**HIV/AIDs as a Health Care Policy Issue in South Africa**

**Introduction**

This paper examines HIV/AIDs in the Republic of South Africa as a healthcare policy issue. Historically, HIV/AIDs originated in Africa in 1920, particularly within the Democratic Republic of Congo where the HIV virus first crossed from the chimpanzees to humans (Fletcher, Klimas & O’Brien, 2008). HIV/AIDs as an epidemic did not capture the global attention until in 1981 when the CDC raised the alarm. In 1981, up to 300,000 people were suspected to have contracted the disease (Fletcher, Klimas & O’Brien, 2008). In 1983, the World Health Organization (WHO) held the first meeting to address the global HIV/AIDs situation (Butler, 2005). In 1995, Highly Active Antiretroviral Treatment (HAART) was approved as an effective method of managing HIV/AIDs, though roughly 4.7 million people globally were already infected by the year 1995 (Avert, 2017). Nonetheless, the World Health Organization in association with governments around the world embarked on a policy-oriented campaign to mitigate the HIV/AIDs epidemic. Succeeding sections of this paper discusses the policy-related approaches to the management of HIV/AIDs in South Africa.

**Discussion of the Policy Issue**

In 2016, over 34 million people were living with HIV/AIDs, and over half (19 million people infected with HIV/AIDs were in Africa (Avert, 2017). In particular, the Republic of South Africa is the hardest hit in regards to the global HIV epidemic where 19% of the world’s HIV-positive people live in South Africa. Approximately 15% of adults in South Africa are HIV-positive, and South African records the highest rates of new HIV infections and AIDs-related deaths globally (Simelela and Venter, 2014). Consequent to the highest prevalence of HIV/AIDs, South Africa runs the largest HIV/AIDs treatment program globally whereby 20% of the global antiretroviral therapy is conducted in South Africa (Avert, 2017). In 2016, South Africa spent averagely $1.42 billion annually to run its HIV/AIDs treatment programs (Avert, 2017). Thus, South Africa is a sufficient case to examine the policy-oriented approaches towards the management of HIV/AIDs.

Prior to discussing the policy-oriented ways that South Africa is using to manage HIV/AIDs, it is first worth examining the nature, causes, and effects if HIV/AIDs as a pertinent healthcare issue. HIV (Human Immunodeficiency Virus) is a virus spread through contact with bodily fluids including vaginal fluids, semen, breast milk, and blood of an infected person (Fletcher, Klimas & O’Brien, 2008). On the other hand, AIDs (Acquired Immunodeficiency Syndrome) is the last lethal stage of HIV infection. Clinically, the HIV virus undermines the natural immune system by destroying the CD4 cells (Fletcher, Klimas & O’Brien, 2008). HIV infection is a multi-organ disease that is not curable, though HIV is manageable through the antiretroviral therapy (Butler, 2005). Symptoms of HIV infection include but not limited to loss of appetite, persistent diarrhea, frequent skin infections, and unintentional weight loss. However, symptoms of HIV infection may remain unnoticed up to 6-10 years after infection (Chibango, 2013).

HIV-negative individuals acquire HIV infections through common routes of bodily fluid exchanges including sharing of drug injecting needles, sexual intercourse, and through breastfeeding (Fletcher, Klimas & O’Brien, 2008). In particular, high levels of transactional sex including sex work encourage the transmission of HIV infection whereby approximately 57.7% of sex workers (both male and female sex workers) in South African are HIV positive (Avert, 2017). Also, HIV infections are more prevalent among populations of injecting drug users compared to the general population because of the exchange of blood through the sharing of syringes (Avert, 2017). In South Africa, HIV prevalence among injecting drug users stands at 19.4% compared to 7.1% prevalence within the general population (Avert, 2017). Besides sex working and drug injection, imprisonment also features as another predisposing factor to HIV infection whereby 17.5% of prisoners in South African are HIV positive (Kathryn et al, 2015). Prison is a high-risk environment for the transmission of HIV because of the frequent sharing of unsterile equipment including tattooing instruments among prisoners (Avert, 2017). Moreover, HIV prevalence is higher within the LGBT populations whereby approximately 16.8% of gay men in South Africa are living with HIV (Simelela and Venter, 2014).

The primary effect of HIV/AIDs to the affected population is high rates of premature mortality. In South Africa, HIV/AIDs accounts for 61.3% of cases of premature mortality. The average life expectancy for people with HIV who start their antiretroviral therapy aged below 20 years was 43.1 years while the average life expectancy for young people aged 20 years who did not use antiretroviral therapy was 31.8 years (Meulemans, Rensburg & Wouters, 2010). On the other hand, the average life expectancy in South Africa in 2017 was 57.44 years. Thus, HIV-positive individuals who started antiretroviral therapy at the age of 20 years lived averagely 14 years less than an average HIV-negative South African. HIV/AIDs also increases child mortality rates whereby the 2-year mortality rates was 547 per 1000 births for HIV-infected children compared to 68 per 1000 births for HIV-negative children (Fletcher, Klimas & O’Brien, 2008). Overall, HIV/AIDs predisposed South African communities to high rates of premature mortalities.

