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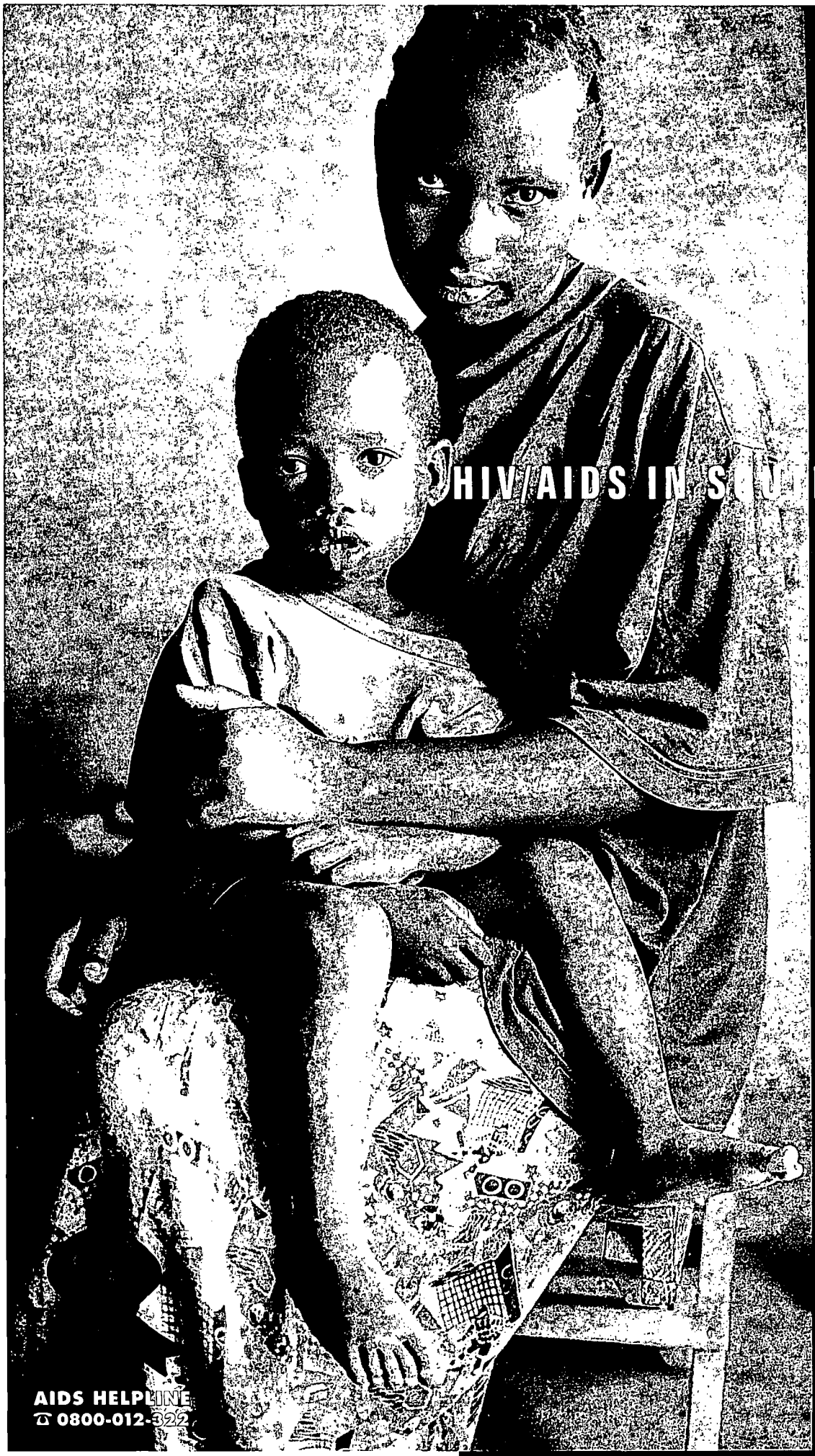

HIV/AIDS IN SOUTH AFRICA:

AIDS HELPLINE
☎ 0800-012-322

DEPARTMENT OF HEALTH

HIV/AIDS TOOLKIT

FOR

LOCAL GOVERNMENT

Draft for testing
September 1999

Health Economics & HIV/AIDS Research Division

KwaZulu-Natal Department of Health

ABOUT THE PROJECT

WHY WAS THE TOOLKIT DEVELOPED?

HOW WAS THE TOOLKIT DEVELOPED?

WHAT IS A TOOLKIT?

WHO WILL USE THE TOOLKIT?

ACKNOWLEDGEMENTS

KwaZulu-Natal Department of Health for financial support to produce the Toolkit

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UNAIDS for their documents on the strategic planning process

Researched and written by:
Rose Smart
HIV/AIDS Consultant
July 1999

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ABOUT THE PROJECT

WHY WAS THE TOOLKIT DEVELOPED?

The Toolkit was developed to assist Local Government in South Africa to define their role in the *Partnership Against AIDS* and to initiate their responses to the epidemic.

HOW WAS THE TOOLKIT DEVELOPED?

The Toolkit was developed following interviews with key stakeholders from business, unions, NGOs and with Local and Provincial Government officials in KwaZulu-Natal. The interviews focussed on the role of Local Government in general and in the context of the HIV/AIDS epidemic, and what Local Government would need in terms of resources, partnerships and technical assistance to mount effective responses to HIV/AIDS.

WHAT IS A TOOLKIT?

A Toolkit is a pack of instruments which can be used for a specific purpose – in this instance to develop or build a Local Government response to HIV/AIDS.

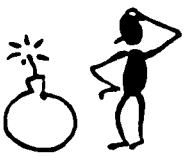
The Local Government Toolkit can be used with other complementary tools such as workplace programme guidelines (see **Useful Resources and Contacts**).

WHO WILL USE THE TOOLKIT?

Nominated Local Government officials and their support structures will be the primary users of the Toolkit. The Toolkit does however have application in other situations and could be of use to anyone with responsibility for developing an HIV/AIDS response for an organisation.

SETTING THE SCENE

THE HIV/AIDS EPIDEMIC
IN SOUTH AFRICA



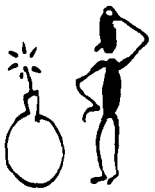
THE IMPACT OF HIV/AIDS
ON LOCAL GOVERNMENT

LOCAL GOVERNMENT'S CONSTITUTIONAL
AND LEGAL ROLES

LOCAL GOVERNMENT IN
THE *PARTNERSHIP AGAINST AIDS*

PILLARS OF A LOCAL GOVERNMENT
RESPONSE TO HIV/AIDS

SETTING THE SCENE



THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA

In South Africa the HIV/AIDS epidemic is among the most severe in the world, with more men, women and children infected than in any other country on earth, with the exception of India. The impact of HIV/AIDS related illness and deaths is already obvious in hospitals throughout the country and the number of deaths due to AIDS will rise dramatically to almost a quarter of a million per year within three years.

Average life expectancy is expected to fall from about 60 years to about 40 years between 1998 and 2008. In 2005 there will be nearly a million children under the age of 15 who will have lost their mothers to AIDS.

Apart from the enormous human toll which this represents, the epidemic constitutes a grave threat to development and social transformation in South Africa. It will be a major obstacle to reducing poverty and has the potential to reverse many gains made during the past decade.

THE EPIDEMIC WILL:

- Reduce the projected number of people
- Reduce life expectancy
- Increase infant mortality
- Greatly increase the need for health care
- Greatly increase the need for poverty assistance
- Exacerbate inequalities
- Result in large numbers of orphans
- Change the demographic structure of the population
- Increase the number of aged who need care (who have lost adult children)
- Affect income and expenditure patterns
- Reduce growth
- Reduce the ability of households to pay for services, rents and rates
- Threaten productivity due to increased absenteeism, higher recruitment, training and employment benefits and loss of skills
- Reverse years of investment in training and education

THE IMPACT OF HIV/AIDS ON LOCAL GOVERNMENT

Local Government is the level of Government closest to the people.

