HIV/AIDS **30** years on...

Looking back, moving forward

By Jay Naidoo

The HIV/Aids debacle will always be a stain on our hard fought democracy. I can remember the discussions in COSATU in the mid-eighties when we began to see the impact of HIV/Aids as a result of the brutal migrant labour apartheid policy, which destroyed the social fabric of our country by tearing men from their families and housing them in dehumanising conditions in hostels.

In 1994, despite the optimism and human rights tradition, we failed to provide leadership and clarity. In fact, our dysfunctional leadership in Government on this issue can be held directly responsible for the epidemic that today affects close to 6 million citizens. How could that happen?

"We need youth to think and work out the content by themselves"

We became passive bystanders in our democracy and allowed the cult of leadership to dominate our public discourse. We believed that our vote in an election was all that was needed to have an accountable state that functioned efficiently and delivered on our promise to secure a better life for all.

Fortunately, our social activism took root: the TAC was born and COSATU girded into action. NGOs such as loveLife, Soul City and many others were formed that focused on prevention among the youth. I joined the loveLife Board in 2004 – prompted by the powerlessness I felt at how Government was behaving, and spurred on by a need to get involved. I was shocked at our officialdom fraternising with Aids denialists, while our people were dying at a rate of almost a 1 000 a day with a similar scale of infection.

Every one of us has had an experience of someone dying of an AIDS-related illness. Today, thankfully to social activism, a strong independent media and a decisive change in Government policy, we have a more effective response to treatment and prevention.

But we need a more holistic policy. ARV treatment is now a right. We need to ensure more monitoring of treatment, resistance rates, and the linkage to >>

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tuberculosis, which is rapidly expanding into an epidemic. The science for eliminating mother-to-child transmission is known. It is shocking that new-born children continue to be infected.

Infectious diseases are never far from the poverty our people face. Issues of youth unemployment, the education crisis that leaves millions of youth in our townships and rural areas without skills or jobs contribute to a sense of absolute disempowerment. In fact, research done by loveLife in focus groups with youth revealed a brutal truth: "To rich people in big houses, HIV may seem like a terrible disease, but when you live on the edge every day, an illness which is still five to ten years away means very little."

Investment in youth by improving education outcomes, building sporting facilities and culture is critical in keeping youth engaged and off the streets. The loveLife groundBREAKER corps of peer educators is an excellent example of mobilising young people and educating them on the linkages between HIV and the dangers of unprotected sex. But, we need youth to think and work out the content by themselves; not be spoon fed by our adult preconceptions.

Let us return to the values that underpinned our freedom struggle. We need role models of ethical and gender sensitive behaviour. Women and girls are not commodities that we trade in. Our Constitution outlaws gender discrimination as it does religious or racial prejudice. We need to curb the 'sugar daddy' phenomenon and ensure that the criminal justice system is zero tolerant of violence against women and children. Ensuring that girls remain in school longer is also crucial to preventing early sexual experiences and the real possibility of HIV infection and teenage pregnancy. That's another lesson I learnt through loveLife.

Our public broadcaster needs to foster a public

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Introduction: Getting a clearer focus

By Grace Matlhape

This year marks 30 years since the first diagnosed case of HIV/Aids. And while breakthroughs have been made – such as the recent finding that early antiretroviral therapy can reduce HIV transmission by 96 percent – Kerry Cullinan (p3) rightly points out that treatment is by no means the answer.

In this special report, we reflect on the lessons learnt so far – and the mistakes we cannot afford to make in the coming decades. Despite the fact the epidemic in SA shows signs of a decline in HIV prevalence among youth – from 10.3% in 2005 to 8.6% in 2008 among 15 to 24 year olds – prevention efforts aimed at young people must be sustained and reinvigorated. Given that 60% of all new infections happen between 15 and 25 years of age, the highest potential returns for HIV prevention in SA still rest in stopping new infection among youth.

This puts the pressure on us to devise programmes that recognise prevention does not exist in a vacuum; to ensure these are responsive to the individual, social, cultural and structural factors driving the epidemic in SA. As loveLife's Scott Burnett highlights on page 4, we need to motivate and empower youth to take action stemming from their own sense of worth and discipline; to say no to high-risk behaviour because there is something to look forward to in the immediate future.

