

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 19425

FolderID:

Folder Title:

Rhodes University, East London Campus [Proposal]

Stack:

S

Row:

66

Section:

6

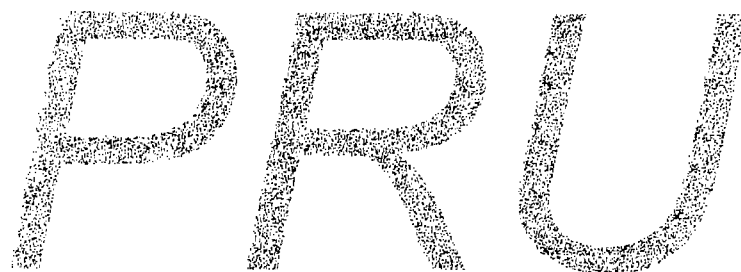
Shelf:

6

Position:

1

Rhodes University (East London)



THE POPULATION RESEARCH UNIT

**RHODES UNIVERSITY
EAST LONDON CAMPUS**

Box 7426, 50 Church Street,
East London, 5200

E-mail: rshell@dolphin.ru.ac.za; rshell@iafrica.com

phone: (O)0431-22539 (H) 0431-353618

fax: (O) 431-438307



Working Paper no 9 November 9, 1998

A proposal for an HIV/AIDS Surveillance at Rhodes University, East London Campus.

Dr Robert Shell, Director

The financial assistance of the Centre for Science Development (CSD) towards the research of the PRU is acknowledged. Opinions expressed in this report/paper/publication/thesis/script and conclusions arrived at are those of the author(s) and are not necessarily to be attributed to the Centre for Science Development.

