Meeting the challenges of the Ottawa Charter: comparing South African responses to AIDS and tobacco control

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SUMMARY

The paper compares the response of the South African Government to HIV and AIDS with the government’s policy development concerning the use of tobacco. The high burden of disease from HIV and AIDS in South Africa and the morbidity and mortality from the use of tobacco are outlined. Using the framework of the Ottawa Charter for Health Promotion, the paper reviews and critiques the Government’s different stance to building public policy, creating supportive environments, engaging community participation, developing personal skills and re-orienting the health services, for HIV/AIDS and tobacco. The result of these policy choices is described. The lack of adequate implementation of the key elements of the Ottawa Charter has resulted in high morbidity and mortality due to the spread of HIV infection in South Africa. This has also influenced the resurgence of tuberculosis, and the accompanying MDR and XDR TB epidemics. The high prevalence of HIV infection has also meant that the health system is unable to cope with the large numbers of patients requiring anti-retroviral treatment, and the early morbidity and mortality of young economically active people has had devastating social consequences, resulting in the large numbers of orphans. In contrast, South Africa is a signatory to the World Health Organizations’ Framework Convention on Tobacco Control, and has successfully implemented many of the policies.

Key words: HIV/AIDS; policy development; tobacco control

INTRODUCTION

The paper compares the response of the South African Government to HIV and AIDS with the government’s policy development concerning the use of tobacco. The review critically examines whether a consistent approach using scientific evidence as propounded for tobacco control could have provided a more coherent and effective strategy for HIV policies and programmes.

The paper highlights some of the important events and compares the different stance adopted by Government for these two major health challenges; it considers the rationale for such differences and concludes by considering the implications for the country’s progress and development. This paper presents first the magnitude of each of the two selected public health problems in South Africa viz., HIV/AIDS and tobacco, followed by an analysis using the five dimensions of the Ottawa Charter for Health Promotion (WHO, 1986).

The Ottawa Charter emphasizes five aspects to comprehensively promote health.
In (1) ‘Building healthy public policy’ government should develop and implement policies that promote optimum health. (2) The Charter recognizes that ‘Creating a supportive environment’ is necessary to facilitate healthy choices, and (3) ‘Community participation’ is required in order to promote healthy living and to encourage people to move from unhealthy practices, e.g. unsafe sex, to more healthy lifestyles. (4) In ‘Developing personal skills’ effective interventions should address the particular needs of the target group and the determinants that influence individual behaviour. (5) ‘Re-orienting health service providers’ to promotive and preventive practices rather than a focus only on the provision of curative treatment requires a change in the attitudes of health providers (WHO, 1986).

In 1994, after 46 years of apartheid, the new government took office in the early years of the HIV/AIDS epidemic in South Africa (Van Rensburg, 2004). In the health sphere, the focus was on transforming the health system to primary health care to alleviate the lack of health services. South Africa has both infectious and chronic diseases, and HIV/AIDS/TB caused 31.0% deaths, and smoking, 8.5% of all deaths in 2000 (Norman et al., 2007). Hence the choice of these two subjects—HIV/AIDS and tobacco control, for consideration.

Prevalence of HIV and AIDS in South Africa

The prevalence of HIV infection in South Africa has increased among women attending public antenatal care clinics from 0.7% (1990) to 28.0% (2007) (DoH, 2008). A national household survey reported that 16.2% of the 15–49 year respondents were infected (Shisana et al., 2005), and UNAIDS estimated in 2007 that 5.7 million people in South Africa were living with HIV (UNAIDS, 2008). The life expectancy of South Africans has decreased to 49.5 years (HDR, 2008), and HIV/AIDS accounted for an increase in all cause deaths of 170% among the 25–49 year age group from 1997 to 2006 (Statistics South Africa, 2008). The high prevalence of HIV and AIDS resulted in a rapid increase in the prevalence of opportunistic infections including tuberculosis, adding further pressure to a health system already under stress brought about through budgetary cuts to hospitals (Boulle et al., 2000).

Use of tobacco in South Africa

Between 41,632 and 46,656 deaths occurred from smoking in 2000 in South Africa with cardiovascular diseases accounting for the largest proportion of smoking attributable deaths (Groenewald et al., 2007). The use of tobacco is also associated with cancer and maternal smoking during pregnancy has been shown to have deleterious effects on both mother and infant (NIDA, 1998). The tobacco product used most often in South Africa is cigarettes. The South African tobacco control policy initiatives have resulted in a decrease in per capita consumption by 40% from 1993 to 2006, and aggregate cigarette consumption has decreased by about one-third. In 1993, 32.5% of adults smoked when compared with 22.4% in 2006 (HST, 2008). There was also a reduction in the use of tobacco by school-goers and the prevalence of tobacco use decreased from 32.5% (1999) to 27.6% (2002) (GYTS, 2002).