This is no easy task given the vortex of disillusionment young people already find themselves in, and so we need to creatively use the tools at our disposal in order to get youth to creatively navigate the challenges they face – all the time making sure awareness of HIV/Aids does not lapse from press-room fatigue into a national coma. Louise Vale's contribution (p5) highlights the role of community papers in connecting with people at the grassroots, while Trina DasGupta celebrates the evolution of technology – especially that of mobile – to inform, educate, empower and inspire new communities of belonging (p5).

Fifteen years into democracy, like any adolescent, our country and its people are still forging an identity/ies .

Lerato Mahoyi shares her experience as a young person growing up in a country that has only ever known HIV/Aids (p7), while Pierre Brouard and Melissa Steyn remind us we cannot afford to ignore the role of identity – real or constructed – in our prevention programmes (p6-7).

Picking up from Mr Jay Naidoo's overview, my hope and commitment is that as a country the lives of our young people will one day be more important than our minor differences in approach; that we will have the collective courage to question traditions that are harmful to the dignity of girls and that perpetuate a sense of sexual entitlement among men and boys; and that all sectors of society will take seriously the idea that HIV prevention is all of our responsibility.

I would like to thank all our contributors for their valuable insights into the various dimensions of HIV/Aids in our combined efforts to one day celebrate the last reported case of HIV. Their openness and honesty about the epidemic sets an exemplary tone for any discussion on the epidemic.

"Prevention does not exist in a vacuum"

Grace Matlhape is the current Chief Executive of the New loveLife Trust. She has working experience in behaviour change HIV prevention for the past eight years, and has worked in the field of social justice and development in South Africa for over 25 years.

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debate that's no holds barred on what is safe sexual behaviour. It is naïve to believe that teens are not engaged in sexual activity – especially when poverty levels are so high and hopes of young people are so minimal for the future. Let us debate the need for mass condom use, the dangers of multiple partners and most importantly give hope to our future generations that our democracy really belongs to them.

Let us ensure that our schools work, that no sexual abuse or demand for sexual favours is tolerated in them. We need not only the Government, but also communities, faith-based groups and parents to be firm and speak out.

Only a smart partnership between the Government, civil society and business working to deliver on a vision of a 'people-centred' democracy will drive our shared goal of a 'born free' generation 30 years later. That is my hope and commitment.

Prevention remains the only cure

By Kerry Cullinan

HIV/Aids remains by far the biggest killer of South Africans, but there seems to be an assumption in many sectors – the media included – that Zuma's government has it under control so we can move on.

While the beetroot-mad old guard have left the centre stage, government is very far from being in control of the epidemic and needs all the help it can get.

Last year, 43% of South Africans who died – over 280 000 people – were killed by an Aids-related infection.

In Vulindlela, a semi-rural area in KwaZulu-Natal's Midlands, two-thirds of the women are HIV positive by the age of 30. Public hospitals in Durban and Pietermaritzburg report that over half the women who give birth are HIV positive.

In Johannesburg General Hospital, the majority of babies who die in the neonatal ICU are HIV positive.

We are very far from turning the tide of the epidemic because we are failing to stop new infections.

Our prevention efforts aren't big enough, bold enough or consistent enough. We still have a high teen pregnancy rate, which obviously means lots of unprotected sex, despite the fact that an entire school subject, Life Skills, is supposed to help prevent just this.

But instead of focusing on prevention, we keep thinking that we can treat our way out of the epidemic with antiretroviral medication.

The plain, ugly truth is that we can't. We are going to run out of money for ARVs if people keep getting infected at the current rate. Last year, an estimated 370 000 people over the age of 15 and 40 000 children were infected with HIV. More people are getting infected every year than are getting treated and as our treatment programme grows, so too will problems of drug resistance and negative side-effects grow.

This year's budget allocated a conditional grant of R26.9-billion to the country's ARV treatment programme, which is almost a quarter of the current health budget. About 40% of this will go to buying ARVs. >>

But scenario planning by Treasury indicates that the demand for ARV treatment and care will only peak in 2021, meaning that spending will go up every year until then. The Treasury estimates that we will need an additional R2-billion every year until 2021 just for ARVs.

Treating only those who are currently infected for ten years will cost in excess of R400-billion at current drug prices.

