

Nola Redelinghuys

Social dynamics fuelling the spread of HIV/AIDS in the Free State: implications for prevention, care, treatment and support

This article examines some of the socio-economic and socio-cultural factors that may have shaped a social context conducive to the spread of HIV/AIDS in the Free State. Among the factors identified driving the spread of the disease in this province, low levels of socio-economic development, population mobility, and gender inequality are paramount. The article further reasons that the successful implementation of strategies aimed at HIV prevention, treatment and care, such as the *Comprehensive Plan* of 2003, hinges on the social context enhancing or inhibiting the implementation thereof. Lastly, it is reasoned that the issues of planning and strategy development for the prevention of HIV/AIDS should slot into broader social policy and planning at the national and provincial levels. Amongst others, this would include policy and planning that target those socio-economic and socio-cultural forces which are fuelling the spread of the disease.

Die sosiale dinamika wat die verspreiding van MIV/VIGS in die Vrystaat aanvuur: implikasies vir voorkoming, sorg, behandeling en steun

Die artikel ondersoek sekere sosio-ekonomiese en sosio-kulturele faktore wat moontlik daartoe bygedra het om 'n sosiale konteks te vestig wat die verspreiding van MIV/VIGS in die Vrystaat in die hand werk. Onder die faktore wat geïdentifiseer is om die verspreiding van die siekte te bevorder, is lae vlakke van sosio-ekonomiese ontwikkeling, bevolkingsmobiliteit en geslagsongelykheid oorheersend. Die artikel redeneer voorts dat die suksesvolle implementering van strategieë wat gemik is op MIV-voorkoming, behandeling en sorg, soos die *Komprehesiewe Plan* van 2003, saamhang met die sosiale konteks wat die implementering daarvan of bevorder of strem. Laastens word daar gereedeneer dat die kwessies van beplanning en strategie-ontwikkeling om MIV/VIGS te bestry, moet inskakel by die breër sosiale beleid en beplanning op nasionale en provinsiale vlak. Dit sou onder meer beleid en beplanning insluit wat daardie sosio-ekonomiese en sosio-kulturele kragte teiken wat die verspreiding van die siekte aanvuur.

Ms N Redelinghuys, Dept of Sociology & Centre for Health Systems Research & Development, University of the Free State, P O Box 339, Bloemfontein 9300; E-mail: redelinn.hum@mail.uovs.ac.za

An effective response to the HIV/AIDS burden in terms of prevention, access to treatment, care, and support to infected people is undeniably one of the most severe challenges facing the health care sector in South Africa.¹ The rapid increase in HIV prevalence in this country has been unprecedented even in Africa, with the development of the epidemic being firmly rooted in the social conditions that determine exposure to the disease. Considering this, the social dynamics fuelling the spread of the disease, such as low levels of socio-economic development, population mobility and inequitable gender relations, hamper effective intervention and increase vulnerability to the impacts of the epidemic. The social context in which the epidemic flourishes consequently creates a cycle of infection and vulnerability that ultimately exacerbates low levels of socio-economic development (Grimwood *et al* 2000).

Within South African society, the prevalence of HIV/AIDS reveals the disadvantaged and powerless sectors of the population being trapped in a cycle of vulnerability in which HIV infection, poverty and the exposure to ineffective intervention build up towards increased vulnerability to exposure. Illustrative of this is the fact that HIV/AIDS is spreading disproportionately among the various provinces in South Africa. Some provinces, such as KwaZulu-Natal, Gauteng and the Free State, are more affected by HIV than others. The argument of this paper is that the roots of this trend are firmly located in the social dynamics underlying exposure and vulnerability to HIV infection.

The Free State has consistently ranked high among provinces with regard to antenatal prevalence in the past five years, and HIV infection rates are set to increase drastically over the coming years. In this social environment, the drivers of high HIV infection are found in particular socio-economic and demographic realities facing the Free State. These realities potentially impact on the response and effectiveness of intervention, treatment, care and support within the framework and the implementation of the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (NDoH 2003b, hence-

1 This article is an adapted version of a presentation at the conference on *Implementing the Comprehensive Care and Treatment Programme for HIV and AIDS patients in the Free State: sharing experiences*. Bloemfontein, 30 March-1 April 2005.

forth *Comprehensive Plan*) in all provinces. UNAIDS (2004a) emphasises that although there has been an increase in countries with comprehensive, multi-sectoral national AIDS strategies, existing plans do not always translate into efficient and concerted action. Ultimately, the success of any action undertaken in respect of HIV/AIDS hinges on the social context enhancing or inhibiting the implementation thereof at a national, regional and local level.

With this in mind, this article firstly reflects on the socio-economic and socio-cultural factors rendering people vulnerable to the disease in the Free State province. Argumentation is based on HIV prevalence data obtained from antenatal clinic survey data for the period 1999-2004. Secondly, the article evaluates the significance of these factors within the context of HIV/AIDS prevention and treatment, care and support as outlined in the *Comprehensive Plan* (NDoH 2003b).

1. Profiling HIV/AIDS in the Free State

Since the early 1990s, HIV prevalence in South Africa has increased dramatically. Likewise, prevalence in the Free State has shown alarming increases and this province has consistently ranked among the top three provinces with the highest HIV rates in the country (with the exception of the year 2000) (Table 1). In 2004 the Free State was ranked fourth among the provinces with the highest antenatal prevalence rates, preceded by KwaZulu-Natal, Gauteng and Mpumalanga. HIV prevalence for the total Free State population is projected at 15.6% by 2010.

A geographical breakdown in terms of district municipal areas in the Free State reveals significant variations in the HIV prevalence rates of the five districts. Motheo (DC17) and Lejweleputswa (DC18) repeatedly display high prevalence rates in comparison with the other three district municipalities over the period 1999 to 2004 (Table 2). Since 1999, the annual HIV prevalence in Lejweleputswa has been consistently higher than the equivalent rates for the Free State and South Africa over the same period (Tables 1 and 2). As will be pointed out, this trend reflects the dynamics of poverty, economic marginalisation and population mobility as driving forces of the disease in the Free State.