East London → Eastern Cape Province → South Africa

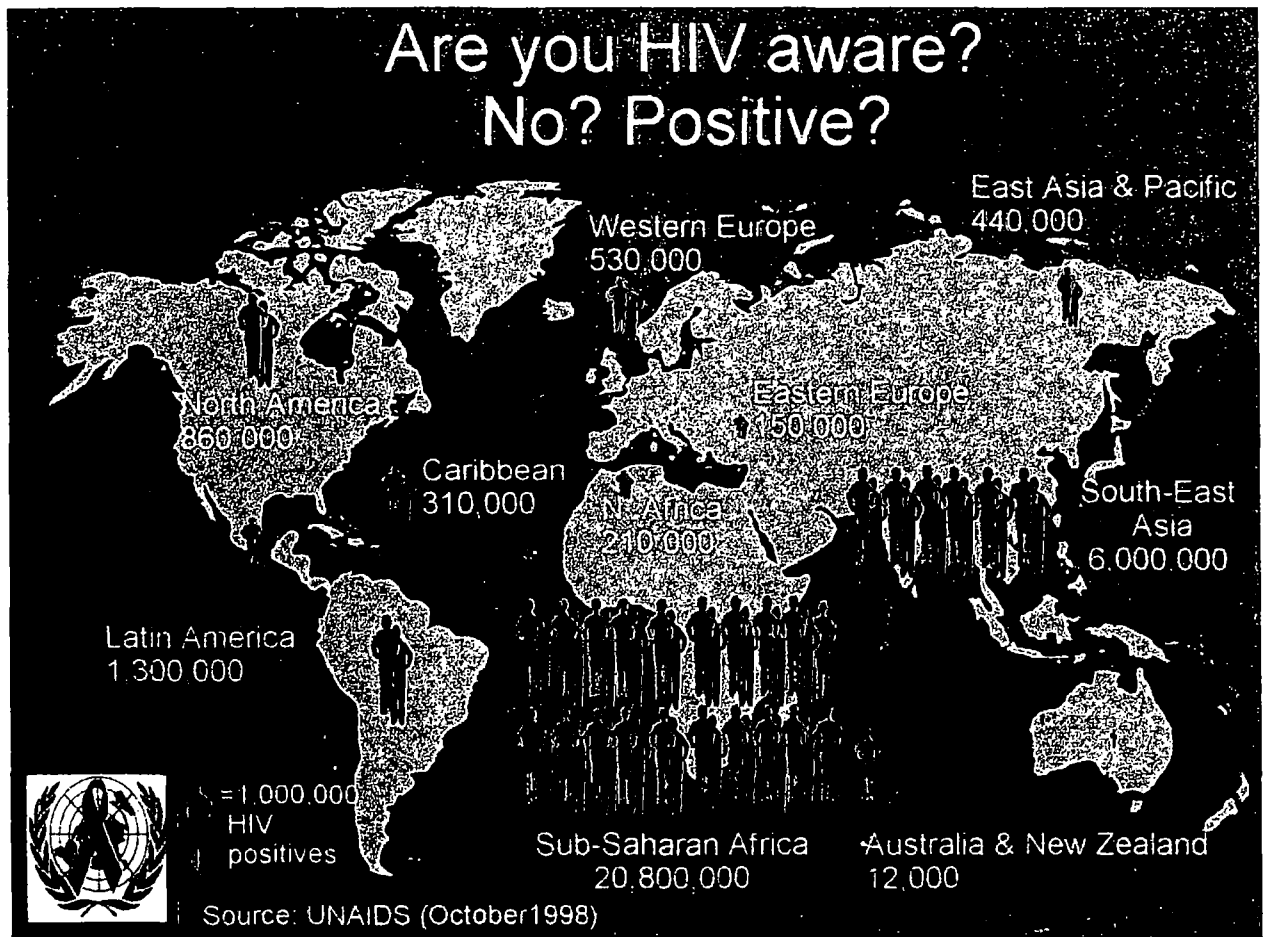
CONF
Rhodes U
11-9-98

Contents

Introduction:	2
A critique of the antenatal incidence methodology	3
An alternative methodology	3
The benefits of the surveillance system to the Provincial Health Services	4
Cost-saving	4
The capacity to construct meaningful intervention strategies	4
The roll-out strategy of the unit	5
Stage one: data acquisition	5
Stage three: automation of data entry	6
Stage four: ongoing analysis of data	7
Stage five: dissemination of results and data	7
Stage six: The establishment of archiving protocols	7
Summary	7
Appendix on the redesign of the ATICC data capture screen	8
Minor flaws in the ATICC data capture screen	8
The existing PRU HIV surveillance variable matrix	9
Provisional budget for PRU HIV Surveillance Unit	13

Introduction:

In terms of numbers of people infected with HIV South Africa is half way to the holocaust figure of 6,000,000 Jews killed in the thirties and forties. According to the recently released figures of the World Bank and UNAIDS, Sub Saharan Africa has more than two thirds of the World's 30 million HIV positives. Underlining the differences in the cultural vectors of the epidemic, North Africa has only 210,000 positives. The fifth largest city in the country and the largest city in the Eastern Cape



has more HIV cases than the whole of Australia and New Zealand combined.

Immigrants to this country are not tested and there are indications that many of our military personnel in South Africa were not tested after their return from elsewhere in Africa. Ironically, our well-developed national roads are excellent corridors for accelerating the epidemic perhaps faster than elsewhere in Africa. South African incidence figures are climbing rapidly and Prof. Robert Dorrington, an actuarial expert at UCT, has warned at the annual meeting of the Demographic Associations of South Africa (DEMSA) that South Africa could be the worst hit country in the world. What can be done?

A critique of the antenatal incidence methodology

Most studies of HIV/AIDS in South Africa rely on antenatal studies to provide comparative indices of incidence for the epidemic. The antenatal incidence statistic was chosen because it promised the most media leverage for intervention. One must ask at what level of incidence will intervention begin? As a nation, we are rapidly approaching holocaust numbers with figures of 3,000,000 positives being routinely reported nation-wide and with perhaps as many as 750,000 in the Eastern Cape. Despite these extremely high incidence levels there has not been an appropriate set of interventions from Municipal, Provincial or National levels.

Moreover, there are several methodological problems associated with this approach. The first is that the rural areas are not serviced by antenatal clinics to the same extent as urban areas. This is a particularly important shortcoming for the North Eastern regions of the Eastern Cape.

How have incidence figures helped in managing the epidemic? Obviously, antenatal data only recover direct information from pregnant mothers. Consequently, men, pre-teens, young adolescents of both sexes and also women beyond their child-bearing years are only included in antenatal studies through a tottering pyramid of assumptions. The alternative case level approach outlined here provides empirical information about the behaviour of the other groups in the HIV positive population and therefore allows for meaningful intervention strategies.

By having a local confidential surveillance unit charged with analyzing the data the Eastern Cape Health services will benefit from locally informed data and analysis which will chart the local contours of the epidemic and allow for local intervention strategies. The current situation is bedeviled by all groups waiting for national initiatives. It would seem imperative to begin local intervention strategies now.

An alternative methodology

An alternative methodology is suggested based on an ongoing analysis of existing case level data of HIV positive test results. Hopefully, this alternative methodology will be based on a more uniform, comprehensive and representative HIV surveillance system for the Eastern Cape. An attempt has already been made by the PRU to obtain HIV case level data from a much broader spectrum of sources. These new, anonymised data include results from pre-employment tests, blood donor tests, District Surgeons, MOH's, private doctors, Provincial (including mental) hospitals, municipal antenatal clinics, insurance companies, the Prison services, the South African Police and the South African National Defence Force . Because of the different collection policies of these various institutions, these data are by no means "clean", but a systematic attempt has been made by the author to homogenize the data.