At the same time, donor funding is drying up. In the 2009/10 budget year, the US President's Emergency Plan for AIDS Relief (Pepfar) donated over R4,3-billion to our treatment programme, while government's total contribution was R5-billion, according Treasury official Dr Mark Blecher.

This means that almost half of the cost of our treatment programme comes from Pepfar, which pays for the salaries of doctors and nurses running treatment centres and clinics, as well as ARVs.

"Our prevention efforts aren't big enough, bold enough or consistent enough"

Kerry Cullinan is managing editor of Health-e News Service and an award-winning journalist who has been reporting on HIV/Aids for over a decade. She has an MA from UKZN, and is based in Durban.

Yet Pepfar donations are flatlining. In 2013, there are rumoured to be further significant cuts to Pepfar.

At the same time, renewed effort is needed to meet the country's target of getting 80% of those who need ARVs onto treatment by 2012. Last year, there was already a backlog of about 600 000 people.

Any complacency about South Africa being on top of the epidemic is thus misplaced. The biggest challenges remain to prevent new infections, ensure that those who need treatment are able to get it and to combine HIV and TB treatment, as over 60% of those living with HIV are also infected with TB. Groups with high prevalence of HIV, but who have been neglected until now, such as gay men and older women, need to be brought into national prevention campaigns.

At the moment, our health system is not up to the challenge – something that health Minister Dr Aaron Motsoaledi is acutely aware of.

Government's HIV/Aids and TB communication campaign, Khomanani, is also defunct but was very ineffective in the past two years anyway – despite being allocated large amounts of money.

Our HIV/Aids national strategic plan ends this year and as a new plan is drafted, new partnerships to prevent HIV, as well as new strategies to fund our campaigns, are urgently needed. – *Health-e News Service.*

Going bold with prevention

By Scott Burnett

Photo: *Florian Kopp*

When the loveLife campaign for HIV prevention among teenagers was launched in 1999, there was something undeniably edgy about bright bold billboards encouraging people to "use their mouths". In communities where talking about teenage was taboo, just opening conversations about sex and sexuality under the tagline 'talk about it' was controversial enough to get the attention of young people.

Young people – in all cultures at all times – love to talk about sex. And in generalised epidemics like South Africa's, HIV is, by and large, transmitted through heterosexual intercourse. So why did South Africans get so sick of talking about HIV so early in the epidemic? By 1999, high levels of 'HIV fatigue' stood squarely in the way of any attempt to prevent new infections through social and behaviour change communication.

So we had to get sexy. If we had launched a campaign about disease and death, we would never have captured the imagination of the young people whose behaviour we are trying to affect. We knew that we were not competing with the traditional communication campaigns targeting adults. Instead, we were competing with local and global brands, like Sprite, Nike, and Loxion Kulca; brands that put all their energy into defining 'cool' among post-1994 adolescents. If we wanted to play to win, we would have to play in their space.

Just five years into our new democracy, there was already a sense that the unbounded optimism of the early Mandela years was beginning to taper off. Though South Africa was starting to gain economic momentum, we were not creating jobs quickly enough to lift enough people out of poverty. And though the optimism of young people was steady and strong, those among them who had stopped planning for future prosperity were contracting HIV at an alarming rate – much faster than their same-aged peers who reported lower levels of optimism.

The research that provided loveLife with its first campaign strategy clearly linked low self-esteem, a lack of future focus, and little parental discussion about sex and sexuality, with risky sexual behaviour. In a country where the majority of people had been treated as second- or third-class citizens for generations, it is unsurprising that many young people would grow up with a lack of self-worth, believing that their possibility and potential is innately stunted, and turning to narrow definitions of culture to provide a sense of identity and purpose.

These were the factors our communication had to address head-on. The first eight years of the loveLife campaign examined every perspective young people had on sex and sexuality, encouraged them to think of themselves as an inherently valuable and values-driven generation, all peppered with healthy reality checks about HIV, sexually transmitted infections, and teenage pregnancy.

But with new generations of young people growing up in an environment of high unemployment, and failing education and primary healthcare systems, we needed to maintain a sense of momentum amidst a growing sense of frustration and limited choice. Despite the plethora of factors standing in their paths, encouraging young people to never stop taking action to attain their dreams and aspirations, became the new imperative. So in 2008 we shifted our tagline from 'talk about it' to 'make your move'.

