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Managing the Sleeping Germ: An Experiential Narrative of the Implications that Political Decisions had on Exacerbating the HIV/AIDS Epidemic in South Africa

Audra Gill
argill@bgsu.edu

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Audra Gill

Honors Project

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Sharon Schaeffer, MPH, RN, Project Advisor

Tim Brackenbury, Ph.D., Project Advisor

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PROJECT INTRODUCTION

FOREWORD

Thank you for your interest in reading about this project focused on the HIV/AIDS epidemic in South Africa. My name is Audra Gill and I am a fourth-year public health major at Bowling Green State University with interests in global health, epidemiology and health equity. Throughout my time at BGSU, I have become very involved with alternative community service breaks and community health initiatives. With a passion for international health efforts, I wanted my project to be geared towards an ethical global health learning experience, perhaps with a component of service-learning. Instead, my project took a strong turn towards social justice during a recent experiential learning opportunity and I plan to use this paper as a way to convey the dominant narratives that I learned about during the time I spent in Durban, South Africa. While a scientific experiment was not conducted nor was data collected of any kind, I promised the people I met in South Africa that I would share the truthful story about the HIV/AIDS epidemic which I anticipate that you may find a bit surprising, or at least contradictory to the dominant narrative portrayed throughout the media regarding South Africa.

ABSTRACT

The HIV/AIDS epidemic in sub-Saharan Africa has been a public health crisis for decades, accounting for well over two-thirds of all HIV cases worldwide. About 13.4% of South Africa's general population is living with HIV/AIDS, driving the purpose of this project to investigate why a country regarded by the United Nations as having a mid-to-high economic status is struggling with an issue that is widely referred to as a socio-economic crisis. Funded by the Hoskins Global Scholars program and BGSU Honors College, this project served as an experiential learning opportunity with Child Family Health International, a global partner of the Economic and Social Council of the United Nations. This project examined the South African healthcare system through the lens of its HIV/AIDS crisis via healthcare rotations in the city of Durban, Kwazulu-Natal. The findings of the project support that poor social determinants of health greatly exacerbated the HIV/AIDS epidemic, yet surprisingly revealed that many South African citizens, healthcare providers and educators attribute the severity of the country's epidemic to the restriction of antiretroviral medications - a political decision made in the early 2000s that that the South African healthcare system is still dealing with the repercussions of to this day, even as the country grows in economic status and international recognition.

PURPOSE

The purpose of this project served to investigate the HIV/AIDS epidemic of South Africa through an ethical, global health learning opportunity.

RESEARCH QUESTION(S)

- Why is the country of South Africa, which is regarded by the United Nations as having a mid-to-high economic status, struggling with an HIV/AIDS epidemic - an issue that is widely referred to as a socio-economic crisis?
- What are the contributing factors to the HIV crisis?
- How has the epidemic been dealt with by healthcare professionals and government officials?

LEARNING OBJECTIVES

The project also served as a public health practicum to where the following learning objectives were met:

1. Learn about the healthcare system in South Africa through public health rotations in a variety of healthcare settings.
2. Engage with organizations that specifically work to address HIV/AIDS within the Durban, Kwazulu-Natal community.
3. Interact with patients and professionals at care centers whose every lives and occupations are affected by HIV/AIDS care and treatment.

PROJECT ORIGINATION

The initial motivations for this project stemmed from my interest in global health efforts and most specifically the HIV/AIDS epidemic in sub-Saharan Africa. In the recent decade, since HIV disproportionally affects lower income areas, marginalized racial and gender groups as well as developing countries, HIV epidemics are commonly being referred to as social justice issues[CITATION NAA15 \l 1033]. A social justice issue is one that can be defined as the inequitable distribution of resources, human rights or opportunities based upon identification or self-classification of an individual within a social group[CITATION Uni20 \l 1033].

During my time at BGSU, I have become most passionate about advocating for social justice as well as public health efforts, thus the HIV epidemic in sub-Saharan Africa has been an interest of mine for a little while now. Wanting to engage in a potential service-learning opportunity in Africa, I began to research ethical global health programs that were ideally longer than one or two weeks in length, fully immersive, yet culturally competent and respectful of the home community.