Redelinguys/Social dynamics fuelling the spread of HIV/AIDS

Table 1: Provincial and national HIV prevalence rates among antenatal clinic attendees, 1998-2004

| Province | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|------------------|------|------|------|------|------|------|------|
| KwaZulu-Natal | 32.5 | 32.5 | 36.2 | 33.5 | 36.5 | 37.5 | 40.7 |
| Mpumalanga | 30.0 | 27.3 | 29.7 | 29.2 | 28.6 | 32.6 | 30.8 |
| Gauteng | 22.5 | 23.9 | 29.4 | 29.8 | 31.6 | 29.6 | 33.1 |
| Free State | 22.8 | 27.9 | 27.9 | 30.1 | 28.8 | 30.1 | 29.5 |
| North West | 21.3 | 23.0 | 22.9 | 25.2 | 26.2 | 29.9 | 26.7 |
| Eastern Cape | 15.9 | 18.0 | 20.2 | 21.7 | 21.7 | 23.6 | 28.0 |
| Limpopo | 11.5 | 11.4 | 13.2 | 14.5 | 15.6 | 17.5 | 19.3 |
| Northern Cape | 9.9 | 10.1 | 11.2 | 15.9 | 15.1 | 16.7 | 17.6 |
| Western Cape | 5.2 | 7.1 | 8.7 | 8.6 | 12.4 | 13.1 | 15.4 |
| National average | 22.8 | 22.4 | 24.5 | 24.8 | 26.5 | 27.9 | 29.5 |

Sources: Compiled from NDoH 2001, 2003a, 2004, 2005

2. Connecting socio-economic forces and HIV/AIDS in South Africa

The most prominent factors conducive to the spread of the disease in southern Africa revolve around wealth inequalities and socio-economic disparities. Socio-economic disparities act in concert with increased economic development and provide impetus to the HIV epidemic by supplying infrastructure (transport routes, industries), and contributing to population mobility (labour migration and urbanisation) — two focal drivers of the HIV epidemic in South Africa. Other prominent factors in the spread of HIV/AIDS in the region relate to the socio-cultural context and include elements such as low rates of male circumcision, relatively low condom use, broad sexual mixing patterns, multiple partnerships and high levels of untreated sexually transmitted infections and reproductive tract infections. Gender inequality and inequity also appear to be an important driver of HIV, especially where this converges with poverty and economic marginalisation. Socio-economic inequalities as manifested in poverty and gender inequity are linked to other social issues that drive HIV infection, such as low literacy levels and high levels of sexual assault (Grimwood 2000 *et al*, Jackson 2002).

Table 2: Free State district municipal HIV prevalence rates, 1999-2004

| District municipality | Local municipality | Estimated population 2002 | HIV prevalence rate (antenatal) | | | | | |
|-------------------------|--------------------------|---------------------------|---------------------------------|--------|--------|--------|--------|--------|
| | | | 1999 % | 2000 % | 2001 % | 2002 % | 2003 % | 2004 % |
| Xhariep DC16 | Letsemeng | 38 604 | | | | | | |
| | Kopanong | 54 150 | * | * | * | * | 25.7 | 21.3 |
| | Mohokare | 39 316 | | | | | | |
| | Sub-total | 132 070 | | | | | | |
| Motheo DC 17 | Naledi | 27 026 | | | | | | |
| | Mangaung | 654 922 | 26.6 | 29.6 | 28.5 | 31.0 | 36.3 | 27.6 |
| | Mantsopa | 54 344 | | | | | | |
| | Sub-total | 736 292 | | | | | | |
| Lejweleputswa DC18 | Masilonyana | 64 409** | | | | | | |
| | Tokologo | 32 456** | | | | | | |
| | Tswelopele | 53 714** | | | | | | |
| | Matjhabeng | 408 170** | 31.9 | 30.1 | 41.1 | 29.8 | 33.3 | 33.0 |
| | Nala | 98 264** | | | | | | |
| Sub-total | 657 013** | | | | | | | |
| Thabo Mofutsanyana DC19 | Setsoto | 119 112 | | | | | | |
| | Dihlabeng | 116 302 | | | | | | |
| | Nketoana | 69 756 | | | | | | |
| | Maluti a Phofung | 383 337 | | | | | | |
| | Phumelela | 49 151 | 27.9 | 27.1 | 27.8 | 26.0 | 28.0 | 27.1 |
| | Golden Gate managed area | 670 | | | | | | |
| Sub-total | 738 328 | | | | | | | |
| Fezile Dabi DC20 | Moqhaka | 183 822 | | | | | | |
| | Ngwathe | 130 231 | | | | | | |
| | Metsimaholo | 116 000 | 27.6 | 21.1 | 29.4 | 28.1 | 23.8 | 32.2 |
| | Mafube | 57 918 | | | | | | |
| Sub-total | 487 971 | | | | | | | |
| Free State | Total | 2 857 519 | 28.0 | 28.0 | 30.1 | 28.8 | 30.1 | 29.5 |

*DC 16 was not included in the antenatal survey prior to 2003

**Data for 2001

Source: Compiled from Barron & Asia 2001, FSDoH 2004, 2005, MDB 2004

Low levels of socio-economic development, as reflected by high levels of poverty, economic marginalisation and resultant poor access to education and low literacy, provide the ideal context in which the HIV virus spreads in the Free State. Furthermore, the combined effects of socio-economic and gender inequality, population movement, and the indirect effects created by a long history of migrant labour and urbanisation, contribute to the spread of the disease in this part of South Africa.