Local Government is responsible for social and economic development and the delivery of many services.

Local Government will, in large measure, bear the brunt of the epidemic.

LOCAL GOVERNMENT'S CONSTITUTIONAL AND LEGAL ROLES

In terms of the Constitution, the objects of Local Government are:

to provide democratic and accountable government for local communities;
to ensure the provision of services to communities in a sustainable manner;
to promote social and economic development;
to promote a safe and healthy environment; and
to encourage the involvement of communities and community organisations in the matters of local government

> ***In the future Developmental Local Government must play a central role in representing our communities, protecting our human rights and meeting our basic needs. It must focus its efforts and resources on improving the quality of life of our communities, especially those members and groups within communities that are most often marginalised or excluded, such as women, disabled people and very poor people.***
>
> EXTRACT FROM THE WHITE PAPER ON LOCAL GOVERNMENT

Section B of the White Paper on Local Government describes **Developmental Local Government** under four main headings:

1. Maximising social development and economic growth by:
   - meeting the basic needs of the poor
   - alleviating poverty and enhancing job creation
   - linking municipal contracts to social responsibility, speeding up approval procedures or proactively identifying and releasing land for development
   - promoting social development through functions such as arts and culture, the provision of recreational and community facilities, and the delivery of aspects of social welfare services

2. Integrating and co-ordinating by:
   - providing a vision and leadership for all those who have a role to play in achieving local prosperity
   - developing ways to leverage resources and investment from both the public and private sectors to meet development targets
   - integrated development planning
   - the establishment of sustainable and livable settlements

3. Democratising development, empowering and redistributing by:
   - promoting the involvement of citizens and community groups in the design and delivery of municipal programmes
   - directing community energies into projects and programmes which benefit the area as a whole
   - adopting inclusive approaches to fostering community participation, including strategies aimed at removing obstacles to, and actively encouraging, the participation of marginalised groups in the local community

4. Leading and learning by:
   - bringing together coalitions and networks of local interests that cooperate to realise a shared vision
   - responsive problem-solving and a commitment to working in open partnerships with business, trade unions and community-based organisations

- raising awareness of human rights issues and promoting constitutional values and principles
- investing in youth development
- actively seeking to empower the most marginalised groups in the community and encouraging their participation

LOCAL GOVERNMENT IN THE *PARTNERSHIP AGAINST AIDS*

President Nelson Mandela in his address to the World Economic Forum at Davos, Switzerland in February 1997 called for a unique response to the challenge of HIV/AIDS when he said:

> ***The vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals - all these are needed if we are to bring AIDS under control. Future generations will judge us on the adequacy of our response.***

Mr Thabo Mbeki, addressing the nation on October 9th 1998 called for all sectors of society to *join hands in the **Partnership Against AIDS**, united in our resolve to save the nation.*

Local Government must define its response to HIV/AIDS within the context of its transformation responsibilities. Despite the fact that Local Government is facing multiple issues often with significant resource and personnel constraints there are many functions which can be undertaken.

These were identified during stakeholder interviews and provide a useful framework for considering the way forward.

PILLARS OF A LOCAL GOVERNMENT RESPONSE TO HIV/AIDS

Leadership

- visible and vocal political and public leadership by Councillors
- leadership by example in the workplace (workplace policies and programmes)

Co-ordination of a local AIDS response

- co-ordination within a multisectoral network called into being by Local Government
- co-ordination with other municipalities, and Provincial and National Government

Planning in consultation

- a local AIDS plan developed with community and sectoral representatives
- AIDS issues and impact incorporated into integrated development planning

Facilitation

- identify and remove barriers to action
- create an environment which fosters involvement, participation and partnerships

Integration

- integrate HIV/AIDS prevention and/or care activities into all Local Government services
- encourage partners from other sectors to do the same

Advocacy and mobilisation

- keep AIDS in the public eye and in the public debate
- conduct local versions of national campaigns

Strengthen community responses

- provide technical assistance
- provide resources/materials and seed funding (Grants-in-aid)

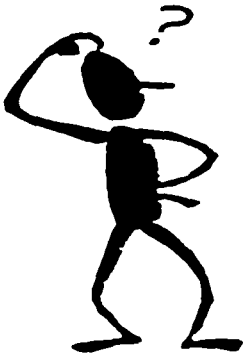
Promote social and economic development

- make AIDS a core issue in all development decision making
- introduce innovative incentives to act on AIDS issues

Monitor

- include AIDS programme targets in all monitoring processes
- include reports on AIDS responses in KWANALOGA fora

WHAT IS IN THE TOOLKIT?



ORIENTATION TO THE TOOLS

HOW TO USE THE TOOLS

MODEL HIV/AIDS STRATEGY FOR A CITY

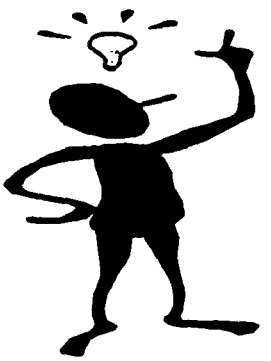
MODEL WORKPLACE HIV/AIDS POLICY

GUIDELINES FOR NETWORKING

GUIDELINES FOR MULTISECTORAL PLANNING

CHECKLIST OF RESPONSIBILITIES FROM
THE WHITE PAPER ON LOCAL GOVERNMENT

A MODEL ADVOCACY PRESENTATION



WHAT IS IN THE TOOLKIT?

ORIENTATION TO THE TOOLS

The Toolkit consists of a number of tools or instruments which can be used individually or collectively to build a new Local Government response to HIV/AIDS or to strengthen an existing response.

The Toolkit includes six tools:

- A model HIV/AIDS strategy for a city
- A model workplace HIV/AIDS policy
- Guidelines for networking
- Guidelines for multisectoral planning
- A checklist of responsibilities from the White Paper on Local Government
- A model advocacy presentation

HOW TO USE THE TOOLS

Each tool is preceded by a brief introduction which:

1. Defines the tool;
2. Describes its purpose;
3. Identifies any process issues which require special attention; and
4. Makes provision for notes on the tool.

TOOL NO.1
MODEL HIV/AIDS STRATEGY FOR A CITY

Definition:
A strategy is a document which describes a vision and defines a framework for action.

Purpose:
An HIV/AIDS strategy for a city describes the framework for a local response to HIV/AIDS by:

- Contextualising the problem - describing the epidemic and the legal and Constitutional requirements
- Stating the core values and guiding principles
- Identifying priority areas for action as well as roles and responsibilities
- Identifying overall indicators of success

Process:
The model strategy may be used as a reference for Local Government Authorities to develop their own **Strategy on HIV/AIDS**.

Use of the model strategy does not replace the need to consult fully with community representatives and key stakeholders.

Multisectoral, consultative planning should underpin the strategy and a process should be embarked upon to ensure that the strategy is "owned" by all stakeholders.

The strategy describes an LGA's "external" response, whereas a workplace HIV/AIDS policy describes an LGA's "internal" response.

Notes:

MODEL HIV/AIDS STRATEGY FOR A CITY

LOCAL GOVERNMENT IN THE *PARTNERSHIP AGAINST AIDS*

Responding with commitment, concern, courage and hope for the future

Preamble

The HIV/AIDS epidemic represents one of the most urgent challenges to our country, Province and Local Government Authority (LGA).1

The present: In South Africa the HIV/AIDS epidemic is among the most severe in the world, with more men, women and children infected than in any other country on earth, with the exception of India. At the end of 1998, 3,2 million people were infected, between 12% and 14% of the adult population aged between 15 - 59. Young adults have the highest levels of infection.

