proactive leadership. Prudence joined 59 other HIV-positive women to form the Positive Women's Network (PWN); today it has 2,000 members throughout South Africa. In such a forum, women began to speak about issues that directly affected them, such as how to discuss their HIV status with a spouse or how to cope with stigma. They also taught each other skills like weaving that could help them generate income. In other words, South African women, finding their families and communities unwilling or unable to support them, learned to support themselves and each other.

In South Africa, AIDS has disproportionately infected and affected women, who comprise the majority of participants in community organizations and care activities for the sick, and the majority of people infected with HIV/AIDS in the country. In May 2006, the Joint United Nations Programme on HIV/AIDS (UNAIDS) released the 2006 Report on the global AIDS epidemic, which states that women account for the bulk of the epidemic: 58 per cent of HIV-positive South Africans are women, or 3.1 million out of 5.5 million infected among adults aged 15 and over. A study conducted by the South African Department of Health in 2004 found that almost one in three pregnant mothers who received antenatal testing was HIV-positive. UNAIDS identified South Africa as the country with the highest number of women infected with HIV/AIDS in the world, almost double the number in India and over triple that in neighbouring Zimbabwe.

Prudence Mabele (right), leader of the Positive Women's Network, delivering HIV pins to Pfizer in Johannesburg, South Africa. Photo/Positive Woman's Network

HIV infection among women worldwide has risen. While the infection rate among both men and women in sub-Saharan Africa in 1985 was roughly equal, UNAIDS estimates that today women comprise 59 per cent of adults living with HIV,1 while among youth the gender imbalance is even more striking. Young women between the ages of 18 and 24 are three times more likely to be infected than men in the same age group. The changing demographic, or feminization, of AIDS is what made UN Secretary-General Kofi Annan declare recently that AIDS has "a woman's face", and UN Special Envoy for HIV/AIDS in Africa Stephen Lewis describe the loss of young women in sub-Saharan Africa as "a pandemic within a pandemic".

While many women have taken action to help counsel each other and prevent the further spread of AIDS, they find themselves combating both biological factors and entrenched social norms. During sexual intercourse, the statistical probability of infection for women is higher than men, since men carry a higher viral load or concentration of HIV in semen than is produced by the female's vaginal fluid.2 However, biology cannot explain entirely the gender nature of the epidemic, as the proportion of women infected with AIDS differs vastly between countries and cultures.

In countries where gender inequality is large, women are at particular risk for contracting the disease. One great failure of prevention efforts is that an option does not exist for women to independently prevent sexual transmission of the virus. The male condom is often not a realistic option for women who live in countries where families and communities are patriarchal, as in South Africa. It is also an especially contentious issue, particularly for married couples, as women have limited leverage and bargaining power; des-pite its obvious limitations, there is no other alternative prevention for them. Microbicides, a clear gel that a woman can use before intercourse, are still undergoing testing and have not been disseminated. And female condoms are not available in clinics.

HIV transmission is also linked to education and economic status. South Africa differs from many countries in the region because girls' enrolment

rate in schools outnumbers that of boys in primary and secondary, as well as in higher education. But despite these statistics, girls face an unequal environment in school. There have been repeated reports from provinces in the country about girls being forced to have sex with teachers for being late to class or in exchange for food at lunchtime. This environment not only increases the rate of HIV/AIDS among youths but also decreases the girls' feeling of empowerment and agency.

Poverty also increases the rate of HIV incidence. In South Africa, women make only 70 per cent of what men earn, which already puts them at a disadvantage for attaining self-sufficiency. Poverty rates are much higher among women, with 60 per cent of female-headed versus 31 per cent of male-headed households, falling below the poverty line. Women's vulnerability often forces them into sexual relationships that they otherwise would not engage in and gives men more leverage for taking on multiple wives. In addition, the HIV/AIDS situation in South Africa has been exacerbated by men's migration to cities for mining and other job opportunities. Men's separation from their wives and their proximity to other women who know nothing about their lifestyle put women at risk for contracting the virus.

