University of Cape Town

Department of Social Development

A comparative study of South African and Brazilian HIV and AIDS rates and policies

Masters Dissertation

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ABSTRACT

HIV and AIDS are still affecting many people in Brazil, South Africa and across the world, even though much has been done to mitigate against its further spread. Often Brazil and South Africa are compared to each other because of their economic position in the world and also because of their similar political histories. This research compares the Brazilian and the South African HIV and AIDS National Strategic prevention policies and it also aims to find out why the HIV and AIDS prevalence rates took significantly different patterns in the respective countries.

The study includes a policy comparison and qualitative in-depth interviews with 14 organisation directors whose main focus is HIV prevention in Brazil and South Africa.

The mains findings revealed that one of the main reasons for the different prevalence rate in both countries was because the civil society in Brazil played a major role in pressurizing the government to respond to the pandemic, while in South African the civil society did not play a major role. The Brazilian government thus started responding to HIV at least 9 years before the South African government did. Also, the Brazilian National HIV and AIDS prevention policy has an action plan for each goal, while the South African Policy does not have action plans for their goals. The Brazilian policy is also decentralized to municipal level, while the South African policy is decentralized only to Provincial level. Another finding was that in Brazil the NGO sector was directly involved in formulating the policy while in South Africa the NGO sector was not.

In Brazil the respondents had a good knowledge and understanding of the policy, while in South Africa the respondents did not have a good knowledge of the policy.

In Brazil NGOs have formed partnerships between themselves in order to deliver better services and to make their voices stronger when pressurising the government. Respondents in Brazil also knew what other organisations were doing. In South Africa organisations did not know what other organisations were doing and the NGOs did not have strong partnerships between themselves.

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INTRODUCTION

1.1 Introduction

This chapter is an introduction to the research process and it presents the motivation for this research. It also gives a brief rationale of the research followed by the research topic and the main research questions and objectives. This chapter also clarifies and defines some of the research concepts.

1.2 Rationale and Significance

The first recognised case of AIDS was found in the USA in the early 1980's. A number of gay men in New York and California began to develop rare opportunistic infections and cancers that seemed stubbornly resistant to any treatment. At this time, AIDS did not yet have a name, but it quickly became obvious that all the sick men were suffering from a common syndrome. Soon after that, HIV and AIDS were discovered (Kanabus and Allen; 2009).

HIV is like no other virus, it attacks the immune system. In 1999 after a 10 year study, a group of scientists from the University of Alabama proved that the HIV virus came from chimpanzees and many theories have been written since on how the virus may have crossed from chimpanzees to the human body (Kanabus and Allen; 2009).

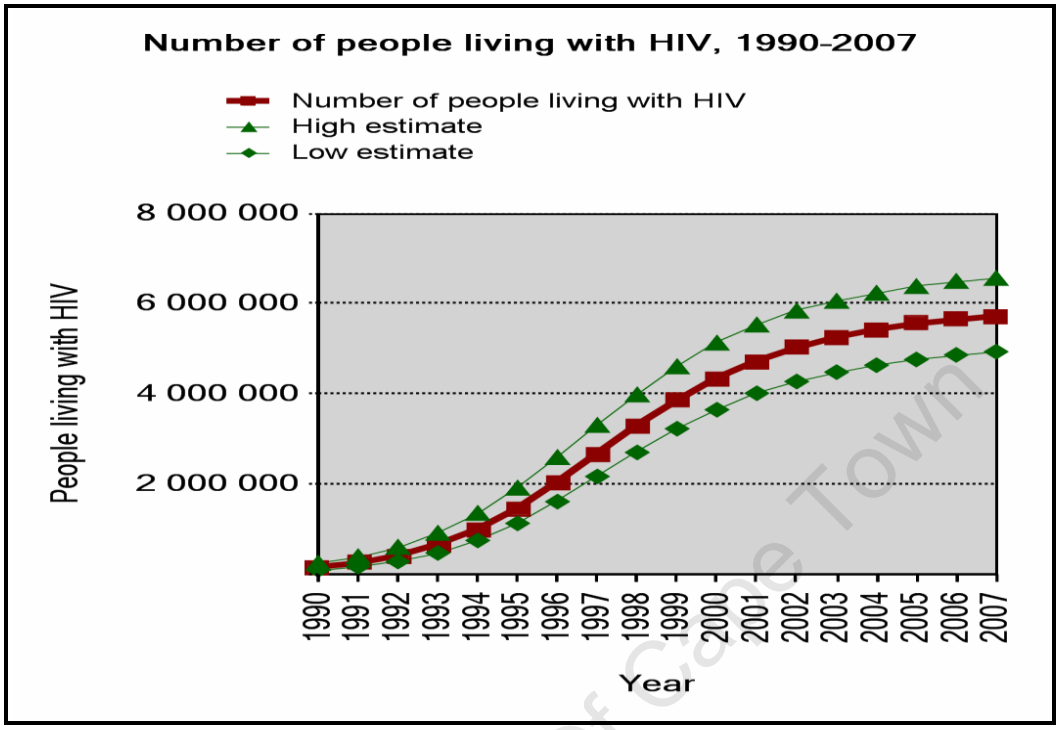
Southern Africa is the region with the highest prevalence level of the disease where it reaches between 10-20% of the population with some countries (Botswana, Lesotho, Zimbabwe and Swaziland) even higher. The HIV prevalence rate has declined in some countries, Uganda in the early 1990s, and recently Zimbabwe, Kenya and urban areas of Burkina Faso. These declines seem to be linked to changes in key sexual behaviours. Overall, HIV prevalence in this region appears to be levelling off, albeit at high levels (Department of Health; 2007:20).

1.3 Problem Statement:

Graphs 1 and 2 reveal that there is a huge difference between Brazil and South Africa regarding the spread of HIV and AIDS. Even though in 1990 both countries had a very similar infection rate, in the past years the HIV infection rate grew at a much higher rate in

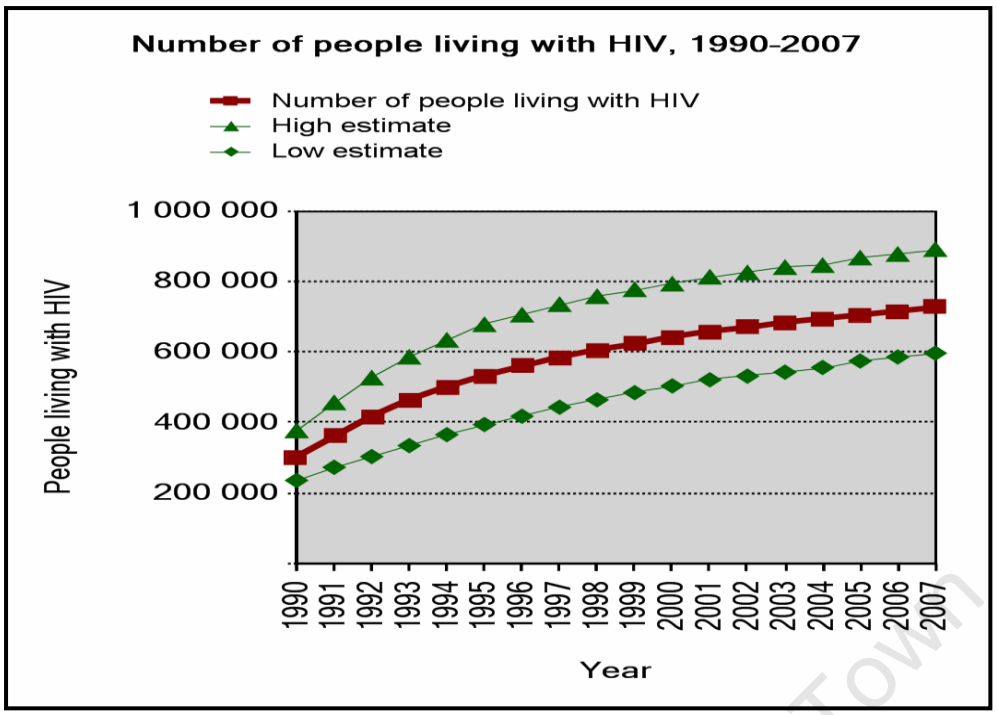
South Africa. Brazil and South Africa are very similar economically and politically and often they are compared to each other.

Graph 1: Number of people living with HIV in South Africa, 1990-2007



Source: UNAIDS; 2008: 4

Graph 2: Number of people living with HIV in Brazil, 1990-2007



Source: UNAIDS; 2008: 5

Both countries have a recent legacy of historical political oppression, both are considered as an emerging country and often both countries form economic agreements with one another. Table 1 shows a profile of both countries.

There are a number of sectors involved with HIV and AIDS in Brazil and South Africa. The three main sectors involved are the Government Sector, The Non Governmental Organisations (NGO) and the Private Sector. These partners are involved with HIV and AIDS across the globe and not only in South Africa and Brazil.

Within the government sectors of both countries there are different partners, mainly Health Department, Education Department, Social Development and also the Provincial and Municipal Departments. The South African Government has developed a plan to address the HIV and AIDS problem.

Table 1: Countries Profile

Country	*Republica Federativo do Brasil*	Republic of South Africa
Population (2007)	191 million	49 million
Urban Population (2007)	85.2%	60.2%
Unemployment rate (2007)	8.4%	23%
First democratic election	1985	1994
Gross Domestic Product per capita (2007)	6852 USD	5826 USD
Number of People living with HIV in 1990	300 000 (estimates)	160 000 (estimates)
Number of people living with HIV in 2007	730 000 (estimates)	5.7 million (estimates)

Source: United Nations; www.un.org

This plan is called "HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011" while in Brazil they have developed the *Plano Estrategico: Programa Nacional de DST e AIDS* which involves all of the Government Departments mentioned above. Within the NGO sector there are a number of stakeholders involved, which are different organisations trying to address the HIV and AIDS issue. Within the private sector there are a number of stakeholders as well which include hospitals and the pharmaceutical companies that produce anti-retroviral drugs and also companies that produce prevention material like condoms and funding organisations which provide money to NGOs. These stakeholders help to decrease and increase the problem at the same time.

The government is helping to address the problem and in some ways is also increasing the problem. Some of the ways in which the government is helping to reduce the problem is by providing services at clinics, providing free condoms, anti-retroviral drugs, providing information about the disease, creating subjects in school to educate the children about the disease and hoping to change youth's sexual behaviour, the government also subsidizes NGOs that address the problem (Department of Health; 2007).

Even though the governments are trying to reduce the spread of HIV and AIDS in South Africa and in Brazil, at the same time they were making mistakes which aggravated the problem. One of the mistakes was that each country had the same Strategic Plan to help prevent HIV and AIDS throughout South Africa and Brazil, respectively. As one knows, both Brazil and South Africa are very diverse countries, and by having one strategy that is effective in one area does not mean that this same strategy will be effective in a different area (Department of Health; 2007).

This research has compared the South African HIV and AIDS policy with the Brazilian HIV and AIDS policy and made clear the difference between both sets of policies. This research explores different organisation directors' views the spread of the disease depicted in graphs 1 and 2 and what South African and Brazilian organisation directors thought were the causes for the difference between them. This research also explored organisation directors' perceptions on the HIV and AIDS prevention policies in their countries and how they perceive the current economic crisis will affect the pandemic.

This study set out to determine why the infection rate for HIV and AIDS was significantly higher in South Africa compared to Brazil during the 1990 – 2007. This research brought new knowledge to the HIV and AIDS prevention field along with new ideas for policy makers to use to find better ways for prevention in both countries and will hopefully inform the Social Policy and management field.

1.4 Research Topic

A comparative study of South African and Brazilian HIV and AIDS rates and prevention policies.

1.5 Main research questions

The main research questions that were asked to the various organisation directors' interviewed as detailed below:

- What is the knowledge that organisation directors have about other organisations in the same field, and where do they get their funding from?
- What do organisation directors think were the causes for the spread in their countries?

- What are the organisation directors' perceptions on the HIV and AIDS prevention methods set by the policy? and
- What do organisation directors' think about the impact of the current economic meltdown on HIV and AIDS?

1.6 Objectives

- To determine and compare the knowledge which organisation directors in both countries have on other organisations and their methods of fundraising;
- To determine and compare what organisations directors' think were the reasons for the spread of HIV and AIDS in their countries;
- To investigate and compare organisation directors in both countries knowledge on the prevention methods set by the policy of their country; and
- To find out and compare what organisation directors in both countries think about how the current economic meltdown will impact on HIV and AIDS.

1.7 Clarification of concepts

AIDS: Acquired Immunodeficiency Syndrome: a viral disease that destroys the body's ability to fight infection.

HIV: Human Immunodeficiency Virus; the cause of AIDS.

ARV's: Anti Retroviral Drugs. Drugs used by those living with HIV to increase life expectancy and quality of life.

Care: The psychological support which people infected with HIV and AIDS get.

Civil Society: Non-Governmental Organisation's that advocate or provide services for the prevention of HIV and AIDS and for those living with HIV and AIDS

Organisation/ Clinic: A place that provides services for people living with HIV and AIDS.

Organisation Director: research respondents that participated in the research. In total there were 7 HIV and AIDS organisations in Cape Town and 7 HIV and AIDS organisations in Sao Paulo.

Prevention Methods: what has been done in order to stop the spread of HIV and AIDS.

NSP: National Strategic Plan

Treatment: The medical support which infected people predominantly through the use of ARV's.

VCT: Voluntary Counselling and Testing

1.8 Conclusion

This chapter has introduced the problem which was researched and motivated the reasons and significance for the research. The research purpose has been outlined along with the main questions and objectives. The following chapter will present the literature and policy review and it will give a brief history of HIV and AIDS in Brazil and South Africa.

CHAPTER 2

LITERATURE AND POLICY REVIEW

2.1 Introduction

This chapter reviews literature that is related to the main research topic. It gives the history of HIV and AIDS in South Africa and Brazil. It also gives a brief description of HIV and AIDS and the STI Strategic Plan for South Africa 2007 – 2011, as well as the *Programa Nacional de DST AIDS* (National Programme for DST and AIDS) in Brazil. This chapter also discusses prevention methods that have been used and the main causes of HIV and AIDS in both countries. It also states the theoretical framework that was used in order to analyse the research findings.

2.2 HIV and AIDS in South Africa

The first recorded case of AIDS in South Africa was diagnosed in 1982. Two white homosexual men were diagnosed with the virus. Both men were flight stewards and had returned from the United States of America. Research done in the early years among homosexuals in Johannesburg, showed that out of 250 blood specimens 12.8% were infected with HIV (Leake; 2009 http://www.avert.org/history-aids-south-africa.htm). This led many people to believe that AIDS was a homosexual disease leaving the population and government to ignore the risk.

Although initially HIV infections seemed mainly to be occurring amongst homosexual men, by 1985 it was clear that other sectors of society were also affected. Towards the end of the decade as the abolition of Apartheid began, an increasing amount of attention was paid to the AIDS crisis. The first black South African (a mine worker) to be diagnosed with AIDS was in 1987 (Leake; 2009).

By July 1991, the number of AIDS cases attributable to heterosexual transmission equalled those due to homosexual transmission. Since then the former has become by far the dominant transmission route (Leake; 2009).

Leake (2009) reported in his article that HIV and AIDS was placed on the government agenda in the late 80s and early 90s, but because of turbulent political times in South Africa, many conspiracy theories attached itself to the spread of HIV. Leake (2009) went further and said that an official publication of the African National Congress in exile alleged that HIV could have been developed in a laboratory, with others suggesting it was spread by police tear gas or through the deliberate infection of black sex workers.