3. Socio-economic factors driving the disease in the Free State

In an analysis of HIV prevalence, one perspective that aims at incorporating social factors, such as social cohesion patterns and socio-economic inequalities is the Jaipur paradigm. This paradigm contends that HIV/AIDS is less likely to spread and more likely to be dealt with effectively in societies where there is higher social cohesion and less wealth inequalities.² Countries with low social cohesion and extreme wealth inequalities, such as India and South Africa, are therefore hardest hit by the epidemic (NPU 2000: 61, Whiteside 2001:5, Whiteside & Sunter 2000). Economic inequalities and poverty are accordingly important drivers of HIV and this is reflected in the Free State context.

The Gini co-efficient³ for the various racial groups, reveals that black people are worse off socio-economically than other population groups, both in the country as a whole and in the Free State. Some 52% of the Free State's population — totaling more than 1.5 million people — were living in poverty in 2003 (SAIRR 2004). However, almost six

- 2 For analytical purposes, wealth is defined as per capita income, *i.e.* the level of income per head. Income inequality is also taken into account, since societies with a low level of social cohesion but a high level of wealth invariably have a high Gini co-efficient, indicating great inequality (NPU 2000: 61).
- 3 The Gini co-efficient is used to measure levels of equality and inequality within countries, or groups of people in a country. It measures the distribution of total personal income (or consumption) among individuals or households between values of zero (which is perfect equality — everyone has the same income) and one (which is perfect inequality — one person has all the income). Commercial sex work as a survival strategy is practised by both sexes, but due to socio-economic and gender inequality, women are more vulnerable than men to the cycle of poverty-high risk sexual behaviour and HIV/AIDS.

out of every ten black Free State residents are living in poverty, compared to less than one in every ten whites. More than a quarter of the Free State population were officially unemployed in 2003, while more or less the same proportion were unemployed in the country as a whole (SAIRR 2004). A significant proportion of the poor resides in rural areas, which puts them in an even more deprived position when it comes to access to health care and health care expenditure. These inequalities inevitably manifest themselves in a large proportion of people finding themselves in conditions conducive to the spread of HIV. In this socio-economic context where poverty, unemployment and economic inequalities prevail, the poverty-high risk behaviour-HIV-cycle feeds on itself, increasingly aggravating the HIV/AIDS epidemic in the province.

Table 3: Gini co-efficient for various population groups in the Free State, 2003

| Population group | Free State | South Africa |
|------------------|------------|--------------|
| Black | 0.60 | 0.62 |
| Coloured | 0.56 | 0.55 |
| White | 0.49 | 0.46 |
| Indian | 0.52 | 0.51 |
| Total | 0.63 | 0.64 |

Source: Compiled from SAIRR 2004 (data supplied by Global Insight Southern Africa)

The social context of the Free State Goldfields is indicative of the effects of poverty and economic inequalities as drivers of the HIV epidemic. In this part of the province, a negative economic growth rate translates into a poverty level of 53%. Faced with such economic realities, the poor find themselves gripped in a self-perpetuating cycle that forces them to engage in high-risk survival strategies (such as commercial sex work.⁴ AIDS pushes the poor further into poverty as households lose their breadwinners to the disease, livelihoods are being compromised, and savings consumed by the costs of health care and fune-

4 Commercial sex work as a survival strategy is practised by both sexes, but due to socio-economic and gender inequality, women are more vulnerable than men to the cycle of poverty-high risk sexual behaviour and HIV/AIDS.

Redelinguys/Social dynamics fuelling the spread of HIV/AIDS

rals (cf Booysen & Arntz 2001: 27-8). The cycle of poverty, high risk survival and HIV culminates in the comparatively higher HIV prevalence of this part of the Free State. The death rate for the Free State is projected to increase by 33% during the period 2001-2011 — a trend that will surely fuel the current cycle.

An unfortunate spin-off of and partner to low levels of socio-economic development is low levels of education. Poverty constrains access to education, perpetuates the poverty cycle and limits access to health care. Contraceptive use and access to health services increase with education and higher economic status. Therefore, education plays a pivotal role in decreasing vulnerability to HIV and other STIs (UNFPA 2004: 76). Although illiteracy, an indicator of low educational attainment, is declining worldwide, illiteracy rates for females are substantially higher than for men, as girls continue to be faced with limited access to education. In the Free State, 16% of people aged 20 and older have not had any schooling, while 30.7% had some secondary schooling. Only 17% of people older than 20 years in this province have completed grade 12 (Statistics South Africa 2001). For all year on year ages in the 16 to 20 years bracket, more boys than girls in the province are attending educational institutions (Table 4). This may increase vulnerability to HIV for girls, through the impact of low educational attainment on poverty, high-risk behaviour and limited access to information and health care in the province.

Table 4: Attendance at an educational institution (Free State), 15-20 years, 2001

| Age | Male | | Female | | Total | |
|----------|--------|------|--------|------|--------|------|
| | N | % | N | % | N | % |
| 15 years | 27 587 | 92.9 | 27 876 | 92.0 | 55 463 | 92.4 |
| 16 years | 27 846 | 89.7 | 27 060 | 87.5 | 54 906 | 88.6 |
| 17 years | 26 162 | 85.6 | 25 354 | 81.7 | 51 516 | 83.6 |
| 18 years | 23 523 | 77.5 | 22 259 | 71.8 | 45 782 | 74.7 |
| 19 years | 19 914 | 65.7 | 18 124 | 58.9 | 38 039 | 62.3 |
| 20 years | 14 203 | 53.1 | 13 415 | 47.9 | 27 617 | 50.5 |

Source: Statistics South Africa 2001

4. Economic development and the spread of HIV in the province

Whereas poverty increases vulnerability to the disease, economic development provides momentum to the spread of the disease in a context of socio-economic inequality. Where pockets of poverty exist within a context of economic development, such as in mining towns or industrial centres, socio-economic inequalities may become visible and pronounced. In the South African context, economic activity converge with other social factors such as high levels of population mobility, socially disrupted urban settlements, violence and poverty to create a context conducive to the spread of the disease. Small wonder then that the highest infection rates in many provinces seem to occur in mine, plantation, highway and border towns where a degree of economic development is surrounded by impoverished local communities (Pelser 2002, IOM 2005).