Child Family Health International

The search for global health partners led to Child Family Health International (CFHI), a nongovernmental organization that is a consultative affiliate of the United Nations Economic and Social Council. CFHI provides community-based global health education programs for students and institutions. Especially important to this project and my personal values was that CFHI works to foster mutually beneficial and reciprocal student-community relationships and believe that students should let the "world change them," not that they will be changing the world – a superiority complex that is unfortunately very common in Western global health initiatives.

CFHI has international health programs across the globe for students in public health, medicine, allied health sciences, nursing, healthcare administration and many others – allowing students to apply for program that is of interest to them, and ideally one that they may have and educational background in.

Finding a public health program focused on HIV/AIDS in South Africa, I jumped at the opportunity to apply for the practicum which would include public health rotations through a variety of different healthcare settings in the city of Durban, Kwazulu-Natal.

Hoskins Global Scholars

The Hoskins Global Scholars Program supports up to three students each academic year on an immersive global endeavor that can serve as an internship, service project, research project or creative activity. With the hopes of the program being able to count as my public health practicum (internship), I applied for the award to help fund the CFHI opportunity to Durban, South Africa. I was gracefully awarded the travel grant for the 2019-2020 year and would like to personally thank Mr. Mike Hoskins and the BGSU Honors College for their support during this experience. Without their help, this project would not have been possible.

Cultural and Historical Orientation

Something that CFHI values alongside myself is the power of education and knowledge to which I received an abundance of throughout this experience. During this next section, I will provide background information I received upon arriving in South Africa, in addition to other supplemental literature that I have found while compiling this paper to fill in any gaps and provide validity.

PRE-DEPARTURE

Prior to departing for Durban, South Africa, CFHI required that I complete online modules detailing many of the cultural norms and expectations held by the country. I appreciated that these modules covered brief overviews of subjects such as apparel, religion, and language. Additionally, I was expected to read articles about the rich cultural history of the region as well as the structure of their healthcare system. This information is not included here for lengths sake.

CULTURAL ORIENTATION: HISTORY OF SOUTH AFRICA

Upon arrival, I sat through a program orientation from the CFHI Health Director who previously served as a nurse in the community and local non-governmental organizations. The orientation workshop was extremely informative and I would later see the implications that the rich cultural history had on its healthcare system. The following information was highlighted during this workshop, reinforced through the referencing of historical documents published by the Republic of South Africa.

Colonization of the Southern African Coast

Indigenous peoples and tribes are estimated to have lived in the southern part of Africa for around 3.3 million years. European settlers arrived in the mid-1600s from the Netherlands colonizing the area, establishing farms and soon after, importing slaves from the Indies, Madagascar and the eastern coast of Africa. Around 1820, British settlers also came upon the area, settling on the Southern Coast[CITATION Rep19 \l 1033]. With the influx of many different groups of people from Europe, India, other parts of Africa, the region became very culturally and racially diverse.

As European settlers began to expand and explore the region, conflict erupted between colonists and native tribes such as the Bantu-speaking peoples, isiXhosa-speaking chiefdoms and Zulu groups, among many others. Continuing through until the late 1800s/early 1900s, the fight for control of the region eventually revolved around the resources of the land, most notably, the

mining of diamonds and gold. This led to the Anglo-Boer/South African War between 1815 and 1915 and the eventual founding of the Union of South Africa[CITATION Rep19 \l 1033].

Modern History and the Apartheid Regime

The Union was primarily dominated by white leaders in power to which social unrest and opposition followed. The African National Congress, a black union created to protest the fact that people of color were being excluded from positions of power, was initially formed in 1921 but unfortunately, the racial oppression continued. In 1948, a new regime began called Apartheid[1] as a group comprised of white South African descendants came to power, arguing that segregation was the answer to improve the country's struggling economy. It wasn't until 1961 though that racially segregative legislation was passed in the form of a Group Areas Act which divided the country into sectors and assigned racial groups to specific residential areas, much like the separate but equal doctrine taken up by the United States during this time; however these residential assignments were anything but equal.