With 'make your move' came a clearer focus on the concept of "opportunity" in young people's lives. Again, this was based on research into the drivers of risk tolerance among our target market, which are all linked to the sense of immediate possibility; the sense that as an individual I am not helpless, that I can choose my destiny, and do not have to conform to destructive social norms.

While the campaign launched with a focus on the identity, purpose, and sense of belonging of young people, it will progress to explore the creativity of young people, and finally, the connectedness that can activate their social capital and create innovation and opportunity that ripple outwards from the individual.

We may not have always got it right, but we stand by the idea that effective social and behaviour change communication to label-conscious, media-savvy young South Africans has to be facilitated through the creation of a bold, aspirational lifestyle brand. The overwhelmingly positive response of South African teenagers to the loveLife programmes and campaigns, and the fact that major national gains in HIV prevention and sexual behaviour change have all occurred in our target market, convince us that we are on the right path in our efforts to develop complete, creative and connected young people empowered to stand up to the drivers of HIV.

"Young people – in all cultures at all times – love to talk about sex"

Scott Burnett is Group Director for Programmes at the New loveLife Trust.

The Fight against HIV goes mobile

By Trina DasGupta

Trina DasGupta is the GSMA mWomen Programme Director and a Digital Strategy Consultant with expertise on leveraging mobile phones in the developing world. Trina previously worked with loveLife to create the world's first mobile social network centered on HIV prevention and youth empowerment, MYMsta.

Today South Africa has 56.3 million mobile phone connections – more than the total population of the country. Across the globe, there are 5 billion connections, making the mobile phone the most accessible tool in the world. And for the first time ever, the majority of people, including two-thirds of the developing world, own a media-device where they can not only receive messages, but can also request support, advice, information and solutions in return.

Mobile's ubiquity has opened up a plethora of opportunities for technology to further health interventions. In particular, it allows health practitioners, governments and civil society to engage with people about their most personal issues on their most personal and trusted device: their mobile phone.

Though not a silver bullet, the mobile phone does provide for a unique opportunity in HIV prevention – allowing for the distribution of key interventions at scale, and at the fraction of previous costs.

For example, without accurate health information, myths about HIV continue to be perpetuated and conservative cultural norms can make it difficult to ask questions about sexual health. Google, MTN Uganda and the Grameen App Lab partnered together to create Google SMS Health Tips and Google SMS Clinic Finder to enable users to find information on sexual and reproductive health and to locate health care facilities in Uganda.[1]

Access to opportunities, such as jobs and bursaries, can also incentivise protection against HIV - the ability to create a better life is good reason for positive behaviour change, not only in health but many other development arenas[2]. Forty-one percent of women in low- to middle-income countries report enjoying increased economic and professional opportunities simply due to owning a mobile phone.[3] And mobile-based job search tools or applications, such as Souktel in Palestine, Vodacom's Mob Jobs or loveLife's MYMsta in South Africa have become popular by linking people to jobs or other opportunities via their phone.

The feeling of isolation associated with the stigma of HIV also remains a critical issue for many three decades into the epidemic. Support services such as Zumbido in Mexico use SMS messages to create communities among people living with HIV.[4] Mobile phones are also enabling treatment. Products like SIMPill remind patients to take their medication by sending SMS reminders, prompting better adherence for better health.

But perhaps the most important thing the mobile revolution is doing is linking people to the world beyond their physical space – connecting them to aspiration, solutions and possibilities. While we learn more about the social determinants of HIV, mobile phones are today allowing many to access possibly the most important intervention of all: hope.

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3. "Women & Mobile: A Global Opportunity." GSMA Development Fund and Cherie Blair Foundation for Women, 2010. http://www.mwomen.org/Research/women-mobile-a-global-opportunity_1
4. "Women & Mobile: A Global Opportunity." GSMA Development Fund and Cherie Blair Foundation for Women, 2010. http://www.mwomen.org/Research/women-mobile-a-global-opportunity_1

Getting back to (grass) roots

By Louise Vale

Louise Vale is Executive Director for the Association of Independent Publishers.

If you really want your message to be heard, then use the 150 Southern African grassroots independent newspapers and magazines, which talk to a massive yet often overlooked 5 million people weekly. Technology may be evolving and aiding the fight against HIV, but the printed word cannot be underestimated as a resource to reach our communities.