4.1 Mining and HIV/AIDS in the Free State

All over South Africa, mining areas display high HIV infection rates, and the Free State display similar patterns. Characteristic social and structural factors underlying the mining industry and the supply of labour to the mines create a social environment in which both mine workers and the local populations are rendered extremely vulnerable to HIV infection (IOM 2005). The Lejweleputswa district — home to the Free State Goldfields — and the Motheo district — an important economic centre in the Free State, as well as a known labour sending area to the Goldfields — display higher HIV prevalence rates compared with the rest of the province (Table 2).

The long-standing tradition of labour migration in the mining sector, and the complex sexual networks that it creates, are central to understanding the spread of HIV in the Free State, particularly in mining areas such as the Goldfields. Some studies suggest that one need not look further than the migrant labour system for understanding the spread of HIV (Horwitz 2001).

Labour migration disrupts family life, while the predominantly male environment and harsh working conditions contribute to loneliness, a desire for companionship and a need for recreation. Mine workers who

have a relatively stable income are in a position to offer financial incentives in pursuit of companionship and recreation. These workers' economic position often stands in stark contrast to the poverty experienced by local, especially female-headed, households (Whiteside 2001: 5). In these social situations, commercial sex and access to alcohol are more or less institutionalised social activities — fostering high-risk behaviour patterns linked to the spread of HIV/AIDS (Fassin & Schneider 2003: 496, IOM 2005). Thus, the social environment, together with the relative wealth of workers as opposed to the poverty of the local community, sets the scene for HIV infection rates to soar. The other factor in the equation is the availability of (female) companions in the form of sex workers or town wives that want to, or need to, benefit from the perceived economic prosperity created by the mining industry. Poverty forces women into commercial sex work, or into dependence on a partner for the sake of survival. Through these practices migrant workers are often infected with STDs and HIV which are then transmitted to their wives and girlfriends at home. This pattern is reflected in the fact that labour-sending communities often display HIV infection rates similar to those in areas where migrant labourers work. However, the sexual network that increases vulnerability to HIV is not only unidirectional, from the miners back home to partners, but is complicated by the fact that partners of migrants may also become involved in high-risk sexual behaviour in the absence of their spouses (IOM 2005). The system of migrant labour has thus created an environment in which men isolated with other men seek out young women and teenage girls for sex and intimacy, while expecting faithfulness from their wives at home (Van Vuren 2004: 216).

Telling is the comparison between the HIV prevalence rates of Lejweleputswa and the Motheo District Municipality, a traditional and well-known labour-sending area to the Goldfields. Similar to Lejweleputswa, Motheo displays high HIV prevalence. One factor certainly contributing to the higher HIV prevalence rates in Motheo is the labour migration and social network patterns linking it with the Lejweleputswa district.

However, over the past decade, the gold mining industry in the Free State Goldfields has dwindled significantly as gold reserves have been depleted and mines subsequently scaled down or closed down their ope-

rations, leading to widespread unemployment and poverty in this region. This, in turn, is spurring extensive out-migration and labour migration as people leave in search of employment elsewhere. This trend will undoubtedly further fuel the already disturbing HIV epidemic here. The Goldfields population has dropped by almost 7% in the period 1996-2001 as a result of out-migration fuelled by the massive unemployment in the region (Pelser & Botes 2005). Future HIV trends in the Goldfields are, therefore, likely to be fuelled by the population mobility that is set to take place as a consequence of the increased unemployment in this region.

4.2 Long-distance trucking and HIV/AIDS in the Free State

The relationship between long distance trucking and HIV provides another dimension of the relationship between economic activity and HIV vulnerability. Across Africa, sex workers operating at truck stops have been found to have high HIV-infection rates. For instance, Leggett (2001), in a nationwide study amongst sex workers, reports that 10 out of 11 women operating at a truck stop near Cape Town tested HIV-positive. According to the Federation of Eastern and Southern African Trucking Associations, more than 60% of long-distance truck drivers surveyed in South Africa were HIV-positive (ECI 2001:8).

A lucrative sex industry is operating along the main transport routes crossing the Free State. Near Ventersburg, a rural town along the N1, truck drivers are known to lure children as young as 13 years of age to have sex with them in exchange for money. This situation again illustrates the self-perpetuating cycle of poverty, high-risk behaviour and HIV infection. Children are allegedly involved in prostitution along the entire route from Bloemfontein to Johannesburg and supposedly some children are forced into this lifestyle by their parents, since this trade is often the family's only livelihood (Bhengu 2002: 9). Sexual and social exchanges operating along main commercial transport routes crossing rural towns, such as the N1 running through the Free State, certainly fuel HIV infection. These exchanges are, however, driven by the combined forces of poverty and population mobility linking impoverished people and long-distance truckers.

4.3 Urbanisation and the creation of socially disrupted urban environments

Economic development and opportunities are perceived to be more prevalent in bigger centres, and this perception has been a major force spurring worldwide urbanisation. In developing countries, the rate of urbanisation has been so rapid that cities are unable to keep up with the provision of infrastructure, or economic opportunities. Consequently, many urban environments in the developing world, South Africa included, are characterised by severe social disruption as reflected in among others, issues such as poverty, unemployment, high levels of violence, delinquency and strained interpersonal relationships (Harper 2004: 188, Weeks 2005: 484). HIV/AIDS prevalence is noticeably higher in such socially disrupted urban environments. This is a further contributing factor to the higher HIV prevalence in the district municipalities of Motheo and Lejweleputswa, which also host some of the largest urban settlements in the province. The national rate of urbanisation of 2.1% per year is among the highest in the world, and the Free State displays similar high urbanisation rates (Pelser & Botes 2005). With increased urbanisation, HIV infections in the province are set to increase because of the social disruptions partly caused by rapid urbanisation. Unemployment and poverty are distinctive features of the two larger urban centres of the Free State. Concomitant to this situation, crime, high levels of violence and high-risk survival strategies create the conditions under which HIV spreads with ease.