Several factors contribute to the severity of the epidemic in South Africa. These are:

- the disruption of family and communal life
- mobility linked to a good transport infrastructure
- high levels of poverty and income inequality
- very high levels of other STDs (sexually transmitted diseases)
- the low status of women in society and in relationships
- social norms which accept or encourage high numbers of sexual partners
- resistance to the use of condoms

The future: The impact of HIV/AIDS related illness and deaths is already obvious in hospitals. The number of deaths due to AIDS will rise dramatically to almost a quarter of a million per year within three years. Average life expectancy is expected to fall from about 60 years to about 40 years between 1998 and 2008. In 2005 there will be nearly a million children under the age of 15 who will have lost their mothers to AIDS.

The impact: The HIV/AIDS epidemic therefore constitutes an enormous threat to development and social transformation in South Africa. It will be a major obstacle to reducing poverty and will reverse many gains made during the past decade.

The solution: President Nelson Mandela in his address to the World Economic Forum at Davos, Switzerland in February 1997 defined the type of response which must be mounted when he said:

The vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals - all these are needed if we are to bring AIDS under control.
Future generations will judge us on the adequacy of our response.

---

1 Adapted from the Department of Health's publication: **HIV/AIDS in South Africa: the impacts and the priorities**, ember 1

Rationale for the development of an LGA HIV/AIDS strategy

> *Some of the most striking images of the HIV epidemic are of families, but of unfamiliar families: a grandparent surrounded by grandchildren, child-headed families, often brothers and sisters and cousins bonded together, dying adults tended by their children and communities of children without parents.*
>
> Peter Piot, Executive Director, UNAIDS

It is well known that HIV/AIDS will reduce the projected number of people, change the demographic structure of the population, affect household structures and income and expenditure patterns and reduce growth. The epidemic will therefore have substantial implications for the type of services that are required and the ability of households to pay for these services.

At the same time, Local Government, because it is closest to the people, arguably has greater potential to make a positive contribution than either the National or the Provincial spheres of Government. In response to the call by Deputy President, Thabo Mbeki to join the ***Partnership Against AIDS***, all LGAs must urgently identify ways to mobilise prevention, care and support responses and to mitigate the impact which the epidemic will have on its areas of influence.

In terms of the Constitution, the objects of local government are –

(a) to provide democratic and accountable government for local communities;

(b) to ensure the provision of services to communities in a sustainable manner;

(c) to promote social and economic development;

(d) to promote a safe and healthy environment; and

(e) to encourage the involvement of communities and community organisations in the matters of local government.

In the context of all the objects of local government, but specifically relating to the responsibility for "social and economic development", there is an implied responsibility on all LGAs to identify and implement effective responses to HIV/AIDS at the local level within the context of good governance.

Mission statement

The Local Government Authority of ..... joins the ***Partnership Against AIDS*** and commits to initiating and supporting a multisectoral response to HIV/AIDS at the local level by:

- publicly acknowledging the seriousness of the epidemic
- protecting and promoting the health of its citizens
- minimising the personal and social impact of HIV/AIDS
- challenging discrimination and
- mobilising and supporting community responses.

Guiding Principles

The LGA affirms the principles contained in the Dakar Declaration of 1 July 1994, namely:

- **The Principle of Responsibility**
  Every person, government, community, institution, private enterprise and medium must be aware of his or her responsibility and must exercise it in an active and sustainable manner.

- **The Principle of Engagement**
  Every person is affected, directly or indirectly, and therefore should respond with commitment, concern, courage and hope for the future.

- **The Principle of Partnership and Consensus-Building**
  All persons, couples, families, communities and nations must work together with compassion to build and share a common vision. These partnerships must reflect and actively promote solidarity, inclusion, integration, dialogue, participation and harmony.

- **The Principle of Empowerment**
  The empowerment of every person, but particularly the poor, the uneducated and children, is essential and must guide all action. Empowerment requires recognition of the right to knowledge, information and technology, freedom of choice and economic opportunity.

- **The Principle of Non-discrimination**
  Every person directly affected by the epidemic should remain an integral part of his or her community, with the right of equal access to work, housing, education and social services, with the right to marry, with freedom of movement, belief and association, with the right to counselling, care and treatment, justice and equity.

- **The Principle of Confidentiality and Privacy**
  Every person directly affected by the epidemic has the right to confidentiality and privacy. It can only be breached in exceptional circumstances.

- **The Principle of Adaptation**
  Every person and community should change and adapt social and cultural conditions to the new challenges of the epidemic in order to respond effectively.

- **The Principle of Sensitivity in Language**
  Language should uphold human dignity, reflect inclusion, be gender sensitive, accurate and understandable.

- **The Principle of Ethics in Research**
  The interests of research subjects or communities should be paramount. Research should be based on free and informed consent, be non-obtrusive and non-coercive, and the results should be made available to the community for timely and appropriate action.

- **The Principle of Prohibition of Mandatory HIV Testing**
  HIV testing without informed consent should be prohibited. HIV testing should also not be a pre-requisite for access to work, travel or other services.

In summary, the LGA is committed to responding to the HIV/AIDS epidemic in terms of people-centred and gender-sensitive development within the bounds of ethical, legal and human rights frameworks and with full community participation.

Beneficiaries

The beneficiaries of the LGA HIV/AIDS strategy are all the citizens residing and/or working in the geographic area served by the LGA. Because certain groups are particularly vulnerable to HIV/AIDS they will receive special consideration. These are the poor, displaced persons, children (especially children in difficult circumstances), young people, women and migrant and mobile workers.

Objectives of an effective, multisectoral response at the local level

Compared to other levels of Government, Local Government has a unique ability to work with and in communities. The objectives of an effective response related to this comparative advantage are thus:

- to provide leadership and commitment
- to identify and mobilise local capacity for prevention, care and support
- to develop local services
- to protect vulnerable citizens
- to establish mechanisms for consultation, communication and collaboration

Structures

Many strategies, plans and policies falter and fail where no persons are identified to take responsibility for their implementation. It is therefore proposed that a Focal Point person, supported by a small HIV/AIDS Action Group, be nominated with a mandate to:

- facilitate the implementation of the strategy
- conduct an analysis of potential partnerships
- facilitate the establishment of an HIV/AIDS Partnership Network

For partnerships to exist and flourish the means to communicate, co-ordinate and share expertise and resources are necessary. It is therefore proposed that an HIV/AIDS Partnership Network be established to:

- enable role players to interact
- promote co-operation and collaboration
- mobilise local capacities for prevention, care and support
- identify emerging issues and appropriate responses
- plan joint activities eg for World AIDS Day
- interact with Regional and Provincial Government and with other LGAs

Agenda for Action

The LGA is committed to an Agenda for Action in nine key areas. These are:

- **Leadership**
- **Co-ordination of a local AIDS response**
- **Planning in consultation**
- **Facilitation**
- **Integration**
- **Advocacy and mobilisation**
- **Strengthening community responses**
- **Promoting social and economic development**
- **Monitoring**

Modus Operandi

1. Plans for action in each of the nine priority areas will be developed through a joint, participatory, inclusive planning process
2. Those plans will form the basis of the LGA work plan – wherever possible, integrating activities into existing projects and programmes, particularly development projects and programmes, to ensure full ownership and responsibility
3. An analysis of potential partnerships will be conducted
4. Mechanisms for consultation, communication and collaboration will be established
5. All services offered by the LGA will be examined to determine the potential impact of the HIV/AIDS epidemic on these services
6. Development projects and programmes which, by their nature, address the underlying factors which fuel the epidemic will be prioritised for support
7. Financial, material and human resources will be identified
8. Short-term (process) indicators and longer-term (progress) indicators will be developed and utilised to monitor the LGA Strategy on HIV/AIDS

Conclusion

The LGA of ..... embraces the challenge represented by the HIV/AIDS epidemic, confident of its leadership commitment and of its ability to mobilise and support non-discriminatory prevention and care responses in partnership with communities and sectors.