In 1992 the National AIDS Coordinating Committee of South Africa (NACOSA) was formed. NACOSA encouraged new political parties, academics, business organisations, trade unions and civil society groups to help raise awareness about the virus. NACOSA's strategy was to address HIV and AIDS in all fronts such as prevention, research, human rights, counselling and welfare with the involvement of a number of government departments. South Africa's National AIDS Plan was adopted within months of the country's first democratic election in 1994 and there was optimism that an epidemic on the scale experienced by other African countries at the time could be avoided (Heywood and Cornell; 1998).

During the government transition period the HIV rate started to experience a rapid growth from 0.7% in 1990 to 2.2% in 1992 among antenatal clinic attendees (Leake; 2009 http://www.avert.org/history-aids-south-africa.htm). By 1994 the South African prevalence rate was still under 5%. After 1994 the action that had been so promising did not materialise and many explanations for the radical increase in infected people have been proposed. One of them was the bureaucratic restructuring of government which included the devolution of power to provincial government, which led to a lack of a shared, coherent strategy to combat HIV. Another reason that may indicate that HIV and AIDS was not a priority was that the AIDS Programme director fell under the Health Department instead of the Presidents' Office and this led to the belief that HIV and AIDS was only a Health Department issue and not an inter-departmental issue. The government claims that AIDS was not prioritized because there were many other issues to be addressed at the time (Leake; 2009).

In 1998 the fight for Anti Retroviral Drugs (ARV's) began after trial tests using Zidovudine (AZT) in Thailand proved to reduce the rate of Mother to Child Transmission (MTCT). The Health Minister at the time Dr Dlamini-Zuma justified that the government was more focused on the prevention of HIV rather than the treatment of HIV. The Treatment Action Campaign,

led by Zackie Achmat who later became a Nobel Prize winner led major protests against the government, to promote the allowance of the use and supply of AZT to the general public. In 1999 the Western Cape Government which was not under the control of the African National Congress (ANC), went ahead and started providing AZT to the infected population (Leake; 2009).

After the turn of the millennium the pressure on government to provide ARV's grew steadily stronger and in 2002, South Africa's National Economic Development and Labour Council (NEDLAC) formulated a National Draft Treatment Plan. Dr Manto Tshabalala Msimang, the Health Minister at time refused to sign the draft delaying and frustrating the process further. At the end of 2003 the Department of Health Services announced that they would provide ARV's to the population. The process was very slow and only in September 2004 was the guidelines for treatment issued. Six months later, in March 2005, the pharmaceutical companies that would provide ARV's were chosen. It was only in March 2005, that the National ARV's roll out began in South Africa (Leake; 2009).

In 2006 Health Minister Dr Manto Tshabalala Msimang was hospitalised and had to have a liver transplant which allowed Deputy Minister Nozizwe Madlala-Routledge to take her role as acting Health Minister of South Arica. With Deputy President Phumzile Mlambo-Ngcuka the pair was given the duty to develop an HIV and AIDS policy. Health Minister Nozizwe Madlala-Routledge and Deputy President Phumzile Mlambo-Ngcuka breathed fresh air into the South African National AIDS Council (Leake; 2009) and in 2007 the HIV and AIDS and Sexual Transmitted Infection Strategic Plan for South Africa 2007-2011 was launched. Some of the key objectives were to provide ARVs for 80% of people living with HIV and to reduce infections by 50% by 2011 (Department of Health; 2007:13).

Deputy Health Minister Nozizwe Madlala-Routledge was fired from her position by then President Thabo Mbeki in 2007 and in 2008 Minister Dr Manto Tshabalala Msimang was stripped of her place by President Kgalema Motlanthe who had replaced Thabo Mbeki after he was asked to step down when he lost the African National Congress (ANC) leadership to Jacob Zuma. President Motlanthe appointed Barbara Hogan as the new Health Minister but she did not complete her term either as she was replaced after the General Elections of 2009. The new president of South Africa, President Jacob Zuma was elected in April 2009 and appointed Aaron Motsoaledi as the new Minister of Health. Many activists were against

Hogan's departure as she was willing to work with civil society to achieve the strategic plan goals by 2011. The new Health Minister, Aaron Motsoaledi carried on the same work as Hogan, giving some hope for HIV and AIDS issues in South Africa for the years to come (Leake; 2009).

HIV and AIDS is a global problem. The Joint United Nations Programme on HIV and AIDS (UNAIDS) and the World Health Organisation (WHO) estimated the number of people living with HIV at the end of 2006 to be 39.5 million worldwide. While approximately 10% of the world's population lives in Sub-Saharan Africa, an enormous 64% of all people living with HIV live in this region. Even though HIV and AIDS is a global issue, by looking at the statistics we can see that the majority of people living with the disease live in a Sub-Saharan countries (UNAIDS; 2008:5).

By the end of 2007 it was reported that 5.7 million people in South Africa were living with the disease and around 1000 AIDS deaths occurred every day (UNAIDS; 2008:6).

2.3 HIV and AIDS in Brazil:

While many developing countries have struggled to contain the spread of HIV and AIDS, Brazil is seen as being a success story regarding the spread of the pandemic. By the end of 2007, 730 000 Brazilians were living with the disease, half the number predicted by experts in the previous decade (Galvao; 2002:4).

Like South Africa, the first reported case of HIV in Brazil was in 1982, even though the number of reported cases remained low, civil society (Non-government Organisations and citizens) were very out spoken and made sure that the government acted quickly and did not ignore the problem.

In 1985 Brazil restored democracy after 20 years of repressive military dictatorship. The National AIDS Programme (NAP) was created in partnership with the civil society. NAP's main purpose was to distribute information on HIV and AIDS especially for high risk groups. Homosexuals in Brazil are known as Men who have sex with Men (MSM), this group accounted for the majority of cases in Brazil. In 1985 the first HIV and AIDS NGO was

formed known as *Grupo de Apoio de Prevencao a AIDS* (GAPA). After that many other NGO's were formed (Galvao; 2002).

In 1988 the new Brazilian Constitution was adopted, which primarily focused on Human Rights. The Constitution also focused on the rights of people living with HIV and AIDS which prevented discrimination and preserved their rights to free health care. An important issue was addressed in the new Constitution which was the "Right for Health for all" and it stated it was the government's responsibility to deliver assistance and treatment. The Unique Health System (*Sistema Unico de Saude*) was developed and later implemented (Galvao; 2002).

In 1996 trials with ARV's showed good success among people living with HIV. At the same time civil society was pressurizing the government to provide free ARV's. In July 1996, the Brazilian Health Minister announced that ARV's would be provided free to all people living with HIV that required them (Galvao; 2002).

Many campaigns were launched during the 90's to prevent people getting infected. The World Bank had predicted that by 2000 Brazil would have 1.2 million people living with HIV and AIDS. However this figure remained around 600 000. In 2006 the mortality rate for AIDS related illness had decreased from 9.6 annual deaths in a 100 000 people in 1996 to 5.1 deaths. Even though Brazil managed to contain the epidemic to a certain extent, the rate of infection among women and people further in the North East of the country had been increasing (Pembrey; 2009, http://www.avert.org/aids-brazil.htm).

Graph 2 shows the trend of HIV in Brazil from 1990-2007. The pandemic has started to stabilize since 1997 at a substantially lower rate that of South Africa.

2.4 Theoretical Framework

This study uses the theoretical framework formulated by Waterston (1965), in which he mentions that there are different ways and approaches in development planning. These approaches vary according to the economic and political situation of the country and depend on what the plan for that specific country is. Based on his framework and the political situation in both countries the best approach for a development plan for HIV and AIDS

would be the Regional Planning. This is because in recent years planners have recognised that regions have peculiar characteristics and economic problems which need special consideration.

South Africa and Brazil both adopted a social development approach. This approach has a vision of the empowerment of people, humanitarian and democratisation of society focused in pro-poor change challenges. It tries to fight the unequal distribution of resources and it tries to improve economic, social and political development nationally and regionally, it encourages proactive involvements in the development social welfare. This approach enables the promotion of social and economic development, the participation of the socially excluded in development efforts to achieve tangible improvements in the quality of life for the people. The approach principles are, to promote social and economic justice, empowerment and collective action to promote public benefit, distributive and libratory values (Patel; 2005).

2.5 Policy

The National Strategic Plan (NSP) for HIV and AIDS in both countries adopted the mixed scanning approach. A mixed scanning approach is the mixture of the incremental and rational approaches. This approach recognises that the rational approach is not always practical and the incremental approach is limited and it is not advisable in some situations. So therefore this approach uses a bit of both.

Even though the NSP for HIV and AIDS uses mixed approaches it does not narrow the problem regarding geographical areas. In the researcher's opinion it should narrow the problem regarding geographical areas and then a number of alternatives and decisions could be made regarding the geographical area and its characteristics.

2.5.1 South African Policy: HIV and AIDS and STI Strategic Plan for South Africa 2007 – 2011:

This strategic plan was developed after the Draft National Strategic Plan of 2000 – 2005 which was never implemented and the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment. It represents the countries multi-sector response to the challenge of HIV infection and the wide-ranging impacts of AIDS.

The HIV and AIDS and STI Strategic Plan for South Africa 2007-2011 states 4 main areas of focus:

1. Prevention
2. Treatment, care and Support
3. Research, monitoring and surveillance
4. Legal and Human rights

(Department of Health; 2007:13).

This research will focus mainly on prevention policy and what is being done around this area.

The HIV and AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP for HIV and AIDS) uses a Medium Term Policy Cycle (MTPC). One of the reasons for being a MTPC is because it is a 5 year plan. It sets out national development policies and the measures to implement them, it also provides the overall objectives. One of the reasons for the government plan (NSP for AIDS and HIV) is to adopt a MTPC is because it makes the plan easier to manage and more transparent and accountable.

The main goals under prevention are:

- Reduce by 50% the rate of new HIV infections by 2011. The intention is to ensure that the large majority of South Africans who are HIV negative remain HIV negative.
- Reduce vulnerability to HIV infection and the impacts of AIDS;
- Reducing sexual transmission of HIV;
- Reduce mother-to-child transmission of HIV; and
- Minimize the risk of HIV transmission through blood and blood products.

(Department of Health; 2007:13).

2.5.2 Brazilian Policy: *Programa Nacional de DST e AIDS* (National Programme for STD and AIDS

The Brazilian NSP was developed in 2005 and has medium term goals and long term goals which are revised according to its criteria. It focuses on the decentralization of finance to State and municipal level, meaning that each State and Municipal Department must have their own strategic plan so that each State and municipality may receive finance from the National Department (*Ministerio da Saude*; 2005).

Brazil is a Federative Republic, meaning instead of having provinces, they have states, which are very similar to provinces. The difference is that states have more autonomy in formulating policies than do the South African provinces

The Brazilian National Programme for STI and HIV and AIDS falls under the Health Department which has a separate department that deals with STI and HIV and AIDS. However this department is only accountable to the National Health Department, so therefore on State and municipal level, the programme for STD and AIDS also falls under the Health Department (*Ministerio da Saude*; 2005).

The National Programme has 3 main overall objectives:

- To improve the efficiency and effectiveness of the National Programme both short term and long term;
- To reduce the infection rate of STD and HIV; and
- To improve the quality of life for people living with HIV and AIDS.

(*Ministerio da Saude*; 2005:5).

The focus on the Brazilian strategic plan will be mainly on prevention.
The Brazilian prevention programme has 7 goals which are:

- To reduce inequality related to race and ethnicity;
- To improve the quality of life of those living with HIV and AIDS, (Prevention programme with positive people);
- To prevent scholars from getting infected;
- Indigenous project (which tries to prevent the spread among Indians).
- To prevent homeless people from getting infected; and
- Prevention of drug users getting infected.

(*Ministerio da Saude*; 2005:24).

2.6 Organisation

The NGO sector has many leaders with political backgrounds. Julie (2009) reports that in the 90's the NGO sector across the world was flooded with funding, donors did not express much concern regarding accountability and transparency. As the years went by a more hostile donor environment emerged, where the emphasis focused more on accountability, transparency,

good governance and measuring the impact of the projects. Many of the frameworks for planning and accountability came from developed countries like the USA and Germany which NGO leaders in developing countries were not used to.

As a result many NGOs closed down as they could not adapt to the new donor environment and many international funders moved from donating money to NGOs and started donating money to government leaving a bigger burden on the NGO sector. This led NGOs to form partnerships and networks like SANGOCO in South Africa and *Forum de AIDS* in Brazil. However many of these partnerships and networks lost credibility as NGOs started competing with each other for funding (Julie; 2009).

A common factor regarding NGO leaders across the globe was that once a particular country reached democracy many NGO leaders left their NGOs to join the new democratic government in that specific country. Thus new leaders in the NGO sector that had left the private sector to run these NGOs, did not have the experience in the NGO sector and did not fully grasp the sector's history specific to the country (Julie; 2009). The new democratic government also put an extra burden on NGOs, as they viewed NGOs as a service delivery agent.

2.7 Prevention

The main prevention method in South Africa is education. The most prominent prevention program in South Africa is called Lovelife, which mainly targets young people.

Lovelife was launched in 1999 and its main aim is to reduce teenage pregnancies and sexually transmitted infections among young people. The campaign uses media as the main tool to transfer information. Lovelife also has call centres, clinics and youth centres. Lovelife provides services for those with HIV and AIDS or for those that need information and guidance about the disease. The programme also travels to some remote areas, but is mainly based in larger urban areas of South Africa (Leake; 2009).

There were other programmes used in South Africa which tried to inform and educate the population about the disease, but most of these programmes were media based. The soap

opera “Soul City” and “Khomanani” were campaigns that used the media to inform about the disease, promote condom usage and promote testing (Leake; 2009).

Other forms of prevention used in South Africa and Brazil which is stated in both countries NSP are by condom distribution. Both governments distribute millions of condoms across the country and use media as a tool to promote condom usage.

2.7.1 Civil Society

Civil society is known to have played and is still playing a major role in the fight against HIV and AIDS. In Brazil civil society is known as one of the greatest contributors to the success in the fight against AIDS. In Brazil civil society has had an active participation in governmental decision making regarding HIV/AIDS policies and in the democratic constitution of 1988. In Brazil there were many organisations that advocated for a better response from the government. People from different sectors like researchers, social workers, members of the community, people living with HIV and AIDS and many others got together and advocated for a better response from government, especially for the treatment of those living with HIV and AIDS (Parker; 1999).

In South Africa, it is known that one individual played a major role in advocating for a better response from the government. This person was Zackie Achmat, a co-founder in 1988 of the Treatment Action Campaign, who advocated for free treatment for all (Merson, O’Malley, Serwadda and Apisuk; 2007). In South Africa it is not known that other organisations were highly involved in advocating against the government. While in Brazil many organisations got together and advocated against the government for a better response.

2.8 The causes of Transmission of HIV and AIDS

When one talks about how HIV is transmitted it can be said that a majority of people know how the disease is transmitted. HIV is mainly transmitted by sexual intercourse, from mother to child, or through the exchange of blood for example blood transfusion or when needles are shared (Department of Health; 2007).

What many people do not look at, is why the disease is still being transmitted. Many reasons have been given for its continued spread. This includes:

- Low Education Level;
- The low status of women;
- Poverty; and
- Cultural factors.