The benefits of the surveillance system to the Provincial Health Services

Cost-saving

If one assumes that there are 3,000,000 HIV positive cases in South Africa and that the currently quoted figure for the monthly costs for the AZT cocktail (R4,300.00) is correct, one must assume that the minimum costs of drugs alone per year for treating advanced AIDS cases in say, five years will exceed R750,000,000,000.00 [sic]. This is not calculating for any depreciation of the Rand, nor for allowing for an increase in the number of AIDS cases. This is the numbing, budget-breaking burden of the future financing of health services which will impose horrible decisions of triage on policy makers of this country.

The epidemic in South Africa is already so deep and broad that alternative scenarios like the famous, but controversial, Cuban Sanitarium system is already too late for us. There is therefore an urgent need at least to understand the epidemic on the ground so that we can come up with some intervention strategies. One way we can begin to do that is to have an HIV/AIDS surveillance scheme for the Eastern Cape. The advantages of a surveillance system which is also charged with analyzing the data is beyond calculation. For every person who is made aware, there will be a saving.

Partly because HIV/AIDS is not a notifiable disease in South Africa, data collection has been more than somewhat haphazard in the country's poorest province. The Aids Notification Act is about to be gazetted but there have been typographical problems with the pilot printed form which has resulted in further delays in the collection of national statistics of the HIV epidemic. The Health Systems Research and Epidemiology Directorate are only now embarking on feasibility studies and have prepared a working form, but they are still at the level of pilot programs. They have acknowledged the sensitive and profound nature of the problems associated with the recording of the epidemic. The proposed PRU HIV Surveillance Unit intends to work closely with them.

According to Informatics (EL), HIV positive anonymised forms are filled out by hospital and clinic staff and forwarded to the Informatics staff around the province, who in turn forward them to District Information Units which ultimately house the forms. The data are not currently electronically entered and there is no archiving policy. The first task of the proposed unit will be to enter this unanalyzed data, archive it and use it.

The capacity to construct meaningful intervention strategies

If one admits that the alternative methodological system based on case level data (outlined in a separate, accompanying paper¹) is useful in targeting intervention strategies, then there is a most urgent need to broaden such anonymised data collection rapidly.

¹Robert C.-H. Shell, "Sexual Culture and Death" PRU Working paper no 8. Executable zipped copies are available from our archivist, S.Rowoldt@ru.ac.za

Further, there is a most urgent need to acquire systematic parallel data for the most rural areas of the province perhaps through sampling of certain regions and perhaps with a saliva rather than the ELISA test. (A program of public awareness in the rural areas must be initiated without waiting for any further results of research).

Ultimately, the new provincial surveillance system outlined here might have national significance. But already the case level approach allows for modest intervention by area, age cohort, gender and institution. For example the military complex abutting Walmer Township in Port Elizabeth is a clear case for intervention. Another area is the counseling and education of young girls in the Walmer High School. Possibly all army bases (and police stations) should be screened for incidence at a national level?

There is no mandated central provincial registry of HIV cases. In more than 95% of cases, testing has been the outcome of clinical recommendation. The results of the test have gone to the individuals concerned. No systematic effort has been made to collect this data. With the exception of the sub-populations noted below, no group is routinely tested for HIV. In certain states in America it is mandatory to be tested for HIV before getting married. In the Eastern Cape, not even a rape victim is automatically tested for HIV. This is undoubtedly the result of the expensive ELISA test procedure, currently set at R60.00 per test but there is also a range of human rights issues (see section on ethics).

An exception to the spotty provincial collection has been the Aids Training, Information and Counseling Centre (ATICC) in Port Elizabeth supervised by the MOH of PE, Dr Etienne du Plessis, which has collected data from 1988 to the present. ATICC have collected data from several sources. In terms of frequency: first, is the provincial hospital system including mental hospitals. Second is the municipal clinic system. Third is the Eastern Cape Blood Transfusion Services (all blood donors are tested). Fourth is the insurance companies (anyone who wants life cover of more than R80,000.00 has to have an HIV test). Fifth is the South African National Defence Force. The municipality of Port Elizabeth also runs pre-employment tests. Private doctors also submit some of their results to ATICC. Each data provider presents their data in their own proprietary format, placing an additional burden on the data capture clerk to homogenize the data.

The roll-out strategy of the unit

Stage one: data acquisition

One of the first aims of the unit will be to collect all existing HIV data forms from ATICC's various repositories to obtain a historical view of the epidemic. These data are not being analyzed at the moment.

Stage two: data capture

The data are currently entered and stored in a database (.dbf format) file. The database was designed by Marcel Jung of the Port Elizabeth municipality and might provide an interim database until such time as the IT department at Rhodes University can design our own. The present author has spoken to Prof. Rinette Roets about this project and she has expressed a keen personal interest in the project of developing an executable DOS or Windows- based data capture program.