These grassroots publications are high powered lenses focused at the ground level to cater to 'community' in all its diverse definitions – geographical communities, language communities and communities of interest.

In SA, independent newspapers publish in isiXhosa, Arabic, Venda, siTsonga, isiZulu, English, Afrikaans amongst other languages.

Geographical communities range from rural Cofimvaba to the urban people of Bonteheuwel, from Makhado to Gansbaai, Mangaung to Jozini – and almost everywhere in between.

Communities of interest vary from South African Muslims to South African Germans, African art and literature fanatics, to social justice activists, teachers, teenagers and fruit farmers.

Some publications are 140 years old, whereas others are as young as six months. Some are one-man operations run from a shack in a squatter camp, converted garages, unused classrooms; others are 15 staff member-strong enterprises and have offices on three floors.

But they all share the same passion: to improve the conditions of their "ground level" by celebrating their people, sharing information, reporting burning issues and holding power to account. And HIV is one of these burning issues where power needs to be held to account.

Take the case of a small university town in February 2011, where students descended in their thousands. A student organisation and the university realistically decided to conduct a safe sex campaign - safe from pregnancy, abuse, STIs and HIV.

The newspaper's front page reported on this campaign and printed in-your-face photographs. The town went into uproar. Some readers tore up the paper and threw it at newspaper staff; others framed it and hung it on their walls. Letters and SMS flew, the debates lasted for weeks. A student's summing up of objections was: "You won't talk about these issues – that's why we can't solve them."

With stigma still surrounding HIV in South Africa, community papers remain key sites of activism and information in our country. As Molefi Nonyane of Ficksburg said about *Your Voice* – a self-funded newspaper started by his friend and recently murdered community activist and teacher Andries Tatane: "… we are like the voices behind the mountain…"

Masculinities & HIV in SA – involving men in prevention

By Pierre Brouard

Thirty years after the first cases of Aids presented among gay men in the United States, the epidemic is still raising critical questions about gender, sexuality and justice.

This is particularly true of South Africa. We have one of the most progressive Constitutions in the world yet we still grapple with huge inequality, unequal access to justice and power, and the 'corrective' rape of lesbian women in our townships, against a backdrop of high levels of sexual and domestic violence.

Our HIV/Aids epidemic has played itself out against this complex fabric – asking us challenging questions about gender relations and gender power. While scientists agree that men and women are differently vulnerable to HIV in a biological sense, it is the gender differences, shaped by social forces, which are more powerful.

These gender differences allow the Aids epidemic to play out along gender fault lines. Norms which dictate what is 'normal' and acceptable behaviour, as a man or a woman, make women AND men vulnerable to HIV. People with alternative sexualities or gender presentations are also affected: they may hide their sexuality, leading to risky sexual practices, they may replicate gender stereotypes in their relationships or they may be the victims of sexual violence.

However not all men are 'perpetrators' with an aggressive and 'promiscuous' sexuality; not all women are 'victims', sexually and socially passive.

By viewing masculinity and femininity as 'opposites' and 'naturally' different, we have tried naively to 'empower' women and improve 'communication' in relationships, rather than addressing structural inequalities and power differentials between men and women.

In recent years, the focus of HIV work has shifted to exploring male involvement, with an emphasis on understanding men in more complex ways. As Lynch et al[1] note, it is accepted today that masculinity is socially constructed, fluid and dynamic, and that many forms of masculine expression exist, hence the term 'masculinities'. But an idealised 'hegemonic' or ruling masculinity is what dominates. This varies across and in countries, mingling with local ideas of masculinity, producing new expressions of what it means to be an "acceptable" man.

Ratele[2] describes a historically ruling masculinity in South Africa as "assertive heterosexuality, control of economic decisions within (and outside) the home, political authority, cultural ascendancy, and support for male promiscuity".

Having employment and subsequently being financially independent, considered as conditions necessary for being able to start a family, also indicate a 'proper' masculinity. But the destruction of the material foundation of African masculinity by colonialism, apartheid and migrant labour, affecting the ability of men to acquire land, look after their families and be present in the home, has led to specific ideas and practices, which put men, and women, at risk for HIV. And when a man becomes HIV positive and ill, as Kometsi[3] has suggested, this "illness seems to interfere with the script of being a 'real' man", where men are expected to be invulnerable.