Besides the effect of premature mortalities, HIV/AIDs also impact the South African economy negatively. Direct economic impacts of the HIV/AIDs epidemic include the higher cost of managing HIV/AIDs. As aforementioned, the South African government spends approximately $1.42 billion to run its HIV/AIDs management programs. This expenditure represents roughly 4% of South Africa’s annual national budgetary expenditure (Simelela and Venter, 2014). Allocating 4% of the national budget to the management of HIV/AIDs puts immense pressure on the economy as it manifests as high inflation as the government increases taxation to cover for the expenditure (Butler, 2005). Also, HIV-infected South Africans are spending their modest savings and meager earnings to manage their HIV/AIDs conditions (Kathryn et al, 2015). Overall, the cost of treating HIV/AIDs puts direct pressure to the economy.

Also, HIV and AIDs are to blame for indirect economic detriments including loss of productivity. In South Africa, HIV is prevalent among young and productive members of the society whereby 79% of people living with HIV fell within the age bracket of 15-49 years (Meulemans, Rensburg & Wouters, 2010). This age bracket is the most productive demographic within a nation (Kathryn et al, 2015). Unfortunately, HIV/AIDs undermine labour productivity through high staff turnover, frequent absenteeism, and the high costs of recruiting and training new staff members (Campbell & Mzaidume, 2002). In South Africa, the mining and the transportation sector are the worst hit where 27% of the current mining workforce is projected to die of AIDs by the year 2030 (Chibango, 2013). The massive loss of the workforce will initiate a decline in productivity within crucial sectors of the South African economy. Therefore, HIV infection is an impactful epidemic that requires concerted policy-oriented efforts to mitigate.

**Discussion of the ways the country is addressing the issue**

The World Health Organization, in its advisory capacity, advised policy makers around the world to commence the campaign against the spread of HIV/AIDs from a social-epidemiological context (Meulemans, Rensburg & Wouters, 2010). Consequently, South Africa commenced the policy-oriented management of HIV/AIDs by understanding the myriad of socio-economic factors that promote the transmission and the prognosis of HIV/AIDs. Five socio-economic contextual factors that played a critical role in the transmission and progression of HIV/AIDs included poverty, labour mobility, gender inequalities, cultural attitudes and practices, and stigma and denial (Chibango, 2013). These contextual factors played crucial roles in the design of policy-approaches for the prevention, care and management of HIV/AIDs.

The contextual factor of poverty contributed to the transmission of HIV infections because poverty pushed most young women to sex work (Campbell & Mzaidume, 2002). On the other hand, gender and gender-based violence played a role in the transmission of HIV infections in South African because women are biologically more vulnerable to HIV infections than men, and because women are socially vulnerable to sexual exploitation (Campbell & Mzaidume, 2002). Regarding labour mobility, the South African mining industry is characterized by massive migration of workers from the rural areas to the mining towns and back to their rural areas. The mining towns were hardest hit by the HIV/AIDs epidemic because sex work is rampant at the mines. Therefore movement of workers to and from the mining sites worsened the transmission of HIV infections throughout South Africa (Simelela and Venter, 2014). Moreover, cultural practices including lack of male circumcision in most South African societies increased the transmission of HIV among men. Lastly, stigmatization prevented most HIV-positive persons from seeking treatment and also prevented most persons from knowing their statuses (Meulemans, Rensburg & Wouters, 2010). These contextual factors informed the design of the HIV/AIDs policy programs in South Africa.

South Africa remained under apartheid until 1994. During the apartheid regime, healthcare provision was a race-related privilege as opposed to being a human right. Thus, the response to HIV/AIDs in South African did not commence until in 1994 when the National AIDs Plan was formulated under the democratic leadership of President Mandela (Chibango, 2013). The National Aids Plan was intended to mitigate the transmission of HIV infections by specifically targeting the prevention of mother-to-child infections. The National Health Systems Trust placed pregnant mothers under antiretroviral treatment to minimize transmission (Simelela and Venter, 2014). Also, this initial plan rolled out community education on the nature of HIV/AIDs and the need to use preventive methods including condoms and avoiding multiple sex partners to minimize HIV transmission (Chibango, 2013). However, this initial policy plan failed because of the confusion regarding the mandate of the different healthcare departments during the plan’s implementation. The political transition from the apartheid regime to the democratic regime caused disarray among the healthcare institutions who were supposed to implement the plan (Butler, 2005). The health education was not conducted sufficiently and the healthcare departments failed to reach sizable portions of the pregnant mothers in the mother-to-child prevention program.

