

SOUTH AFRICA: TOUCHED BY THE VENGEANCE OF AIDS...¹

Published: South African Journal of International Affairs Vol. 7 #2
Winter 2000 p.23 – 39.

The South African HIV/AIDS epidemic defies description. It is characterised by three main features - a) the rapid and unchecked growth of the epidemic b) a lack of any coherent policy documents on crucial issues and c) the failure of public prevention campaigns to have an impact. It is at one and the same time, the most fascinating and the most depressing of sagas. Recently it was claimed that 'it simply does not seem that the government can get it right on AIDS'² an accusation all the more telling in the light of the fact that South Africa now has the fastest growing epidemic in the world. With over 1500 new infections a day, South Africa has one tenth of the total daily infections and more infections a day, than some countries have in a year. An estimated 4 million people are living with HIV and many people have died from AIDS related illnesses.

Well into the second decade of the epidemic, very few South Africans could claim not to have heard of AIDS. Few could claim to be entirely ignorant of its mode of transmission and its effects, and increasingly families and individuals are experiencing the infection, illness and death of family and friends. South Africans are a largely AIDS aware population, but not one that has not seen the necessity to turn this awareness into personal behaviour change and support and care for those who are infected.

Part of the reason for the growth of the epidemic is the failure on the part of government and NGOs involved in prevention work to persuade a sceptical population that AIDS is a real disease and not some part of some other more devious agenda.³ The campaigns also largely failed to get a general appreciation that infection with HIV can cause AIDS a decade or so later and that this is overwhelmingly a sexually transmitted disease. So despite a great deal of money and many initiatives people with HIV and AIDS are still treated as social transgressors and the change in behaviour required to turn such an epidemic around has not happened.

Recently, in an absolutely bewildering move, the president has thrown the AIDS debate back years by his public musings as to whether HIV is the cause of AIDS, or whether there is not perhaps some other causal connection for the deaths that are called AIDS. It may be co incidental that this debate is coming

¹ Vera Ngowi a woman from Tanzania who gave a posting on an email forum - we have been touched by its vengeance - referring to AIDS.

² Edwin Cameron; acting judge of the Constitutional Court - in an address to the Second South African Conference of People with AIDS, Durban, South Africa, March 10.

³ There have always been ideas that AIDS came in from outside as part of a plot - such as The American Intention to Destroy Sex; and that it was a myth or not a real illness.

just as the country is to host the 13th international conference on AIDS in Durban 2000. These international conferences throw the spotlight on the host country. Over 10 000 people attend and the response of the host to their own epidemic is scrutinised. By raising an AIDS 'red herring' it may be hoped that the attention will move from what South Africa has not done, to the view of 'AIDS orthodoxy' vs. the 'AIDS dissidents'.

Despite having an out of control epidemic, the South African Government, announced on Feb. 28th that it is to convene a panel of international experts to amongst other things determine 'local evidence regarding the causes and diagnosis of AIDS and opportunistic infections' as well as review the evidence that HIV causes AIDS and allegations that the AIDS drug AZT is poisonous.

Given the reality of HIV/AIDS in South Africa this is an extraordinary move. It is extraordinary, not only because of the rate and pace of the epidemic, but also because it has completely ignored the voice and expertise of local scientists and AIDS NGOs. It is also extraordinary that in an attempt to find an 'African response' to AIDS, outside experts are called in and local experiences ignored. The newly established National AIDS Council (which is quite distinct from this expert committee) also lacks any representation from the experienced AIDS World.

The magnitude of the problem, the escalating costs of dealing with the epidemic and the failure adequately to address the AIDS crisis and to ensure care and support for people with HIV and AIDS has led to some desperation and some way to make the picture look less desperate.

What this public questioning has done, is to reinforce in the minds of the population the doubts and denial that have caused the lack of behaviour change. If, as the dissidents claim, HIV neither causes AIDS nor is infectious, then the safe sex message, the message of responsible sexual decision making, gender issues and domestic violence along with the seriousness of the epidemic fall away. It means that the vexing questions of culture, race, sexual behaviour need *not* be addressed. It will be unnecessary to deal with patterns of male sexual behaviour, with gender imbalances in vulnerability to infection and to changing peoples attitudes to behaviour change. HIV infection now will be seen as the 'logical' outcome of poverty, malnutrition and poor socio economic conditions, and hence there is very little that the government can, or need do, to try to combat it.

However, whatever the government might decide as the cause of AIDS, they will still be required to treat people who are ill and dying, so avoiding HIV as the cause of AIDS offers no release from their obligations.