Yet this also opens up the possibility for HIV to transform ideas around masculinity, and a chance to reflect on sexual practices and gender identity. But, even when they challenge dominant masculinity, by negotiating more equal relationships with their partners, men can be marginalised.

Male-focussed programmes must acknowledge that male dominance is protected by a cultural machinery that supports hegemonic masculinity and patriarchy. While this comes with privileges and power, it also leads to stress and 'performance' anxiety.

Men often get contradictory messages about masculinity and fear giving up their traditional roles, leading to frustration and resistance. If programmes accept that identities and roles can change and involve men actively in the development of programmes, so that they have more responsibility and support for change, we can build agreement and equity.

Power CAN be shared between and within the sexes, and this can benefit the whole of society and lessen the spread and impact of HIV. ■

1Lynch, I, Brouard, PW and Visser, MJ. (2009) Constructions of masculinity among a group of South African men living with HIV/AIDS: reflections on resistance and change. Culture Health & Sexuality, 1 – 13.

2Ratele, K. (2006) Ruling masculinity and sexuality. Feminist Africa, 6, 48-64.

3Kometsi, K (2004) (Un)Real AIDS Review. Centre for the Study of AIDS, University of Pretoria.

Pierre Brouard is the Deputy Director of the Centre for the Study of AIDS (CSA) at the University of Pretoria and is a registered Clinical Psychologist. He has worked in HIV since the mid-80s and at the Centre for ten years.

HIV/Aids won't define my generation

By Lerato Patricia Mahoyi

On 16 June 1976 high-school students took part in the Soweto Uprising - not just to protest against Afrikaans as their medium of instruction but to be treated as equal citizens. It meant a new beginning for us, the youth of South Africa, so that we could access better education and become who we want to be – no matter the odds in our lives – 35 years later.

My generation is now fighting a different battle. We live in the days of HIV/Aids, which was considered a death sentence when I first heard about it. I was 13 years old. It was hard enough to speak to my mom and stepdad about "girl meet boy, boy meet girl", so speaking about HIV/Aids was really taboo. I would have had to use words like "sex" and that would have given my mom heartache. While I found out the 'facts' about HIV/Aids at school and in the media, I could never really talk to anyone about it. In fact, most people my age couldn't speak to their parents about HIV/Aids, which didn't make it easier to understand. That was our struggle.

"The challenge is to break down the stigma because that'll kill us before the disease"

My mom first spoke to me and my little brother about sex and HIV/Aids when she found condoms in the house – I think she thought my brother was having sex. Even though she spoke about condoms, she has never encouraged us to get tested she and other people in our community still believe it's better not to know your status because you're not really at risk of dying. For me though, knowing your status is the best thing you can do. The challenge is to break down the stigma because that'll kill us before the disease.

But HIV does not define me and my generation – we are not HIV, we are just in the situation. Sometimes we just forget to separate the two, and lose sight of who we really are. ■

Lerato Mahoyi is a former loveLife groundBREAKER (peer educator). The 23 year old now works as a Training Assistant at loveLife.

HIV/Aids and identity

By Melissa Steyn

Melissa Steyn is Director of Intercultural and Diversity Studies and an Associate Professor in the Sociology Department at the University of Cape Town. Melissa is author of *Whiteness just isn't what is used to be: White identity in a changing South Africa* (2001, SUNY Press,) which won an Outstanding Scholarship award in 2002 from the National Communication Association, USA.

Q: *How are youth identities/sexualities constructed in South Africa today and what are the implications for infection with HIV?*

A: The ways in which we construct gender in South Africa remains one of the key issues. Right at the heart of so many of our social problems is the way in which hegemonic heterosexual masculinities still operate to encourage sexual conquest and bravado, and hegemonic femininities are still shaped around pleasing and acquiescing to these masculinities. These dynamics really need to give way to more appropriate ways of "doing gender" – not only for the physical health of our young people, but also for them to enjoy richer emotional lives.

Coupled to this, we have a situation where youth are confronted by high levels of poverty and unemployment, and often don't have environments that are supportive of their agency in shaping the everyday realities of their lives. This encourages an ethos of nihilism, which is really a recipe for high-risk behaviour. One has to believe in the value of, and prospects for, your life if you are going to be motivated to protect it!