The population was divided into the following racial groups: Blacks, Indians, Coloureds[2], and Whites. People of color were primarily assigned to less accessible areas while the capes, coasts and well-developed areas of the country were given to white communities. This racial organization intentionally marginalized the Black, Indian and Coloured racial groups, leading to the systematic oppression of these groups in all senses of social identity and justice, which later trickled into the healthcare disparities currently present in the country.

Throughout this Apartheid regime, the black African National Congress (ANC) continued to push back against the group in power, referred to as the pro-Afrikaner National Party (NP), or Afrikaners. A rising leader in the opposition movement was Nelson Mandela, who empowered leaders of the ANC even while being imprisoned for over twenty-seven years. Leaders like Mandela were imprisoned throughout the country as the government banned organizations and parties such as the ANC which led to violence, riots and civil unrest. Collecting international attention and internal social pressure to remove the discriminatory apartheid policies, in the late 1980s, South African leader F.W. Clerk began to make important administrative changes that moved in the direction of a democracy. Some of these changes included releasing Nelson

[1] The word apartheid means a segregative system that divides populations often into discriminatory social groups, but is now commonly used as a proper noun to refer to this era of South African history[CITATION Mir20 \l 1033].

[2] Coloureds is a multiracial ethnic group in South Africa comprised of people that identify as having ancestry from different ethnicities and native populations.

Mandela and associates from prison, reinstating the permission of political parties to gather and convene such as the ANC, and Clerk actually stepped down from leadership.

After the first South African democratic election in 1994, Nelson Mandela as a representative of the ANC was elected as the first democratic President to lead the country that was newly organized into nine provinces based on geographic location and population distribution.

HEALTHCARE SYSTEM OVERVIEW

Patient Influx

As the Apartheid regime controlled South Africa for over four decades, it was to be expected that post-regime, there would be many challenges as the country transitioned to a more representative democracy. With the healthcare system specifically, after the Group Areas Act was repealed, citizens of any city or region had the freedom to seek healthcare wherever they saw fit or could afford. This led to the rapid influx of people seeking care at hospitals which in turn, quickly resulted in overwhelmed healthcare professionals. It is also important to note though that even while the healthcare options were increasingly legal to seek, health disparities were still disproportionately affecting marginalized racial identities. In a 2008 South African study, healthcare professionals Zeida Kon and Dr. Nuha Lackan discovered that 40.8% of Blacks and 22.9% of Coloureds were going without medical care compared to 10.9% of Whites for that given year [CITATION Kon08 \l 1033].

Professional Brain Drain

For context, the current South African healthcare system is structured with two different tiers: the government-run public sector that serves the large majority of South Africans, while the privately-funded sector tends to serve the more financially privileged 16% of the population [CITATION Mah15 \l 1033]. The World Health Organization though estimates that even though there is a much higher need for physicians in the public sector, that these professionals are estimated to make up 30% of the healthcare workforce in South Africa, with the other 70% of healthcare workers having employment in the private sector.

There are two major contributors to the lack of physicians working in the South African public sector. The first, and more obvious of the two is the fact that these professionals are simply able to make and charge more independently if they work privately. Now relating to Apartheid, the second and largest contributor to the shortage of healthcare workers is related to the fact that during the regime, people were not allowed to leave the country thus when provided the opportunity to emigrate and move elsewhere for higher pay, the country began to experience “brain drain.” Brain drain is a phrase commonly used in the healthcare field to refer to highly educated and skilled professionals leaving one country or field for better pay or living conditions elsewhere [CITATION Mer20 \l 1033]. For South Africans, this meant that physicians were finishing medical school, had very marketable skills and training and left for Australia, the United States or the United Kingdom [CITATION Igh17 \l 1033]. This is a much larger problem

than simply seeming understaffed. As of 2015, the World Health Organization wrote that "Africa bears more than 24% of the global burden of disease, but has access to only 3% of health workers and less than 1% of the world's financial resources [CITATION Wor06 \l 1033].[3]

Systematic Changes to Address Healthcare Needs

With the increasing number of patients combined with the severely understaffed and overwhelmed healthcare professionals, South Africa started making dramatic changes to their healthcare system to address the post-Apartheid burdens.