BUILDING PUBLIC POLICY

HIV and AIDS public policy (1990–94)

The first cases of HIV/AIDS were seen in the early 1980s. In 1992–94, NACOSA (National AIDS Co-ordinating Committee of South Africa) was established and developed the National Action Plan for South Africa. This aimed to lower the incidence of HIV and reduce AIDS morbidity and mortality through an integrated response, including education and prevention strategies, counselling about the disease, provision of health care for those infected, and respecting the human rights of those infected and affected by HIV (Fourie, 2006).


In 1994, President Mandela took office. In the health sector, the emphasis was on the transformation and the restructuring of the health system. The focus included building clinics in rural areas, and the provision of PHC training for nurses who would provide the services (DoH, 1997). There were few effective AIDS policies instituted and little consultation between Government, scientists and civil society experts. Thus, the response to the HIV
and AIDS epidemic in the first 5 years was problematic with the country failing to implement the prepared National AIDS Plan, and adversarial relationships between Government and many in civil society.


In the critical years from 1999 to 2004, Government displayed both a lack of vision and sense of urgency in its handling of the HIV and AIDS epidemic. Some progress was made, in that many departments drafted AIDS policies, e.g. Department of Education (1999) and Department of Social Development (2000, 2001), but implementation of the policies was limited in scope, and seldom evaluated. The HIV/AIDS strategy for 2000–05 did not include antiretroviral treatment (DoH, 2000). Using the Bill of Rights entrenched in the Constitution, civil society, especially through the Treatment Action Campaign (TAC) used this human rights’ framework to challenge Government and in a landmark decision the Constitutional Court ruled in favour of public provision of drugs to prevent mother to child transmission of HIV, and this initiation of antiretroviral medication proved to be a turning point in Government’s HIV treatment policy (Heywood, 2005). The promulgation in 2003 of the operational plan for provision of antiretroviral drugs (ARVs) in the public sector was greeted with much optimism (DoH, 2003), but although South Africa was implementing the largest public ARV programme in the world, the ART roll-out was inadequate due to the high prevalence of AIDS.

Building healthy public policy: tobacco control in South Africa

The advocacy role of the Tobacco Action Group (TAG), established in 1991, was central in mobilizing both the South African Government and community support for the anti-tobacco legislation (Malan and Leaver, 2002). The Tobacco Products Control Act (Act 83 of 1993) resulted in a series of policies to reduce tobacco consumption in South Africa. The legislation banned sales of tobacco to persons under 16 years of age, and introduced health warnings on cigarette cartons. The 1999 Tobacco Control Amendment Act banned tobacco advertising, sponsorships and gifts, and prohibited incentives for tobacco purchases. This anti-tobacco policy was further strengthened by the Tobacco Products Control Amendment Bill, 2003, and then enhanced by the 2006 Tobacco Amendment Bill that banned the display of tobacco products at the point of sale, and increased fines that could be levied for contravention of the Act. Tobacco Control in South Africa was assisted by the escalation in excise tax with the inflation-adjusted price of cigarettes increasing by 115% in the decade from 1993 (Van Walbeek, 2002). On the international front, South Africa signed the Framework Convention on Tobacco Control committing the country to the goal of reduced tobacco consumption (WHO, 2003).

CREATING A SUPPORTIVE ENVIRONMENT

Creating a supportive environment for HIV/AIDS prevention and treatment

The Constitution enshrines gender equity (Constitution, 1996), but enforcing this remains a major challenge in a country where patriarchal cultural traditions remain deeply ingrained, with a high prevalence of sexual violence and rape (Dunkle et al., 2004). In 2000, President Mbeki confirmed his belief that it is poverty that causes AIDS (Fourie, 2006), and indeed the high levels of poverty and unemployment exacerbate the epidemic and have proved difficult to address. The transmission of HIV is influenced by the lack of gender equity, poverty and unemployment with women unable to refuse unsafe sex, the antithesis of a supportive environment (Pelser et al., 2004; Heywood, 2005). In 2000, Mbeki established the President’s AIDS Panel to which South African scientists and dissidents who questioned the existence of HIV/AIDS were appointed, a clear indication of his lack of support for HIV and AIDS scientific initiatives. Further, statistics indicating that AIDS was causing the majority of deaths in South Africa were challenged by Government, despite the evidence that the mortality rate among women of 25–29 years in 1999/2000 was 3.5 times higher than 1985 (Dorrington et al., 2001). No concerted effort was made to respond to the challenge of the HIV epidemic by acknowledging that changing sexual behaviour is essential, accepting the
large numbers of people infected and affected, and encouraging more open communication to reduce stigma, and promote HIV testing and treatment (Nattrass, 2004; Heywood, 2005; Fourie, 2006).