And then we also have the pressures (which youth today are under globally) towards consumerist identities signaled by the display of fashionable brands, etc. The pressure is felt particularly poignantly by those who have fewer means to service this implicit social coercion. The materialism encourages subtle (and not so subtle) transactional dimensions to sexual relations, where for example, young girls will be involved with older men who can buy them the items that represent a certain desirable identity to the world.

These cocktails of pressure to identify in certain ways make it very hard for young people to identify in other ways that would counter the behaviours which make them susceptible to infection. And counteracting all of these pressures, in one way or another, requires developing in young people a positive sense of their worth and value.

Q: *Earlier generations of South Africans formed a collective identity around the 'Struggle'. Can the same be said for HIV/Aids?*

A: This challenge is much more difficult to define as a common enemy. The way in which stigma works locates 'the problem' in the bodies of those who are infected; not in the understandings of broader society – which is where it really resides.

So, the power dynamic is oppressive of those who are seen to 'carry' the enemy within the community, and to deny the way in which we are all participants in the problem. This is very different from the Struggle years when people collectively could rally around an enemy that could be located outside of the community, which is how apartheid was perceived.

It was much easier to create the kinds of dichotomies on which ideological identities are constructed, the goodies and baddies, and to identify oneself on the side of the suffering righteous, as it were.

What we are dealing with now is much more complicated, and requires self-reflection and ownership of personal responsibility on the part of all of us, which is a real challenge for any society.

30 years of HIV/Aids

1981

- US Centers for Disease Control and Prevention (CDC) report first cases of rare pneumonia in gay men on 5 June

1982

- CDC formally establishes the term Acquired Immune Deficiency Syndrome (AIDS)

1984

- HIV, retrovirus that causes Aids, is independently discovered by Luc Montagnier of the Pasteur Institute in Paris, France, and Robert Gallo of the National Cancer Institute in Washington DC, USA

1985

- First International AIDS conference is held in Atlanta, USA

1988

- The World Health Organisation (WHO) declares the first World AIDS Day on 1 December

1991

- The South African Department of Health commissions ad agency to develop advertising campaign: "AIDS, don't let it happen"

1995

- One million cases of AIDS have been reported to the WHO and 19.5 million people have been infected with HIV
- The Department of Health in SA introduces the 'red ribbon' logo

1996

- 90% of all people infected with HIV live in the developing world

1999

- 33 million people are infected with HIV, and 14 million have died of AIDS worldwide
- loveLife launches in South Africa as an ambitious attempt to reduce HIV infection among 12 to 17 year olds
- Manto Tshabalala-Msimang becomes South Africa's Health Minister until 2008

2002

- loveLife's mass media campaign extends to include 2 049 billboards, 850 communter taxis and 160 water tanks with messaging
- loveLife's 13 part reality TV series *(S'camto groundBREAKERs)* reaches 899 000 viewers 16 years and older
- 2 405 504 calls made to loveLife's toll-free youth line
- The loveTrain launched to bring messaging to remote communities reaching 16 000 young people at stations nationwide

2003

- Five million people are newly infected with AIDS during 2003, the greatest number in one year since the epidemic began.
- loveLife has distributed more than 27 million copies of its youth magazines *thethaNathi* and *S'camtoPRINT*

2005

- Around 40 million people are infected with AIDS worldwide

2008

- loveLife launches MYMsta – world's first social mobile platform dedicated to HIV prevention and youth development
- More than four-fifths of South Africans had seen or heard at least one aspect of SA's major communication campaigns – up from less than three-quarters in 2005
- HIV prevalence declines among children aged 2-14, from 5.6% in 2002 to 2.5% in 2008
- HSRC reports substantial decrease in incidence for the single age groups 15, 16, 17, 18 and 19 years
- HIV prevalence decreases among youth aged 15 - 24 years, from 10.3% in 2005 to 8.6% in 2008

2010

- loveLife has permission to work in 6 526 schools and a total of 880 hubs from which groundBREAKERS (peer educator) can implement loveLife programmes
- A total of 1 433 905 youth participate in loveLife programmes – a 450% since 2006

2011

- On 1 June, UNICEF reports HIV infections among world's youth down 12% since 2001, but short the 25% target set by world leaders

Sources: South African History Online, The New Scientist, The Henry J. Kaiser Family Foundation, UNICEF, loveLife Monitoring & Evaluation data 1999-2010

The New loveLife Trust
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