Where have we come from?

In 1993, Schneider, Steinberg and Isselmuiden wrote;

South Africa is in the early phase of a rapid and exponential growth in the HIV/AIDS epidemic. By the end of 1992, 2.4% of antenatal clinic attenders nationally were HIV-positive, almost double

and treble the figures for 1991 and 1990 respectively ... Based on the behaviour of the epidemic in South Africa so far, it is very probable that our HIV/AIDS epidemic might follow a similar pattern to ... other African countries.

AIDS, they continued, constitutes one of the biggest challenges facing South and Southern Africa. AIDS has been shown elsewhere to have a devastating impact on individual families and communities. Those infected are only a proportion of those finally affected by the loss of breadwinners, parents and children.⁴

By 1994, South Africa had a National AIDS Plan developed through NACOSA⁵ This Plan was underscored by the understanding of what an AIDS epidemic might do to South Africa. It recognised the socio economic determinants of the epidemic, the effects of discrimination and prejudice, and the economic realities of the epidemic. It highlighted the need for legal reform and legislation and research, all underpinned by prevention strategies and planning for care.⁶ The plan was imbued with the notion of effective AIDS prevention being closely aligned to Human rights

In other words, South Africa, in 1994, with an infection rate below 5% was ready for the epidemic - ready in the sense of having information about the epidemic in the USA and Europe, ready in the sense of having seen the epidemic in other African states, and Latin America. Ready in having a group of highly literate AIDS specialists in prevention, care and research that could drive the programme. We knew about the links between poverty, migration, unemployment and the effects of poverty on general social well being.

No one could claim that the country did not know what it was facing. The National Plan was accepted and endorsed by the Minister of Health, Dr Nkosazana Zuma and the Cabinet and supported by the many AIDS NGOs and CBOs, religious groups, trade unions and business representatives that had helped to shape it. Its crucial recommendation, ignored in the end, was to have the final authority for AIDS rest in the president's office to ensure that there was enough weight thrown behind its implementation. The crucial role of People with AIDS was recognised by establishing the principle that PWAs should be involved in all stages of policy and programme planning and implementation. Although not located within his office AIDS was declared a Presidential Lead Project, and as such able to access funding from a variety of sources.

It was very clear that AIDS would have a dramatic effect on development and on the future hopes and promises of the new democracy. It was clear that it

⁴ Schneider H et al, 1993, Understanding the possible: policies for the prevention of HIV in South Africa. University of the Witwatersrand; MRC; p 1

⁵ NACOSA drew together a wide spectrum of players - the old regime, the ANC, unions, religious groups, AIDS organisations in a unique consultative process. Working groups were established to develop the components of the National Plan and the plan was a reflection of years of experience.

⁶ The Plan has six key areas, with priorities for immediate attention. The bulk of the plan could have been effectively implemented in less than two years.

would fuel the economic crisis - through skills loss, unemployment, loss of productivity and shrinking of markets. It was clear that education, health, transport and welfare would all suffer greatly as the epidemic started to take its toll. There were both the doomsday predictions as well as the more carefully researched projections to guide policy makers and to allow for proactive planning. It was already clear in 1994, that AIDS was likely to be devastating on the countries growth and future hope unless swift action was taken.

We knew about AIDS - this was not some new unfolding mystery that we were the first to experience. We had a time lag of infection, the oft-repeated 'window of opportunity', a committed government, an excellent plan and the relative wealth and advanced infrastructure to set our response apart from that of the rest of the continent. And there was a strong NGO sector committed to Partnership.

But this was a plan that did not come together and instead South Africa has been touched in many ways by the vengeance of AIDS.

Failed plan or failed planning?

Given what we knew then and know now, it is quite extraordinary that the Minister of Health can ask for an expert panel (largely of non South Africans) to explore all aspects of prevention and treatment strategies and review areas (in which South Africa has internationally recognised experts) such as

- Treatment of HIV/AIDS and opportunistic infections
- General prevention of the disease
- Prevention of mother to child infections
- Prevention of infection after rape or needle stick injuries
- Local evidence,⁷

The fate of the National AIDS plan is well documented⁸. It was heralded as one of the first major breakthroughs of the new regime and confidence was high that it would be implemented. In the same way that South Africans had confounded the world with the transition to democracy - so too would they confound the world with the way in which they would deal with HIV and AIDS.