A further dimension is added to the socio-economic development status of the Free State population when the position of women in Free State society is scrutinised.

5. Women's disproportionate exposure to the cycle of poverty, high-risk survival practices and HIV

In South Africa, one in every two female-headed households (52%) is regarded as poor or very poor, compared with one in three (35%) male-headed households (Statistics South Africa 2000). Therefore, where poverty is prevalent, women will suffer the effects the most. From 1996 to 2001 the number of unemployed women in South Africa increased by approximately a million and the Free State (25.46%), together with Gauteng (25.8%) and KwaZulu-Natal (26.47%), had the highest per-

centages of unemployed women in 2001. The Free State is also ranked third of all provinces in terms of the biggest rise in female unemployment after KwaZulu-Natal and the Western Cape. Unemployment figures in the Free State reveal that more women than men are unemployed, or are not economically active. The situation for African women was worse than that of women in other population groups and that of African men (Dept of Social Development 2004: 14, Statistics South Africa 2001).

Table 5: Employment per gender and population group (Free State), 2001

| | Gender | Employed | | Unemployed | | Not economically active | | Total |
|---------------|--------|----------|-------|------------|-------|-------------------------|-------|-----------|
| | | N | % | N | % | N | % | |
| Black African | Male | 284 395 | 39.0% | 181 385 | 24.9% | 263 564 | 36.1% | 729 344 |
| | Female | 192 675 | 24.0% | 244 636 | 30.5% | 364 984 | 45.5% | 802 296 |
| | Total | 477 071 | | 426 021 | | 628 548 | | 1 531 640 |
| Total | Male | 349 737 | 41.8% | 191 028 | 22.8% | 295 960 | 35.4% | 836 725 |
| | Female | 241 265 | 26.3% | 255 245 | 27.9% | 419 460 | 45.8% | 915 969 |
| | Total | 591 002 | | 446 272 | | 715 420 | | 1 752 694 |

Source: Statistics South Africa 2001

Poverty amongst women has far-reaching effects on the empowerment of women and their ability to take responsibility for their own reproductive behaviour. The position of women in sexual relationships, however, is not only based upon their ability to negotiate safe sex. In fact, women constantly negotiate sex, using their bodies as capital to promote their economic welfare, most often at the expense of their health (Network 2000: 23). The term “survival sex”, denotes women using their bodies as an ordinary economic resource, outside the context of prostitution, but within the culture of male dominance (Fassin & Schneider 2003: 496). Low access to employment opportunities, health care and other social services compel impoverished people to resort to survival sex, increasing their risk of contracting HIV (Pelser 2004: 288). Poverty, therefore, encourages women to subject themselves to exploitative relationships for financial gain. With less access to employment opportunities, health care and other social services, impoverished people are more likely to resort to commercial sex, thus creating a vicious cycle (Pelser 2002).

The South African Demographic and Health Survey (SADHS) (1998) found that a quarter of Free State women reported economic abuse by partners. Economic abuse is defined as failure to provide basic support to a spouse and/or children in the form of food, rent, payment of bills, etc before spending money on other items (NDoH 2002: 90, 92). This kind of abuse results in women and children experiencing conditions of poverty and hardship that may increase these women's vulnerability to the cycle of poverty and high-risk behaviour.

Economic hardship is, furthermore, considered a driving force behind (female) sex work worldwide, whether occasional or commercial (UNAIDS 2001). Commercial sex work makes women more vulnerable to HIV infection, because a significant proportion of their clients is either reluctant to use or refuse to use condoms. This is, according to some reports, the case with child prostitutes working along the N1 between Bloemfontein and Johannesburg, as was previously noted (Benghu 2002: 9). Girls are more often exploited in this way, due to their subordinate position in families.

Sexual exploitation of young girls, taking various other forms, also contributes to the high rate of infections. Many young girls become involved in exploitative sexual relationships with much older men in an effort to improve their economic position, or merely to survive. As a result, large numbers of women and girls find themselves in relationships in which they are risking exposure to HIV/AIDS. In several schools in the Free State, young girls were found granting sexual favours to teachers in return for pocket money or food (De Klerk 2001). Teachers were also pointed out as the perpetrators in 32.8% of childhood rape in South Africa when data of the 1998 SADHS were analysed according to perpetrators and instances of rape experienced by women (HSRC 2005). Teachers in southern Africa have one of the highest group infection rates – a problem imbedded in the exploitative nature of teacher-student sexual relationships in many schools (McGeary 2001, Pelser *et al* 2004: 290). The exploitation of young girls by teachers, in part, contributes to the fact that teenage girls in sub-Saharan Africa are infected with HIV at a rate five times higher than their male counterparts (UNAIDS 2001). Poor socio-economic conditions are the main drivers of this practice, as teachers exploit the vulnerable and desperate economic circumstances of these girls to their own advantage.

Gender inequality in relationships renders women powerless to protect themselves from the disease. In fact, gender-based inequalities are, according to some researchers and policy-makers, the number one obstacle to women protecting themselves from HIV infection. Gender inequalities transpire in the status of women in relationships and also overlap with other social, cultural, economic and political inequalities between men and women.

6. Socio-cultural norms regulating relationships between genders and the spread of HIV/AIDS

Traditionally, South African women are brought up to accept subservience to men in society. This is particularly evident in matters relating to sexual relationships. In many sub-Saharan African countries, governed by male-dominant socio-cultural beliefs and male dominance over economic resources, women generally possess little power to determine the terms on which they have sex. As a result they are in a poor position to control their bodies through negotiating safe sex. Evidence of this is found in cases of men beating and even murdering their female partners when they refuse intercourse or request using condoms (McGeary 2001: 52). Requesting a condom is perceived to be equated with mistrust in relationships, preventing individuals from introducing the subject, even when in fixed relationships.