Moreover, it is essential to record this data electronically and analyze them using existing GIS systems such as ARCVIEW and perhaps use existing GIS grids from the Surveyor-General, Telkom and those municipalities which have embarked on GIS. Erf number and Longitude and Latitude variables might have to be added to the post coding procedures.

Perhaps scanning images of the incoming documents might be a solution if space and time limitations become critical. By “scanning” the author does not mean Optical Character Recognition (OCR) scanning which is time-consuming but DIS (digital image scanning). Digital image scanning needs more disk space than OCR scanning but is much faster. It is suggested that a 600 dpi scanner with the appropriate software be purchased as an interim archiving measure until such time as a uniform data form is designed.

Stage three: automation of data entry

A much preferred alternative would be to distribute a pre-coded HIV data record form to all data donors and/or to have an auxiliary e-mail system for those individuals or institutions who have Internet capability. This could be set up in such a way that records prepared in ASCII with recognized tab delimiters would automatically accelerate data capture procedures. All database programs will read ASCII data (and all e-mail is sent in ASCII). As data capture is labor intensive and as the epidemic grows there will be increasing pressure on the accuracy of the data capture system which might result in increasing degradation of this important data. Provision might have to be made for a dedicated data capture clerk (or indeed several) in each city. Once HIV is notifiable the proposed PRU HIV surveillance unit might be able to tap into that data stream. Whichever system is chosen it is essential to have people who analyze this data with local, regional and even anthropological insights.

The early HIV cases (1988-1998) reveal how the epidemic began and how it changed. The entry of that early material and all subsequent will not take much time as the data are few. This process will take place at Rhodes University (East London Campus) employing PRU interns in conjunction with existing Provincial Health Units.

Stage four: ongoing analysis of data

The data will be analyzed at the PRU and the results published and disseminated through the Provincial Informatics services on an ongoing basis. Informatics can bear the costs of publishing and disseminating the material.

Stage five: dissemination of results and data

Data in SPSSPC format will be disseminated by CD or hard copy. The main thrust of the unit will be to provide analysis with which to establish intervention policies.

Stage six: The establishment of archiving protocols

Since the incoming data forms are irregular, it is strongly advised that central archiving protocols be established so that electronic data might be checked against the originals. Ms Sandy Rowoldt, who is the PRU librarian and archivist, has offered her help and advice in this matter. Researchers in the USA have used detailed HIV archival data to establish the early social patterns of infection in that continent.

A note on ethical issues

The use of such anonymised data falls far short of contact tracing and other aggressive measures used elsewhere in the world. Yet the cohort regional data will enable one to know where the vectors are coming from and which groups are being hit by the epidemic. This project will have to be thoroughly screened by an ethical committee as many of the issues are very sensitive. Ideally, the data should include names and addresses so as to be able to reach people who might have to be counseled or be made aware of new treatments but also for sorting so as to identify duplicate testing, in itself a worthwhile research project.

Summary

The HIV/AIDS epidemic will become known as the equivalent of the Black Death in Europe (1379) in South Africa and will present the nation with the most devastating human losses and financial burdens it has ever faced, far bigger than experienced in the second world war for example or, one hazards, more damaging than the terrible effects of Apartheid. There is no solution and cures are unlikely to be developed or deployed in time to avert a massive onslaught of deaths. There is therefore the most urgent need to understand the vectors of the epidemic and to develop intervention strategies quickly. We may not be able to halt the epidemic but we have an urgent need to avoid the moral consequences and burdens of an unmanaged viral holocaust of the poor.

Appendix on the redesign of the ATICC data capture screen

Minor flaws in the ATICC data capture screen

The ATICC data capture screen was modified and vastly extended in 1996 but there are still problems with the procedures of data capture which threaten to compromise several variables. For example, since there is no default “unknown” value for the “age of diagnosis” variable, it has become practice to enter the average age for that month. In the first workaround, the mean, mode and median will tend to converge and complicate the retrieval of statistical results. Most statistical procedures are based on measures of central tendency or the deviations from such measures of central tendency. It is easier for the statistician to estimate measures of central tendency if the data are entered with proper “missing” values no matter how numerous they may be.

Another workaround in this variable was to enter “0.0”. However, any statistical program interprets this as a real age “diagnosis at child birth” which is nonsense as infants cannot be properly tested for six months owing to the presence of the mother’s antibodies in the infant’s blood supply. However there are cases of still births with HIV+ mothers when it would be appropriate to enter “0.0”. In the second workaround system, the net result will be for all “unknowns” to inflate the number of infants. The accurate proportion of infants in the data analysis process is critical as it reveals the progression of the “vertical” or “uterine” vector of transmission, the relative size of which is an important indicator of the stage of the epidemic. The second workaround results in a bimodal distribution and artificially represents an increase in the ratios of lateral/vertical infection. Since there is no archive it is impossible to correct such workarounds and one has to guess at how much distortion there may be in a single variable. We therefore need an archiving policy so as to correct such workarounds.

