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Post-Apartheid South Africa's Ultimate Challenge

After gaining freedom from apartheid, many South Africans may have deemed violence, injustice, and poverty to be the most difficult problems that they would have had to face, and they may have expected the road to democracy to be an easy path to tread. Consequently, no one could have predicted or accounted for the devastating effect of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (WHO, 2012). South Africa, which continues to struggle with the aftermath of apartheid, was not prepared for the nefarious effects of this epidemic at a time when it was working toward peace and reconstruction after its newfound status as a free country. Therefore, this pandemic gradually escalated, costing the lives of many unprepared South Africans. It also exacerbated the struggles of the nation by obstructing its educational, financial, and political recovery (Oglethorpe & Gelman, 2008; Weiser et al., 2007). Building upon extensive research on the factors associated with the gradual increase in the incidence of HIV in South Africa, this paper seeks to analyze how apartheid—or rather, its demise—contributed to the alarmingly rapid spread of this pandemic in South Africa. In so doing, this article will analyze (1) the prevalence of HIV/AIDS; (2) the manner in which education, or the lack thereof, influences the spread of the disease; and (3) the seemingly mutual relationship between poverty and HIV/AIDS.

The Prevalence of HIV/AIDS in South Africa

HIV/AIDS is an illness of the immune system that is primarily transmittable by sexual contact. It is characterized by the impairment of the immune system's ability to fight infection (AVERT, 2011a). No cure has been found for the virus, although certain treatments, such as antiretroviral medication, enable the afflicted to lead normal lives (Jones, 2011). Nevertheless, such treatments are not readily available in underdeveloped countries, making HIV/AIDS one of

the most dangerous diseases in the world (Tsai, Chopra, Pronyk, & Martinson, 2009). It is currently the number one killer in Africa (WHO, 2012), which has the highest incidence of HIV/AIDS worldwide; more than 22.5 million people in Africa live with HIV (AVERT, 2011a). According to UNAIDS (2011), approximately 6 million individuals in South Africa live with the disease, a figure accounting for approximately 30% of global HIV/AIDS cases and 45% of Africa's total number of cases. Close to 40% of people infected with the disease in South Africa are between the ages of 15 and 49 years (AVERT, 2011a). In contrast to other nations, such as the United States, where HIV/AIDS was primarily associated with the homosexual population, in South Africa, the infection is usually transmitted by sexual contact between heterosexuals (Shisana, Rehle, & Simbayi, 2005). This disease has considerably reduced South African life expectancy from 62 to 47 years, and, over the past decade, the number of premature deaths due to HIV/AIDS has dramatically increased from 39% to 75% (Harrison, 2009). Nearly 1,000 people in South Africa die of HIV/AIDS every day, amounting to 350,000 deaths each year (AVERT, 2011a). UNAIDS (2009) estimates that if no treatment to slow down the infection is found, more than 55 million people will die between 2000 and 2020.

Most of the deaths due to HIV/AIDS occur among South Africa's minority populations. South Africa's women, who constitute a portion of the country's minority population, are the most significantly affected by the disease (Shisana, Rice, Zungu, & Zuma, 2010). One in three females aged 25 to 29 years lives with HIV/AIDS (Karim, 2012). According to UNAIDS (2009), nearly 14 million women in Africa are infected with the disease. The younger the women, the higher are their risk of contracting the disease. The World Bank (2005) indicates that, approximately 2% of young men and 5% of young women between the ages of 15 and 25 years are infected with the disease. The percentage of infected women (57%) in South Africa is higher

than it is in the rest of the world (UNAIDS, 2004). According to Gregson, Zaba, and Garnett (1999), HIV/AIDS not only kills women, but also decreases female fertility. These authors also indicate that the rate of infertility, which is 25% for HIV-negative females, increases to 40% for HIV-positive females. HIV-positive women are often marginalized, isolated, and humiliated (Brown, Macintyre, & Trujillo, 2003). Furthermore, they have to cope with the added burden and guilt of knowing that their offspring may be infected with the same illness and that they may not be well enough or even present to provide their children with the necessary support.