All these factors are linked to each other and it can be said that one causes another.

In both countries the researcher could not find programmes that focused on parent education. Research done by De Bruin, Downs, Fischhoff and Palmgren (2007) showed that adolescents where the parents are less educated are more likely to be sexually active from a younger age. The research also showed that adolescents whose parents were less educated, did not have a greater knowledge about HIV and AIDS. This research also showed that adolescents who were less educated or that got lower grades at school knew less about HIV and AIDS and were not aware of the best forms of prevention.

Sneed (2008:76) showed that parent-child communication was efficient method in transferring knowledge about HIV and AIDS and preventing their children from initiating sexual intercourse from earlier age. Sneed's study showed that over 70% of those who communicated with their parents about their relationships discussed sexually transmitted diseases.

Sneed (2008) argues that adolescents that communicated about sex with their parents are more likely to be sexually active. However it can also be said, that those who communicate with their parents are more likely to be at a lower risk of contracting sexually transmitted diseases, as they know more about the risks and know how to protect themselves (Sneed; 2008). In her research, she showed that adolescents were more comfortable discussing sexual topics with their mothers instead of with their fathers (Sneed; 2008). This however is in contrast to what happens in Africa, as women do not have the autonomy to discus these topics and due to cultural practices, they tend to be less educated than men.

Sneed (2008) also argues that messages of abstinence may influence adolescents to delay the time of first coitus. It was also found in the study that adolescents that received direct messages from their parents that they should not have sex were less likely to have had sex.

Chinsemby, Siziya, Muula and Rudatsikira (2008:134), indicated a correlation between drinking, smoking and sexual practices. Their research showed that adolescents who drink, smoke or take drugs were more likely to be sexually active than those who did not do any of these things. This may be because 50% of adolescents replied that alcohol facilitated the communication with peers of an opposite sex.

It has also been argued that students who perceived they had adequate parental supervision in their free time were less likely to have sexual intercourse than those without supervision. Parental supervision has been documented to be proactive to prevent other unhealthy behaviours in diverse settings (Chinsemby et al; 2008).

Research done among soldiers in Brazil in 2002, showed that young men between the ages of 17-21 with a higher level of education and a higher level of income tended to use condoms more often those with less than 8 years of education. The research also showed that young men with higher levels of education started their sexual life at older ages than those with less than 8 years of education (*Ministerio da Saude*; 2005:7).

Another main prevention method is the prevention of mother-to-child transmission (PMTCT) of HIV. This form of prevention was first released to the public at large in 2003 after much debate. It was approved by the South African government that pregnant mothers living with HIV and AIDS could be treated with nevirapine and AZT (the drugs which prevent mother-to-child transmission) (Thorn; 2008).

The mothers were advised not to breast feed their babies. However this form of transmission is still very high in South Africa. In 2006 it was reported that 64 000 babies were infected via mother-to-child transmission (Leake; 2009:http://www.avert.org/history-aids-south-africa.htm).

Up to 2005 there were 9000 reported cases of mother to child transmission in Brazil. Although 95% of the pregnant women in Brazil attend antenatal clinics, only 65% of this population had an HIV test and only 52% got their results before their children were born. In the northern region and north east region of Brazil these statistics were lower, being only 44% of the pregnant women who did a HIV test while they were pregnant and only 24% of

those who did the test got their result before the child was born (*Ministerio da Saude*; 2005:12).

One thing that may be leading to an increase in risk behaviours is the efficiency and availability of ARV's. In a study done by Cassell and Halperin (2006), he showed that because of the easy access to free ARV's and the efficiency of the ARV's, people get involved in more risky behaviours, like sharing needles or having sex with no protection.

Another sexual phenomenon known as "Bare Backing" has been occurring. This is when people interact sexually without using a form of protection. A report by Bouer (2002) showed that many people said that using a condom decreases sexual pleasure and because of the efficiency of treatment, people are no longer scared of not using protection.

In other research done by Goodroad, Kirksey and Butensky (2000), they showed that people were attending "Bare Back" parties. At these parties it was common knowledge to the participants that one or more participants were infected with HIV. The mass "orgy" provides participants not only with sexual pleasure but also with the adrenaline rush of possibly being infected. In their research they also showed that people have grown tired of years of prevention methods, messages demanding condom use, abstinence and the constant drive by the media and other sources about the dangers of HIV and Aids. These "Bare Back" parties and events could be a warning that people are growing tired of safer-sex.

2.8.1 Support for people living with HIV and AIDS

In South Africa and Brazil the main treatment for those living with HIV and AIDS is with ARV's. This form of treatment was implemented at the end of 2003 in South Africa (Leak; 2009) and in 1996 in Brazil (Galvao; 2002). Before this, ARV's were only available for those who could afford to buy the drugs which were expensive.

The South African government reported that in February 2008 around 418 000 people were receiving the treatment which accounted for 29% of the population living with the disease (Leake; 2009:http://www.avert.org/history-aids-south-africa.htm).

Brazil was the first developing country to start distributing free ARV's to its population. In 2007 it was reported by the Brazilian National Programme for STD and AIDS that 180 000 people were enrolled in the government for free treatment programme. Also have to remember that in Brazil there are many people getting ARV's from private medical practices (Galvao; 2002:14)

Other forms of support which people living with HIV and AIDS get are through family members. In many cultures families often take on the responsibility to care for a sick member of that particular family (Ajala and Adejumo; 2007). These family members are responsible for providing emotional support and financial support for the sick person, thus increasing the burden on the family. However once the family members discover that the sick person has HIV and AIDS they may abandon that person as HIV and AIDS is know as an immoral disease and it brings shame to the family (Ajala and Adejumo; 2007).

HIV and AIDS are related both spiritually and socially. It is a social disease due to its association with sexuality and spiritual due to the people's belief that it is a punishment against adultery. Because of this it can be said that many people suffering with the disease leave their home towns and move to bigger urban areas where they seek treatment and also to avoid their family and shame and embarrassment. Once these people move to urban areas they suffer huge psychological distress as they are alone to deal with the stress of dealing with HIV and AIDS. When they become to sick to work, they often experience financial difficulties, thus compounding their stress (Ajala and Adejumo; 2007).

Other reasons for sick people moving to the urban areas is the availability of more Non-Governmental Organisations, who provide services for people living with HIV and AIDS, religious institutions and hospitals (Ajula and Adejumo; 2007). This may explain why in both countries the highest prevalence rates are in urban cities.

2.8.2 The status of women

Women bear the brunt of the epidemic of HIV and AIDS. Of those living with HIV and AIDS, women account for 55% of the total population with the disease in South Africa (Shisana, Rehle, Pillay, Zuma, Puren and Parker; 2007:194). This phenomenon is more pronounced in the age groups 20-24 years and 25-29 where the HIV prevalence rates are 23.9% for women to 6.0% for men and 33.3% for women to 12.1% for men, respectively

(Shisana et al; 2007:194). The peak age for HIV infection in women is 25-29 years while for men it is the 30-35 years age group (Shisana et al; 2007:194).

In Brazil during 1980-1990, there were less women infected compared to men, for every 2 men infected there was 1 woman (*Ministerio da Saude*; 2005:10). Research done in 1998, showed that for every 14 women infected, 10 men were infected, meaning that the infection rate among women increased significantly (*Ministerio da Saude*; 2005:10). One of the reasons is that in the early years mainly homosexuals were infected with HIV.

There is no scientific evidence as to why women have a higher prevalence than men. Some academics say women have a higher prevalence because of lower levels of education compared to men and that this may be one of the reasons that women are more vulnerable to contract HIV. Women also have less access to and control of productive resources outside their home, in most cases women are required to run and care for the house hold while the men leave home to work. Men therefore supply these homes with the financial means. If this process is broken for example if the man passes away or he divorces the women, it can bring huge distress to the woman (Karim and Karim; 2005). Karim and Karim (2005) also shows that there is a link to why women who have low economic statuses are at an increased risk of being infected with HIV. They argue that as some women have no means of income she may rely on sexual work to guarantee a form of income.

Leclerc-Mandlala (2002) argues in her article that in a study done in St Wendolins a neighbourhood near Durban, unmarried women are drawn towards sex for material and economic advantage. She says that women exchange sex for material things and also to secure or to acquire a job. She intimates that women from that area finds in a man a way to guarantee money for food, school fees, rent and clothes (Leclerc-Mandlala; 2002).

Karim and Karim (2005) give the impression that women exchange sex for material value because of political heritage. One of the reasons may be because of the past political system where many women did not have jobs which led to poverty. So the only way in which women could guarantee their survival was through selling sex or through sexual behaviour which rewarded them materially (Dorothea and Coetzee; 2004).

Gender inequality also makes women more vulnerable than men. The low status of women does not allow negotiating their sexual behaviours. In many of cases they do not even choose with whom they are going to have sex and women are subjected to violence and they are not allowed to discuss condom use with their partners (Dorothea and Coetzee; 2004).

2.8.3 Poverty

It can be said that poverty is one of the main reasons for the spread of HIV and AIDS. The low status of women is linked to poverty. Sub-Saharan African countries bear the biggest burden of the pandemic. These countries are considered as developing countries. Many of the people living in these countries do not have access to proper education, water, sanitation and health services (Department of Health; 2007).

Also political regimes in some countries (Apartheid is an example) did not allow the majority of people proper education, both secondary and tertiary. These regimes also allowed the decay of rural areas where the majority of people lived by not developing these areas (Department of health; 2007).

After Apartheid was abolished, a huge migration of labourers seeking work in the countries bigger cities occurred. These labourers moved away from the "homelands" because these areas were under developed and did not have enough jobs. Mainly men moved to the cities looking for work, leaving their families in the rural areas. Money earned while living in or around the cities would be sent back to the "homelands" where the woman remained taking care of the homestead. Informal settlements sprang up almost over night at the out-skirts of major cities all around South Africa. Men living in these settlements developed new relationships (adultery) or had sexual intercourse with sex workers. The spread of HIV and AIDS was rapid among these new communities. When the migration workers returned home they passed the disease to their wives, as their women do not have the status to discuss safe sex. This form of transmission is still happening today (Department of Health; 2007).

The high migration rate also brought other issues, like the increase in informal settlements. These informal settlements are not provided with proper sanitation, schools and health care. Usually these areas are of high density, there are many people living in the same dwelling and usually this dwelling is small. Because of space constraints within the informal

settlement itself, many families would share a shack and as many as 15 people would live under the same roof. Together with over crowding, lack of clean water and very poor sanitation standards, many people suffered from Tuberculosis (TB) (Department of Health; 2007).

The same issues that plagued woman in the rural areas, unemployment and gender equality, seeped into the informal settlements. Women and children became sex workers, as this was the only way to earn an income. It also has been reported that some clients pay more to have sex without a condom (Department of Health; 2007).

Poverty also affected the ARV's treatment, before only those who had money were able to afford the drug. Today the ARV's are distributed by the government. However for the drug to be effective the person needs to have a healthy diet, which in most cases is not possible as either they are too sick to work or they are unemployed. So they either have to rely on family members or communities to take care of them (Ajala and Adejumo; 2007). The distribution of ARV's still mainly happens in the urban areas, those living in the rural areas do not have access to ARV's as easy as those living in urban areas. This may also explain why there are more people living with HIV in the urban areas.

2.8.4 Misconception of HIV

One factor that may have increased the spread of HIV is the misconception people have about HIV.

One factor in South Africa which may have led to the increase in the infection rate and debunks the prevention methods in place is what some public figures said about the disease. Some examples are when former president Thabo Mbeki said that he has not met anyone who has died of AIDS (Murphy; 2003). Thabo Mbeki also questioned the static's of HIV in South Africa and said that poverty was a cause of immune deficiency and on the dangers of ARV's, together with government stalling on the roll out of AZT to prevent transmission of HIV from pregnant mothers to their babies (Fassin and Schneider; 2003)

When then the African National Congress deputy leader Jacob Zuma said that he showered to prevent infection after having had sex with an infected woman. He also said that he was

prepared to marry the woman who he had been accused of raping (Hollowed; 2008). Jacob Zuma is also involved in a polygamous relationship. These two political leaders are well regarded among the population at large and the population tend to follow their words. As well as these two incidents among others, did not help in the prevention of the disease, it actually helped increase the problem.

While in South Africa some political leaders denied that HIV and AIDS was a issue, in other parts of the world, public figures like Rock Hudson (America actor), Cazuza (Brazilian singer), Betinho (Brazilian political activist), Freddy Mercury (British singer) disclosed their HIV status to the whole world and informed the people about the new disease (Merson et al; 2007).

In Brazil one misconception which may have helped the spread of the pandemic in the early years, was that the disease was known as a gay plague, meaning that only gay men could be infected, leaving many of heterosexual people unaware of the risk behaviours (Merson et al; 2007).

2.8.5 Cultural Factors

One factor that has helped the spread of HIV and AIDS across the world is cultural factors. Researchers have shown a huge correlation between HIV and AIDS and multi-concurrent partners. In many African cultures polygamy is accepted. However Halperin and Epstein (2007) mention in their research that African men do not have more sexual partners than other men across the world. However in the same research they have shown that African women tend to have more sexual partners than Western or Asian women and usually these relationships often include an element of sexual-economic exchange, related to issues of gender and income inequality, sexual culture, poverty and the globalisation of consumerism.

In Halperin and Epstein (2007) research also shows that people tend not to use condoms in long term relationships. This makes a huge difference when comparing to other countries, as in many African cultures polygamy is accepted, therefore meaning that one man might have a long term relationship with more then one women, therefore it means that he may not use a condom in any of his relationship, thus increasing the risk of contracting an STD.

Another factor which does not help the treatment of HIV and AIDS is herbal treatments. In many cases people living with HIV and AIDS rather rely on traditional treatments instead of ARV's. (Mills, Foster, Van Heeswijk, Phillips, Wilson, Leonard, Kosuge and Kanfer; 2005).

Some traditional healers believe that the disease is curable and that they can cure the disease. Sometimes they prescribe people living with HIV and AIDS to do some rituals and sometimes traditional healers say that if people living with the disease have sexual intercourse with a virgin then he will be cured. This has been reported to increase the abuse in women (Ajala and Adejumo; 2007).

2.8.6 Stigma

The stigma attached to HIV and AIDS impacts on the prevention and support and care of people living with HIV and AIDS. In many cases the disease is not talked about. In some areas of Nigeria those living with the disease are abandoned because they believe that the person is being punished for adultery and it brings shame to the family and community (Ajala and Adejumo; 2007).

Research done by Riffe and Fouche (2007:25) shows that AIDS caused 73% of female and 61% male death at the ages 15-44 years. However the official data reported that only 40% of the deaths were AIDS related in South Africa. In their study only 2 out of 42 people reported that they either have been to a funeral of someone who died of AIDS or had known someone who died of AIDS. People reported that they had been to a funeral where they did not know the cause of the death of the person, even though the cause of death may give the impression that the person died of AIDS, it is not spoken about in public that the person died of AIDS.

Some reasons why people do not talk about AIDS is because when a person is diagnosed with the disease he is talked about everywhere in the community and if the family admits that the person died of AIDS they are subjected to be isolated from the community. Another explanation is avoidance, people tend to avoid contact with sick people or another explanation is denial. South African people still deny the impact of AIDS in the country. Another explanation for people not knowing anyone with AIDS is ignorance of the disease and symptoms. If one does not know about the disease they may think it is something else, like intentional poisoning (sejeso) or some other natural forces (Riffe and Fouche; 2007).