The problem of multiple testing by one individual

There is also no easy way to identify duplicates in the testing process. Many people understandably deny the accuracy of the result and go for another, or several tests, sometimes using a variation of their name in the hope that their first result was a false positive. Only by tedious sorting on certain variables, e.g. address, can the extent of the duplicates be estimated. The accurate recording of address data and perhaps adding height in cm as an additional variable might help here. The confidentiality of the database cannot be compromised. The measurement of height has become a subject in its own right (autology) and measurement of the anonymous characteristic of height would help researchers in identifying duplicates without compromising anonymity.

These simple examples of how data are compromised at entry should be sufficient cause for the funding of a training course for data capture clerks (on site), or more broadly, through an appropriate three week data capture certificate course which could be offered through the PRU. There must be on site data training and fine tuning.

The existing PRU HIV surveillance variable matrix

DISPLAY DICTIONARY OF CURRENT DATABASE

List of variables on the working file

Name	Label
INT_LINK	Internal link
INT_NO	Internal number (by year)
INT_YEAR	Internal code: year
INT_CODE	Internal code
B_SURNAM	Biographical: Surname
B_FRST_N	Biographical: First name
B_KIN	Biographical: Kin relationship with any +
	Value Label
	1.00 Father
	1.10 Husband
	1.20 Common law husband
	2.00 Mother
	2.10 Wife
	2.20 Common law wife
	3.00 Son
	4.00 Daughter
	5.00 Uncle
	6.00 Aunt
	7.00 Lateral
	10.00 Solo
B_SEX	Biographical: Sex of respondent
	Missing Values: 'U'
	Value Label
	F Female
	M Male
	U M Unknown
B_ETHNIC	Biographical: ethnicity of respondent
	Missing Values: 'U'
	Value Label
	A Asian
	B Black
	C Coloured
	U M Unknown
	W White
B_BTHDAT	Biographical: Birthday
	DATE9
B_HEIGHT	Biographical: height in cms.
RES_LAT	Residence: latitude (GIS)
RES_LONG	Residence: longitude (GIS)

RES_ALLT Residence: allotment, EA enumerator area

RES_CIT Residence: city

RES_SUB Residence: suburb

RES_STN Residence: street number

RES_ST Residence: Street of Residence

RES_TYPE Residence: Type of residence

Missing Values: 'U'

Value	Label
BASE	Army/Pol
FARM	Farm
HOST	Hostel
HOTEL	Hotel
INS	Institution
LOC	Location
PER	Care of
POB	P.O. Box
SS	SiteServ
ST	Street
U	M Unknown

DIAG_AGE Diagnostic: Age at diagnosis

Missing Values: .00

Value	Label
.00 M	Missing

DIAG_DAT Diagnostic: date

DATE9

DIAG_WDY Diagnostic: Weekday of diagnosis

Comment: This and the following variables are derived from the date format of DIAG_DAT
WKDAY3

Value	Label
1	Sunday
2	Monday
3	Tuesday
4	Wednesday
5	Thursday
6	Friday
7	Saturday

DIAG_MON Diagnostic: Month of diagnosis
MONTH3

Value	Label
1	January
2	February
3	March
4	April
5	May
6	June
7	July
8	August
9	September
10	October
11	November
12	December

DIAG_DOC Diagnostic: doctor

DIAG_PLA Diagnostic: place of diagnosis

DIAG_INS Diagnostic: Institutions

Missing Values: 'Unknown'

Value	Label
Army	Army Bases
Blood	Eastern Cape Blood Transfusion
Hosp	Provincial Hospitals
MentHosp	Mental Hospitals
MuniClin	Municipal Clinics
Prison	Prison services

DIAG_CIT Diagnostic: city of diagnosis

Missing Values: 'Unknown'

DIAG_CI Diagnostic: numerical code of city, town and village

COUN_RCP Counseling: date of receipt of test

DATE9

COUN_DAT Counseling: date (when counseling began)

DATE9

COUN_PLA Counseling: site

DIAG_LAB Diagnostic: Testing lab

DIAG_LBN Diagnostic: Lab number

DIAG_RSN Diagnostic: Why did test take place?