Socio-cultural norms supporting male dominance are also prevalent in parts of the Free State. Some 58% of respondents in a study among clients of PHC facilities in the southern Free State indicated that they do not use condoms, because they trust their partners, pointing towards the perception that condom use is equated with mistrust (De Wet *et al* 2002: 10). Condom use in the Free State is comparatively higher than in other provinces, with 26.9% of women reportedly using a condom during last sex with an unmarried partner, and 11.8% of women having used condoms during last sex with spouse. In comparison, 11.6% of women used a condom during sex with an unmarried partner and 5.5% during sex with a spouse in KwaZulu-Natal. However, only 10.9% of women reported using a condom during last sex with a casual acquaintance in the Free State (NDoH 2002: 89). This may indicate reluctance by women to introduce the topic of condom use during casual sexual en-

counters, due to male dominance of the situation. Clearly, socio-cultural norms governing (hetero-) sexual relations reduce women's power to negotiate the terms on which they have sex, in relationships or otherwise.

Social and cultural norms also allow the possibility that one partner, most often the man, engages in sexual relations with other individuals while in a supposedly monogamous relationship. Many women in marriage relationships assume that they are not at risk of HIV because of the fact that they are faithful to one partner. A significant number of HIV positive women interviewed in a study in Thabong were, however, infected by their husbands (Summerton 2001). The rules for men and women are very different when it comes to what is acceptable in relationships, also in the Free State. Men, even when in a monogamous marital relationship, generally have freedom to have more than one sexual partner at a time, while women do not.

In a study regarding impediments to the practice of safe sex, particularly in the Free State township of Thabong (Welkom), the issue of social norms regulating relations between men and women is pertinently emphasised (Summerton 2001). Although it is not suggested that these norms are universally present in the Free State population — given the high prevalence of HIV in the Goldfields (of which Thabong forms part) — this case certainly illustrates the importance of social norms governing sexual relations in driving the spread of HIV/AIDS. Women interviewed for this study reported that although they view sex as an activity involving two participants that should have an equal say in issues regarding sex, their sexual rights tend to be overshadowed by men's control over their sexual behaviour. As a result, women feel that they have little control over HIV prevention. Socio-cultural norms in this community support the gender-role stereotype that expects men to be dominant, authoritative, aggressive and decisive and women to be submissive, subservient, passive and respectful. The male interviewees indicated that socio-cultural norms in this community foster an environment conducive to the violation of women's sexual rights, and result in men resorting to coercion/force, violence and economic sanctioning against women, defying the existing norms governing sexual relations. When these norms govern behaviour against the backdrop of socio-economic vulnerability, as is the case in the Free State Goldfields for example, socio-cultural factors are likely to be an additional potent force

in fuelling HIV infection in a context of socio-economic inequality and gender inequity.

A substantial number of new HIV infections are attributed to sexual violence in homes, schools, the workplace and other social environments. Low socio-economic development creates the ideal breeding ground for crimes, such as sexual violence against women (Pelser *et al* 2004: 288). For as many as 31% of South African female youths their first sexual experience was involuntary (CASE 2000). Very disturbingly, the age of victims of sexual violence is decreasing, as is the age of offenders. The National Democratic Lawyers Association reported that 41% of rapes and attempted rapes were of girls younger than 18, while 50% of these involved girls younger than eleven years (HSRC 2005). Young girls are particularly vulnerable to rape and sexual coercion, because of the perception that they are more likely to be infection free, or the widespread belief in some communities that sex with a virgin can cleanse a man of infection (HSRC 2005, UNAIDS 2001). Within this context, protecting women from violence and coercion in sexual relationships is paramount, and only possible if the culture of violence (against women and children) makes way for a culture of equality and respect for life. In addition, decreasing women's risk of HIV infection through access to post-exposure prophylaxis (PEP) that includes access to antiretrovirals, is an important element in dealing with sexual violence against women.

Worldwide, the number of women reporting physical assault by an intimate partner varies from between 10% to more than 50% (UNAIDS 2001). In South Africa, the 1998 SADHS found that one in eight women had been beaten by her partner and in the Free State some 12.4% of women reported that they had ever been abused by their partner, while 4.1% of women in this province reported that they had ever been forced or coerced to have sex (NDoH 2002: 95). Physical violence, the threat of violence and the fear of abandonment are significant barriers for women in negotiating the use of a condom, or to leave relationships where they are physically at risk. In this environment, women are rendered vulnerable to HIV infection.

7. Evaluating HIV/AIDS intervention against the backdrop of factors fuelling the disease

Faced with the reality of extreme global and regional variability in HIV prevalence, much has been written on the social and economic characteristics that seem to explain the disproportionate rate and increase of HIV across the globe. The widespread attention that the disease has generated over the past two decades has, particularly earlier on, leaned heavily towards social-behavioural explanations that tend to: “reduce the problem to the ‘default option’ of sexual behaviour”. In response, HIV/AIDS intervention tended to focus on narrow, cost-effective interventions (Schneider & Fassin 2003: 549). Particularly in respect of prevention strategies, much emphasis was placed on behavioural and lifestyle changes to curb the spread of the disease.

A core component of the South African Department of Health’s response to HIV/AIDS is to ensure that further infections are prevented and in this regard, lifestyle changes and behaviour are seen as “a critically important starting point in managing the spread of HIV and the impact of AIDS” (NDoH 2003b: 15). This principle is also carried through to the *Comprehensive Plan* (NDoH 2003b). Following from this, the provision of quality care, universal access to care and treatment and equitable implementation are guiding principles of the *Plan* (NDoH 2003b: 16, Health Systems Trust 2005: 2). The *Comprehensive Plan* is a comprehensive approach to HIV and AIDS and outlines a multi-sector response to the disease that recognises the critical role of ARV drugs in treating people with AIDS (Health Systems Trust 2005:2). This again emphasises improving quality of life of those infected and affected by HIV/AIDS.