HIV/AIDS imposes equally tragic effects on children. According to UNAIDS (2011), more than 600,000 African children are infected with HIV/AIDS through childbirth each year and these infants often die before they reach their second birthday (Gregson et al., 1999). In 2009, more than 300,000 children under the age of 15 lived with the disease (UNAIDS, 2011). Only around 10% of infected children have access to the treatment necessary for their survival (Zwemstra & Loxton, 2011). The number of South African children who lost a parent to HIV/AIDS is 2 million (UNAIDS, 2010), of which 70% were left without mothers (Budlender et al., 2008). These children are frequently forced to quit school to take care of younger siblings, and sometimes to care for a living parent who is infected (Van Dyk, 2008). Some have to leave their homes to live with other relatives, and those who are less fortunate are forced to live in the streets (Zwemstra & Loxton, 2011). These children experience a great deal of emotional distress—in the form of anger, helplessness, and depression, for example—because they are often marginalized by association (Neuberg et al., 1994) in addition to being exploited, undernourished, and uneducated (Airhihenbuwa et al., 2009). Those who are infected are typically mistreated by their peers and other people.

The Role of Education in the HIV/AIDS Pandemic

One reason for the uncontrolled spread of AIDS in South Africa may be poor education about the virus. First, one global misconception is that HIV/AIDS is a homosexual disease and that it, therefore, does not affect heterosexuals (Fee & Brown, 2006). Second, for decades, the South African government denied the existence of HIV/AIDS, blaming conspiracy theories and mythical political and racial motivations, which were allegedly aimed at diminishing the country's newfound stability (Van der Vliet, 2011). The African National Congress (ANC) even reported that the virus was created in a laboratory, while other individuals blamed ex-ANC agents for deliberately contaminating black prostitutes (Van der Vliet, 2011). Scientists, such as Duesberg, Rasnick, Gesheckter, Papadopoulos, and many other physicians worldwide, did little to help matters when they refused to acknowledge a relationship of causation between HIV and AIDS (Sitze, 2004). Following suit, the Mbeki and Manto governments opposed the provision of antiretroviral therapy treatments and declared that AIDS was not caused by HIV, but by socioeconomic factors such as poverty, malnutrition, and unhealthy lifestyle (Sitze, 2004). Accordingly, they discouraged the population from seeking medical help and encouraged them to use garlic, lemon, and beetroot as preventive and treatment measures (Malan, 2001). It was only when President Jacob Zuma took office in 2009 that HIV/AIDS was recognized as one of the most detrimental and destructive infections in South Africa (Malan, 2001).

Although lack of preventive education plays a critical role in the spread of HIV/AIDS in South Africa, the disease also poses an equally significant threat to the South African educational system (Van Dyk, 2008). HIV/AIDS decreases demand for education because for children who are already infected, the perceived value of an education is diminished (AVERT, 2011a). According to Zwemstra and Loxton (2011), the mortality rate for children born with HIV/AIDS

is very high. As previously stated, very few infected children make it to their second birthday, thereby considerably reducing the number of school-age children. Children with HIV-positive parents usually drop out of school because their parents are either too sick to care for themselves and, therefore, need their children's help, or are unable to provide the financial support required for their children to finish school (Zwemstra & Loxton, 2011). Upon the death of their parents, these children typically have to take on laborious jobs in order to survive. The school enrollment rate also decreases because of child mortality due to HIV/AIDS; the rate of primary and secondary school enrollment in South Africa is substantially decreasing as a result (Van Dyk, 2008). Furthermore, a gender component characterizes dropout rates: girls are more likely to be removed from school so that they can take care of their sick parents and younger siblings; they also typically marry at a very young age (Shisana et al., 2010). HIV/AIDS also decreases educational supply as many schools are forced to close their doors because of low enrollment rates (Van Dyk, 2008). As the number of children decreases, many schools face financial challenges that make it difficult to continue their operations (Van Dyk, 2008). Education is also affected by the rate of teacher mortality; research found that 21% of teachers between the ages of 25 and 34 years were living with AIDS in 2006, and an estimated four or more teachers die of AIDS every day (UNAIDS, 2006). This deficit in education can only exacerbate the increasing rate of poverty in South Africa.