DIAG_TST Diagnostic: Symptoms presented

DIAGMODE Diagnostic: Mode of Transmission

DIAG_ADA Diagnostic: Diagnosis date

DATE9

B_ALIVE Biographical: degree of infection

Value	Label
1	Positive
2	Rapid positive
3	AIDS
4	Dead

B_DTH_DT Biographical: Death date

B_D_PL Biographical: Death place

B_D_AGE Biographical: Age at death

DIAG_IND Diagnostic: comment

B_COHORT Biographical: 5 year cohort

Missing Values: 0

Value	Label
1	0 to 4
2	5 to 9
3	10 to 14
4	15 to 19
5	20 to 24
6	25 to 29
7	30 to 34
8	35 to 39
9	40 to 44
10	45 to 49
11	50 to 54
12	55 to 59
13	60 to 64
14	65 to 69
15	70 to 74
16	75 to 79
17	80+

DIAG_MOD Diagnostic: Estimated transmission mode

Missing Values: 'Unknown'

Value	Label
Bisexual	Bisexual
Child of	Descent
Haemophi	Haemophilic
Heterose	Heterosexual
Homosexu	Homosexual
MP	Multiple partners
NS	Needlestick
Other	Other
Rape	Rape
SA	Sexual abuse
Unknown M	Unknown

B_D_COHO Biographical: Death cohorts

Value	Label
1	0-4
2	5-9
3	10-14
4	15-19
5	20-24
6	25-29
7	30-34
8	35-39
9	40-44
10	45-49
11	50-54
12	55-59
13	60-64
14	65-69
15	70-74
16	75-79
17	80+

Provisional budget for PRU HIV Surveillance Unit

Startup costs: once off costs

Sunsparc Station with GIS and multi thread capabilities, graphics accelerator and 21" monitor	R260,000.00
Portable Iomega Bernoulli removable hard drives for backup and data sharing	R70,000.00
Acer Laptop with large capacity disk drive and built in CD ROM for collection of data for archivist	R21,000.00
Redesign of HIV/AIDS data capture program (subject to final quote for pulldown menus)	R105,000.00
Six Pentium computers for ATICC sites at PE, EL, Queenstown (and Umtata)	R36,000.00
Six 266 Megahertz Pentiums for data entry at the PRU	R40,000.00
Two laser printers @ R3,600.00	R7,200.00
A3 High resolution HP colour printer for GIS output	R23,000.00
High speed CD tower server and HIV Web Site for PRU HIV surveillance unit @R28,000.00	R28,000.00
Six ARCVIEW (GIS) site licenses and dongles @R3,000.00	R18,000.00
700 lumen portable data projector for PRU HIV presentations	R45,000.00
Nashua photocopier for HIV surveillance Unit	R17,000.00
Archiving costs, stationery, filing cabinets and office furniture, office equipment	R60,000.00
Discretionary fund for capital costs	R45,000.00
Capital costs (subtotal)	R775,200.00

Annual costs

Updating and fine-tuning database program	R20,000.00
Library costs for journals, CD licenses and HIV/AIDS literature (may be shared with HRC)	R130,000.00
Staff Costing unit (salary) for one HIV/AIDS demographer (1-3 year contract)	R160,000.00
Six PRU Data capture clerks' salaries at hourly or monthly rates @ R30,000.00 p.a.	R180,000.00
Annual travel budget for PRU HIV surveillance unit staff visiting sites	R60,000.00
Staff costing unit for full time secretarial assistance for managing data entry system and staff	R60,000.00
Discretionary staff costs	R20,000.00
Annual costs (subtotal)	R630,000.00
Total	R1,405,200.0
Rhodes University Admin costs 15% of all	R210,780.00
GRAND TOTAL	R1,615,980.00

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.



RHODES UNIVERSITY

RHODOS

STAFF NEWSLETTER

30 October 1998 VOL 10 No18

A New Generation of Environmental Professionals at Rhodes

A new programme of environmental studies is going to give Rhodes the competitive edge in this popular and fast-moving field.

According to Christo Fabricius (Associate Professor and Head of the Environmental Science Programme), the newly established programme will attract students who would not necessarily have come to Rhodes. "We want to teach students to think in new ways, and to respect and understand different viewpoints about the environment. They need to become leaders who can build bridges between different role players; professionals who understand sustainable development. We'd like our students to be prepared for the real world when they leave here; people who can analyse problems critically but sensitively, and who can work in teams. To do this we will build on the many strengths which already exist at Rhodes but also bring in specialists from outside if necessary. We also have to consult with employers and donors to see what their needs are. But we must take care to build on our reputation as a "centre of excellence" which can measure up to international standards."