As the number of physicians was dramatically lower than the country needed, nurses became a crucial piece to the South African healthcare system. In 2008, a national strategy was introduced to help boost their success and abilities[CITATION Mah15 \l 1033]. This meant that clinics were now strictly run by nurses who would refer more severe cases to hospitals or secondary care centers where they could be treated by physicians. Their job expectations are very different from the abilities of nurses here in the United States. In South Africa, nurses often prescribe medication, perform clinical assessments and do all but surgical procedures if their facilities have the capacity.

To promote retention of professionals in the public sector, in 2002, the government began to allow physicians to both work in the private sector while also working publicly. Then in 2007, a remuneration policy for health professionals was implemented which provided additional compensation for healthcare workers in the public sector [CITATION Dep10 \l 1033].

RISING HIV EPIDEMIC

As the country was getting oriented to the new political government and addressing the new challenges within their healthcare system, South Africa was faced with a new challenge: the Human Immunodeficiency Virus (HIV) accompanied by its successor, the Acquired Immunodeficiency Syndrome (AIDS). During the late twentieth century, much of the world was attempting to tackle this new virus that would entirely change the country of South Africa for decades to come.

About HIV/AIDS

HIV is a virus that is thought to have originated from the Congo prior to the 1970s. When contracted, the virus attacks the immune system of its host, destroying and hijacking CD4 cells, or white blood cells responsible for fighting off other foreign threats and illnesses[CITATION Ave \l 1033]. As the virus progresses, it eventually weakens the host's immune system as they are

[3] Mindful of the fact that South Africa is one of the countries included in this statistic, but not entirely responsible for the continental burden of disease.

unable to fight off outside illnesses with progressively less and less CD4 cells. An individual is diagnosed with AIDS consequentially if their HIV goes untreated or unsuppressed to the point where the host's immune system is too weak to fight off infections. Patients often die from "AIDS-related illnesses" meaning that the individual gets sick with a different infection, disease or condition that leads to their passing.

The viral cells are contained within human semen, blood, vaginal secretions, anal fluids and breastmilk, making unprotected sexual intercourse a very high risk activity for HIV transmission. HIV cannot be transmitted to an individual via sweat, saliva or urine[CITATION Ave \l 1033]. Treatment plans for HIV include prescribed antiretroviral medications (ARVs) which work to fight against the viral cells that are killing the body's white blood cells. HIV is not curable, but the virus can be suppressed to the point where the host can live a healthy life if ARVs are started early enough and taken correctly for an extended period of time[CITATION USD20 \l 1033]. HIV can go unnoticed for months to years if the host is not tested, as many individuals are asymptomatic or present with temporary flu-like symptoms[CITATION USD19 \l 1033].

Since it is very important to get individuals that are HIV positive started on ARV treatment plans as early as possible, HIV testing, sexual health education, resources and contraceptives are crucial in HIV management. As a developing country, South Africa, like many other countries, was highly impacted by HIV starting in the 1980s.

HIV in South Africa

During the early twentieth century, ARV treatments were being released and implemented worldwide to which the government of South Africa refused to implement a national program for. In fact, ARVs were almost restricted entirely by the South Africa government, led at the time by President Thabo Mbeki. The Mbeki-led government withdrew support from clinics using a drug that reduced mother-child HIV transmission and restricted the use of nevirapine, a donated ARV that reduces newborns from HIV contraction [CITATION Har19 \l 1033]. Thabo Mbeki had very skeptical beliefs over the seriousness of the HIV virus and the medications needed to treat the virus.

Like other sub-Saharan countries, South Africa was already experiencing disproportional rates of the virus as a developing country, however the decision to restrict ARVs just between the years of 2000 and 2005 exacerbated the epidemic leading to what is now reported as 330,000 deaths that could have been avoided with treatment distribution [CITATION Har19 \l 1033].

Watching the increasing burden that HIV was having on the already overwhelmed healthcare system, healthcare professionals unionized and began protesting against the government. Even against international recommendations from the World Health Organization, for five years the South African government kept up the ARV restrictions until there was a federal lawsuit taken to

the Supreme Court of South Africa where it was decided that the government had been wrongfully withholding rightful medications to the citizens of South Africa.

In an apology letter, Mbeki later claimed that his judgement was clouded by the racial discrimination that South Africa had faced for decades and that the medications were thought to have been linked to a Westernized, developing-world superiority plan.