Although HIV/AIDS encompasses socio-behavioural elements that must be, and indeed are, taken into account in the Department of Health’s response to the epidemic, the disease is fuelled by a complex dynamic of socio-economic, socio-cultural and behavioural factors that also have to be taken into account in strategies aimed at HIV/AIDS prevention, treatment, care and support. The socio-economic and socio-cultural environments in different parts of the country are unique with regard to the particular forces driving the epidemic. Therefore, in all provinces, and in this case particularly in the Free State, the socio-cultural and socio-economic contexts need to be factored into HIV strategising, if such efforts are to be successfully implemented. HIV/AIDS planning

and strategising can therefore not be divorced from larger social policy and planning at the national and provincial level that aims at addressing the root socio-economic and socio-cultural forces driving the spread of the disease.

From a global perspective, the eradication of poverty and hunger, achieving universal access to education, promoting gender equality and empowerment of women, as well as combating HIV/AIDS, constitute four of the eight Millennium Development Goals (UNFPA 2004: 11). Flowing from this, a major focus of the South African government is the alleviation of poverty and removing inequalities in society. Poverty alleviation is addressed through initiatives such as basic needs provision, employment creation, economic growth programmes, policies on equity and policies aimed at improving quality of life (Pelser 2004: 209). The effects of poverty, unemployment and gender inequality on the spread of HIV are particularly evident in the Free State. Without attention to initiatives such as those mentioned above, current efforts to address the issue of HIV/AIDS in the province will certainly be hampered by the presence of low levels of socio-economic development. While not specifically addressing the constraints in implementation posed by the socio-economic context, the *Comprehensive Plan* does make it clear that efforts relating to the prevention and treatment of HIV/AIDS are supported in the broader context by social programmes that aim to reduce poverty and improve education (NDoH 2003b: 15).

Undoubtedly, the position of women, in South Africa in general, and in the Free State province in particular, is another factor that can potentially hinder the successful implementation of the *Comprehensive Plan*. Thus, development initiatives that aim at reducing income inequalities and gender imbalances are particularly crucial, since raising the socio-economic position of women may reduce women's vulnerability to the disease. Among the aspects of relevance is the *Plan's* emphasis on providing a comprehensive care package for survivors of sexual assault that includes post-exposure prophylaxis (PEP) with antiretrovirals. Again, while having access to PEP with ARVs is certainly a basic right of any woman who has suffered sexual assault, the issue of exploitation of women must be dealt with through broader social reforms that increase women's access to economic resources and target the social mechanisms that support violence against women and children. Assisting women through deve-

lopment initiatives decreases their economic vulnerability, allowing them to get an education without having to pay the ultimate price in terms of health and life expectancy.

8. Conclusion

HIV/AIDS intervention should slot into a comprehensive national and provincial strategy addressing or mitigating the socio-economic and socio-cultural forces that drive the spread of the disease. Without acknowledging the impact of the social context on the disease, successful implementation of any plan to address prevention, treatment, care and support would ultimately collapse in a socio-economic and socio-cultural context that is unable to support or maintain implementation of any strategy devised to deal with the onslaught of the disease.

In terms of planning, the aim flowing through the international to the national and to the provincial channels is to decrease HIV/AIDS vulnerability. However, with the impacts of HIV-related deaths increasing socio-economic vulnerability, the cycle of poverty, high-risk behaviour and HIV infection is set to become perpetually worse over time. Clearly, the economic position of the Free State population, especially in respect of women, is a factor that increases the population's vulnerability to the disease. Poverty and inequality also have definite implications for access to information, education and health care, all of which become severely compromised in the light of low socio-economic development. If the spread of the disease is to be brought under control, it is imperative that inequalities in wealth be diminished through the expansion of economic and educational opportunities, since the reduction of poverty and increased equity will certainly play a crucial role in decreasing vulnerability to HIV/AIDS infection, especially for women. Strongly related to this issue is the impact that lack of economic opportunities has on labour migration patterns in the province. Creating or expanding economic opportunities in the Free State is likely to reduce the need for widespread labour migration, another force powerfully driving the spread of the disease, as has been pointed out.

The presence of these particular forces driving the spread of the disease may also hamper the successful implementation of the current strategies aimed at HIV/AIDS prevention, management, care and support.

In the light of this, the implementation of the *Comprehensive Plan* may greatly benefit from improvements in the socio-economic position of the people infected and affected by HIV/AIDS.

Bibliography

BARRON P & B ASIA

2001. The district health system. *Health Systems Trust* 2001: 17-48.

BEZUIDENHOUT F J (ed)

2004. *A reader on selected social issues*. Pretoria: Van Schaik.

BHENGU C

2002. Help for child prostitutes. *Sowetan*, 20 December: 9.

BOOYSEN F LE R & T ARNTZ

2001. *The socio-economic impact of HIV/AIDS on households: A review of the literature*. Bloemfontein: Centre for Health Systems Research & Development.

COMMUNITY AGENCY FOR SOCIAL ENQUIRY (CASE)

2000. *Youth in brief: a summary of the Youth 2000 Report*. Johannesburg: CASE.

DE KLERK E

2001. Rilverhale oor seksuele teistering in VS skole. *Volksblad*, 1 Augustus: 1.

DEPARTMENT OF SOCIAL DEVELOPMENT

2004. *A comparative analysis of 1996 and 2001-census data on vulnerable and special target groups*. Pretoria: Department of Social Development.

DE WET M, L ACKERMAN & A CRICHTON

2002. Incorrect condom programming in the primary health care setting: 'A prescription for a disaster'? *Curationis* 25(2): 4-13.