But it was not to be. Almost a decade later the plan remains unconsulted, unimplemented and largely ignored. From what was the most creative plan, loudly praised by the international community, it has become the most condemned plan - condemned to being ignored and accused even by those who wrote it as 'having problems'⁹

⁷ Statement issued by the Minister of Health, Dr Manto Tshabalala-Msimang, 2 March 2000.

⁸ See Marais H 2000, On the Edge: Review 2000, University of Pretoria and Crewe M 1999, Siyaya! Issue 6 Summer 1999, Idasa.

⁹ Almost immediately people responsible for the implementation of the plan began to undermine it - it became the fault of the plan, rather than of Govt. or NGOs that the plan was not used nor implemented. This failure is another South African 'AIDS scandal'

It seemed as if the knowledge generated and the expertise that went into the development of the plan suddenly ran out when faced with the reality of implementation. For there was sufficient funding and despite claims to the contrary there was sufficient will and capacity to get substantial parts of the plan implemented and a response to the epidemic underway. There was a basic infrastructure through which this could be done - the previous government had created a network (albeit in mainly white local authorities) of AIDS centres which had amassed a wealth of experience and training. These could have been transformed, expanded and developed satellite operations.

There were HIV clinics in some of the main hospitals with Drs and volunteers who had been watching the epidemic unfold and had a real understanding of what services were needed. There were programmes of change and transformation in many government sectors that created an ideal opportunity for the integration of HIV/AIDS work. There was too, a body of researchers with experience in trials and in running services. And there were many local and national NGOS and ASOs who had developed significant responses to AIDS and mechanisms for prevention and to some degree care.

But not for the first time, the government at both national and provincial level turned its back on this experience and expertise. Their understanding of the epidemic was denied and expertise was sought from else where - from Thailand, from Zimbabwe and from the donor agencies. What could have been a creative synthesis of different realms of experience with the outsiders being able to sharpen up the thinking and responses of the insiders - there seemed to be a belief that it was necessary to start again. New plans, new strategies, new posts, delayed appointments and a creeping epidemic.

In part the failure to implement the plan stems from the political settlement in 1994, which allowed for a national government and nine provincial governments, making it possible to have 10 different policies in key areas. There are in effect 10 different AIDS plans as each province vies for autonomy and control. What this has meant is that much energy has been spent in feuding and in arguments over ownership, policy and programmes, rather than looking for shared vision and policy and programme developments. This has allowed for an uneven response to the epidemic and the response will as often depend on individuals who have commitment to the epidemic, rather than on a coherent plan of action.

Where are we going?

Within a year of the new plan - the new strategies and the desire for an effective response the AIDS programme was in disarray. This was due to the Sarafina debacle in which the excellent idea of a national youth based AIDS drama developed into Sarafina 2 with irregularities of funding and dubious granting of tenders. While the ZAR14 million allocated to the play was actually not a great sum given that the play was destined for over 8 million young people (less that ZAR2.00 per child) the money became the focus of public dissent. Although the government was intransigent at the time Mandela was later to cite Sarafina as one of the ANC's key mistakes.

In some ways AIDS in South Africa has never recovered from the vengeance of the Sarafina response - it brought to the surface the simmering tensions between the government and AIDS NGOs and CBOs. Criticism, in every way valid, of the content of the play and of the processes that had shaped it was construed as an attack on government and as an attempt to undermine the response.

This criticism led, correctly, by the AIDS consortium and echoed by NACOSA, was the turning point in the response of the govt and the NGOs. For now, the NGOs were forced to choose between matters of principle and their old comrades in the AIDS struggle - many of whom like Minister Zuma were holding high positions. Defending the government became almost impossible and made worse when the message from govt was clear - are the NGOs with us or against us?¹⁰

Sarafina introduced the beginnings of AIDS orthodoxy - the 'govt line' was the one orthodoxy and the 'NGO (or PWA) line' the other. It was extremely difficult to be outside of either of these. Independence was likely to ensure that either the govt. or the NGOs rendered that position untenable. So far from having - as the NACOSA plan so optimistically had suggested - A United Response to AIDS, there was developing quite the opposite - Govt and civil society were not united and there was little true unity in the NGO world.