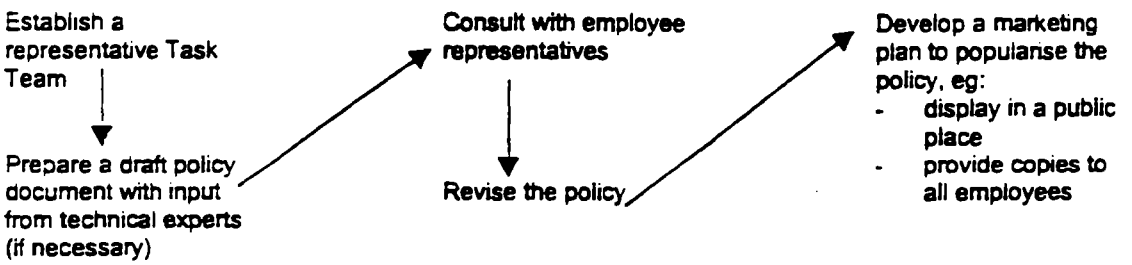
TOOL NO.2
MODEL WORKPLACE HIV/AIDS POLICY

Definition:
A policy is a document which describes commitment to a course of action

Purpose:
A workplace HIV/AIDS policy defines what an LGA will do (internally) about HIV/AIDS

Process:
It is proposed that the model policy be used as a reference for LGAs to develop their own **Workplace HIV/AIDS Policy**. Use of the model policy does not replace the need to consult fully with employees and their representatives.

A suggested process for developing a policy is the following:



Notes:

MODEL WORKPLACE HIV/AIDS POLICY

LOCAL GOVERNMENT IN THE *PARTNERSHIP AGAINST AIDS*

HIV/AIDS is not someone else's problem
It is my problem. It is your problem

Background

1. The HIV/AIDS epidemic is well established throughout South Africa. Reliable predictions indicate that national adult infection levels could be over 20% by 2005. With the dramatic rise in AIDS deaths, this will result in severe economic burdens for families and communities and increasing poverty. This in turn will pose a serious threat to the ability of any Local Government Authority (LGA) to manage the rapidly increasing numbers of infected employees and to administer and deliver the services to its communities for which it is Constitutionally responsible.

2. On 9 October 1998, Deputy President Thabo Mbeki launched the ***Partnership Against AIDS***, calling on all South Africans to *join hands ... united in our resolve to save the nation*. He described the challenge as follows: *We shall mobilise all possible resources to spread the message of prevention, to offer support to those infected and affected, and to destigmatise HIV and AIDS ...*

3. LGAs are amongst the largest employers in South Africa and are therefore well placed to develop and implement comprehensive workplace HIV/AIDS policies and programmes.

Ten Workplace Facts

1. The crisis is immense - AIDS is a real problem affecting workers, services and business operations - many organisations are losing around 3% of their workers to AIDS each year

2. 80% of HIV transmission in Southern Africa occurs due to heterosexual sex

3. Young adults have the highest levels of infection and our nation's economically active population, parents of young children and future leaders are at greatest risk

4. AIDS will decrease life expectancy in South Africa by 20 years to about 40 by the year 2008

5. HIV/AIDS has increased the burden of ill health and mortality in the 15 - 50 year age group two- to three-fold. According to the ILO, an average of 15 years of working life will be lost per employee due to AIDS

6. The indirect costs of HIV/AIDS are greater than the direct costs. The costs of lost time have been consistently shown to be the most significant costs to organisations

7. HIV infected persons have 5 - 10 years on average of asymptomatic productive working life. This period can be lengthened by health promotion and stress management

8. Transmission of HIV poses little or no risk in most work settings

9. Averting an HIV infection through prevention programmes yields a cost benefit ratio to organisations of anything from 1:2 to 1:400

10. The workplace is an appropriate and important setting for HIV/AIDS programmes becau workers sp id a significant amount of time at work.

Statement of intent

The Local Government Authority of ..... acknowledges that the HIV/AIDS epidemic constitutes a serious threat to the functioning and future of the Local Government Authority and, within the context of the following Workplace HIV/AIDS Policy, commits to providing the necessary leadership and resources to develop and implement a Workplace HIV/AIDS Programme to reduce new HIV infections amongst employees and to minimise the impact of the epidemic on its structure, operations and functions.

Ten Workplace Principles

The following principles apply to the workplace setting:

Principle 1: Promote non-discrimination and openness around HIV/AIDS

Principle 2: Because HIV/AIDS is a preventable disease it makes sense to offer prevention education to all employees and to specifically invest in targeting situations of high risk

Principle 3: HIV/AIDS prevention works - we can change behaviour. But, information alone is not enough to change behaviour. Behaviour change is only possible if we reach solutions by developing our own responses and people need to be taught skills to enable them to put the information into practice

Principle 4: Education needs to be complemented by supportive services

Principle 5: HIV/AIDS programmes in the workplace can help control the epidemic and reduce the impact on the organisation's functions and future

Principle 6: Effective HIV/AIDS prevention yields enormous savings in averted 'AIDS costs'

Principle 7: The most powerful change agents are our friends and peers

Principle 8: The involvement of people living with HIV/AIDS is central to an effective workplace programme

Principle 9: HIV/AIDS programmes must be simple, specific, concrete and verifiable. Use core management principles (simplicity, focus, precise targets, strong performance monitoring) and an explicit results chain (required inputs, outputs, outcomes and impacts)

Principle 10: Strategies and projects in areas of economic and social development which address poverty, income inequality, the bargaining power of women, housing, migrancy and so on will address the underlying factors which fuel the epidemic

The LGA affirms the above principles and states in addition that:

- The policy will be developed and implemented in consultation with employees and their representatives.
- Employees living with HIV/AIDS have the same rights and responsibilities as all employees and are therefore:
  - →protected against discrimination
  - →ensured of confidentiality regarding their HIV status.
- Testing for HIV infection will not be imposed on employees. Where HIV testing is done at the instance of the employee, this will be with his/her informed consent, accompanied by counselling.

WORKPLACE HIV/AIDS PROGRAMME

Context of the LGA Workplace HIV/AIDS Programme

1. Whilst the main focus of the Workplace HIV/AIDS Policy is "internal" i.e. concerning employees, workplaces are influenced by and in turn influence the communities within which they are situated. The Workplace HIV/AIDS Policy shall therefore complement **the HIV/AIDS Strategy for a City** which describes the LGA's commitment to use all opportunities in which the LGA interacts with other LGAs, other levels of Government and with communities and civil society to contribute to the ***Partnership Against AIDS***.

2. The creation of an HIV/AIDS Partnership Network will provide a mechanism for communication and co-ordination (**see Guidelines for Networking**).

Elements of the LGA Workplace HIV/AIDS Programme

The Workplace HIV/AIDS Programme will consist of four elements, namely Co-ordination, Management strategies, Prevention, and Care and support.

1. Co-ordination (**see Terms of Reference for Nominated Official** in **Useful Resources and Contacts**)
   1.1 An HIV/AIDS Focal Point person will be nominated and supported by an HIV/AIDS Task Group with representation from all Departments within the LGA.
   1.2 Regular reports on progress with the Programme will be made to the LGA Executive / Management Committee.

2. Management strategies (**see Checklist of Management Strategies** in **Useful Resources and Contacts**)
   2.1 Leadership
   The political and public leadership of the LGA will utilise all appropriate opportunities to demonstrate support for the Workplace HIV/AIDS Programme.
   2.2 Recruitment
   In accordance with the Employment Equity legislation, provided that a prospective employee is deemed fit to perform the job applied for, he/she will not be denied employment if he/she is HIV infected.
   2.3 Needs assessment
   The LGA will conduct an annual, internal needs assessment to inform the Workplace HIV/AIDS Programme. This will take account of the risk profile of the workforce.
   2.4 Impact assessment
   The LGA will commission regular impact assessments to inform strategic planning, including an assessment of the costs of the epidemic.
   2.5 HR issues
   The LGA will regularly review employee benefits in the context of the impact of the epidemic. In addition, a skills succession plan will be developed.