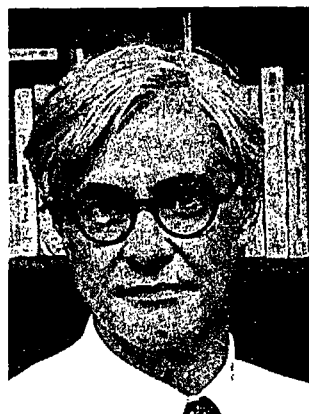
According to the Deputy Permanent Secretary of the Eastern Cape Department of

Economic Affairs, Environment and Tourism, Maria Mbengashe: "There is a great need in the Eastern Cape for education, training and capacity-building in a number of areas involving the human and natural environments. These include sustainable development, environmental impact analysis, pollution control, environmental health, natural resources management, and community participation in environmental and economic decision making. There is also a need for co-ordination of the efforts of a number of tertiary institutions and private institutions in the overall area of integrated environmental development."

Apart from focusing on the management of our plant, animal and earth resources, the course also allows students to specialise in Environmental Law and Policy (in collaboration with the Law Department), Environment and Society (in collaboration with Anthropology and Geography), Coastal Resource Management (in collaboration with Botany and Zoology) and Environmental Economics (in collaboration with the Economics Department). Another speciality direction, Sustainable Water Resource Management, is planned and is being developed together with Zoology and Geography.

Page 4

The PRU leads the way



One of Rhodes University's high profile research institutes is set to receive more public attention, as Port Elizabeth's demographic projections up to 2021, carried out by the Population Research Unit at Rhodes East London campus, gets set to publish its final results.

The Port Elizabeth demographic projection project was funded by SEDA and the Hifab consultancy - both Swedish donor foundations - and is part of Port Elizabeth's Comprehensive Urban Plan (CUP).

The Population Research Unit (PRU), directed by Dr Rob Shell, is one of three new units which are funded by the Centre for Science Development (CSD) in Pretoria. They are national, not provincial units, which produce component projections of urban and rural areas and do a full range of demographic research. These projections forecast major trends in the location and growth of workforces

and migration into the cities, factors that will affect the growth, in this case, of the greater Port Elizabeth metropolitan area. The recent completed project has provided estimates of the greater Port Elizabeth area of 1,960,000 in the year 2021, "though this figure is dependent on PE's aggressive intervention in the AIDS epidemic," said Dr Shell.

Part of the PRU's portfolio is HIV/AIDS surveillance of the Eastern Cape, an under-studied subject in the region. Using data collected by the Port Elizabeth ATICC clinic, Dr Shell and his intern, Nomonde Qaga, have created a database of HIV cases, and some shocking results have already emerged.

Dr Shell likens the spread of AIDS within the Eastern Cape to a 'viral holocaust' - a disaster that will ultimately affect more people than the six million Jews killed in the thirties and forties. According to Peter Doyle's projections, by 2006 AIDS deaths will outnumber all other deaths. By 2021 the life expectancy within the province may drop below 40 years. These projections may, with some certainty, be extrapolated to other provinces, and indeed the whole country. According to Dr Shell, AIDS patients currently occupy 30% of all beds in some hospitals. The expense of AIDS treatment is

Page 5

4 pages



RHODES UNIVERSITY

MARKETING AND COMMUNICATIONS • Tel: (046) 603 8513 • Fax: (046) 636 1902 • e-mail: adad@giraffe.ru.ac.za

Fax to: Ms Sandra L Thurman, Office of USA National AIDS policy
Executive Office of the President, Washington
Fax number: 091 202 632 1096
Date: 16 February 1998
Subject: AIDS consortium progress

Dear Sandy,

I hope all is well with you and everyone else in the office - and that the parcel of papers etc arrived safely. I was pleased to hear on the news today that President Clinton's visit to SA is on after all (barring further catastrophes either at home or abroad no doubt) and wondered if your own next visit was also back on track.

Rod Fisk was out here just a couple of days after you left - it was such a pleasure to meet him after so many months of dealing with him by email and phone alone. He has given me your email address, but he rather gave me the impression that faxes work better in the White House. Or do you use yours now?

Since your visit, I have been liaising with Jane Adar (the lady who spoke up rather timidly at the end of the Rhodes meeting about her consortium). It turns out that this embryo organisation may well be able to provide the basics for just the sort of consortium or forum which we had in mind. Jane is the wife of a Rhodes academic who has come here recently from Kenya, where she created the Kenya National AIDS Control Secretariat which drafted AIDS policy among other activities and for some 8 years she ran a major Family Health care provision service, which was deeply involved in AIDS/HIV/STD issues.

Dragged from her own career because of her husband's new posting, Jane is still finding her feet in the local environment, although she is now lecturing at a series of workshops being held at Rhodes in East London (as a result of your visit), organised by Equity, and had started gathering together AIDS workers in Grahamstown to create the beginnings of a forum. Your visit and the realisation among such a wide group of the necessity for such a forum, has spurred her - and me! - on.