The Relationship between Poverty and HIV/AIDS

Most HIV-positive individuals in South Africa live below the poverty line (Tsai et al., 2009) and few have the finances or skills necessary for daily survival (AVERT, 2011). Unfortunately, this situation forces people to make regrettable choices. They often engage in risky behaviors, not because they are no longer concerned about the consequences or are

unaware of the dangers, but because their economic circumstances rob them of the “luxury” of worrying about an infection that may soon cause their death (AVERT, 2011; Weiser et al., 2007). For instance, poverty drives many South African women, who are usually the heads of the household, to engage in risky practices, such as prostitution, to take care of themselves and their children (Oglethorpe & Gelman, 2008). In 2005, 33.5% of South African women living below the poverty line have engaged in some form of prostitution; many women work as “permanent” prostitutes, while, for others, sex for pay is an occasional endeavor (Shisana et al., 2005). Some men are often willing to pay an excessive amount of money to forgo the use of a condom during sex; therefore, numerous women and young girls engage in this unsafe practice (Shisana et al., 2010). Even women living with spouses are endangered; when men travel significant distances to work in the mines, they often keep a mistress, thereby increasing their chances of contracting the infection and transmitting it to their wives (Shisana et al., 2010). Furthermore, the sex trafficking and exploitation of children is another poverty-related problem that contributes to the spread of HIV/AIDS in South Africa (Zwemstra & Loxton, 2011). Young girls are forced to marry very early to alleviate their family’s financial burdens and because some men prefer to have young wives (Shisana et al., 2010). Men believe young girls are less likely to have HIV, and such preferences perpetuate the cycle of poverty.

HIV/AIDS is detrimental to many countries’ financial growth; the disease worsens the conditions of an already impoverished nation (Avert, 2011). Deaths caused by HIV/AIDS reduce the number of trained employees and numerous infected people leave their jobs to stay home or relocate (Oglethorpe & Gelman, 2008). According to the World Bank (2009), South Africa’s financial growth will decrease by 0.4% on a yearly basis because the HIV/AIDS pandemic will cause a decline in GDP. Many South Africans will spend more than 13% of their income to care

for their HIV-positive relatives (World Bank, 2009). The numerous lives lost to HIV will eventually reduce the number of qualified employees and farm workers, which will, in turn, result in deficient food production (Oglethorpe & Gelman, 2008). Given the daily struggles that South Africans face in their efforts to satisfy their basic needs, they have difficulties obtaining medical treatment and support necessary to survive and enjoy the quality of life that is evident in developed countries, such as Europe and the United States (Karim, Churchyard, Karim, & Lawn, 2009). The South African government has been mostly implementing a preventive approach to the disease rather than investing in both prevention and treatment (Malan, 2001).

Conclusion

Throughout history, South Africa has experienced numerous upheavals related to slavery and apartheid, or to natural, socioeconomic, and political misfortunes. Against this background, the country appears to be constantly beset by overwhelming disasters. Although the spread of HIV/AIDS has decreased in many countries, this is not the case for many African nations and, most notably, South Africa, where the number of HIV-positive individuals is increasing considerably. The post-apartheid South African government's denial of the existence of HIV/AIDS and other factors such as education and poverty contribute to the uncontrolled spread of AIDS in South Africa. With more than 6 million people infected, the country has the highest number of HIV cases worldwide, with women being the primary victims. The disease also leaves many children orphaned and forced to fend for themselves and their siblings. The more destitute among these orphans are forced to live in the streets. HIV/AIDS has a dual effect on education; lack of preventive education worsens the spread of the pandemic, while the increasing incidence of AIDS reduces the quality of education and decreases enrollment rates. Poverty also plays a critical role in the spread of HIV/AIDS. It would, however, be erroneous to conclude that

HIV/AIDS is a disease of the poverty-stricken, in the same way that it was wrongly labeled a gay disease in the 1980s. Rather, this essay argues that poverty and HIV/AIDS are mutually correlated. The poorer a country, the higher the prevalence of the disease, and the higher the incidence of disease, the poorer the country is likely to become. To lessen the spread of the disease, the South African government should aggressively redouble its efforts to implement more preventive measures while promoting and investing in antiretroviral therapies.

Additionally, the government should aggressively implement strategies designed to reduce the rate of mother-to-child transmission, and promote the use of condoms by making them freely available or considerably reducing their prices so that the underprivileged can afford them.

Another worthy endeavor is creating programs that help to protect orphaned children because this is the only way to ensure a reduction in the number of unnecessary AIDS/HIV-related deaths in South Africa.

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