While universal drug access has increasingly spread to the poorest areas and patients, the proliferation of clinics has not managed to erode one of the most destructive characteristics of AIDS: stigma. Women who have received antiretroviral treatment have been known to crush and hide the medicine under the bed so that no packaging or pills could be traced to them. A study conducted in 2002 demonstrated that upon disclosing one's status, one in ten people was met with outward antagonism. "There was this woman who, when she tested positive and told her husband, her husband poured boiling water on her face, even on the child", said Elizabeth Gordon of the United Nations Development Programme (UNDP) in South Africa.

Women in Africa attending an HIV-and-AIDS awareness session
UNAIDS/AVECC/H. Vincent

Stigma due to AIDS is a reality in many African countries, but it is made particularly virulent in South Africa because of the country's conflicted history with the illness. Whereas certain countries in the region, such as the United Republic of Tanzania, snapped into action when they were hit with the epidemic, the South African Government still seems wary to acknowledge the devastation caused by the disease. President Thabo Mbeki

had promoted the notion that HIV did not necessarily cause AIDS. "Does HIV cause AIDS? How? Indeed, HIV contributes, but other things contribute as well", he told the Parliament in 2000, pointing to poverty and malnutrition as the core reasons for the sickness. The Minister of Health followed the President's lead, voicing public support for the use of vitamin supplements over antiretroviral treatment.

The recent rape trial of former Deputy President Jacob Zuma in early 2006 was a low-point for HIV prevention and women's rights. While testifying in support of his innocence in court, he admitted to having unprotected sex with a woman he knew was HIV-positive, but maintained that he took a shower afterwards which, he claimed, eliminated the chance of transmission. Mr. Zuma's subsequent acquittal underscores the gender inequality in the country, where a woman is estimated to be raped every 17 seconds. Violence against women is one of the leading reasons why the HIV rate among this vulnerable group has skyrocketed in South Africa.

Arguably, a heavy burden of the disease also falls on women who are not necessarily infected. Because of traditional gender roles, women account for the majority of caregivers for the sick-the consuming nature of this work is unfathomable. As AIDS progresses, family members will usually become bedridden, requiring constant supervision and care for their most basic needs. Once the infected individual dies, children are left behind-a phenomenon that has become a pandemic of its own. In South Africa alone, there are 1.1 million AIDS orphans and by 2010 the number is estimated to increase to approximately 3 million. Again the burden falls on women, as over 60 per cent of these orphans end up being cared for by their grandmothers.3 There have been efforts to equip grandmothers with the capacity to support orphans they have taken in; for example, the "Gogo Grannies" programme in the Alexandra township, outside Johannesburg, gives grandmothers a plot of land and seeds to grow and sell food.

Many organizations in South Africa have acknowledged the particular vulnerability of women to HIV/AIDS and have worked to incorporate women's interests and live-lihoods into their programmes. The United Nations has been particularly active in gender mainstreaming in South Africa in its HIV/AIDS programmes. Nonetheless, gender-specific projects should not always trump those that are gender-blind. Love Life, one of the country's most active campaigns in promoting positive sex messages to youths, does not target only the most vulnerable populations through its projects. "Our target group is equally young men and young women", said its Deputy Chief Executive Officer, Grace Matlhape. "Even as you focus on issues that render women vulnerable [to HIV], you will have limited returns if men are not brought into the fold."

Notes

1. www.unifem.org/gender_issues/hiv_aids/ and www.unaids.org/en/HIV_data/2006/GlobalReport/

2. www.genderlinks.org.za/

3. Steinberg M., Johnson S. et al. (2002), "Hitting home: how households cope with the HIV/AIDS epidemic" Henry J. Kaiser Foundation and Health Systems Trust, available at www.avert.org/aidssouthafrica.htm

Biography

Alexandra Suich has worked with several organizations, including UNDP in South Africa, Pathfinder International in Kenya, the UN Development Fund for Women in New York, the

Global Exchange in San Francisco and the National Organization for Women in Washington, D.C. She is a student at Yale University, majoring in history and African studies.

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