PUBLIC HEALTH PLACEMENTS

All of the cultural information detailed previously helped put into context the healthcare system that I would be immersed within for the month that I spent in Durban, South Africa. I was able to experience and witness the burden that HIV does have on different aspects of the healthcare system, but I was also able to see how the country has come together to recover from the epidemic. I have broadly detailed my experiences below.

MALUKAZI ISLAMIC CLINIC

The first location of my practicum was a very small wellness clinic in a town called Malukazi. Prior to Apartheid, the community had been primarily reserved for people who identified as Indian. Because the end of Apartheid happened relatively recently in modern history, there is still a large Indian presence throughout the community.

The clinic was very small, with just two nurses seeing patients for the day. In South African culture, they refer to nurses as Sisters, and I was assigned to spend a few days shadowing one of the Sisters. The first day I was there, the Sister and I saw around 70 patients between the hours of 8am and 1pm. That by no means was a quota of patients that she had to see, however, she mentioned that they were exceptionally busy that day due to the winter holiday. The next few days Sister did not see as many patients, but still a number much higher than anything we would see in the United States.

While shadowing, I noticed that the nurses at this clinic truly performed a clinical examination just as a physician normally would. They would analyze vital symptoms, assess the patient(s), prescribe medications and then go to the cabinet to retrieve the medications all within a maximum of 5-10 minutes spent with each patient. Sometimes families would come in together and all be seen at the same time. It was astonishing to see not only everything be taken care of in one room, but that the nurses seemed very qualified to be doing the tasks they were doing and the patients seemed to trust them for the most part with all of their care.

As mentioned previously, in 2003, the South African government changed the healthcare system to rely more heavily on the work and experience of nurses in the field; shadowing the Malukazi Islamic Clinic visualized this for me as these two nurses saw a very high number of patients in a very short time and were able to perform most of the duties that a family practitioner would.

The Sisters working at this clinic attributed the business of their days to the fact that patients needed to get a referral from the nurses at the clinic to be able to visit specialists or physicians at secondary or tertiary facilities.

CHATSWORTH HOSPICE

The second placement was quieter than the first and the nurses were less busy than the ones at Malukazi. Demographically, Chatsworth is primarily an Indian community and all of the patient interactions that I shadowed were with Indian patients.
I first spent time in the in-patient ward where individuals would stay if they needed regularly nursing assistance and monitoring for existing conditions or end-of-life care. The center had ten beds and to my surprise, only two of the beds were filled. The nurses spent much of their day sitting in the patients' rooms with them or working at the nurses station. It was pretty much exactly the opposite from Malukazi's clinic but the nurses did not seem satisfied at Chatsworth either. Their work-load was almost too little.

I was also able to spend a day shadowing the Chatsworth nurses that would travel around town and do home visits for patients that are doing well and returned home. Of the twelve houses that we visited, almost all of them suffered from some type of cancer, unrelated to an HIV diagnosis. This was the only placement where it surprisingly seemed like they were not burdened by HIV.

BLUE ROOF WELLNESS CLINIC

Blue Roof Wellness Clinic was where I did my third placement; a wholistic wellness center that has such a rich and fascinating cultural history rooted in HIV/AIDS. The building itself had originally been a nightclub that the Wentworth community decided to shut down due to the drug activity and risk of HIV transmission for community members.

The building was later bought by Alicia Keys and her foundation Keep A Child Alive, in partnership with the Stephen Lewis Foundation to address the great need of HIV/AIDS in the KwaZulu-Natal province. The Blue Roof Wellness Center was initially implemented to focus on the diagnosis, counseling and treatment of HIV for thousands of patients in the community. During 2016 though, the US Presidential Administration cut funding to African countries forcing Keep A Child Alive to have to pull efforts from Blue Roof.

Rather than leaving the community without necessary care and medications, a nonprofit named Zoelife stepped up and took over the HIV Clinic and implemented holistic wellness efforts in addition to the existing HIV treatment. The clinic now has a life coaching program, a career exploration center, an in-building pharmacy, HIV testing, Lalela (art and dance classes), and Made for More, which is a nonprofit organization that aims to empower and equip people with disabilities through sport – in addition to the HIV clinics, counseling, education and treatment provided from the center originally.