This division came at the time when a united response could have worked to shift public perception about the disease and about people who were living with HIV. Instead, the general public was largely excluded from the AIDS world - instead of creating a climate of inclusiveness, the AIDS orthodoxy drove people away.¹¹

AIDS became a world of exclusion - both by the government who shunned at all times local expertise and experience - looking to outsiders to generate an 'African response' and by the AIDS organisations who fiercely guarded who was 'in' and who was 'out' who could talk and who could not.¹²

This rigour was important. It is important how people with HIV and AIDS are treated, talked about and challenges must be made to prejudice or stigma. But what happened was that people focused too much on the images and not enough on the substance - and for many other people who wished to be included they felt alienated and intimidated by this. In its turn government was not prepared to concede that there was a wealth of experience behind each criticism, that such criticism was not driven by racism or funding constraints. The attempts made by the powerful AIDS NGOs such as NACOSA, the AIDS

¹⁰ Question asked by the Director of the National HIV/AIDS and STD Programme to one of the co chairs of the AIDS Consortium, after the Consortium had given a submission to the Public Protector.

¹¹ The language of AIDS seen to be important for creative a positive response, has the effect of excluding people who may not have been introduced to the need for sensitivity - they feel undermined by the response to their language as well as to their grappling with certain issues

¹² It was clear that certain people and NGOs were able to speak on behalf of PWAs or on AIDS issues and their comments were valid, whereas others were dismissed if they asked different questions or gave a different view. The media and government alike were able to exploit this.

Consortium, the AIDS Law Project to defuse the situation were rebuffed and attempts at constructive engagement were taken as hostile criticism.

Why was government so jumpy about AIDS criticism? It is true that the AIDS response has been a litany of mistakes and disasters. But the extent of the response, the hostility from the government was ill considered in the world of AIDS and the depth of the anger and hostility is difficult to understand.

After Sarafina 2 came Virodene, 1997 -the 'miracle' South African cure for AIDS - fully supported by the Cabinet and indeed in the media by Mbeki himself. Criticism of Virodene, which was later shown to be a toxic industrial solvent, was again regarded as unfair and hostile. It was even alleged that people working in AIDS did not wish for Virodene to succeed, as they then would be out of a job!¹³ Still in 1997 came, the decision to make AIDS a notifiable disease, announced in contradiction of the findings of the expensive and time consuming review. The recommendations of this review have never been implemented.

In 1988 came the firing of the AIDS advisory committee. In 1999, came the decision not to supply AZT or latterly Nevirapine to pregnant women and survivors of rape and in 2000 the creation of the National AIDS Council, Mbeki's stance on HIV and AIDS and the pending appointment of the expert committee. And throughout this was the failure of government and of the Ministers in particular to support the National HIV/AIDS and STD Directorate, which suffered as a consequence a rapid turn over of Directors and a lack of capacity as well, most crucially a lack of autonomy.

Balancing the chaotic government response, which seemed 'never to get it right on AIDS', was the response from the NGOs. These have grown into a powerful lobbying and advocacy group with the AIDS Consortium having a membership of over 100 organisations, and NACOSA extensive community based networks and organisational affiliations. NAPWA - the National Association of People Living with AIDS, has recently gone through a difficult time as the competing demands of various PWA groups and expectations tore it apart. The AIDS Law Project and most recently the Treatment Action Campaign have been fighting for the rights of people with HIV as well as together with international activist groups been lobbying for free (or significantly reduced in price) treatment for people with HIV and AIDS.¹⁴

These organisations are mainly concerned with lobbying and advocacy and have ensured that the issues facing people with HIV and AIDS and their families and communities are constantly in the public debate. They ensure that the government is constantly 'on guard' in not being able to be complacent or neglectful of its AIDS response. The government is certainly feeling beleaguered and uncertain, but this seems to be driving it into a hostile

¹³ Person communication from a high placed official to a person using Virodene. Mbeki fully supported Virodene, a known toxin but later rejected AZT as being 'too toxic' - no one has questioned him on this.

¹⁴ A major drug company announced April 3 free distribution of an AIDS drug. The actual details of this offer have still to be published, as well as the current status of this drug vis a vis new treatments.

and defensive position, rather than into one that tries to find effective and speedy interventions.

Whilst these NGOs are strong on advocacy they are not geared up for delivery of services. For this there are many NGOs and CBOs who are active in offering services to people with HIV and AIDS as well as running prevention programmes. The National database on AIDS organisations cites more than 600 organisations that are active in HIV/AIDS work. Many of these have modest operations and are small community based programmes. Most are competing for funding and often cannot compete with the large better known national NGOs.

They are also at the mercy of the ongoing funding cuts in government support for NGOs a fate made worse by the failure of the health department to spend up to 40% of its HIV/AIDS budget, whilst funding for NGOs has been cut¹⁵.