3. Prevention
   3.1 Information and education
   Education is central to any comprehensive HIV/AIDS Programme - employees will have access to comprehensive, on-going education programmes including awareness activities and distribution of small media materials.
   3.2 Peer education
   The source of information must be legitimate - peer educators will be trained and supported to disseminate information on HIV/AIDS.
   3.3 Barrier methods
   The use of barrier methods, particularly male condoms, provides protection against STD and HIV infection - employees will have access to free male condoms.

3.4 HIV testing and counselling

Confidential HIV testing accompanied by pre- and post-test counselling provides an opportunity to review lifestyle options - employees will be encouraged to seek HIV testing and counselling.

3.5 STD management

The presence of untreated STDs greatly increases the risk of acquiring HIV - employees will be encouraged to seek early treatment for STDs.

3.6 Occupational exposure

There is a very small risk of HIV transmission from blood in an accident situation - employees who render First Aid will be supplied with personal protective equipment in accordance with Health and Safety legislation and will be trained in its use.

4. Care and support

4.1 Managed health care

Although there is no cure for HIV infection, there are medical interventions and lifestyle adjustments that can prolong the life of employees with HIV. Where feasible and practicable, the LGA will offer such interventions to infected employees as part of the package of health services offered to all employees.

4.2 Counselling

Counselling is a valuable intervention to assist both persons infected with HIV and those who are affected to deal with issues and episodes related to HIV disease. The LGA will endeavour to provide access to counselling for infected and affected employees either at work or in conjunction with community services.

4.3 Disclosure

When an employee is no longer able to perform his/her duties as a result of HIV disease, he/she is encouraged to inform his/her supervisor.

4.4 Protecting the rights of employees with HIV

Non-discrimination and the protection of the rights of employees with HIV/AIDS are necessary to create an environment for an effective Workplace HIV/AIDS Programme. The LGA will act decisively to prevent discrimination and to promote equal rights regardless of HIV status.

4.5 Benefits

HIV infected employees are entitled to the same benefits as uninfected employees.

Resources

The LGA will identify the necessary human and financial resources to develop, implement and sustain the Workplace HIV/AIDS Programme.

Programme monitoring and review

The Programme will be subject to regular monitoring and review. Data will be collected and analysed to monitor trends. Any amendments to the policy will be communicated to all employees.

TOOL NO.3
GUIDELINES FOR NETWORKING

Definition:
A network is a mechanism which enhances the operation of a partnership.

Purpose:
The guidelines describe:
- what a network is;
- how to create an HIV/AIDS Partnership Network (HAP Network); and
- how to sustain the HAP Network.

Process:
Local Government has a responsibility to *bring together coalitions and networks of local interests that cooperate to realise a shared vision.*

There are numerous examples of how Local Government has created networks to attend to issues of significance. These can serve as precedents for the establishment of a HAP Network.

Notes:

GUIDELINES FOR NETWORKING

LOCAL GOVERNMENT IN THE *PARTNERSHIP AGAINST AIDS*

Building solidarity, enhancing collective capacity and uniting in common cause

One of the major challenges faced by individuals and organisations working in HIV/AIDS is the need to form partnerships in order to work more effectively. Networks, of individuals and organisations, are one way of operating in ***Partnership Against AIDS***. At the local level it is proposed that an HIV/AIDS Partnership Network (HAP Network) be established to guide and support the Local Government Authority's response to the HIV/AIDS epidemic.

This document describes what a network is (PART ONE), how to create a HAP Network (PART TWO) and how to sustain the HAP Network (PART THREE).

PART ONE: WHAT IS A NETWORK?

> *Networks are created out of a powerful sense of shared mission, shared vision, shared commitment, of shared action. Networks are created by people who want to be connected, to communicate, plan and act in concert. A network is a process of rapidly disseminating information - lessons, innovations, techniques, ideas, news, requests, questions. A network gives its participants a strong sense of solidarity and connection across geographic distance and isolation.*
>
> Robertson Work

Definition of a network

A network consists of individuals and/or organisations willing to assist one another or collaborate to achieve common goals.

Characteristics of a network

Most networks have some or all of the following characteristics:

- member-ownership
- commitment to shared objectives and means of action
- a jointly developed structure
- shared responsibility
- shared action
- reduced duplication and resource wastage
- communication, exchange and mutual learning
- synergy (the effect of things done together is greater than the sum of individual activities)

Additional characteristics of an HIV/AIDS Network

- involves people living with HIV/AIDS
- maintains the trust of involved communities
- strengthens advocacy
- influences others (inside and outside the network)
- broadens understanding of HIV/AIDS (by bringing together different constituencies)
- provides a sense of solidarity and moral and psychological support

Additional characteristics of an LGA HAP Network

- a geographic focus
- formal links with local government

Elizabeth Reid, former Director of the UNDP HIV and Development Programme described the value of HIV/AIDS networks as follows:

In the process of creating these networks, we are learning that they are fragile entities, difficult to get established and to sustain. They require much commitment and patience from their members, particularly their founding members. But we are also learning that they form an essential part of the community response to the epidemic. Without them, people are often merely told what others think they should do. With them, we can strengthen the process of questioning, reflection and learning. They are the places in which an individual in search of help can go, spaces in which communities can seek to understand how, wisely and humanely, they can respond.

HIV/AIDS network activities

Though there are many different reasons why HIV/AIDS networks are formed and many different ways in which they operate, there are some basic activities that are common to most HIV/AIDS networks.

Alliance building. Networks can provide for relationships among partners.

Generating and sharing information. Networks can provide a structure for members to establish and maintain essential communications with each other.

Advocacy. Networks can co-ordinate advocacy action on matters identified by members.

Skills and capacity building. Networks can provide both formal and informal opportunities for enhancing the skills of members.

Building solidarity. Networks can assure members that their work is important, particularly when the political and social environment is not hospitable.

Creating opportunities for co-operation. Networks can generate and/or support programmes which are complementary, collaborative and which reinforce one another.

Monitoring network indicators. Networks can assess progress being made and identify problems needing to be addressed.

Network structure

Networks can sometimes be established within existing structures, at other times, new structures are required. Networks can be formal or informal in nature. Typically, most networks fall somewhere along a continuum between a loose, single-purpose network for information exchange and a highly formalised network conducting and/or co-ordinating activities. It is also important to note that network structures are not static and tend to change over time.

Factors that will influence the structure of a network are:

- what the network is trying to achieve
- what resources (time, money and people) are available
- how the members want the network to be organised.

Membership

Most networks have both individual and organisational members. Individuals should ideally have a constituency that they represent. In the case of HIV/AIDS networks, in order for the network to be truly representative of and responsive to the needs of people living with HIV/AIDS it is imperative to ensure the involvement of PWAs in a meaningful way.

Membership should therefore consist of:

- Individuals and organisational representatives
- PWAs
- Local NGOs providing AIDS related services
- Decision makers from key sectors or people who can influence decision makers
- Technical experts

Letters of commitment

It may be useful to define what is expected of members representing organisations by means of a letter of commitment that states:

- the organisation's commitment to the goals, objectives and activities of the network
- what the organisation expects in return for its participation in the network
- how much time the organisation's representative may commit to the network
- that the organisation recognises that this commitment is part of the representative's job
- the level of resources that the organisation can commit (funds, in-kind contributions, volunteer time, expertise etc)

PART TWO: CREATING AN HIV/AIDS PARTNERSHIP NETWORK

Ten important network dynamics

Successful networks provide us with the following lessons:

- A network needs a well-focused vision to which all the stakeholders agree.
- Few networks begin life with clearly defined goals - so, during the start-up period, it is reasonable to expect some ambiguity.
- Begin with those who want to participate - balance the importance of being inclusive with pragmatism.
- Choose people to be responsible for specific tasks who are respected and recognised by all concerned.
- Ensure that there is mutual recognition of the mandates, unique roles and responsibilities and areas of expertise of all persons and organisations involved - every member needs to feel that their voice is as important as any other member's.
- Prevent burnout and overwork by setting realistic expectations and respecting members' personal needs.
- Develop a network culture in which members come to realise an awareness of themselves as a group.
- Networks need to be flexible, with the potential to adapt to changing internal and external environments.
- Effective communication is a major challenge - establish firm procedures for communication.
- Networks must not be in competition with members for activities, funds, people or influence.