Consequent to the failure of the National AIDs Plan, the prevalence of HIV infections in South Africa rose dramatically from 1.8% of the population in 1994 to over 10% of the population by 1999 (Campbell & Mzaidume, 2002). The dramatic rise in HIV prevalence aroused anxiety among national and international healthcare policy makers; hence, necessitating the introduction of more effective policies to fight the HIV epidemic (Butler, 2005). In early 2002, the South African Cabinet joined hands with international partners including the World Health Organization, USAID, and the Clinton Foundation to provide sufficient funding and logistical support for the newly established Joint Health and Treasury Task Team (Simelela and Venter, 2014). By 2003, the Task Team had developed the Comprehensive HIV/AIDs Care, Management and Treatment Plan which was intended to promote HIV testing and counseling nationally and to promote the use of antiretroviral treatment among persons already living with HIV (Kathryn et al, 2015).

Socio-epidemiological studies had indicated that in 1999, only 12.8% of South Africans were aware of their HIV statuses; thus, the new program sought to promote HIV awareness nationally by establishing free HIV testing and counseling centers within each healthcare clinic in South Africa (Kathryn et al, 2015). The HIV testing program yielded considerable success whereby in 2016, approximately 86% of South Africans were aware of their HIV statuses. The high rate of awareness translated to increased uptake of antiretroviral treatment among both adults and children (Chibango, 2013). In 2016, approximately 65% of HIV-positive South Africans were on active antiretroviral treatment, and 81% of those on the treatment had exhibited virally suppressed outcomes meaning the 81% had limited chances of transmitting the disease to HIV-negative persons during sexual intercourse (Avert, 2017).

Besides the approaches of HIV testing and antiretroviral treatment, the Comprehensive HIV/AIDs Care and Management plan also promoted voluntary medical male circumcision. Clinically, male circumcision reduces the risk of HIV transmission from females to males by approximately 60% (Avert, 2017). Thus, the South African healthcare department rolled out the voluntary male circumcision program with the aim of reaching HIV-negative men in specific districts including the Kwazulu Natal and the Northern Cape regions where male circumcision was not practiced commonly. By 2016, the voluntary male circumcision had reached 60-79% of HIV-negative men (Avert, 2017). Recently, the HIV prevention program has been expanded to include the recently-discovered pre-exposure prophylaxis (PrEP). The PrEP program targets HIV-negative persons at increased risk of contracting HIV including sex workers, adolescent girls, injecting drug users, and homosexual men. The PrEP program strives to reach up to 80% of the target population between 2017 and 2022. So far, the synergy of all these policy approaches towards the prevention, care, management, and treatment of HIV/AIDs has reduced the annual HIV transmission rate and annual mortality attributable AIDs.

**Conclusion**

Overall, HIV is a serious healthcare policy issue in the Republic of South Africa. Currently, HIV/AIDs remain incurable and HIV and AIDS are detrimental not only to the medical health of individuals but also to the social and economic health of communities in South Africa (Fletcher, Klimas & O’Brien, 2008). Thus, the South African government in collaboration with international stakeholders has enacted policies for the prevention, care, management and treatment of HIV/AIDs. Examples of these policies include the free HIV testing services, the voluntary male circumcision program, and the use of antiretroviral therapy. So far, the policy-oriented approaches to HIV/AIDs in South Africa have yielded commendable successes.

**References**

Avert. (2017). HIV and AIDs in South Africa. *Avert.org*. Retrieved from <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa>

Butler, A. (2005). South Africa’s HIV/AIDs policy, 1994-2004: How can it be explained? *African Affairs, 104*(417), 591-614, <https://academic.oup.com/afraf/article/104/417/591/32035>

Campbell, C & Mzaidume, Y. (2002). How can HIV be prevented in South Africa? A social perspective. *British Medical Journal, 324*, 229-232, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1122138/>

Chibango, C. (2013). South Africa’s HIV and AIDs policy and legislation: An analysis. *Greener Journal of Medical Sciences, 3*(6), 240-250, <https://pdfs.semanticscholar.org/7df9/da2ea2a8faf2d00561b1ce63b30e4120de0c.pdf>

Fletcher, M., Klimas, N & O’Brien, K. (2008). Overview of HIV. *Psychosomatic Medicine, 70*, 523-530, <https://pdfs.semanticscholar.org/493c/f033aacdf6bf8c89e2b9f42b05e8c30908dd.pdf>

Kathryn, C et al. (2015). A comparative analysis of national HIV policies in six African countries with generalized epidemics. *Bulletin of the World Health Organization, 92*, 457-467, <http://www.who.int/bulletin/volumes/93/7/14-147215.pdf>

Meulemans, H., Rensburg, H & Wouters, E. (2010). The national strategic plan of South Africa: What are the prospects of success after the repeated failure of previous AIDs policy? *Health Policy and Planning, 25*(3), 171-185, <https://academic.oup.com/heapol/article/25/3/171/600049>

Simelela, N and Venter, W. (2014). A brief history of South Africa’s response to AIDs. *South African Medical Journal, 104*(3), 249-251, <http://www.samj.org.za/index.php/samj/article/viewFile/7700/5855>