Managing the Sleeping Germ

As mentioned, Blue Roof Wellness Center conducts many wellness programs, with HIV counseling being one of the foundational services provided to Wentworth patients. Child HIV counseling was the aspect of HIV treatment that I found the most interesting, and where I requested to spend all of my unscheduled time at Blue Roof.

In South Africa, many children that are HIV positive are living in children's homes due to their parents or guardians battling HIV themselves, or having family members that have passed from the virus. All children living with HIV whether they are living with families or within a children's home must meet with the HIV counselor every month before receiving their antiretroviral medications. Until the age of 13, children are not explicitly told that they are HIV positive; rather, they are told they have a "sleeping germ" in their body that can be put to sleep (through suppression). To aid in the counselors in their difficult conversations with children, Blue Roof uses a really helpful tool created by professionals with Zoelife. A team of psychologists, pediatricians, counselors, social workers and physicians within Zoelife came together to design a tool where children would enjoy listening and learning about HIV, hopefully in a way they could relate.

The design team eventually decided on choosing a narrative that centered around a frog and its caregiver, which in this case was the frog's grandfather. The KidzAlive tool, now endorsed by the South Africa National Department of Health, details the frog's life with disease and illness, talking about the common germs that children encounter such as diarrhea, influenza, stomach bugs and how these germs can be treated and killed. The story then outlines how the frog has a "sleeping germ" which developers intentionally disguise as HIV until the children reach age 13 – the age to which counselors and caregivers should disclose to children about their HIV status.

It was while I shadowed these children's group counseling sessions that I realized how important HIV counselors are in helping children to begin their life-long antiretroviral treatments. Rather than stigmatizing the virus and making children feel embarrassed for being born with a life-long virus that was outside of their control, counselors work diligently to help each individual understand what the diagnosis means for them individually. I was beginning to see how successful South Africa has become with managing their "sleeping germ" epidemic, both from a clinical and mental health standpoint.

KING EDWARD TEACHING HOSPITAL

Placements at the King Edward VIII Teaching Hospital varied between the Neo-natal Intensive Care Unit (NICU) and the hospital's separate HIV clinic. Having a vary clinical focus, I shadowed medical residents and interns in the hospital as they made their rounds visiting patients. Many of the mothers and newborn babies that we visited were HIV positive which

might have been because we were at a tertiary hospital in a critical department for serious conditions. Not having a medical background, I really appreciated the clinical practice taking place around me, though I did feel a bit intrusive while walking around with the medical students.

Later in the placement, I was shadowing physicians specifically assigned to the HIV clinic within the hospital. Similarly to the patients interactions that I witnessed at Blue Roof, many of the people that were HIV positive in this clinic were virally suppressed in terms of their HIV viral load. This is great news and re-emphasized how healthcare facilities across the country are successfully managing HIV.

Physicians in this placement frequently brought up President Mbeki and the implications of his decision to restrict antiretroviral medications to the public. They highlighted that yes, it is great that the healthcare system is making great strides in managing the HIV cases presently, but that it doesn't make up for all of the children that healthcare workers see on a regular basis who now have a life-long diagnosis and perhaps have unnecessarily lost family members as a consequence. Yes, hundreds of thousands of people passed during that five-year time period, but even today millions of people are still impacted. That is something, they claim, that apologies from politicians will never be able to make up for.

PROJECT DISCUSSION

THE ROAD TO RECOVERY

Since the instatement of national ARV programs, international donations and support, assistance from PEPFAR the U.S. President's Emergency Plan for AIDS Relief, South Africa is well on its well to managing its HIV epidemic, contrary to the media representation of the epidemic. HIV is a diagnosis that individuals will live with and manage every day for the rest of their lives, consequently, national rates will remain high for decades to come. Considering that the antiretroviral medication restriction was just over fifteen years ago, the South African healthcare system is still working to manage the 7,700,00 people living in the country that are HIV positive.