When creating a HAP Network there are many factors to consider. Although it may not be possible to undertake the following steps systematically, these nine steps can guide members in their network building.

STEP ONE: Establish the HAP membership
Identify key people to serve as members of the HAP Network.

HOW?
Use a Membership Checklist to identify suitable persons and send each one an official letter inviting them to become a member of the HAP Network.

Example:

SECTOR	REPRESENTATIVE/S
Local Government	
Parastatals	
Political organisations	
Traditional leaders	
People living with HIV/AIDS	
Religious organisations	
NGOs and CBOs	
Media	
Private sector (employers and trade unions)	
Schools and youth organisations	
Sporting organisations	
Academic and/or research institutions	
Health services	
Other	

STEP TWO: Prepare a statement of purpose
This is a precise and agreed upon statement of the reason for your HAP Network's existence, the values that underpin your work and what you wish to accomplish.

HOW?
Brainstorm with the network members and complete the following:
"Our purpose is to ..." - then check that your statement of purpose covers all the following elements:
- Who are we?
- Why do we exist?
- What would we ideally like to accomplish?
- Where and for whom?
- How are we unique?
- What are our principles and values?

Example:
As committed individuals and representatives of concerned organisations from the Local Government area of ....., our purpose is to promote and support non-discriminatory HIV/AIDS prevention, care and support initiatives.

STEP THREE: Define goals and objectives
With clear goals and objectives, you will have a good idea of what your HAP Network wants to accomplish. A goal describes broadly what we want to create or change because of our action. Objectives describe what specific problems are to be addressed, how and when.

HOW?
Setting goals:
List what your HAP Network wants to create or to change, then work in groups to develop your goals - one goal focusing on each area to be accomplished.

Example:
Within the Local Government area of ...., the HAP Network will:
1. Connect persons and organisations to enable them to communicate and to share.
2. Lobby for the promotion, implementation and evaluation of effective multisectoral responses to HIV/AIDS.

HOW?
Setting objectives:
Once there is agreement on the goals, work in groups to develop the objectives for each goal - remember objectives are specific, measurable statements of how the HAP Network will accomplish its goals.

Example:
Objectives relating to the "Connecting goal":
To provide leadership support for local HIV/AIDS work.
To forge alliances on HIV/AIDS with neighbouring LGAs.
To create a forum for the sharing of information, ideas, experiences and resources.
To promote co-operation and collaboration in AIDS work amongst all HAP Network members.

Objectives relating to the "Lobbying goal":
To promote human rights and accessible and acceptable HIV/AIDS prevention, care and support programmes.
To support national and provincial HIV/AIDS campaigns.
To identify and mobilise local capacities for prevention, care and support.

Additional objectives
To equip members with skills to enable them to function optimally as members of the HAP Network.
To monitor progress of the HAP Network regularly.

STEP FOUR: Create an action plan
An action plan is a set of steps to achieve a specific objective.

HOW?
Convene a planning meeting with network members. Present a summary of any relevant background documents to inform the planning process (eg the LGA HIV/AIDS Workplace Policy and the LGA Strategy on HIV/AIDS). Divide the members into groups and define the task for the groups. A template may be used which provides guidance to:
- Identify the actions that are needed to accomplish each objective
- Identify the resources needed and those that your network and its members can contribute
- Identify the skills needed for the activities that you will undertake
- Designate responsibilities
- Set a timetable for the actions that must be undertaken

Example:
Objective: To create a forum for the sharing of information, ideas, experiences and resources.

ACTIVITY	RESPONSIBILITY	RESOURCES AVAILABLE	RESOURCES NEEDED	TIME FRAME
Hold monthly meetings of the network	LGA Focal Point	Venue, secretariat	Refreshments	Commence May '99 (on-going)
Circulate a quarterly newsletter	Communications Sub-committee	Layout, photocopying	Paper, postage	Jul & Nov '99 Mar 2000
Conduct HIV/AIDS update for members	ATICC	Venue, training materials	Transport for 4 members	Sept '99

STEP FIVE: Set ground rules
In order to establish how members will interact with one another, many networks have developed a set of "ground rules".

HOW?
At the first HAP Network meeting, ask all members to list the ground rules that they think should guide the work of the network. Invite each member in turn to give one and record until there is a comprehensive list. Discuss any which are in conflict and get agreement on the final ground rules.

Example:
Network ground rules
- show respect for each other
- participate
- be prepared to listen, debate and question
- consider the language you are using
- respect the need for confidentiality
- always act in the best interests of the network
- build group strength
- once a decision is taken by the network, defend the position of the network
- stay informed about issues relating to the work of the network
- stay in touch with the needs of your constituency and reflect them accurately

STEP SIX: Define a decision-making process
To accomplish agreed-upon tasks involves making decisions. It is important for members to know how those decisions will be made. A consultative approach is one suitable form of decision making, where the views of the majority determine the final decision. Alternatively, consensus building, in which parties are persuaded to agree with or support a decision, may be appropriate.

HOW?
Describe the two options (consultative and consensus building) to members. Take a couple of examples of decisions that could need to be made and discuss which option the members prefer.

Example:
Decision to be made: Should the HAP Network lobby for a rally to be held to mark World AIDS Day?
Consultative: All members have an opportunity to voice their opinions and the majority view becomes the view of the network.
Consensus: Following discussion of the options, consequences, barriers to implementation etc members agree to support the decision of the network.

STEP SEVEN: Develop a communications plan
Good communications are absolutely crucial to the success of a network. It is important to identify the mechanisms by which information will be circulated.

HOW?
List the key people in the HAP Network who must receive communications, when they will receive them and how you will, in turn, obtain their feedback. Include specific instructions about how people should deal with content eg read and comment, when, how etc. Then decide who will have the responsibility for making sure that communication between members happens.

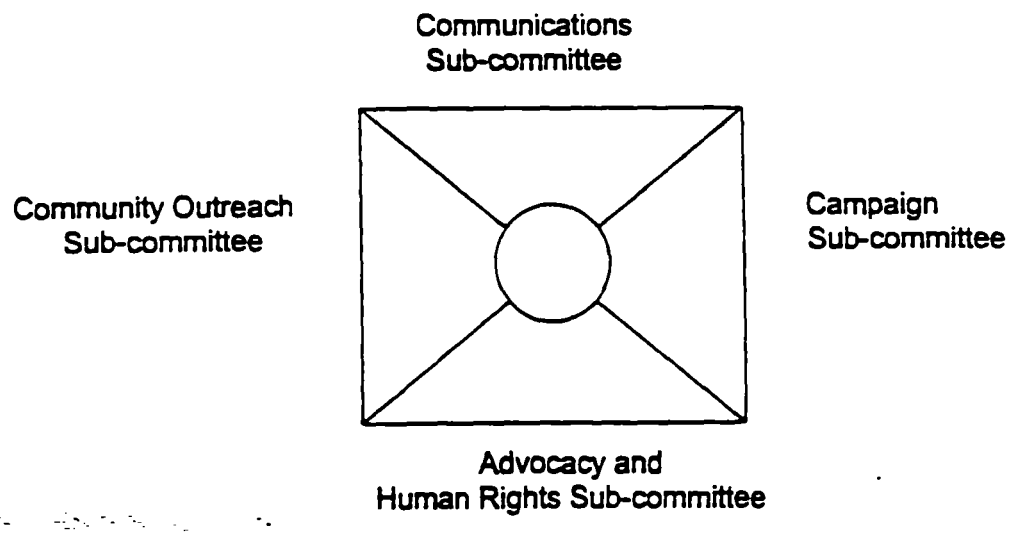
Example:

COMMUNICATION	RESPONSIBILITY	FREQUENCY	TO WHOM?	SPECIAL CONDITIONS
Minutes of meetings	Secretariat	Monthly	Members LGA Executive Committee	Feedback (written or telephonic) by deadlines
Newsletter	Communications Sub-committee	Quarterly	Members Neighbouring LGAs Provincial HIV/AIDS Programme	To contain a diary of events
Sub-committee proceedings	Sub-committee facilitators	Monthly	Sub-committee members	Feedback (telephonic) by deadlines

STEP EIGHT: Choose an organisational structure
Structure is central to how a network will achieve its goals. It must be appropriate to the network's plans, the environment in which it exists, the technology available to it and its human and financial resources.