Creating a supportive environment: tobacco control

In contrast, the legislation concerning tobacco control assisted in providing a supportive environment in South Africa for informed anti-tobacco decisions and behaviours. The legislation altered the environment, by reducing access to tobacco and pro-tobacco advertising, and by promoting a tobacco-free environment (Saloojee, 2000). Regulating smoking in public places resulted in increased awareness among non-smokers of their rights and the detrimental effects of smoking. Passive smoking in public places was thus reduced, creating a less smoke-polluted environment.

COMMUNITY PARTICIPATION

Community participation: interventions for HIV and AIDS

Community participation strategies for the primary prevention of HIV/AIDS have been inadequate. The predominant focus has been on the care of people with HIV/AIDS, and the Department of Health has used different strategies such as establishing hospital and clinic committees and training community health workers and home-based care workers. Communities are involved because the high prevalence of HIV infection has overwhelmed the capacity of the health services and most people infected with HIV/AIDS will be cared for, and die at home (Urdaneta, 2003; Akintola, 2006). The increasing number of orphans has resulted in relatives and elderly grandparents now responsible after the death of the children’s parents (Pelser et al., 2004). The high social and emotional cost to caregivers and the children themselves, in addition to the financial costs has been documented (Akintola, 2006). In order to move Government to action AIDS civil society organizations in South Africa have used a variety of community mobilization strategies to prod Government to implement AIDS treatment programmes.

Community participation in tobacco control

In contrast to the above, activities of TAG and the anti-tobacco legislation raised awareness among communities of the detrimental health effects of tobacco and the implied message that smoking was an anti-social activity. The supportive environment created by the anti-tobacco legislation provided communities with an effective strategy to defend their right to a tobacco-free environment with restaurants and coffee shops obliged to provide a separate room for smokers.

DEVELOPING PERSONAL SKILLS

Developing personal skills: reducing HIV infections

The majority of people in South Africa are aware that HIV is sexually transmitted and that the use of condoms can prevent HIV transmission (Pelser et al., 2004). The Department of Health’s policy of ‘Abstinence, be Faithful or use Condoms’ is supported by the supply of free condoms. The Life Skills’ Programme is part of the school curriculum that aims to reduce HIV incidence, but young people demonstrate a lack of personal skills to prevent infection with a HIV prevalence of 12.9% among young women (15–19 years) attending antenatal care (DoH, 2008). Government has used mass media including television to increase awareness about HIV prevention and treatment, but policy is contradicted by the behaviour of high-profile public leaders (e.g. African National Congress president Zuma’s lack of condom use when having sex with a woman he knew to be HIV positive), resulting in confusing messages regarding safer sex (Sember, 2008).

Build personal skills for tobacco control

Over 90% of respondents were aware of the harmful effects of tobacco use (DoH, 1998) and the importance of prevention among children and youth. Cultural differences in the use of tobacco are protective, with females in many communities less likely to report lifetime use (DoH, 1998). The Department of Education’s Life Skills’ programme in schools aims to prevent behaviour that adversely affects students’ health and to reduce the prevalence of
substance use, including preventing youth initiating smoking.

RE-ORIENTING HEALTH SERVICES

Re-orienting health services during the HIV and AIDS epidemic

The Ottawa Charter aims to re-orientate health services from a solely curative towards a more health promoting approach. South Africa has a massive disease burden, with the highest prevalence of HIV infection in the world (UNAIDS, 2008), resulting in the high prevalence of opportunistic infections and South Africa’s TB burden (5.5% of all deaths in 2000 and which is now among the severest in the world) (DoH, 2007). There is thus a focus on clinical care with an additional constraint being the shortage of clinical staff (Kumar, 2007). Re-orienting health services has proved problematic in this context.

Re-orient health services for tobacco control

The shortage of health-care workers and devastating HIV/AIDS and TB epidemics has diverted attention from tobacco control within the health services. In some instances, attention has been paid to the primary prevention of tobacco use—for example, the cessation of smoking among pregnant women (Steyn, 1997).

DISCUSSION

This paper reviewed the South African Government’s approaches to two different health problems. Government’s steadfastness in implementing policies for tobacco control, despite protests from the tobacco industry stands in sharp contrast to its prevarication concerning HIV and its policy development around this. Government was prepared to take on the powerful tobacco industry which provided sponsorship for the major sporting events, not with standing that South Africa is a sports’ loving country. Alternative sponsorship was sought and found. The purposeful introduction and repeated fine-tuning of South Africa’s anti-tobacco legislation contrasts with the legal confrontations and court actions required for Government to provide antiretroviral treatment. Early provision of these lifesaving drugs could perhaps have influenced the course of the epidemic and saved lives. However, even without ARV provision, a clear position that HIV causes AIDS and the need to ensure safe sexual practices was essential. As a result of public statements and the position taken by South Africa’s leadership on prevention, treatment and care, the public has been confused about their personal risk of HIV infection (Dladla et al., 2001).