This stigma prevents effective prevention methods and also prevents people from going in for treatment.

2.9 Conclusion

This chapter has presented related literature to the main research topic, it also gave a brief - description of the HIV and AIDS and STI strategic plan for South Africa 2007 – 2011 and the *Plano Estrategico Programa Nacional de DST e AIDS* and what are the main prevention plans are and what are the main causes of the spread of HIV/AIDS are. It also gives the theoretical framework intended to be used during this research project. The next chapter will present the methodology used in this research.

CHAPTER 3
METHODOLOGY

3.1 Introduction

In this chapter the researcher will describe the qualitative research design that was used during this research study. The sampling method will also be described with the data collection the method that was used to analyse the data. Ethical considerations are also accounted and the reflexivity reflects on the researcher's feelings that he experienced during the process. This chapter of the research also will state the limitations regarding each of these techniques and what the researcher did to overcome these limitations.

3.2 Research Design

The research that was conducted was qualitative research, which sought to understand the meaning that the respondents gave to the exploration of why Organisation Directors (from now on will be called respondents) thought the HIV and AIDS pandemic took different growth patterns between Brazil and South Africa. The reason for choosing a qualitative research was because the topic of the research was sensitive and therefore more in-depth data was needed.

This research is also a comparative study which has looked at the HIV and AIDS policies and prevalence of Brazil and South Africa. This research includes secondary data analysis of articles and policies which have been formulated by the respective governments in order to try to reduce the rate of infection of HIV over the years.

This research was conducted in a natural setting. The researcher went to organisations, which specialised in addressing HIV and AIDS prevention in the greater area of Cape Town and in Sao Paulo. These organisations were selected by acceptance as some organisations refused the researcher's presence. By acceptance the researcher means that first he contacted each organisation and explained what the research was about, then if the respondent agreed and interview was scheduled. All interviews were conducted with permission from the person willing to participate.

In this research, the researcher was interested in describing the actions of the respondents in greater detail and then attempting to understand those actions in terms of the actor's own beliefs, history and context. The researcher used an inductive approach, where he found related literature, he also looked for information and statistics on the HIV and AIDS in both countries before doing the research (Babbie & Mouton; 2005). The researcher was interested in finding out what was done differently in Brazil than in South Africa.

3.3 Sampling and population

According to Babbie & Mouton (2005) sampling is a process of selecting observations. Specific sampling techniques allow us to determine and control the likely hoods of specific individuals being selected for the study. There are two types of sampling, probability sampling and non-probability sampling.

Probability sampling tries to give every person forming part of the population an equal chance of being part of the research without any bias. There are different methods in probability sampling in choosing the respondent, which involves random sampling, systematic sampling, stratified sampling and implicit stratification in systematic sampling (Babbie & Mouton; 2005). In this research the researcher did not use this kind of sampling, as there were a limited number of organisations.

The other type of sampling is non-probability sampling. Non-probability sampling is often conducted in situations where one can not select the kinds of probability samples used in large-scale surveys. There are five types of non-probability sampling which are reliance sampling, judgmental sampling, snow ball sampling, quota sampling and purposive sampling (Babbie & Mouton; 2005).

Because the topic of this research is sensitive, the researcher used the purposive sampling method, where firstly he had to find organisations that address HIV and AIDS prevention and that were willing to participate in the research. The other type of sampling which may have been used was snowball. According to Babbie & Mouton (2005) snowball sampling is used when members of the population intended to research are difficult to find. In this case it was difficult to find organisation directors willing to participate in the research.

Snowball sampling refers to locating someone who is willing to participate in the study and then asking him to refer you to someone else that he knows that also is part of the population intended to be studied and might be willing to participate in the study (Babbie & Mouton; 2005).

The researcher intended to use a sample of 20 organisations to be interviewed in the study, 10 organisations in Cape Town (South Africa) and 10 in Sao Paulo (Brazil). In the end the researcher interviewed 14 organisations, 7 in Brazil and 7 in South Africa. The reasons for interviewing 7 organisations in South Africa was because 3 organisations refused to take part in the research and in Brazil 2 organisations refused to take part in the research and the other respondent was not in Brazil at the same time as the researcher. The researcher also conducted a pilot interview before interviewing all of the organisations.

A list of all organisations in Cape Town was selected from SANGONET directory. A total of 10 organisations were selected in Cape Town, which covered the entire population of organisations whose main focus is on HIV and AIDS prevention. So therefore this research covered 70% of the total population which is a good representation.

SANGONET is one of the only organisations in Africa that provides information and communication technology (ICT) services in order to assist and broaden the NGO sector. SANGONET continues to receive local and international recognition for its services. Information on SANGONET can be found on www.sangonet.org.za.

Organisations interviewed in Brazil were selected from the *Forum de ONGs AIDS do Estado de Sao Paulo* (AIDS NGO Forum of the State of Sao Paulo), the total population of organisations in Sao Paulo that focus on HIV and AIDS prevention were of 12 organisations. So therefore this research covered 58% of the total population, which gives a good representation.

The forum is an organisation which tries to bring all NGOs the deals with HIV and AIDS issues from the state to Sao Paulo together. More information on the Forum can be found on www.forumaidssp.org.br.

3.4 Data Collection

The way the researcher conducted the interviews were face to face in-depth interviews. According to Babbie & Mouton (2005) the in-depth interview is a process where the researcher is interested in the content of the conversation. At an in-depth interview the researcher asks occasional WHY questions. During an in-depth interview, the researcher will come to know more about the way in which the respondent's opinions came into being, rather than what exactly his opinion is. An in-depth interview is an advanced and complex technique and is not recommended for people who have not had much interviewing experience or some training in the communication skills.

A face to face interview sometimes requires more then one interviewer. In South Africa face to face interviews are very popular because of the high level of illiteracy. Face to face interviews have some rules, one of them is to be able to speak the home language of the respondent, it is also good to match the ethnicity, gender and age of the respondent, thereby making them feel more comfortable during the interview.

The interviews were semi-structured interviews. Semi-structured interviews are useful when wanting to gain a detailed picture of someone's perceptions and beliefs on specific topics (Babbie & Mouton; 2005). The semi-structured interview was developed by the researcher and can be found in appendix 1.

This kind of interviewing allows more flexibility as it allows the respondent to choose where they would like to start. Therefore, semi-structured interviews are more accommodating as they allow the respondent the opportunity to introduce their own themes and ideas during the interview schedule.

The researcher used an electronic recorder to record the interviews. He also had a note pad to make some notes on the interview and also to write some points of the interview in case the respondent did not give consent to use an electronic recorder. In only one case the interviewee did not allow the researcher to record the interview.

The other form in which the researcher collected data was by looking at secondary research which has been written on the policy. The researcher also analysed the policy theories which

have been set in how to draft a policy and see to what extent has this policy followed the steps.

3.5 Data Analysis

Analysis and interpretation can be done utilizing two methods, inductive and deductive (Babbie & Mouton; 2005). For the purpose of this research an inductive approach was used. An inductive approach is when data is generated through previous literature and then correlated with the collected data gathered through the interviews. The researcher tries to find a relationship or pattern between the two data sets.

During data analysis there are two central decisions which are of concern in how the data should be assembled and how the data is going to be analysed. There are three strategies in data analysis when doing qualitative research which are constructive typologies, analytic induction and grounded theory.

To analyse the data the researcher used Tesch (1990) methods analysing data. This approach involves first reading through all transcriptions. After that, the researcher read through the transcription one more time, but this time the researcher asked questions and made notes using the NVIVO computer package. The researcher created themes which related to the objectives of the research. The researcher used the NVIVO computer package to do the coding of themes, categories and sub-categories. This computer package allowed the researcher more flexibility in arranging and rearranging themes, categories and sub-categories. Once the main themes, categories and sub-categories were decided, a framework for analysis was formulated which can be found in appendix 2.

3.6 Ethical Considerations

According to De Vos (2002) ethic is a moral principle which is suggested by an individual or group, is subsequently widely accepted and which offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents.

Before conducting the interview the researcher asked for consent from those participating in the study. Other ethical considerations that the researcher followed was to do no harm to the participants that will be researched. According to De Vos (2002) the ethical principle of no

harm to subjects requires that the participants in the study are protected from harm, both physical and emotional during the research. The researcher did not obligate any respondent to answer any questions that they do not want to respond too. The interviewees were informed what the interview and research was about before they were interviewed.

The researcher used an electronic recorder during all the interviews and only in one case he used a note pad. The electronic recorder was used with the knowledge and expressed consent of the participants (De Vos; 2002). So therefore the researcher asked each participant for their consent to use an electronic recorder.

According to De Vos (2002) the participant's right to self determination should be respected and they have the right to decide when and to whom their views are revealed. Therefore had an interviewee wish to exclude a comment that he or she made from the recording the researcher will respect that decision.

The researcher is ethically obliged to ensure that he has the adequate skills and competence to undertake the research. The researcher informed the participants about his credibility (De Vos; 2002). Therefore the participants were informed that the researcher is a Masters student, and that the purpose of interview was for his masters' research dissertation.

Other ethical considerations the researcher followed was not to try to manipulate the interview to fit his own assumptions. The researcher also followed the professional code of ethics which states the importance of privacy, anonymity and confidentiality which is emphasised in the research. The anonymity and privacy of the participants were ensured as the interviewees will not be identified. Pseudonyms were used in order to guarantee privacy and confidentiality.

Finally the researcher was ethically obliged to ensure the final report is written as accurately and objectively as possible to ensure that the findings were not misunderstood. In accordance with the ethical principles of research the participants should be informed about the outcome and findings of the study (De Vos; 2002). Therefore, feedback will be given to the organisation/clinic if requested once the researcher is finished.

3.7 Reflexivity

The researcher's current fear was that he might not have gotten enough participants to be interviewed. The researcher also feared that participants would not be willing to participate as it is a sensitive subject. The researcher also worried that he will not have enough time to finish this research project, as the researcher only had 6 weeks in Brazil to conduct the interviews. Fortunate then fear proved unfounded.

3.8 Limitations

3.8.1 Research Design

Qualitative research design has inherent limitations in that it relies strongly on the subjectivity of the researcher. All qualitative research is time consuming and may take away some of the participant's interest. Other limitations of the research design are that by only using the qualitative method, it is only possible to cover a small portion of the population.

3.8.2 Sample

The sample may have been small; however the sample covered a good representation of the population.

3.8.3 Data Collection

One of the limitations with the data collection was that the respondents felt intimidated by the electronic recorder which may have limited or reduced the richness of the data. Also the semi-structured interview may have been too long, which may have resulted in fatigue of the respondents. In South Africa organisations did not want their name published or mentioned in the research.

The researcher overcame this by making each participant relaxed before the interview began. The researcher also conducted a pilot interview where he could time the length of the interview and also what and how questions could be changed to fit the researchers purpose in a better way.

3.8.4 Data Analysis

It is a very complicated process that may have been affected by the bias of the researcher.

3.8.5 Self

The researcher may have carried his own bias and affected the research process, also the researcher does not speak any other official language besides English and Portuguese, some of the respondents were Afrikaans.

To overcome this, the researcher re-phrased every question that the interviewee did not fully understand. During this research process there were only 2 respondents whose first language was Afrikaans and both of them spoke English well, all of the other interviewees were either English or Portuguese speakers.

3.9 Conclusion

This chapter has outlined the methodology used during the research process. For this particular research a qualitative approach was used. In this chapter the researcher has outlined the sampling method used during the research and the ways in which data was collected and the ways in which the data has been analysed. The ethical considerations have also been stated as well as the research reflexivity. The researcher also outlined some of the limitations regarding each technique that happened during the research process. The next chapter the researcher will discuss the findings of the research.

CHAPTER 4

DISCUSSION OF FINDINGS

4.1 Introduction

This chapter aims to explore the findings of the interviews conducted with 7 organisations in Brazil as well as the 7 organisations in South Africa. The profiles of the organisations are shown in table 2. Some repetitive ideas were found through the interviews and have been listed as themes, categories and sub-categories which are shown in the framework of analysis in appendix 2. Some direct quotes have been used in order to clearly illustrate each of the themes. Individual views which were different from the majority of the respondents have also been included so discrepancies can be shown. Patterns between thoughts expressed by the interviewees and other literature on the same topic are examined and it is indicated whether or not their views reflect previous literature.

4.2 Organisation Profile

Table 2: Organisation Profile

Name Of Organisation	Country	Year that was established
Organisation 1	Brazil	1994
Organisation 2	Brazil	2002
Organisation 3	Brazil	1986
Organisation 4	Brazil	1997
Organisation 5	Brazil	1995
Organisation 6	Brazil	2000
Organisation 7	Brazil	1985
Organisation 8	South Africa	2001
Organisation 9	South Africa	2001
Organisation 10	South Africa	1994
Organisation 11	South Africa	2003
Organisation 12	South Africa	2001
Organisation 13	South Africa	2004
Organisation 14	South Africa	2001

4.3 Organisation

Organisation is the entity which provides the social service.

4.3.1 Knowledge of other organisations

Knowledge of other organisations is to determine how much respondents know about the services of various organisations in the HIV and AIDS field.

4.3.1.1 Brazil

All 7 respondents in Brazil knew at least one organisation that had the same focus of services as them.

> "There are other organisations that work with HIV, but working on the same area as us there are other two organisations" (Organisation 2).

> "… that works with prevention there are many, but that work with prevention and that provide psychological services, I think there is one more, they are very strong with prevention, they work with professionals like teachers, it is an old organisation, so there are them and us, but there are 179 organisations that are registered with the Sao Paulo Forum for HIV and AIDS NGOs" (Organisation 1).

One aspect which the researcher noticed was that most respondents in Brazil were acquainted, as they queried if the researcher had interviewed the others. By knowing what other organisations are doing it brings about better coordination and rules out the possibility of two organisations doing the same project in the same area. This concurs with Julie (2009), where he mentions that NGOs should form partnerships to help each other survive as this will also aid in improving service delivery.

4.3.1.2 South Africa

In South Africa all 7 respondents mentioned that perhaps there are other organisations which focus on the same areas as themselves. Two respondents confirmed knowledge of other organisations which covered the same work as they did, whereas the other 5 respondents considered themselves unique.

> "I think we are unique in a sense, because we work nationally we even worker broader, and the people that we have communication with, and make use of service is wider then South Africa, so there are other countries in Southern Africa, and we have a specific lead in what we do" (Organisation 9).

> "That may be bias in my thinking but I know we in Cape Town we are the only ones" (organisation 13).

The researcher observed that none of the respondents in Cape Town had enquired whether interviews with other organisations had been conducted nor did they have knowledge of personnel details of another organisation. The lack of interaction between organisations allows the possibility of 2 organisations focusing on the same kind of work in the same area. This non communicative work ethic thus highlights that organisations do not form partnerships. This also concurs with Julie (2009), where he stated that many NGOs in South Africa do not make use of partnerships and they actually lobby for the same funding.

4.3.2 Public view on HIV and AIDS

A public view on HIV and AIDS relates what respondents perceive to be the general publics view about HIV and AIDS in their country.

4.3.2.1 Brazil

Respondents were asked what they thought the public view on HIV and AIDS was and whether in their opinion it had become a stale issue. In Brazil 6 out of the 7 respondents mentioned that HIV has indeed become a worn out topic amongst the general public and society were not as alarmed of this epidemic as they had been in the 90s.