South Africa, among other sub-Saharan African countries, has since gathered support for their HIV/AIDS epidemic via international donations, independent agencies, nonprofit organizations and governmental organizations such as the U.S President's Emergency Plan for AIDS Relief (PEPFAR) which have greatly contributed to the decreasing HIV rates. Indicating the progress, are the many national statistics that are beginning to take more positive trends: as of 2018, there had been a 50% decrease in the death rate from 2010 which is quite the feat for an eight year time period. HIV infections decreased as well within this period from 390,000 to 240,000 which implies that HIV transmission is decreasing as well. In 2018, 90% of the people living in the country knew their HIV status, 62% of the population that was living with HIV was on treatment with 54% of that same population being virally suppressed[4][CITATION UNA20 \l 1033].

PROJECT SUMMARY

To summarize, South Africa, recently free from the Apartheid regime, was almost immediately faced with one of the largest battles of their healthcare system: the HIV/AIDS epidemic. With about 13.4% of the country's general population living with HIV/AIDS, the virus is continually presenting as a burden to the overwhelmed and understaffed healthcare system that has been trying to cope with changes post-Apartheid. This project examined the South African healthcare system through the lens of its HIV/AIDS crisis via healthcare rotations in the city of Durban, Kwazulu-Natal. Placements reflected the highly crowded clinics, the limited number of healthcare professionals, and the added stress of managing HIV. It was evident that social determinants of health greatly exacerbated the HIV/AIDS epidemic in marginalized communities

[4] Viral suppression can be defined as the point where one's viral load, or the amount of HIV found in the blood, reaches an undetectable level[CITATION USD20 \l 1033]. This does not mean that the individual is HIV negative, just that the virus' functioning is suppressed in the body and that it is not actively attacking the immune system.

where racist social systems existed during the Apartheid regime, yet surprisingly revealed that many South African citizens and healthcare professionals additionally attribute the severity of the country's epidemic to the restriction of antiretroviral medications from 2000-2005.

POST-REFLECTION

Continuously grateful to have had this experience – I am humbled to reflect upon the opportunity that enabled me to be immersed within the rich South African culture while also studying the rapidly adapting healthcare system that is managing one of the largest HIV/AIDS epidemics in the world. Had I not had the opportunity to visit Durban, I wonder how long I would have taken part in global health conversations fueled by the dominant narrative that South Africa's HIV/AIDS epidemic is attributed to the country's lack of education, resources or social structures; completely ignoring the recent history of the country that is rooted in racial oppression or the government's decisions to disregard the recommendations of the global scientific community.

I do not take my privilege for granted in the fact that I was able to first-hand witness some of the amazing work that South African healthcare professionals are doing to help millions of citizens that are HIV positive. As mentioned early on in my experience, finding an ethical global health opportunity was important to me. I do recognize that my experience could be viewed by some as intrusive or voluntour-isty, however, I want to mention that the goal of traveling to Durban was not to offer any of the healthcare skills or professional advice that I have to give, because quite frankly, I have very limited healthcare knowledge, let alone clinical experience.

I wanted to visit South Africa because I was not convinced that the narrative portrayed by American or global media was true. I did not believe that the epidemic was solely attributed to lack of health literacy or access. I wanted to be immersed within a culture of people that had first-hand lived through many political, economical and healthcare changes as of late. I wanted to hear the stories of the people of South Africa – the people to which I had promised that I would return to the United States and tell the true narrative of their country: that yes, South Africa is considered a developing country, and yes, South Africa may have a ways to go in terms of economic development compared to the United States, Australia or the United Kingdom, but that the people of South Africa were wrongfully silenced and oppressed for decades. I wanted to share that the people of South Africa are resilient, that the healthcare workers are dedicated and successful, and that politics is very important to delivering equitable healthcare. Hopefully, I have at least been able to convince you to ponder these concepts, if nothing else.

CLOSING

Uniquely, this project works to tell the story of a real-life health epidemic that was exacerbated by a government that was unable to integrate science within the political concern for its citizens. I think the narrative of HIV/AIDS in South Africa shows the devastating risks posed to communities when their elected officials make decisions where they may be unqualified or inadequately prepared to advise upon. Especially during present-day epidemics/pandemics such

as COVID-19, citizens should continue to recognize the importance of political participation as well as critically analyze the power that representatives hold to make legislative decisions that impact large populations of people and even generations to come.

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