The Ottawa Charter has been an important framework used for health promotion of populations and to strengthen peoples’ health potential (WHO, 2007). Further, the Ottawa Charter provides guidance on actions to be taken to address the determinants of health through policy, and environmental, social and behavioural interventions (WHO, 2007). The initiation of healthy public policy aims to create an environment that encourages behaviours such as safe sex and tobacco-free environments. Government has a crucial role not only in developing appropriate policies but also in ensuring their implementation through monitoring and evaluating the effectiveness of such programmes. An example is the policy development for tobacco control that has resulted in new amendments that addressed gaps found in the legislation (e.g. prohibiting advertising of tobacco products, and reducing point of sale access to cigarettes).

An alternative response

South Africa needed visionary leadership to talk openly about the challenges that AIDS would bring to the young democracy and that acknowledged the fractured inequitable South African society; leadership that would emphasize personal sexual responsibility and individual risk of infection and that challenged existing gender mores, e.g. President Musoweni of Uganda raised the topic of ‘no grazing’ frequently in public (Kirby, 2008). South Africa also needed leadership that accepted the science; that HIV causes AIDS; and that antiretroviral treatment is essential for both prevention and treatment and should be readily accessible. Leadership was required to provide ART for the prevention of HIV transmission from mother to infant and to save lives, and equally to focus on behavioural change to prevention HIV. The history of tobacco control suggests that this was an achievable goal as
South Africa is one of the few countries in the world to have comprehensive anti-tobacco policies.

South Africa witnessed the inexorable spread of HIV and AIDS from the north of the continent and needed to develop and implement policies to mitigate the effects of this disease. The adverse social conditions in South Africa include the high levels of poverty and historic migrant labour practices that contribute to and exacerbate the spread of the HIV epidemic among the hetero-sexual population (SAD, 2006). It is not an easy task as South Africa’s entrenched system of migrant labour facilitates the transmission of sexually transmitted diseases. Campbell (2003) has emphasized the difficulties in changing sexual mores and practices. However, Government has failed to create a supportive environment to reduce the stigma associated with HIV, and fear of disclosing one’s HIV serostatus is a powerful driving force of the epidemic. Early testing for HIV could raise awareness, and enable those infected with HIV to choose positive living, and those not infected with HIV to try to remain uninfected. The statement by a high profile South African (Mbeki when he was President) claiming not to know anyone with HIV was hardly credible, and such discourse discourages people from admitting infection and encourages them to remain silent (Bor, 2007).

Effective community participation in respect of HIV/AIDS has been limited with communities reeling under the impact of the HIV/AIDS/TB epidemics (Akintola, 2006). Households have had to take in the children of the deceased, or to assist families whose breadwinners have passed on. However, community participation can be effective as has been clearly demonstrated by the TAC, which successfully mobilized the community in the fight for antiretroviral treatment. In an environment where parents do not talk to children about sex, the driving force of the epidemic, community participation is an important factor. Further, community participation is required to acknowledge and work to reduce the high rates of sexual violence which contribute to HIV transmission (Abrahams and Jewkes, 2005). Community involvement facilitates support for tobacco control, but the addictive nature of the substance means that relatively few adults are able to stop smoking, and thus are poor role models (Arnett, 2000).

Personal skills

Preventing adolescent and youth risky behaviour is critical. In South Africa, young women are at significantly greater risk of HIV infection than young men and both sexes require information and to hone their skills and self-efficacy to protect themselves. Encouraging youth to set and achieve goals can contribute to reducing risk behaviour (Moore and Davidson, 2006). Further, the tobacco industry targets young people with enticing offers and youth need to develop the skills to resist. Smokers also need to be assisted with skills to cease smoking (Saloojee and Steyn, 2005).

Re-orient health services

Using techniques such as motivational interviewing which requires little extra time (Thevos et al., 2000), health providers can encourage clients towards more health promoting behaviours, whether motivating condom use or reducing smoking.

In summary, the lack of adequate implementation of the five key elements of the Ottawa Charter has resulted in high morbidity and mortality due to the spread of HIV infection in South Africa. This has also influenced the resurgence of tuberculosis, and the accompanying MDR and XDR TB epidemics (DoH, 2007). The high prevalence of HIV infection has meant that the health system is unable to cope with the number of patients requiring antiretroviral treatment and the early morbidity and mortality of young economically active people has had devastating social consequences resulting in large numbers of orphans who need care. In contrast, South Africa is a signatory to the World Health Organizations’ Framework Convention on Tobacco Control, and has implemented many of the policies (WHO, 2003).

REFERENCES