> "I think that in the general public it does not have the same importance as it had in the 90s and 80s, it is not as important, today there are other epidemics which are more debated, which has more value in Brazilian Society" (Organisation 7).

> "No it is no longer a primary topic like it should be, there is no point of doing condom campaign only during carnival, there is no point" (Organisation 3).

> "Look the other day I heard a Brazilian actor who is HIV positive; he said that AIDS is asleep in Brazil, primarily at government level, people are too relaxed…"(Organisation 4).

As mentioned by Goodroad et al (2000), people were impervious to hearing about HIV and the preventative measures which needed to be taken and had subsequently lost interest in the whole saga as such.

Three out of the 7 respondents mentioned that one reason for people not being as careful as they had previously been is because of the efficiency of the ARV's.

> "I see that people think it is not as important, many groups have left the prevention field, and the tactic of safe sex, because they think there are drugs, they think that if you take the drugs before sex, you have intercourse without using a condom and even if the partner is infected you wont get it because they think they have prevented because they took the drugs, which is an absurd" (Organisation 2).

> "Look the opinion that we get when we take part on events and seminars is that things are like… Because of the efficiency of the cocktail people are not as careful as they should be" (Organisation 6).

This concurs with Cassel and Halperin (2006) where he mentioned that people are not as careful as before due to the efficiency of the ARV's, therefore they get involved in risky behaviours, as they think they can live a healthy life with ARV's.

Five out of the 7 respondents in Brazil said that there is less discrimination among the public with HIV positive people.

> "Like I said, in the beginning there was a lot of prejudice, but as time went by this prejudice started to diminish, today we are accepted really well among the community…" (Organisation 5).

4.3.2.2 South Africa

In South Africa all 7 respondents said that people are tired of hearing about HIV and AIDS, 5 of them mentioned that there is still a lot of discrimination against the people living with HIV and only 1 respondent mentioned that ARV's have had a negative impact.

> "I think so, I think there is an element where we are tired of listening to this, I think there is some elements to that, but I think this is on the ground that people don't wanna hear about, people don't want to hear about this in any case, they don't want to face it head on, I think they are tired of hearing, I think they tune out when they hear about this huge awareness campaign about using condom, about HIV and AIDS" (Organisation 13).

> "Well the general view is still very negative, people are very bias there is a lot of prejudice there is still a huge stigma around AIDS with people that are infected, we often hear how people are treated. In general there is a negative perception on HIV" (Organisation 8).

> "Yeah especially the younger kids and the teenagers are very tired of the topic, there are many campaigns like Love Life and so on and the children are very tired because they think, look there is another one talking about HIV and they think they know every thing about it and they can't hear any more. And also know they are thinking because of the ARV, oh no problem because there are medications, so it is fine we don't have to worry about it." (Organisation 10).

This concurs with Goodroad et al (2000), where they mentioned that people have grown tired of prevention messages about HIV and AIDS and they no longer prevent themselves as much

as before. This also relates with Chinsemby et al (2008) where they have shown in their research that there is a correlation between alcohol and drug taking and how people in this inebriated state are able to avoid contracting HIV during sexual intercourse, albeit by default.

4.3.3 Finance

Finance relates to the source of funding either from the government or from private institutions and what methods are used to raise funds for their organisation.

4.3.3.1 Government

Government means the funding which organisations obtain from administration, as well as if the respondents think NGOs are deemed fit for government funding.

In Brazil only 2 out of the 7 organisations received money from the government and only 1 being over 50% of its funding. It was interesting to notice that out of these 5 organisations that do not receive money from the government, all of them voiced that they should not get funds from the government, because it maintains their autonomy and they can demand from the government.

> "Look I am against this government funding in a way, I think that civil organisations must have autonomy so it can demand because from the moment that the government finance all your actions how are you going to complain about your funder, so it becomes a bit limited." (Organisation 2).

> "I think that that the government does not provide enough, but I think this kind of relationship with government money is not favourable because you loose your freedom of not being dependent and you vote, its because if you became dependent you don't demand, this happens to a lot of organisations which receives money, they become scared" (Organisation 6).

> "Look I think that NGOs must have one or other project financed by the government, but they must have autonomy to search for its own resources because like that the organisation can say, this not right, I want more from

this, if everything is financed by the government you became limited..." (Organisation 1).

In South Africa 4 out of the 7 organisations received some money from the government, however only 1 received more than 50% of its funding from the government. Five of the organisations mentioned that the government provides a lot of money for the HIV and AIDS cause.

"Well when you look at the number of HIV infected people there can never be enough money and the numbers keep increasing so there can never be enough money, but we have the biggest ARV's programme in the world in South Africa, so there is an enormous amount of money being spent and the budget is huge, so it is harsh to say that the government must give more" (Organisation 8).

"I know that there is a lot of money from government going for services like ARV's, meds and the different hospitals that provides services, I have been to the AIDS conference and it really is impressive what can be reported I don't want to criticize that" (Organisation 9).

"The government funds some of our projects in the Northern Cape, the government has a huge budget for HIV and AIDS" (Organisation 12).

"Well we don't get anything for HIV, well the children get free treatment but its all very well providing money for HIV and all but what is really needed until they can address the poverty and the economic problem then they can address the AIDS problem." (Organisation 10).

4.3.3.2 Private fundraising

Private fundraising means the funding which the organisations receive from private corporations and the methods which they use to fundraise. In Brazil all 7 organisations used writing of project proposals for private funders as a method of fundraising. However 5 out of the 7 used a different activity to fundraise which did not include proposal writing. In Brazil none of the respondents mentioned that they received funding from an overseas foundation.

> "We created a fundraising department which we did not have before, this department is responsible for the marketing, it does campaigns, it writes letter, it keeps the mailing list organised, it main contact with donors, this we did not have before, so we organised this at long term" (Organisation 7).

> "We fundraise with the sales from our second hand clothes shop, we ask for donations from private individuals, sometimes we organise events, like in June we had a classic music event in a theatre close by which raised some funds for us and helped us a lot during the month of June, but that was that month, sometimes we make events like bingo, bazaars which maintains us." (Organisation 3).

> "We have had different methods, like once we got books donated together with JovemPan (radio station), which we sold, in one day we sold 8 thousands books, once we got donated a private box in Rio de Janeiro which we auctioned, but we always do events." (Organisation 7).

In South Africa all 7 respondents used writing project proposals as their main method of fundraising. However only 1 of them used a different method to fundraise besides proposal writing and only 1 of them had their own fundraising department. All 7 organisations mentioned that they received funds from overseas institutions.

> "We have tried sponsorship that comes from overseas, but the main method is writing proposals to organisations, making people aware you know, we appeal… we used have collection tins but we cant do that any more, because people used to get robbed, so a lot of places stopped with the tin collections. Pick 'n Pay are very good to us as well" (Organisation 10).

> "We get money from all over the world, we have bilateral organisations and we have a trust fund in Germany, so our main area is Germany and South Africa" (Organisation 8).

> "We get funding from US based organisations PEPFAR for example and the national institute of health" (Organisation 13).

> "Well we receive funds from overseas funders, and we receive some money locally, a little bit form businesses, and we also try to generate funds from out training, we do training where we try to generate some money for ourselves, so there is a wide variety, not only one source that carry us, so we have a wide variety of sources that carry us." (Organisation 9).

This concurs with Julie (2009), where he states that many organisations have became too dependent on external funding and government funding and have not done much to become independent. In Brazil, many organisations have created different methods to fundraise in order to be independent from donors as well as from government.

Julie (2009) also mentioned that many South African organisations could not adapt themselves to foreign funding institutions restrictions and therefore could not sustain themselves. By not receiving money from foreign funding institutions it could mean that organisations do not have to follow demands from them.

4.4 Comparison of the Brazilian and South African Policies

There are many similarities between the Brazilian and the South African National prevention policies, however, 4 major differences were found.

The Brazilian policy has an action plan for their goals. For each goal which they have listed in their policy they have stated how they intend to achieve that goal. In South Africa, the policy also has goals, however, they have failed to illustrate their action plan on achieving those goals. According to Waterson (1965) it is very important to have an action plan for policy goals, as it sets a path and a vision to achieve what was formulated.

The Brazilian policy mentioned that it is very important to decentralize finance as well as goals to State level (Provincial) and Municipal level to be more effective as different geographical areas may have different issues regarding HIV and AIDS. In South Africa, it is

not mentioned. However, the researcher found that the South African NSP is decentralized up to Provincial level and through some interviews conducted by the researcher it was established that they are starting to decentralize up to municipal level.

This concurs with Patel (2005) where she mentioned that resources must be decentralized in a developmental approach.

The Brazilian policy also has great participation from the NGO sector that work in the HIV and AIDS field, these NGOs have helped in formulating the policy, whereas in South Africa there is not much contribution from the NGO sector in policy formulation.

Another difference between the polices is that in South Africa they look at different preventative methods, while in Brazil they are still very fixed to one preventative method which is condom usage. In South Africa they look at different prevention methods, like circumcision, risk of multi-concurrent partners and the economic status of women.

4.5 Organisation Perception of the HIV and AIDS prevention Policy

Organisation perception means the knowledge in which organisation leaders have on HIV and AIDS policies.

4.5.1 Knowledge of past policies

Knowledge of past policies means, that respondents are aware of previous HIV and AIDS policies in their countries and how did they came about.

4.5.1.1 Brazil

Respondents were asked what they knew about previous HIV and AIDS policies in Brazil, all respondents had some knowledge of past policies. Even though the years which they said the policy was created varied, 5 out of the 7 said it started in the 80's more specifically between 84 and 85.

> "From what I know it was in the 80s at the time I wasn't in the movement, but it was before the 90s, it was the civil society that pushed." (Organisation 7)

"It was in 83 or 84 if I recall correctly, after that it was the civil society that created a programme to discuss STD and AIDS, because before that there was no programme, there was a department that had started studying the question of the new disease which we were having here in Brazil, but it was between 85-90 that the first programmes were created with the pressure of the civil society requesting an answer from the government." (Organisation 6).

"The first programme created in the Sao Paulo state was in 84, a governmental programme, the first institution that really worked with people living with HIV and AIDS was the GAPA from Sao Paulo in 1985, so every thing started here in Sao Paulo" (Organisation 2).

4.5.1.2 South Africa

In South Africa only 2 respondents answered with conviction when asked when was the first programme created, they also had some knowledge on past policies. Some respondents did not know when the first programme was created or who was the first organisation to work with HIV and AIDS in South Africa. All of the answers were varied and there was uncertainty of when the first policy was formulated.

"Well the first plan that we had, well we had a draft plan, first we had the national strategic plan, I think before the one we have now from 2007-2011, before that we had a draft plan and before that we had a draft plan, so it took while to get a national plan, I think we had in the mid 90s we had already a draft plan, but it was not well known, it was not well distributed and at grass roots level not a lot of people knew about this plan , or knew that it meant for them so it was a government policy that was not communicated down directed inform to people working or dealing with HIV direct." (Organisation 11).

"I don't know, but I will say 1994, but I am not sure" (Organisation 13).

"God I don't know… but not long ago" (Organisation 12).

> "There was one programme a musical, when was that? 96? But that was a complete disaster, they gave money for an awareness thing, that was a musical and in the end it was a disaster. I can't remember the name, it was around 96, but basically it was a disaster." (Organisation 8).

The response in both countries concurs with Waterson (1965), where he mentions that the people who implemented the policy should have an input in the policy and also should have a good knowledge of the policy for it to succeed especially in a developmental approach. One can see that the Brazilian respondents had a better knowledge of past policies than respondents in South Africa. It is important to have knowledge on the policy as it puts every one inline with the same vision.

4.5.2 Knowledge of current policy

Knowledge of the current policy means what respondents know about the policy in their countries at the time the research was conducted.

4.5.2.1 Brazil

When organisations were asked about what they knew about the current HIV and AIDS policy, in Brazil all 7 organisations knew about the National Programme for STD and AIDS and how it worked.

> "Well, it is like this, there is not specific policy for prevention which determines that the Brazilian government have to apply X in the prevention for HIV and AIDS, but there are policies which are more directed in the area of education, but there is not specific legislation do you understand? This policy is the out come of the act 8080 in the creation of the SUS which stated that the government must invest to prevent any kind of disease been AIDS or any other disease." (Organisation 2).

> "Well every policy is developed at the Articulation Commit of the social movements and the National commit of AIDS, we discuss every thing there, so the policy is made in conjunction." (Organisation 7).

> "The National Programme states that the prevention should be done with condoms, but there are other more effectives methods which are been discussed, but the national programme adopted the use of condom as the main" (Organisation 5).

4.5.2.2 South Africa

In South Africa only 3 organisations had knowledge on the National Strategic Plan, the other 4 knew that the National Strategic Plan existed but did not know what the goals and plans were.

> "There is the new strategic plan set out , on paper, I think on paper is not too bad, we have come through that, I think that's not too bad, but the Department of Health is mainly responsible for HIV." (Organisation 14)

> "Well I think the current strategic plan, I think it is a good target and I think it took in account what is happening with HIV and AIDS in South Africa and in the report I'm going to give you that came out last month we managed to report in some of the indicators that the NSP set for. But for me again in my little that I think it is a big step forward in South Africa was that for the first time in NSP they mention that they need to provide more prevention strategies, health care and also for the MSM population of South Africa, in term of that I think it is more reality based then before, reality is not the word, I think there are more realistic goals and I think it was a good document I remember in 2007 they had actually discussion with communities to ask them what the government has to do in term of HIV and AIDS, they called communities discussion or something like that, where people had the opportunity to contribute to that document" (Organisation 8).

> "I don't know much at all about it, there has never been any from the government to inform us about the plan" (Organisation 9).

This once again concurs with Waterson (1965) where he gives the understanding that for a policy to succeed the people who implement it should understand the policy. In Brazil respondents had a better knowledge on the policy than respondents in South Africa.

4.5.3 Organisation Influence on the Policy

Organisational influence on the policy formulation process relates to the input that each organisation had on the formulation of the policies in their countries.

4.5.3.1 Brazil

When respondents were asked if they had any direct influence on the policy, in Brazil all 7 respondents said that they had direct influence on the policy.

> "We also put some pressure, and they always bring it to us. We no longer accept them doing the policy by themselves, either we built together or we do not participate at all, but if we don't participate in building the policy then we won't follow it as well…" (Organisation 4)

> "We write the plans together, so there is a parliament commit of member of parliament which we meet once a month, today we were arguing the reduction of damage, however we stayed 6 months working to direction of tax for people living with HIV and we only finalized the plan in the last meeting, now the member of parliament will vote to became an act, so therefore we construct together, there is a democratic participation." (Organisation 5)

> "Yes, I have just come from the parliament, I was in a meeting with the STD and AIDS commit, we were arguing some policies for the STD and HIV and AIDS for the State of Sao Paulo, so we built together, we work really close with the legislative power." (Organisation 6).

4.5.3.2 South Africa

In South Africa when respondents were asked if they had any direct influence on the policy, only 2 respondents stated they had a direct influence on the policy, the other 5 said that they had no influence in the policy formulation.

> "No only indirectly through our work but not directly, no" (Organisation 14).

> "Unfortunately I don't think, I think the only organisation that has any influence on the government is TAC and we really…" (Organisation 9).

> "Not directly, we have been partnered with the provincial government and also with the Health Department of the city of Cape Town. We were running a project with traditional healers and then the provincial government realised that how important it to recognise and introduce and recurrent system between the local clinics and sangomas" (Organisation 8).