Jane has prepared a draft proposal of which I am faxing you a summary for your comment. Do you think there is any likelihood of the forum receiving financial assistance from the US to get off the ground? If she and I can make that work as a result of your visit, we will have taken some major strides in improving the delivery of AIDS services in the Eastern Cape.

I have taken up snorkelling since you were here - spend as much of each weekend as possible lying motionless in sea pools watching the incredible world that exists just below the surface. Yesterday, among shoals of bright little fish I came face to face with a very large octopus - both of us got a terrible fright!

I look forward to hearing your news - my email address is adad@giraffe.ru.ac.za if you would like to use that.

Greetings and best wishes

ALETTA DE VILLIERS

RECEIVED FROM RHODES MED ET 401 311902 10.02.70 13.11 10.02

**PROPOSAL FOR THE ESTABLISHMENT OF
THE EASTERN CAPE AIDS CONSORTIUM
(ECAC)**

Contact:

Mrs Jane Adar, MPH

Telephone 046 2174

Fax 046 622 4345

email spaj@giraffe.ru.ac.za

Ms Aletta de Villiers

Telephone 046 603 8513

Fax 046 636 1902

email adad@giraffe.ru.ac.za

Problem statement

The impact of the AIDS epidemic is gathering impetus. (World stats which you know), AIDS-related costs to SA businesses are expected to be made up of 36% from absenteeism, 30% recruitment and retraining, 13% burial and mourning time (a cost not taken into account in most statistics, but very significant in SA) and 21% AIDS health care.

In the Eastern Cape, the antenatal survey showed a prevalence rate rising from 4,5% in 1994 to an estimated 16,2% by the end of 1997.

Without any cure in sight, this disease threatens the social and economic stability of this very poor province, where few and fragmented intervention projects are in place with no networking between implementers. This means that the resources which are available are not used to their optimum, and skills and knowledge are not handed on.

Proposed solution

There is a serious need for co-operation, co-ordination and collaboration. We need to put in place a consortium for the sharing of expertise and resources, advocacy muscle and a system for co-ordinating service provision.

Goal

To promote co-ordination of AIDS activities among NGOs, local and international agencies, religious groups, government departments and so on.

Objectives

1. To strengthen the province's capacity to respond to AIDS by providing a forum to:
 - * share experience and resources
 - * build and maintain an inventory of all AIDS activities in the province
 - * provide a forum for planning and advocacy
 - * act as a clearing-house for the distribution of AIDS/HIV information
2. To do the above by:
 - * facilitating communications between individuals, communities, local and international agencies
 - * complementing government efforts in identification of appropriate target groups and implementation of AIDS interventions
 - * creating and maintaining a resource centre
 - * sharing resources, materials and information
 - * ensuring all bodies participate in the formulation of the province's AIDS/HIV policy
 - * promoting integration of AIDS interventions into health, education and other development fields
 - * promoting activities at the community level
 - * conducting or facilitating research into and evaluation of AIDS activities

Structure

1. Advisory Board, representative of all AIDS interests and donors in the province
2. Core staff of a co-ordinator and an assistant
3. Consortium members made up of all AIDS organisations in the province

The consortium was established in late 1997 with a handful of Grahamstown-based organisations. Since the visit of Ms Sandra Thurman, many implementing agencies in the province have expressed interest in belonging.

Activities

- * recruitment of members
- * maintenance of database
- * creation and maintenance of AIDS activities inventory
- * Identification of issues affecting members and lobbying on their behalf with appropriate bodies
- * production and distribution of quarterly newsletters
- * facilitation of a liaison system with national and international agencies
- * documentation and circulation of AIDS/HIV materials and information among NGOs, government and other agencies
- * organisation of workshops and meetings for members
- * fundraising
- * organisation of annual conference
- * representation of the province on National AIDS committees
- * organisation of representation for the province at international meetings, workshops and

conferences and facilitating feedback to members

- * conducting assessment for AIDS materials needs and production of relevant materials
- * organisation and operation of an AIDS RESOURCE CENTRE
- * facilitating preparation of activity reports obo NGO's
- * conducting research and evaluations on request

BUDGET

I believe that to start with we would need little more than a salary for the co-ordinator and administrative/production expenses. I am very happy for the consortium to operate from our office at Rhodes University. Once the East Cape AIDS Consortium (ECAC) had proved itself to be a successful and valuable contribution to the battle against AIDS, we would consider developing the consortium further, with concomitant need for funding.

First experimental year:

	R	
Co-ordinator	82 000	
Administrative assistance	15 000	
Administration (Telephone, fax, postage, stationery etc)	29 000	
Travel	20 000	
Educational video purchase	10 000	
newsletter production	12 000	
miscellaneous	5 000	
Total	R	\$
	173 000	37 000