These smaller organisations tend not to get involved in the macro political struggles of AIDS. They struggle with the consequence of the failure of leadership within the government and the failure of government to provide adequate services and support. In many instances they are doing work that should be covered by government programmes and they experience first hand the pain and suffering, the poverty and desperation which so many people and communities are facing in this epidemic. They are supported in some areas by the AIDS training and Information Centres (where these have not been destroyed through the provincial/local authority power struggles) and they get some support from provincial structures. These NGOs and CBOs are mainly concerned with the development of community based education and prevention programmes, with counselling and counselling training and increasingly with home based care and legal rights support and social welfare.

While they tend neither to get embroiled in the disputes with government, nor to challenge the state they reap the consequences of a unchecked and unco-ordinated response to the epidemic. Lack of security in funding allows for a high turn over of such NGOs with communities being left to pick up the pieces.

The response of both government and the NGOs accounts for where we are in the country and the present time. The adversarial relationship has soured the AIDS field and discord, disunity and a lack of trust underpins the players in the AIDS world. Although recognition is given to a 'common enemy' in the virus, this does not create a united vision or shared resources. This is also a feature of the AIDS orthodoxy mentioned earlier, with a growing intolerance from both sides of voices of disagreement. Squeezed in-between this are the PWAs, their partners, families, children and communities. They are the ones who suffer from the infighting and the division between civil society and the state, but they are the ones most used by them to justify such disharmony.

¹⁵ Pretoria News, March 9th 2000.

The vengeance of AIDS seems to have created a deep seated inability to accept difference of opinion, to include as many people in the combating the epidemic as possible¹⁶. There is a pattern of distrust and undermining of other programmes that feeds into the governments belief in a dogmatic AIDS world, that refuses to even consider other approaches or possibilities. By the same token the government remains unaccountable, intransigent and unable to get an effective response from the drawing board and into communities.

The history of the epidemic world wide has shown just how difficult it is to deal with an epidemic of this nature raising as it does all the difficult questions of culture, sex, death and social patterns of behaviour. It has been shown to be especially difficult in South Africa with the added complexities of race and culture, class and levels of illiteracy and unemployment. AIDS raises all kinds of questions about cultural beliefs and practices and it feeds into all the existing prejudices and stereotypes.

In our racially insecure and still racially raw society it also feeds into all the racial pain of the past years. So much so that in the debates on Virodene, Minister Zuma could suggest that the DP do not care about blacks - they would be happy if they all died.¹⁷ Likewise as much of the AIDS criticism and activism was initially led by white people they were dismissed racially as whites feeling aggrieved by not being listened to. There are also the conclusions that are drawn about the racial categorisation of the epidemic, fuelling white perceptions that this is a black epidemic and evoking a response from blacks about AIDS being a white created ploy to kill off Africa. While these may now seem less important and less obvious than they were a few years ago, they still surface and are still obstacles to be overcome.

This situation continues because of the lack of understanding about why our society reacts in the way that it does, how it is created now, post apartheid and how intervention programmes could be informed and enhanced by a theoretical understanding of the epidemic. The response to AIDS has been overwhelmingly populist and as such is not underpinned by any real understanding of what the interventions are doing. There is little understanding of what works and what does not, and when programmes are seen not to work, more money is allocated or another outside external agent - poverty, migration etc is brought in as justifications. Linking AIDS to poverty is a descriptive explanation. It is not an explanation that is based on a real understanding of what the forces that have shaped where we are now or determine how a population comes to understand a particular phenomenon such as AIDS.

¹⁶ It I often remarked upon how the AIDS world in South Africa fights itself, and that differences of opinion become sites of destruction rather than site of constructive engagement. This is in part, because there are too few players in the AIDS world, it is too 'closed'.

¹⁷ See Marais H, 2000, To the Edge, AIDS review 2000, University of Pretoria

The determinedly anti intellectual stance and the refusal to take theoretical explorations and explanations seriously means that we have no tools to describe our failure and decide on new and creative programmes of action.¹⁸

Is there a way past this?

There has been one programme where an attempt, informed by theory, to move past the common understandings and responses has been tried. An area in which the difficult cultural, racial, moral and ethical issues of AIDS were addressed and a programme implemented.

This has been in the National HIV/AIDS and Life skills programme, which has aimed to get HIV/AIDS education into all schools through teacher training and curriculum innovation. While this has not been a uniformly successful programme, it has explored ways in which diverse groups of people can overcome suspicions and tensions and work together to develop an appropriate effective and dynamic response.