However the 2 respondents which stated they had influence on the policy said that they worked directly with the Government.

> "We being, through out quarterly meeting and the process we assisted in writing a lot of district plan and now were are writing sub-district plan for each of the sub district in the western cape so we directly using the national strategic plan but we writing a local, plan for each of the local sub district. Now we are the first NGO that is writing sub district plan, and this sub district plan will then inform local government and then they will write from that, we couldn't wait any more to come from the top to the bottom so we decided to write from the bottom to the top. So we going, they going to use the information that we going to collect from the district plan and then the district plan will inform the national plan" (Organisation 11).

> Also Organisation 12 stated that they work directly with the department of health and that they currently have an input on the policy and as well worked together with the government with the prevention from mother to child.

Both countries concur with Patel (2005), where she states that the community should have an input in the policy in order for it to be a success. In Brazil all respondents stated that they had an input, that may explain why Brazil is considered to have the best AIDS programme in the world, while in South Africa, most of the respondents stated that they had no input, this may explain why the prevalence is so high in South Africa.

4.5.4 Organisation views on Policy makers

Organisation views on policy makers refer to what respondents think about the people who formulate the policy in their country.

4.5.4.1 Brazil

When respondents were asked if the people formulating the policies were experts on the HIV and AIDS matter and that if they thought that they should be formulating the policy, in Brazil, 6 out of the 7 said that the policy makers were not experts, however all of them mentioned that civil society helped these people to formulate the policies.

> "Look the legislators are not, but all policies were started from civil society, which elaborate the minutes of a policy which is then forward to a legislator, and then the discussion starts, so this policies were thought directly by people working with HIV and AIDS, so in a way the legislator have to use it." (Organisation 2).

> "No Legislator is expert on the matter, what we have been doing today is, we take the projects which are related to STD and AIDS which are more then 40 projects, and in some projects there are mistakes in them, so we get this projects and make it better. They see that we have more knowledge so they want more information, so today we have been improving some policies because we have more information and knowledge then them" (Organisation 4).

> "No they are not experts. A lot of the draft policies from 97, 96 they would come to us, we would have a look. So the Members of Parliament used to make it and sent to us to make the critic, like here is good and here is not and etc… so the Member of Parliament writes and send to the NGOs so they can have a look and their input." (Organisation 6).

4.5.4.2 South Africa

In South Africa there were mixed responses if they thought that the people formulating policies were experts, 4 out of the 7 said that they thought they were experts. However 5 out

of the 7 said that they should have more input of the NGOs in the policies. Also respondents were happy with the current National Strategic Plan.

> "I think there were some experts but not a lot, but not all experts but I think they didn't include many of community based organisation involvement in writing the policy from the bottom up" (Organisation 8).

> "I think there are many good people, experts, but as I said it would do good if they could get input from local universities and NGOs, it would do good" (Organisation 12).

> "I think the present policy was written by experts but informed by real statistics, on grass root level, so it is a better effort from before" (Organisation 11).

> "That's a very difficult question, if you look at the document the strategic plan you get the impression it is not written bad, its not that bad, so I guess that he people the wrote and they were one or 2 open meeting where people were asked for their imputed, the problem with our organisation is that our capacity is so small and we are up to a few month ago we were so busy with our own projects and if you were… suddenly you get an e-mail inviting for a meeting in Pretoria where the future policy will be discussed, we get e-mails like that from time to time, you have know to decide if you can go to this meeting, you know in the end it will be only 2 hours of real discussion and in the end will be backing up people introduction and all that political thing you know, your first reaction is that I can't do this, I can't go there, and you know there will be many people and yeah its not only the ability… yeah for a small organisation with a small capacity it very difficult to play a role" (Organisation 9).

This once again agrees with Patel (2005) and Waterson (1965) where they stated that in a developmental approach there should be an input from the people at grassroots level. In Brazil organisations at grassroots level are highly involved in the formulation of the AIDS

policy, while in South Africa those who formulate the policies are on top and they do not have much knowledge of what is happening at grassroots level.

4.5.5 Views on what the best prevention methods are for their country

Views on what the best prevention methods are what respondents think the best prevention methods are for their country.

4.5.5.1 Brazil

When respondents were asked what the best prevention methods would be for their country and what they would change in the current prevention methods set by the policies, in Brazil all of the respondents mentioned that the best prevention methods would be a continuous education program as well a greater distribution of condoms.

> "I believe that the education is still very much traditional, from the time where the teacher still rules, the education haven't moved forward. I believe in health education, the education is fundamental." (Organisation 1).

> "I would make a prevention programme included in the school curriculum, like a subject, but not only in the school, we also need the family involvement, I think it is important that the parents know that sex exists and what their child thinks" (Organisation 6).

> "The best methods are communication and distribution of condoms" (Organisation 2).

> "The best methods of prevention are to take knowledge to the population and the use of condoms" (Organisation 7).

This concurs with Sneed (2008) and De Bruin et al (2007), where both stated that the best prevention methods are through education and especially through parent child education.

4.5.5.2 South Africa

In South Africa 6 out of 7 respondents mentioned education as one of the best prevention methods. However they also had different ideas from Brazil which can be very effective.

> "I would say the leaders should take the right example in the way they talk, and they way they walk, they should set the example of behaving differently, of respecting women and respecting marriage and you know talking about, they should set the example of accepting people living with HIV so not only the image but giving body to the imagine, showing the people what does this message mean for us, how we conduct our self, I think this what we need for our country" (Organisation 8).

> "I think probably voluntary counselling and testing and behaviour change campaign general awareness campaign, but focusing on multiple concurrent partners hmm men that have sex with men, women and youth, sort of teenagers, focusing on the vulnerable group will be defiantly most important" (Organisation 12).

> "I think prevention I think education should start much earlier which they are doing more now in the primary schools and there need to be a on going intervention among the youth in the youth group but in a more active way not just going there and preaching them what to do but actually getting them involved actively in caring you know, getting them interacting from children" (Organisation 14).

> "I think people should talk more freely, there should be more communication campaigns, promote more kind of discussion because you know in the family in the house hold, no one talk about sex. If my dad or my mother had to talk about sex or HIV or what ever or any thing, it didn't happen, it didn't happen then and it does not happen now, so more communication about sex, open communication, people are so conservative about it, I mean it sex so you have to be more openly and talk more about it, but I don't know how this will translate into a prevention strategy with the government I don't know how" (Organisation 9).

This relates to many different articles, one of them is Karim and Karim (2005), where they state that the low status of women helps to increase the HIV and AIDS prevalence. It also relates to Hollowed (2008), where he reported the misconception of some South African political leaders regarding HIV and AIDS, which sends the wrong information to the overall population.

4.5.6 Views on government response towards HIV and AIDS

Views on government response means what respondents think about how the government in their country responded towards the HIV and AIDS pandemic.

4.5.6.1 Brazil

When respondents were asked if they thought that government paid enough attention for the HIV and AIDS cause, In Brazil 6 out of the 7 respondents said that it was satisfactory and mentioned that the only reason that the government pays attention towards the pandemic is because the civil society keeps eye on them.

> "I think the response is satisfactory until today, but always with a lot of demand, because if we don't go there and ask for a response the legislation will not be implemented like other legislations in Brazil, we always have to pressure for our civil rights and that the government must implement the policies." (Organisation 1).

> "I don't think it is the best programme, we still need to improve a lot like many other issues in Brazil, we need a more serious action from the politicians which we don't have it, we need to reduce corruption, and a better social control so AIDS can be placed as an issue in the country" (Organisation 4).

> "Yes because we are here to demand, we don't give them a break, we still se that there are gaps, because when you address one issue you uncover another one, like for example, not so long ago, the rate of women infect was 1 woman for 10 men, today it is almost 1 to 1, so I think there was a lapse in the last years" (Organisation 5).

4.5.6.2 South Africa

In South Africa, 6 out of the 7 respondents said that the government does not pay enough attention. However 5 out the 6 said that the government is improving.

> "No they don't… know they do but I think it should be more, I don't think it is enough I think its more then they have done before, but I think it should be more." (Organisation 8).

> "Ye obviously it can never be enough attention, ye there are quite a lot of bad mouthing, but there are doing a good job if you look at the big part where they actually, so I think they are not too bad" (Organisation 10).

> "We have I think here in the western cape very good treatment our ARV role out is very good on this province but in some provinces, like the northern cape the eastern cape is not very good, so there they should focus more on treatment and care. But I don't think there are a lot of money put on behaviour change campaigns." (Organisation 11).

This relates to Patel (2005) where she mentioned that the government must get information from grassroots stakeholders, however South African organisation should follow Julie's (2009) advice, where he mentions in his article that NGOs should get together and form partnerships to advocate and demand a better response. One can see that in Brazil the involvement of the NGOs has helped the government improve their policies.

4.6 Perception on the Spread of HIV

Perceptions on the spread are what respondents perceive may have been the cause for the spread of HIV and AIDS in their countries.

4.6.1 Reason for the spread of HIV in Brazil

Reasons for the spread are what may have caused the spread of HIV and AIDS in Brazil.

4.6.1.1 From 1990-1996

In Brazil 5 out of the 7 respondents interviewed mentioned that the reason for the spread between 1990 to 1996 was the lack of information on the disease as many people did have knowledge on HIV and AIDS.

> "I believe it is a period of discoveries, I think epidemic process and the discoveries of ARV, the discoveries in the medical field, also the time for everyone to organise themselves, for the social movement to built this power, I think it takes time."

> "Yeah from 90 to 96 the social movement worked a lot to acquire drugs and all discoveries on the field."

This was suggested by Merson et al (2007), where they mention that a lot of misconception has helped to increase the HIV prevalence. During those days there was not much information on the disease, as it was still a new disease in the world.

4.6.1.2 From 1997-2007

However 6 out of the 7 of the respondents attributed the stabilization of the pandemic because of the discovery and the free distribution of ARV's.

> "Its really easy to explain, its because in 96 its was when the ARV roll out started here in Brazil, so you increased the quality of life of those living with HIV and AIDS, so you start controlling a stabilization" (Organisation 2).

> "The main reason for the stabilisation was the introduction of ARV in 96 and increased the quality of life of people." (Organisation 3).

> "From 90 to 96 you only had the treatment with AZT and in 96 it was the first indication for ARV, until November 96 only Sao Paulo that distributed after November it started the distribution all over Brazil. So with the distribution of ARV there was a stabilisation and a reduction on people been hospitalized and death." (Organisation 7).

This relates with the Brazilian Department of Health, where they introduced free ARV for all in 1996.

One respondent did not believe the graph and said that there are more people infected in Brazil than the graph indicates.

> "We know that here in the eastern suburbs there are 18 thousand people with HIV, you have to multiply that at least by 3, which are people who are infected and do not know, and it is increasing everyday, we also know that the prevalence among elderly people are increasing rapidly as they refuse to use condoms" (Organisation 6).

4.6.2 Reason for the spread in South Africa

Reason for the spread is what may have caused the spread of HIV and AIDS in South Africa

4.6.2.1 From 1990-1996

In South Africa there were different answers among respondents regarding the reason for the spread of HIV between 1990 to 1996. However 5 respondents stated the one of the reasons for the spread was because of the political time that South Africa was going through and that people were more worried about the political change and did not look at the HIV pandemic.

> "Hmm the first period will be when it was relatively unknown, there was no real… the focus on that stage was in the change of government it was a new democracy and the focus was not really on HIV, it was known, people knew about it but there were very few systems in place, there was no treatment care and support, there was no ARV at that stage and that obviously pushed up the infection rate, there was very little awareness about HIV" (Organisation 8).

> "South Africa before 1994 was obliviously going through turbulent times amongst the population and during that time HIV did not play a major role in the politics and may be it was ignored for too long" (Organisation 10).

> "At that time South Africa was going through a political change and people were not worried about HIV" (Organisation 12).

This concurs with Merson et al (2007), where they stated that there was only one individual advocating against HIV in South Africa, while other people where more worried about the democratic change that was happening in South Africa, not much attention was paid to the HIV and AIDS cause.

4.6.2.2 From 1997 – 2002

From 1997 to 2002 where South Africa experienced a huge increase in the HIV and AIDS prevalence, 5 out 7 South Africa respondents attributed the shift in change stating that people were already infected before but there were more people being tested during those years.

> "In between 1996 and 2003 I think it was when we got a larger number of deaths, I would say because of the increments in the beginning you know I have seen a lot of babies getting sick and dying, there wasn't enough awareness I think the number were just so great and overwhelming, most probably they go infected way back here but it only started manifesting here, also because of the stigma as well" (organisation 10).

> "The second stage it was probably trying to sort to stabilize the amount of numbers obviously the prevalence rate was already there, there were already million of people infected and then more and more people started testing so the numbers went up, it is not necessary that the infection rate went so much up it that people realised that they need to start getting tested that is why that period had a very steep incline" (Organisation 8).

> "I think that people tested more VCT increased" (Organisation 13).

This relates with Ajala and Adejumo (2007), where they propose that because of the stigma many people left the rural areas and stared seeking help in the urban areas, as they could not disclose their status in the area they lived because of the stigma. This may mean that once people moved to the urban areas they started getting tested.

Two out of the 7 respondents attributed the increase to the government.

> "The attitude of the previous government towards HIV was absolutely ignorant and the misconception that was spread between 95 and 2001" (Organisation 11)

> "When Mandela, the ANC government came into position, I mean, there was such euphoria about the struggle is over now so it was beyond their imagination in how important this could have be, I think they started to realize at the end of Mandela thing that we need to start, but when Mbeki comes, came in power… I agree that he just didn't want to know about it, it was not part of their plan for South Africa, so they ignore it, so he had other question if it is something to really think, so politically wise they missed…" (Organisation 9).

This relates with Fassin and Schneider (2003), where they have reported the misconception of the South African political leaders regarding HIV and AIDS and the speeches they make regarding HIV in South Africa has helped to increase the infection rate.

4.6.2.3 From 2003 – 2007

In South Africa from the period of 2003 to 2007 there was stabilization in the pandemic, respondents attributed the main reason for stabilization to the introduction of ARV's. However they also stated that one of the reasons for the pandemic stabilizing was because of the prevention programmes.

> "Because of that they were a lot more education and awareness and may be a break up on stigma when people were talking about when they were going to became available and that what happened with us, it wasn't only when the ARV started probably a couple of year before when the stigma started breaking down and people were talking about more and the drugs were going to help and people started coming out more you know so that could be." (Organisation 9).

> "Well I can see for there, which was the time our children went on treatment and in the end of 2004, so I will say that it has a lot in levelling off the ARV." (Organisation 14).

> "Then in 2004 ARV was introduced it was very constant, obviously the number still high but it has level to 18/19%" (Organisation 13).

This coincides with the Department of Health publication (2007), where it states that in 2003 the South African government started to form a plan for the free roll out of ARV's, which was later introduced in 2005.

4.6.3 What made the government respond against HIV and AIDS

What made the government respond means, what caused the government in each country to start acting against the HIV and AIDS pandemic.

4.6.3.1 Brazil

When respondents were asked what had made the government in their countries respond, in Brazil all 7 respondents said that it was the social movement the pressurised the government to respond. Also all 7 respondents stated that they got the government to respond through protests and marches.