HOW?
Define:
- what work needs to be done?
- what groups (or Sub-committees) do we need to form to do the work?
- what are the roles and responsibilities of these groups?
- how do we want to govern ourselves within the groups?
- how do we want to communicate between the various groups?

Once there is agreement on the above, draw a diagram of the groups that will make up the network, indicating lines of authority. Get the members to endorse the structure.



In this example, the members decide to create four Sub-committees, each of which is responsible for specific tasks. They allocate roles and responsibilities to members according to the tasks to be done and the expertise of the members. They communicate with one another on a "need to" basis and report to the main HAP Network at regular network meetings.

STEP NINE: Secure resources
Networks need adequate and consistent resources to support their operations. It is important to have an accurate assessment of the resources available to your network. There are three kinds of resources: money, people and in-kind contributions.

HOW?
Conduct an audit of the resources available to your HAP Network and compare these with the resource needs identified in the action plan. The exercise should cover the following:
Money: Decide how much money is needed and how much is available. Then decide if you can continue without additional funds.
People: Identify the talents that you already have in the HAP Network, before deciding to bring in any skills from outside. Check what tasks need to be done, which skills are needed to do them and who has these skills.
In-kind contributions: Individuals or organisations may be willing to provide support such as office space, photocopying, faxing etc.

Once you have identified those resources that your HAP Network does not have and must have to function, prepare and submit a proposal (or proposals) for these.

Example:
Resources: People

TASKS	AVAILABLE IN THE NETWORK	NOT AVAILABLE IN THE NETWORK
Facilitation	✓	
Secretarial	✓	
Committee procedures	✓	
Training		X
Lobbying		X

PART THREE: SUSTAINING A HAP NETWORK

The constantly changing nature of the HIV/AIDS epidemic demands an evolving response and networks must adapt accordingly. Aside from this requirement, sustaining commitment to a network is critical to any network's survival. Networks that make clear what is expected of members are more likely to sustain commitment among members than networks that do not. Another important element of sustaining commitment is on-going evaluation - of how well a network functions (process) and what a network achieves (outcome). A further threat to a network's survival is conflict, particularly when a network is going through a process of change. It is important to have mechanisms in place to deal with conflict.

Evaluation
People and organisations need proof that their efforts are having an impact, that their participation is justified. Evaluations also provide information on how to re-prioritise objectives (when necessary) and how to make the network more efficient and relevant.

The evaluation process involves several steps: design, data collection, analysis, feedback and action.

Design the evaluation plan and tool:
- Decide who will do the evaluation
- Prepare a clear description of the desired outcomes of the evaluation
- Determine what information is required
- Test the evaluation tool

Implement and analyse the evaluation
- Deliver the evaluation instrument to the selected participants
- Compile the collected information
- Conduct an analysis of the evaluation results
- Develop recommendations
- Validate the recommendations with a small sample of those who participated in the evaluation
- Present a full report to the network and use the results to plan action

Conflict
Although members are committed to a common purpose, they will approach tasks differently and this may lead to conflict. Conflict may arise from differing assumptions and perceptions, individual or organisational values, needs and goals, emotion, competition or a lack of information or clarity. A constructive approach to the reality of conflict is to expect it and to develop the skills to resolve it. A win-win negotiation style which results in both parties being clear on both positions and having mutual respect for each one's abilities, values and expertise is most appropriate for conflict resolution in a network.

Resolving conflict:
Decide who will facilitate the conflict resolution process
Review the situation and revisit the results you need to achieve - then identify the issues that must be resolved.
Ask the parties involved to define their needs and look for alternatives
Decide jointly on the solution and on the action steps for implementation

CONCLUSION

Networking in the area of HIV/AIDS is increasingly recognised as an essential component of an effective response to the challenges posed by the epidemic. The establishment of a HAP Network at the level of Local Government provides the best chance for building solidarity, enhancing collective capacity and uniting in common cause - for working in ***Partnership Against AIDS***.

References
African Network on Ethics, Law and HIV (1994), Proceedings of the Intercountry Consultation (Dakar, Senegal)
GMC Task Force on HIV/AIDS Co-ordination (1994), Framework of Guiding Principles for HIV/AIDS Co-ordination at Country Level
ICASO (1997), HIV/AIDS Networking Guide

TOOL NO.4
GUIDELINES FOR MULTISECTORAL PLANNING

Definition:
Multisectoral planning implies the creation of a plan by means of a consultative process with key role players

Purpose:
Multisectoral planning for a local HIV/AIDS response means devising strategies:

- which are relevant to local circumstances
- flexible enough to be adapted when necessary
- realistic in terms of available resources
- jointly owned by all partners

Process:
The planning process described assumes that a strategic vision for the LGA response has been defined and will serve as a reference for the multisectoral planning process.

It recognises that planning is a central function of all LGAs and seeks to complement this planning rather than compete with it.

Readers seeking additional information on planning an HIV/AIDS response are referred to the UNAIDS ***Guide to the strategic planning process for a national response to HIV/AIDS***

Notes:

GUIDELINES FOR MULTISECTORAL PLANNING

LOCAL GOVERNMENT IN THE *PARTNERSHIP AGAINST AIDS*

The world has to respond effectively and with courage to what is a complex epidemic that demands a multi-dimensional and dynamic response

An effective multi-sectoral response to the HIV/AIDS epidemic must be situated in a joint understanding by all role-players of the problem. This implies a consultative planning process.

This document describes certain key concepts, an understanding of which is central to planning an HIV/AIDS response (PART ONE), a four-part planning process (PART TWO) and a guide to developing indicators of process and progress (PART THREE).

PART ONE: USEFUL CONCEPTS FOR PLANNING

HIV/AIDS as a social and development issue

Planning must take account of the social, economic, political and indeed all the development-related consequences of the epidemic. This also implies recognising that some social and development programmes (the construction of a major road, the creation of a free-trade zone) can in fact exacerbate the epidemic.

Risk and risk reduction

Risk is defined as the probability that a person may acquire HIV infection. Many interventions aim at reducing risk-taking behaviour through targeting individuals and groups to adopt protective behaviours and practices.

Vulnerability and vulnerability reduction

In the context of HIV/AIDS, vulnerability is influenced by the interaction of a range of factors including (i) personal factors; (ii) factors pertaining to the quality and coverage of services and programmes; and (iii) societal factors. Some factors may create or exacerbate vulnerability, others may reduce vulnerability.

Gender inequality

Women are more easily infected with HIV than men, they have little or no choice on how or when they become infected, they progress to disease more rapidly, have poorer health care, benefit from treatment more slowly, and they suffer some of the severest consequences of discrimination. Policies and programmes should aim to bridge the gender gap, ensuring equal access to education, fair income distribution, sharing of ownership, equal employment opportunities and wages, equality before the law and so on.