It was clear that getting HIV/AIDS education into schools should be the work of the education departments (all 10) This was achieved through collaboration in the first instance between the National Departments of Education and Health. In a unique move the Department of Health raised the money and gave education the authority to spend it. A national committee was established with representatives from all the provincial education and health departments, as well as representatives from national NGOs, youth organisations and teacher unions.¹⁹

This committee has to grapple with the fears of the education department and of the parents of how AIDS work - dealing as it must with sex - would be integrated into schools. After a great deal of debate and often-acrimonious exchanges a training programme and a basic curriculum was agreed upon. Teachers were trained throughout the country and by the end of 1999, just on 14, 000 teachers were trained both to be able to design and run effective AIDS programmes themselves but also to train other teachers.²⁰

In some areas this hope was instantly dashed as the education authorities refused teachers the kind of time they would need to develop and run programmes. In other areas teachers were redeployed, or even retrenched. Nevertheless, through the work of the life skills programme a National AIDS Policy Act for schools was developed and finally passed into law. This act determined that all children must receive HIV/AIDS education in schools, that children and staff with HIV will be treated in a just and humane way and that schools will lay down the basis for a non discriminatory response to HIV and

¹⁸ See Crewe M, Nov. 1999 They Roam the Landscape like packs of leaderless dogs; paper presented to Commonwealth Heads of Universities, Durban.

¹⁹ This is the National Project Committee for HIV/AIDS and Life-skills, which is responsible to the Minister of National Education. It has been in operation for 5 years.

²⁰ Whilst the numbers trained has been impressive, it is how they use this training that is crucial.

AIDS by ensuring that the pupils are well taught in terms of compassion and understanding.

Immediately, the life skills programme was attacked as being 'out of touch', run by people who do not understand the epidemic' and doubts were cast (mainly by medically trained people) as to whether teachers should and could do AIDS education.²¹ The people raising these concerns seldom questioned their role in similar activities!

Clearly there are some teachers who are, like some nurses and doctors and community workers, quite unsuitable for HIV/AIDS education. There should be sufficient checks and balances to ensure that they are not trained and asked to do such work. Despite the criticisms, which are in some cases valid, there are now many places where effective and dynamic HIV/AIDS education is taking place in schools. This is being done in collaboration between two government departments as well as with the full involvement of many NGOs.

What the life-skills programme has addressed is how to deal with the complex issues of race, class, culture and attitudes through the introduction of school based programmes. These debates and difficult decisions have generated a new and refined understanding of the process of education and the ways in which such radical diversity as we have in south Africa can be addressed and challenged. In essence it was found that there are far greater similarities between families and communities than generally believed. Many of the difficult moral and ethical issues can be dealt with in a multi-cultural and racially diverse way, with the aim of uniting young people around the common hope of a united South Africa that can defeat the AIDS epidemic.

The programme has been extended to primary schools. The ultimate hope is that all young people will have comprehensive HIV and AIDS education that will enable them to remain uninfected, support those who have been infected and know how best to deal with HIV and AIDS in their communities.

The TV soap drama SOUL CITY is another positive example of how really difficult racial, cultural, gender and violence issues are tackled unflinchingly through the medium of a television soap drama. In addition to dealing with the difficult cultural issues and having a dramatic story line, SOUL CITY effectively introduces understanding about social issues such as AIDS through its dramatic medium. It is a highly effective and successful programme and highly complementary to the life skills programme.

What both of these examples - one driven by the government and one driven by an NGO show is that it is possible to transcend the historical barriers as well as to unite people around a common theme. Both of them highlight the possibility to intervene in such a way that many people from diverse and various backgrounds and experiences can be reached in creative and

²¹ The attacks on the Life skills programme began almost before it was launched. There was suspicion of the education departments and a refusal to 'widen the response'. It was believed that NGOs should carry this work - despite the logistical nightmare of dealing with an education system of the size and complexity of South Africa.

effective ways. The formal life skills programme requires the ongoing commitment from the government, schools parents and communities - this will be forthcoming as long as the programme is allowed to be creative and try for new methods of education and curriculum innovation. The TV drama and the workbooks that accompany it are high in the ratings and will be a part of the South African response for a long time.

The way in which AIDS will finally play itself out in South Africa, like the South African response, defies description. It is too late to halt the effects of a major epidemic - it is not too late to avoid a catastrophe. To do that we need to focus on the real issues, forge unity and put aside government and NGO differences to forge a new and common understanding of how we can respond in a way that is mutually respectful, critical and challenging and ultimately effective.

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