> "I believe that it was the social movement, the social movement of organisations, the NGO forum used to do a lot of marches. The gay movement was also fundamental, because they were not shy to go out in the streets, so the people that were dying brought a lot of power, and union. The organisations helped a lot to make this group stronger, so they could go out in the streets, so there were a lot marches and protests." (Organisation 2).

> "One of the biggest reasons was the pressure of the civil society. Because what was happening was that the infected people were dying very quickly, so it was created a belief that those people could not live in that situation so people started asking the government for an answer regarding AIDS, so it

was the pressure from the civil society on the government so they would give a answer for the epidemic…" (Organisation 6).

"I think it was the fight from the AIDS NGOs and the civil society, the NGOs fought a lot so the human rights could be addressed…" (organisation 5).

This relates to Parker (1999) where he mentioned that in Brazil the civil society played a major role in advocating for the government to respond to the HIV cause.

4.6.3.2 South Africa

In South Africa there were different responses to what made the government act against HIV. However all 7 respondents mentioned the Treatment Action Campaign as one of the major contributors for the South African governments response. Four respondents mentioned that international pressure also contributed to the South African governments' response.

"I think the biggest activist was the Treatment Action Campaign, responses of our government were so slow in buying ARV. I think in my mind that is historically something that is made an impact." (Organisation 13).

"TAC is the strongest organisation that really made a lot of noise a lot of progress in term of ARV role out and the attention from international media to South Africa to put pressure on government to change their opinion and policies." (Organisation 10).

"Yeah because the pressure of the general public and because of overseas pressure, a lot of pressure from there in the AIDS conference and the health minister made statement and the whole world realised, but also NGOs played a role where they actually campaigned and put huge pressure in the government and pushed them with the national role out, so I am sure that played a big role" (Organisation 8).

Once again this concurs with Merson et al (2007) where they mentioned that the only organisation that advocated against the government was the Treatment Action Campaign.

This also concurs with Julie (2009) where he mentions that South African organisations are very dependent on external influences.

4.6.4 Views on when the government thought HIV and AIDS were an important issue

View on when the government thought that HIV and AIDS were an important issue means, when the government in each country started to respond towards the HIV and AIDS cause.

4.6.4.1 Brazil

In Brazil when respondents were asked when they thought that the Brazilian government realized that HIV was and important issue, 6 out of the 7 respondents said it was during the 90s while 1 respondent mentioned that it was in the 80s. However most of the respondents mentioned that the biggest achievement was the free ARV's roll out.

> "I can say it was from 95 forward, like I said in 94 I knew HIV existed, but there was not as much information as today and also the information that was there was that the only group of risk was homosexuals and drug users" (Organisation 5).

> "I see that it was more in the 90s, I would say more specific in 96. Because in 96 it was when there was a lot of pressure on the Brazilian government in relation to treatment of people living with HIV and AIDS, it was when the free ARV roll out started." (Organisation 4).

> "From what I see from my work it started during the Fernando Henrique Cardoso (former president elected in 1992), from there forward it was more interesting, he was more interested in the cost in the government budget, so there was the break in the ARV patent" (Organisation 7).

This once again relates to the Brazilian Health Department (2005), where it is stated that free ARV's roll out was introduced in 1996.

4.6.4.2 South Africa

In South Africa, all 7 respondents said that not much was done from the government side during the 90s and most of them stated the government has only started to respond towards the HIV and AIDS cause more recently.

> "Well they didn't do any thing from 1990 to 1999 I will say, there wasn't much off effort done in regards to… when was the ARV? I think in 99. We know that our government was very slow in responding to HIV and you most probably know that. Thabo Mbeki was one of the biggest AIDS denialist out there" (Organisation 8)

> "Like I said not much was done in 1990s and luckily in 2004 was very late we were 20 years into the disease and then the action was taken and we have had successes and the incidents rate have dropped so the government action is success to a certain extent" (Organisation 10).

> "You meant the attitude towards HIV and AIDS, I am not sure about the decisions and the actions that was taken, but what I know is that not much was done and we can see of the graph nothing happened from he government side, and at the same time we had a rapidly increase with the number of HIV."

This also concurs with the South African Department of Health (2007) that states they only introduced the first HIV and AIDS strategic plan in 2007. By this one can see that that the Brazilian government started responding almost 10 years before the South African government, and this may be one of the reasons why the HIV rate in Brazil has remained at a lower level.

4.6.5 Views of why the HIV prevalence is not dropping

Views of why the prevalence is not dropping means what respondents think the reasons to why the prevalence is not dropping in their countries.

4.6.5.1 Brazil

When respondents were asked why the prevalence was not dropping, in Brazil all 7 respondents stated that a better prevention programme from the government should be implemented. They also stated that the Brazilian government only does prevention campaigns during carnaval and during big events.

> "I think is because of the prevention, we should discuss this again, because if we only talk about condom is not enough, this doest change behaviour, the teenagers and elderly don't use condom, and the women are vulnerable, so we need to re think a new way for prevention." (Organisation 1)

> "I think it lacks continued education, it lacks continued education, because the same time we have the civil society going out and doing the work but the resources are very scarce, so I think if there was more investment from the government in prevention, on the education, so I think the way is to invest on the education of the people." (Organisation 2).

> "I think the government should invest more in campaigns, it doesn't work only giving pamphlets saying use a condom in big event like carnaval and the gay parade where they distribute tons of condoms and after that the topic dies, you must have a continues work on this…" (Organisation 3).

This concurs with De Bruin et al (2007) where they state that the best prevention is through education, especially through parent child education. As mentioned in chapter 2, the researcher could not find any prevention programme that focused on parent child education.

4.6.5.2 South Africa

In South Africa there were different responses to why the prevalence is not dropping. However 6 out of the 7 respondents stated the cultural practices is one of the causes that the prevalence is not dropping.

> "I think because there is not a lot of behaviour change campaigns, people are aware of that, but people still have multiple concurrent partners hmmm they still don't test, stigma and discrimination still prevent a lot of people

from testing or disclosing their status which make treatment support and care much easier (harder), ye I think stigma discrimination and lack of behaviour change"

"Obliviously a lot of ignorance cultural barriers and sexual and every thing that goes with including HIV and AIDS it was a big taboo, too many South Africa cultures and African cultures that's one reasons it too them so long to realise how bad it is and as I said earlier the political changes that happened in the early 90s also play a role"

"I think it is a natural process, where we stabilizing then drop after a couple of years. In South Africa, I don't know what about in Brazil, culturally my parents never talked to me about sex and about using a condom. Culturally sex and talking about sex is not done, so I think in a huge aspect of the social norm that guide men and women contribute to the HIV prevalence. It's stabilized but still in a very high rate."

This agrees with Halperin and Epstein (2007) where they found a big correlation between multi-concurrent partners and HIV and AIDS. There were other cultural factors which cause the prevalence not to drop. One of them is mentioned by Mills et al (2005), where they state that in many African cultures they prefer to use traditional medicine instead of Western medicine.

4.6.6 Views on how the prevalence in the future

A view on how the prevalence will look in the future is how respondents think the prevalence will look in the next 15 years in their countries.

4.6.6.1 Brazil

When respondents were asked how they though the prevalence will look in the future to come, in Brazil 5 out of the 7 respondents stated that they think it will remain at the same level and it will not drop because of the current prevention plans.

> "I think it is going to remain the same, if we work really hard on the prevention then it will start to drop. I think the number of infected people might have an increase, but it will not be a significant increase because we have people that does not want to prevent themselves and we cant obligate them every one to prevent themselves." (Organisation 5).

> "I would like to drop, but the way it is I don't think it is going to go down, I think it will remain the same" (Organisation 3).

> "I think its going to maintain, I am not very optimistic in relation to prevention, but I think that is it, to going to remain, I don't think it is going to go up because of the history." (Organisation 4).

While 2 respondents stated that is going to increase.

> "Well I think it is going to go up, if we carry on the way were are it is going to go up, I think it is going to go up because if we get the young population that was born during the pandemic, and born when the treatment already existed, they have not experienced the devastation of HIV in Brazil and in the world, so I think this will make the numbers go up significantly of people infected in Brazil." (Organisation 2).

> "The way we are going, I think it will increase" (Organisation 7).

This agrees with Ajula and Adejumo (2007), where they mention that in our days there are more organisations helping people living with HIV and AIDS and also there is free ARV therapy. So this means that less people will die of AIDS, therefore the prevalence level will either remain the same or it might increase.

4.6.6.2 South Africa

In South Africa there was a more positive answer with regards to how the HIV pandemic will look in the years to come. Six out of the 7 respondents said that in the next 10 years the prevalence will tend to decrease.

> "Hmmm I don't think that there will be such a huge change, my personal feeling it will probably flatten and by 2015 it will go down a little bit, very little bit" (Organisation 8).

> "Yeah I think so, but not any time soon, I think there will be a few years, personal opinion I think we going to start seen big change in 5 to 10 years." (Organisation 9).

> "I think it would fall, for a couple of year it would be stable. Well 2015 is the millennium goal should be reached. We say that the overall prevalence at the adult population is at 10% now, I can show you. I think in 2015 should go more to drop that's what I think" (Organisation 13).

This also concurs with Ajula and Adejumu (2007) but other reasons may be that South Africa is looking at different prevention programmes and as well because the prevalence rate in South Africa is too high, so therefore more people will die of AIDS, bringing the prevalence level to a lower rate.

4.7 Impact of the economic crisis

4.7.1 Impact on the organisation

Impact on the organization means how the economic crises have impacted and will impact on their organizations.

4.7.1.1 Brazil

When respondents were asked if they had suffered an impact on their funding because of the economic crisis, in Brazil 4 out of the 7 respondents said that they did suffer an impact, 1 respondent stated that their income reduced by 60%.

> "Look, we get a lot of our resources from the class A population which seems to be more frightened, the middle class are still the same. I believe that it has dropped by 20 -30%, it was a huge cut, we are retrenching staff,

we are reducing everything… we are also reducing and cutting projects to adequate ourselves." (Organisation 1).

"We had an impact, we are very worried because we receive a lot of donations in food, like basic things, but this years we have experience a reduction, not that we don't receive any more but it was reduced by 60% which is very significant, and I believe it is going to carry on for a few years." (Organisation 3).

"Of course, like I said, the projects are approved like human relations, so what happened last year there were 40 projects under this aspect, but today it dropped to 20, so every thing is more rigorous, sometimes we try to bargain to see if we can do the projects at a lower cost…" (Organisation 7).

However 3 respondents in Brazil stated that they have not suffered an impact, however they gave the impression that they might be an impact in the near future.

"So far we haven't, because we working with last year funding, which was budget before the crisis, however we work on a deficit which is predicted, because we never have money, we try to save…" (Organisation 2).

"It can be reduced, because we work a lot with private donation, so it can drop, even the help which comes from the government. The private because you only donate if you have money left, but if it is affecting your pocket, so it might impact, but I hope not but…" (Organisation 4).

4.7.1.2 South Africa

In South Africa, 5 out of the 7 respondents stated that they have suffered an impact on their funding because of the economic crisis. The organisation that received money from the United States mentioned that they suffered a cut.

"Ye definitely, funding is scarcer, and funder wants to see more return in their social investments. We defiantly… I think there were a lot of

> American funding has been withdrawn from Africa slowly. So ye definitely…" (Organisation 13).
>
> "Yes we has some national cuts on department of health and social development, we also lost some American funders ye generally it is not as easy to get funds any more." (Organisation 14).

> "Yeah well, I will say that we have seen a loss of promise income of at least 20% in total." (Organisation 9).

However 2 respondents stated that that they have not suffered an impact. One of them even mentioned that they are not worried.

> "Not a big impact, the donations that we get from Germany on a regularly base has dropped, from last month people are sending less donations. I don't think we going to be affected, because we have long term fund and it was signed before the recession took place. But I m sure other organisations will suffer in the next couple of month or a year." (Organisation 9).

Organisation 12 said that they did not suffer an impact and they don't think they will, he also mentioned that the only thing the economic crisis means is that they have to work harder to get funding.

Both countries concur with Julie (2009) when he states that organisations are very dependent on funding institutions. One of the reasons for the Brazilian organisations not to have suffered a big impact on their funding is because they have different fundraising methods, while in South Africa organisations are still very dependent on funding institutions especially foreign funding institutions.

4.7.2 Views on the impact which the economic crisis might have on the prevalence

Views on how the economic crisis will impact the prevalence mean how respondents perceive an impact on the prevalence because of the economic crisis.

4.7.2.1 Brazil

When respondents were asked if they thought that the economic crisis would have an impact on the prevalence of HIV and AIDS, in Brazil all respondents said that they thought there would be an impact. However none of them could answer what the extent of the impact would be and what should be done to prevent it.

> "I believe so, because there are fewer project, there are less action of the civil society…"

> "So… more people can be prostituting themselves, but I can not assure that, we know that with unemployment and people vulnerability tends to increase, they can be putting them self in risk behaviours, this can happen, so we have to work on this, but not only in the health matter, we also have to work around the social matter.

> "If you think that that poverty has a direct impact on the people then I think yes…"

4.7.2.2 South Africa

In South Africa they had a similar view with what the Brazilian respondents perceived in how the economic crisis would impact on the prevalence. However they also could not say to what extent the impact will be and what should be done to prevent it.

> "We I think that this will definitely play a role, especially in lower income countries where we have this kind of behaviours, like you said sex they can get for free, or they can use to get income if they don't have any where to get"

> "Ye definitely, one of the biggest contextual factors that contributes to HIV and AIDS its poverty. In South Africa that plays a huge role, labour migration ye… and sex work I think it has been one of the biggest contextual factors in terms of a driver for the epidemic"

> "I will not be surprised if creating a situation where risk behaviours increase"

This concurs with the South Africa Department of Health (2007), where they state that poverty is one of the major causes for the spread of HIV and AIDS, where people tend to migrate to other places seeking jobs and people tend to engage in risk behaviours like eliciting prostitutes and having multiple-concurrent partners.

4.8 Conclusion

This chapter has clearly outlined the main themes found in the interviews that were conducted with the 14 organisations in Brazil and South Africa. Direct quotes have been used to allow the voice of the interviewee to the findings of the study and give more meaning to the data. These quotes have been linked with the literature that is either supported or against by the interviewees responses. This chapter has also pointed out the main differences between the two countries prevention policy. Table 3 gives an outline of the differences between the 2 countries found throughout the discussion of findings. The next chapter will look at final conclusions and recommendations.

Table 3: Summary of main differences between Brazil and South Africa

Brazil	South Africa
Policy has action goals	Policy does not have action goals
Decentralized Policy	Centralized Policy
Started distribution of ARV in 1996	Started distribution of ARV in 2005
Many NGOs advocated against the government	Only 1 NGO advocated against the government (TAC)
Many NGOs have an input on the policy	Not many NGOs have input on the policy.
NGO does not want money from the government	NGO does want money from the government
NGOs not dependent form external funding	NGOs dependent on external funding.
NGOs use diverse methods for fundraising	NGOs mainly uses proposal writing as the mains fundraising method
NGOs are united	NGOs are not united
Adopt condom use as main method for prevention	Looks at different methods for prevention

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In this chapter the researcher will provide the objectives of the studies and evaluate them against the findings. By doing this the researcher hopes to make important recommendations and draw fundamental conclusions as to why the HIV and AIDS prevalence took a different path in both countries and the views which respondents have regarding the HIV and AIDS policy in their respective countries and the knowledge which they have about different organisations.