EBONY CONSULTING INTERNATIONAL (ECI)

2001. *Gauteng government inter-departmental AIDS unit: literature review of behavioural surveys (Draft report)*. Pretoria: Gauteng Provincial AIDS Directorate.

FASSIN D & H SCHNEIDER

2003. The politics of AIDS in South Africa: beyond the controversies. *British Medical Journal* 326 (March 2003): 495-7.

FREE STATE DEPARTMENT OF HEALTH (FSDOH)

2004. *HIV antenatal survey report for 2003*. Bloemfontein: Free State Department of Health.

2005. *Free State province report of the national HIV and syphilis seroprevalence survey of women attending public antenatal clinics in South Africa - 2004*. Bloemfontein: Free State Department of Health.

Redelinguys/Social dynamics fuelling the spread of HIV/AIDS

GRIMWOOD A, M CREWE &
D BETTERIDGE

2000. HIV/AIDS — current issues. *Health Systems Trust* 2000: 287-99.

HARPER C L

2004. *Environment and society: human perspectives on environmental issues*. Upper Saddle River, NJ: Prentice Hall.

HEALTH SYSTEMS TRUST

2000. *South African Health Review 2000*. Durban: Health Systems Trust.

2001. *South African Health Review 2001*. Durban: Health Systems Trust.

2005. *Implementing the Comprehensive Care and Treatment Programme for HIV and AIDS patients in the Free State: sharing experiences*. Conference report. Durban: Health Systems Trust.

HORWITZ S

2001. Migrancy and HIV/AIDS — A historical perspective. Unpubl paper presented at the AIDS in Context Conference. Johannesburg: University of the Witwatersrand, 4-7 April 2001.

HUMAN SCIENCES RESEARCH
COUNCIL (HSRC)

2005. *HIV risk exposure among young children: a study of 2-9 year olds serviced by public health facilities in the Free State, South Africa*. Cape Town: HSRC.

INTERNATIONAL ORGANISATION FOR
MIGRATION (IOM)

2005. *HIV/AIDS, population mobility and migration in Southern Africa: defining a research and policy agenda*. Geneva: IOM.

JACKSON H

2002. *AIDS Africa: continent in crisis*. Harare: SAFAIDS.

LEGGETT T

2001. Drugs, sex work, and HIV in three South African cities. *Society in Transition* 32(1): 101-9.

MCGEARY J

2001. Death stalks a continent. *Time*, 12 February: 46-54.

MUNICIPAL DEMARCATION BOARD
(MDB)

2004. Municipal profiles 2003. <<http://www.demarcation.org.za/municprofiles2003/index.asp>>

NATIONAL DEPARTMENT OF HEALTH
(NDoH)

2001. *National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa 2000*. Pretoria: Department of Health.

2002. *South African Demographic and Health Survey 1998*. Pretoria: Department of Health.

2003a. *National HIV and syphilis antenatal sero-prevalence survey in South Africa*. Pretoria: Department of Health.

2003b. *Operational Plan for Comprehensive HIV and AIDS Care*,

Acta Academica Supplementum 2006(1)

Management and Treatment for South Africa.

<<http://www.gov.za/documents/subjectdocs/2003/300h.htm>>

NATIONAL POPULATION UNIT (NPU)

2000. *The state of South Africa's Population Report 2000*. Pretoria: Department of Social Development.

NETWORK

2000. User, partner attitudes influence barrier use. *Network* 20(2): 23-6.

PELSER A J

2002. The dynamics of HIV/AIDS in South Africa. Van Rensburg *et al* 2002: 19-54.

2004. Health, environment and development. Van Rensburg (ed) 2004: 171-214.

PELSER A J & L J S BOTES

2005. *Comparative socio-economic trends and indicators for selected regions in South Africa*. Bloemfontein: Centre for Development Support, University of the Free State.

PELSER A J, C NGWENA &

J SUMMERTON

2004. The HIV/AIDS epidemic in South Africa: trends, impacts and policy responses. Van Rensburg (ed) 2004: 275-314.

SCHNEIDER H & D FASSIN

2002. Denial and defiance: a socio-political analysis of AIDS in South Africa. *AIDS* 16(suppl 4): S45-S51.

SOUTH AFRICAN INSTITUTE OF RACE RELATIONS (SAIRR)

2004. *South Africa Survey 2003/2004*. Johannesburg: SAIRR.

STATISTICS SOUTH AFRICA

2000. *Measuring poverty in South Africa*. Pretoria: Statistics South Africa.

2001. Primary tables: Free State. <<http://www.gov.za>>

2003. *Census 2001: census in brief*. Pretoria: Statistics South Africa.

SUMMERTON J V

2001. Perceptions among a group of at-risk individuals: the discrepancy between unsafe sex practices and knowledge about HIV/AIDS transmission. Unpubl MA dissertation. Bloemfontein: University of the Free State.

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

2001. Gender and HIV. <http://www.unaids.org/fact_sheets/index.html>

2004a. Report on the global AIDS epidemic.

<http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_00_en.htm>

UNITED NATIONS POPULATION FUND (UNFPA)

2004. *State of the world population 2004*. New York: UNFPA.

VAN RENSBURG H C J (ed)

2004. *Health and health care in South Africa*. Pretoria: Van Schaik.

Redelinghuys/Social dynamics fuelling the spread of HIV/AIDS

VAN RENSBURG D, I FRIEDMAN, C
NGWENA, A J PELSER, F STEYN, F
BOOYSEN & E ADENDORFF

2002. *Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa*. Bloemfontein: Centre for Health Systems Research & Development.

VAN VUUREN A

2004. HIV/AIDS: humanity's most daunting challenge. Bezuidenhout (ed) 2004: 205-20.

WEEKS J R

2005. *Population*. Belmont: Wadsworth.

WHITESIDE A

2001. AIDS and poverty, the links. *AIDS Analysis Africa* 12(2): 1-5.