# H I V / A I D S

*"The Worlds Highest Infected Region"*

## K w a Z u l u - N a t a l

South Africa is currently living with the largest number of HIV infected people in the world, with the province of KwaZulu-Natal being the most affected province. As of 1999, more than four million people were infected in this region. South Africa, having the highest infection rate in the world, is thought to have the fastest growing HIV/AIDS pandemic in the world.

Based on a 2005 South African National HIV Survey, of the 9 provinces in South Africa, KwaZulu-Natal Province still reports the highest percentage of HIV / AIDS, with Mpumalanga Province coming in second. Additionally, USAID - 2005 listed Kwa-Zulu Natal, South Africa as “the world’s highest infected region.” The conclusion reached by all recent HIV / AIDS studies is that there is an exceptionally severe epidemic of HIV/AIDS in South Africa, with KwaZulu Natal bearing the largest brunt of the pandemic.

## S o u t h   A f r i c a

UNAIDS estimated that by the end of 2003, there were 5.3 million people in South Africa living with HIV, equivalent to 21.5% of the adult population. A survey published in March 2004 found that South Africans spend more time at funerals than they do having their hair cut, shopping, or having Braiis (Bar-B-Qs). The survey found that more than twice as many people had been to a funeral in the past month than had been to a wedding. It has been estimated that a minimum of 600 people in South Africa die of HIV-related illnesses each day.

In 2004, there were approximately 2.2 million orphaned children in the country. This means that 13% of all South African children had lost either a mother or father and nearly half of these orphans had lost both parents to AIDS-related illnesses (UNAIDS, UNICEF, USAID, 2004). The worst affected children – those in deeply impoverished households – are losing their health (through infection, inadequate nutrition, and poor health care), their livelihoods (through the illness and death of breadwinners and working adults), their parents (to illness and death), their families (as they are separated from caregivers and siblings and sent to stay with other relatives or caregivers), and their social networks. The deterioration of "normal life" for such children starts long before their parent/s die. By the time these children are orphaned, the extended family networks that have traditionally supported vulnerable members have been over-stretched.

It is widely accepted, based on experience in South Africa and the rest of the continent, that the best models of care for vulnerable and orphaned children are found within the children’s communities, not in institutions. Orphans fared better if they remained in familiar surroundings, in family units, even if not with their biological families. If extended family networks and communities are to continue to play this role, it is essential they receive social and material support from government, development agencies, and the private sector. Early identification of vulnerable children; succession planning; facilitating kinship and community foster care; assistance with social grant applications, counseling, and psychosocial support are all essential components of a community-based strategy.

**sub-Saharan Africa**

The photographs that make up this Flash video in the web page are of people affected by HIV/AIDS. Some have HIV, others are dying of complications from AIDS, and others are orphans, the result of family members dying and leaving only the children. In some areas an entire generation has died, leaving elder relatives to take care of orphans, in other cases all of the older generations have died ... leaving only the children!

**An Example in KwaZulu-Natal**

HIV/AIDS is sometimes seen as being a disease of the poor, and in South Africa there is some correlation between extreme poverty and high levels of HIV, although the virus is prevalent in all sectors of society. Dr. Hutter's ’s introduction to the extreme problem HIV/AIDS inflicts on rural areas in southern Africa occurred while visiting (in 2004) the 280 bed hospital in Manguzi, northern KwaZulu-Natal. During that visit, Dr. Hutter was given a tour of the facilities and was told that all of the beds were full-- 279 beds were occupied by patients dying of complications from AIDS, and the one remaining bed was occupied by a young boy who had been gored by an impala. The physician in charge, Dr. Mark Blaylock, related that 10 to 15 people die each day, and there is a waiting list to fill vacant beds as soon as someone dies. Dr. Blaylock advised that his biggest challenge is to allow these AIDS patients to die with dignity and as pain free as possible. Dr. Blaylock sees an immediate need for a hospice facility on the hospital grounds, thus freeing hospital beds for patients with other health concerns. While seeking funding for its own Mission, CESLA will also publicize the needs of physicians, such as Dr. Blaylock of the Manguzi hospital.