5.2 Conclusions

By restating the objectives the researcher is able to ascertain whether each objective was in fact realized and conclude concisely by the findings of the research. The following conclusions are based on the research results presented in chapter 4:

To compare the knowledge which respondents in both countries have on other organisations working in the same field and their methods of fundraising.

The research revealed that respondents in Brazil had a better knowledge about other organisations working in the same field. Respondents knew the names of other directors and services provided by other organisations. In South Africa respondents did not have much knowledge of other organisations and their services.

By knowing the services provided by other organisations it reduces the possibility of 2 organisations doing the same project in the same area. Also by knowing other organisations it is easier to get together and advocate against the government whenever it is needed.

The research also revealed that organisations in Brazil use different methods of fundraising. While in South Africa organisations do no use different methods to fundraise and their main method of fundraising is proposal writing.

The research also showed that South African organisations are very dependent on government funding and funding institutions, especially from foreign institutions. By being dependent on government funding it may restrict organisations from advocating against the government as they may be scared of loosing their funding. By being dependent on foreign funding makes organisations adapt to foreign restrictions which may not work for the organisation and may not work in South Africa and therefore affect their services.

To determine what may have caused the spread of HIV in their countries and the cause of stabilization of the pandemic:

In Brazil respondents attributed the mains cause for the spread of HIV to be a lack of information on the disease. They also acknowledged that the reason for the pandemic stabilizing was because of the introduction of free ARV's. Respondents also acknowledged that one of the main reasons for the government to respond was because of the pressure civil society put on the Brazilian government.

In South Africa respondents attributed the main cause of the spread of HIV to be the political situation which South Africa was going through. They mentioned that many people may have been infected before but they only started getting tested during the 90s. They also acknowledged that the misconceptions put forward by some political leaders helped in the spread of HIV in South Africa. Respondents in South Africa acknowledged the main reason for the prevalence level stabilizing was the introduction of free ARV's.

Another reason for the pandemic to have taken different paths was because the Brazilian government started to respond to HIV and AIDS at an earlier stage than South Africa. One example was the free ARV's roll out. While in Brazil it started in 1996, in South Africa it only started in 2005.

In South Africa the respondents were very optimistic about the future spread of HIV in South Africa. Some of the reasons were because for the first time in South Africa there is a president that is talking about HIV and AIDS, for the first time in South Africa there is a National Strategic Plan for HIV and AIDS. Another reason is that South Africa has reached stabilization of the pandemic in the last few years, so therefore the pandemic will either decrease or carry on in the same rate in the next few years.

In Brazil respondents were pessimistic about the future spread of HIV. Some of the reasons were because there are not many prevention programmes in place. Another reason is because the civil society has not been very active in the past years.

To determine the knowledge which respondents have on the prevention methods set by the policy in their country:

The researcher determined that respondents in Brazil had a good understanding and knowledge of the NSP. One of the reasons for them having a good knowledge on the policy is because they were directly involved in formulating the policy. Other reason for respondents having a good knowledge of the policy is because they have an HIV and AIDS forum, which represents NGOs in the government. This forum passes information from the NGO sector to the government and from the government to NGOs through quarterly meetings.

Another reason for the Brazilian respondents have had an input on the policy is because they are also looking at what the government is doing and if the government does something without their consent, they protest against it.

In South Africa only 2 respondents had a good understanding and knowledge of the NSP for HIV and AIDS. Some of the reasons are because other organisations are not involved in the formulation of the policy and also there is no institution or organisation that connects the government with the NGO and the NGO with the government.

The research also revealed that organisations in South Africa do not protest or advocate much against the government. All of the respondents pointed out TAC as the main organisation which advocated against the government, none of them pointed themselves as an organisation that protested against the South African government.

To find out how organisation directors think that the current economic crisis impact on the HIV and AIDS issue:

The researcher found that the respondents in South Africa think that the economic crisis will have a big impact on their organisations and on the prevalence, while in Brazil respondents were not so worried. One of the reasons may have been because organisations in Brazil have

different methods of fundraising while organisations in South Africa are still reliant on government funding and funding institutions.

5.3 Recommendations

One recommendation for the research process is to do a comparative study with another country which has managed to decrease the HIV and AIDS prevalence rate in order to find out what they have done and how it can be incorporated in other countries.

5.3.1 Brazil

Even though Brazil is known to have a success history in relation to the HIV and AIDS pandemic the researcher has some recommendations.

One of the recommendations for Brazil is to look at alternative prevention methods such as circumcision and the risk of multi-concurrent partners, as most respondents in Brazil mentioned that the condom was the only prevention method being used, as the Brazilian policy did not mention any programmes that look at the risk of multi-concurrent partners and circumcision.

Brazil should also have more VTC campaigns as some of the respondents mentioned that there are many people that do not know their HIV status. Brazil has large campaigns for the vaccination against poliomyelitis which covers most of the population in Brazil. The HIV field should also have large campaigns for VTC.

As was mentioned by some of the respondents in the last few years many women are being infected, therefore Brazil should pay more attention to this factor and create prevention campaigns focused on women. Another factor which was mentioned by most of the respondents was that in the last decade there was a huge increase of infections among the elderly population. Therefore specific prevention campaigns should be developed to contain this problem. Brazil should also have a more effective testing in pre-natal clinics among pregnant women, as it has been reported that not all pregnant women are tested for HIV. This would help prevent mother to child transmission.

Another recommendation for Brazil is to have better information on the side effects of ARV's and how the ARV's works in the human body. As it was mentioned by most of the respondents many people, especially the youth, are not as careful as before because they think that if they get infected with HIV they can take ARV's and live a healthy life without knowing the side effects of these ARV's.

In the researcher's experience that the best way to inform people in Brazil are through the media-television, radio and through educational institutions. Therefore the Brazilian government should develop campaigns which could provide information through these media.

5.3.2 South Africa

South Africa does not have a success story regarding the HIV and AIDS pandemic so therefore the researcher has some recommendations.

One recommendation for South Africa is to have more involvement from the NGO sector in the formulation of policies, as they are the ones who implement them. By giving them the opportunity to participate in the formulation of policies, it would also give them the sense of belonging and they would work harder to achieve the goals which they have helped to create. This recommendation is not only for the HIV and AIDS field but also for other NGOs that addresses social issues.

The South Africa organisations that deal with HIV and AIDS should create a forum or a partnership network. NACOSA is one network organisation which more organisations should be join because by getting together organisations can make their voices heard on governmental level. By being part of a network organisation it could also give more credibility to those organisations when it comes to looking for funding as funders would know that organisation are looking after one another. By forming a network organisations would also prevent two or more organisations doing the same kind of work in the same area.

Other important issues that organisations in South Africa should address is developing better fundraising strategies, as many organisations are still very dependent on foreign funding and

government funding. They should also look at different strategies which could make the organisation self sustainable.

Other recommendation would be to provide information on the language which is spoken in the area which services are provided. South Africa has 11 official languages and it is important to spread the information in a language that is understood by the intended audience.

South Africa should look at other countries which have had success in relation to HIV and find out what they have done and adapt it to the South African context. South African organisations should also advocate more against the government, as most of the respondents mentioned that they do not advocate or demand better responses from the government.

In relation to the policy, South Africa should have action plans for each goal which they have formulated the policy in and layout who would be responsible to achieve these goals. This is because in the NSP for HIV and AIDS there were no action plans for the listed goals. The South African policy should be more decentralized even though some of the respondents mentioned that they are starting to decentralize. The researcher did not find any policies that concentrated at a district or municipal level. This is because some areas may have different problems therefore needing a specific plan for that area.

South Africa should have bigger prevention campaigns which address the danger of multi-concurrent partners, as in some cultures multi-concurrent partners are legally accepted. Like Brazil, South Africa should hold more campaigns to inform the population of the side effects of ARV's and how they work in the human body. South Africa should also have campaigns which incentivises parent to child communication about HIV and AIDS.

Another recommendation is that political leaders of South Africa should speak more openly about the disease and not deny the disease as has happened in the past. In the researcher's opinion, political leaders should be tested and their status should be announced to the general public. This would help to break the stigma attached to HIV and AIDS.

5.4 Conclusion

This chapter has clearly reflected all of the objectives of the research and established a conclusion regarding the findings in the research. Some recommendations were made regarding the research process and some recommendations were made regarding what the respondents have suggested. It is hoped that the conclusions that were reached in this research will help organisations in Brazil and in South Africa to improve their services so a reduction in HIV and AIDS infection rate can be achieved.

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APPENDICES

Appendix 1: Interview Schedule

1 - Organisation:

Name of Organisation: **Name of Interviewee**:

a) Can you tell me a bit about your organisation?
   - When was it established?
   - What were the reasons for this organisation to be formed?
   - The area which this organisation focus and why this area?
   - How many people are employed by this organisation?
   - How long have you been working on HIV and AIDS field?

b) Are there many organisations in Cape Town focusing on this area of service?

c) In your opinion what are the general public views on HIV and AIDS? Are they positive or negative?

d) Do you think HIV has become old news among the general public?

e) What is the role of this organisation regarding HIV and AIDS in your country?

f) What is the mains source of funding of this organisation? Private or government?
   - What percentage of your funding comes from government? From what sector? *(Provincial, national, health, development, education…)* Does the funding come with any restrictions? If so what are they? Why do you think it comes with restrictions?
   - What area from sector from the government allocates most money to the HIV prevention cause? Why do you think it is that sector? Any specific political party or person involved in that sector?
   - Do you think the government provides enough funding for you organisation? And for HIV?
   - From the private sector, who are the main donors? What are the main organisations that donate money to your organisation?
   - Does the money come with restrictions? If so what are they?
   - What is this organisation main method of fundraising?
   - Have you had to change your methods of fundraising along the years? If so how and why have you changed?

2- What do key informants think about the difference on the spread of the pandemic in the two countries?

a) Looking at the graph we can see 3 different periods regarding the spread of HIV? What has happened in South Africa during period of 1990 to 1996? What happened in South Africa during 1997-2003 where the pandemic rose at its fastest rate? What happened from 2004 to present where the rate stabilized? What was done different between those 3 periods regarding HIV/AIDS? (*only to be asked in South Africa)*
What happened in Brazil during the period from 1990 – 1996 where the pandemic rose at its highest rate? What happened during the period of 1997 – present where the pandemic to have stabilized? What was done different in those 2 periods regarding HIV/AIDS? *(only to be asked in Brazil).*

b) What does the graph say about your government response?
c) When did Brazilian/South African government first realise that HIV was an important issue?
d) What led to that? Was there a conference, protest?
e) Looking at the other table what does it say about the other country response?
f) What are the reasons for taking this time for the pandemic to stabilize in your country? Why do you think your country didn't learn from other countries like Uganda?
g) What do you think about South African/Brazilian decisions regarding HIV in the early years?
h) What rate in your opinion would you consider as reasonable giving your country's situation?
i) In your opinion why isn't the prevalence dropping in both countries?
j) What is the cooperation between Brazil/South Africa and other countries? What are the countries? Do you think there should be more or less cooperative and why?
k) What is the degree of cooperation between Brazil and South Africa regarding HIV and AIDS? Do you think there should be more or less and why?
l) From you expert opinion how do you think the graph will look in the years to come? And why?
m) Do you think it is possible to one day control the pandemic? (reasons)

3- What are the key informant's perceptions on the current and past HIV and AIDS prevention methods set by the policy?

Policy History:

a) When was the first response to the pandemic drawn? Who was responsible for this response, was it government or private?
b) What and when was the first government response against HIV? What made the government to respond?

c) How long did it take for the first policy to be implemented? When was it?
d) Has this organisation had any influence on past policies? What is your view regarding past policies? Were they good or bad?
e) What sector of the government was responsible for HIV and AIDS prevention? What was the government structure regarding prevention? Were they national policies or provincial?
f) Was there any political party that is more active in HIV and AIDS prevention?
g) Who had input in the policy? Were these people experts on the matter? Who had influence on the policy
h) How does outside organisations like UNAIDS, PEPPFAR and others have input on the policy? Do you think they should have input on the policy?

Current Policy:

a) What do you know about the current prevention methods set by your government strategic plan? Is there any framework that this organisation has to follow? How did you get to know?
b) What do you think about the prevention methods set by the policy is good or bad? Would you change any thing and why?
c) Has this organisation had any influence on present policy?
d) What are your views on the people that is responsible for writing up the policy? Are these people experts?
e) Do you think the prevention goals set by the policy are achievable? Why?
f) In your opinion what is the best prevention methods for your countries context and why?
g) If you could change any thing on the policy what would it be and why?
h) What is the connection between this organisation and the government regarding policy implementation? Has this organisation ever been consulted by the government regarding implementation and monitoring of the policy?
i) What sectors of the government are responsible HIV and AIDS? What sector of the government is responsible for prevention? Do you think that is the appropriate sector?
j) Do you think the government pays enough attention to HIV? What area of HIV should the government pay more attention and why?

4. What do key informants think about the impact of the current economic crisis on HIV and AIDS?

Where does the funding come from?

As it has been reported the economic crisis has impacted quite drastically in some private organisations, therefore also has impacted the government, as less money will be raised in tax. (It has been reported by the economist magazine that the South African GDP will drop to from 1.8% in 2009 and 3.1 in 2010.) (as it has been reported by the news paper Estado de

Sao Paulo in 22nd April 2009, the Brazilian GDP is predicted shrink by 1.3% in 2009 and then recover and increase by 2.3% in 2010).

a) Has your organisation been impacted by the current economic meltdown? If so How? By how much? If not do you think its going to be impacted in the longer run?
b) Have other catastrophes like the swine flu or major floods, impacted on funding for HIV and AIDS? If so how?
c) With the economic crisis more people will be unemployed; do you think this will lead to a raise in risk behaviours? Eg: raise in prostitution, more people with more free time and sex is a "free" form of "entertaining". Do you think this will impact on the prevalence rate? If so how?
d) Do you think any changes should be made to the prevention methods because of the economic crisis? If so in what areas and why?
e) What is the impact of HIV and AIDS on the economy?

Is there any thing that you want to tell me that may contribute to this study?

Appendix 2: Framework of Analysis

Themes	Categories	Sub-categories
1. Organisation	I. Knowledge on other organisations	i. Brazil ii. South Africa
	II. Public views on HIV	i. Brazil ii. South Africa
	III. Finance	i. Government ii. Private fundraising
2. Policies	I. South Africa Policy	i. Brazil ii. South Africa
	II. Brazilian Policy	i. Brazil ii. South Africa
	III. Knowledge on past policies	i. Brazil ii. South Africa
	IV. Knowledge on current policy	i. Brazil ii. South Africa
	V. Organisation influence on the policy	i. Brazil ii. South Africa
	VI. Views on Policy Makers	i. Brazil ii. South Africa
	VII. Views on Best prevention methods	i. Brazil ii. South Africa
	VIII. Views on Government response	
3. Perception on the spread	I. Reason for the spread in Brazil	i. From 1990-1996 ii. From 1997-2002
	II. Reason for the Spread in South Africa	i. From 1990-1996 ii. From 1997-2002 iii. From 2003-2007
	III. What made the government respond	i. Brazil ii. South Africa
	IV. View when the government realized it was an important issue	i. Brazil ii. South Africa
	V. Why the prevalence is not dropping	i. Brazil ii. South Africa
	VI. Views on the prevalence in the future	i. Brazil ii. South Africa
4. Views on Economic Crisis	I. Impact on the organisation	i. Brazil ii. South Africa
	II. Impact on the prevalence	i. Brazil ii. South Africa