PART TWO: HOW TO PLAN A MULTI-SECTORAL RESPONSE TO HIV/AIDS

The planning process consists of FOUR elements. At each step, it is critical to ensure full participation of key role players. This, in turn, will lead to a shared ownership of the plan.[2]

1. Situation analysis

Identify factors related to the LGA which contribute to risk and vulnerability to HIV infection, i.e. put the epidemic into its local social, economic and cultural context

(i) ***describe*** who is infected, or vulnerable

(ii) ***analyse*** why, identifying important determinants and obstacles and opportunities

(iii) ***prioritise*** what has the 'best chance of making a difference (at an acceptable social, financial and political cost)

2. Response analysis

Describe the current response, i.e. what services are available, to whom

A *Response Analysis* should cover:

(i) prevention (including safer sex promotion, reducing the vulnerability of specific target groups and STD prevention and control)

(ii) care (including access to voluntary counselling and testing, clinical management and home/community-based care)

(iii) mitigating impact (including social welfare support, non-discrimination and community based self-help projects)

Then analyse:

(i) what is ***working*** and needs to be continued or expanded?

(ii) what is ***not working*** and needs a new approach or to be dropped?

(iii) what has ***not been addressed*** at all?

Response checklist

- What was planned?
- What was achieved and why?
- What were the obstacles?
- What were the opportunities?
- What were the recommendations?

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[2] Adapted from the UNAIDS Guide to the Strategic Planning Process for a National Response to HIV/AIDS (1998)

3. Analysis of potential partners

Identify current role players and potential future role players

Who is involved in:

(i) policy making

(ii) co-ordination

(iii) implementation

(iv) technical input

and **how** do they work together

Then describe:

(i) **who** else has the potential to become involved in each of the areas

(ii) **how** should they be recruited

(iii) what are the optimal **mechanisms** for consultation, communication and collaboration

4. Strategic plan formulation

Following the *situation* and *response* analyses and the *analysis of potential partners*, the planning team will:

(i) set ***objectives*** in priority areas

(ii) develop ***action plans*** to reach objectives

(iii) examine each for ***acceptability, technical soundness, feasibility/affordability, chance of succeeding, potential impact***

(iv) indicate ***responsibilities***

(v) identify ***resources***

(vi) establish a ***monitoring system***

Checklist for selecting programmes

- Will the programme be supported by decision-makers?
- Are there funds and/or resources to support the programme?
- Does the programme have:
  a goal and objectives that are easy to understand
  a clear and realistic time frame?
- Are there the necessary alliances for the programme to work?
- Does the programme provide opportunities for people to become involved?

PART THREE: INDICATORS OF PROCESS AND PROGRESS

Monitoring and evaluation of an LGA's response should be an integral part of that response, right from the planning stage. It is important to choose appropriate indicators that will allow for meaningful monitoring and evaluation of the response and for the development of recommendations for change where this is needed. Indicators are therefore the tools used to measure progress towards achieving objectives.

Deciding which indicators are appropriate should be guided by what information is already available. Continued use of the same indicators is advised as this shows trends over time. Indicators may be short or longer term and may measure either process or progress (sometimes called 'outcome' indicators).

Process indicators may be:

- the establishment of an 'HIV/AIDS Action Team'
- the creation of partnerships with civil society, community organisations and the private sector
- the development or expansion of services such as HIV/AIDS information points, counselling centres and community-based care services
- the development or expansion of services for citizens in high risk situations such as the youth, sex workers and migrant/mobile workers

Longer-term progress indicators relate to the overall goal of a programme (for example: reducing new HIV infections and providing care and support to those infected and affected).

They may be:

- economic and/or social indicators
- demographic indicators
- behavioural indicators
- epidemiological and/or health status indicators

Examples of progress indicators may be the following:

- Number of programmes in the LGA and in other institutions that have integrated relevant HIV/AIDS interventions
- Number of sectors that have taken full responsibility for HIV/AIDS prevention and control interventions on the basis of their comparative advantages
- Increased service utilisation
- Changed social/peer norms
- Level of funding for HIV/AIDS activities

CONCLUSION

A comprehensive plan, which is endorsed by all key role players, becomes a valuable framework within which a LGA response to the HIV/AIDS epidemic can take place. It also serves as a tool by which that response can be measured.

TOOL NO.5
CHECKLIST OF RESPONSIBILITIES FROM THE WHITE PAPER ON LOCAL GOVERNMENT

Definition:
The checklist identifies those responsibilities of LGAs which have relevance for an HIV/AIDS response

Purpose:
The purpose of the checklist is to provide a user-friendly means by which a LGA can check if:

- its emerging HIV/AIDS response is consistent with its legal and Constitutional obligations; and
- if considerations relating to HIV/AIDS are being incorporated into relevant functions, particularly development functions

Process:
There are two opportunities to use the checklist:

(i) During the multisectoral planning for an HIV/AIDS response
(ii) At all stages of the integrated development planning process

There are instances where whether or not a certain decision will compound or alleviate the HIV/AIDS situation is not immediately apparent. However, many decisions which do not appear to be related in any way to HIV/AIDS, may in fact to have significant implications particularly when AIDS is considered within a broad developmental framework.

Notes:

CHECKLIST OF RESPONSIBILITIES FROM THE WHITE PAPER ON LOCAL GOVERNMENT

Section B of the White Paper on Local Government looks at what development means for LGAs. It describes the transformation which is necessary to change the ways things are done to ensure that:

- communities have access to basic services
- everyone can participate in decision-making and planning
- the local economy grows
- job opportunities increase
- local resources are used wisely

KEY DEVELOPMENT ROLES	PERFORMANCE MEASURES
Provide community leadership	Work with all sections of the community to build a shared vision and set goals for development
Promote social and economic well-being	Ensure that all plans, policies, programmes and actions lead to economic and social development and a better quality of life for all
Promote local economic development	Enhance employment and investment and provide special economic services (eg with other Government Departments)
Co-ordinate and integrate all efforts to develop the area	Keep open channels of communication with other spheres of government and build partnerships with civic, private and public organisations
Promote and build local democracy	Involve local citizens and groups in decisions and processes which affect them, particularly marginalised groups
Create livable, integrated cities, towns and rural areas	Structure the environment to facilitate the participation of disadvantaged groups in the social and economic life of the city
Provide household infrastructure and services	Prioritise the delivery of at least a basic level of services to those who currently enjoy little or no access to services
In summary: **Meet developmental goals**	• **Improve management** • **Empower the workforce** • **Consider a range of new creative approaches to service delivery**

Now consider the implications of each of these roles in relation to HIV/AIDS.
Answer the following questions:

Will the fulfilment of this development role facilitate:	**YES**	**NO**	**If YES, how?**
HIV/AIDS prevention	☐	☐	
Care and support	☐	☐	
Non-discrimination	☐	☐	

Use the results of the above analysis to inform your advocacy work to demonstrate:

- the links between development and HIV/AIDS
- the areas where LGAs have a role to play

TOOL NO.6
A MODEL ADVOCACY PRESENTATION

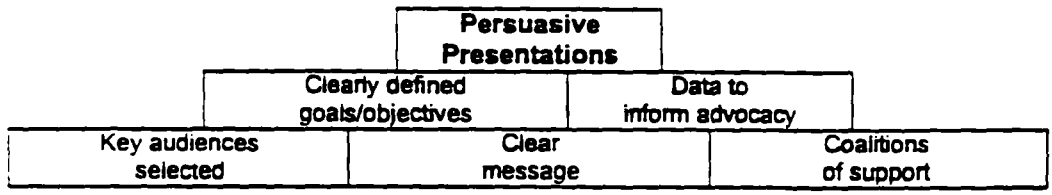
Definition:
Advocacy is defined as action which aims to change policies, positions or programmes – putting a problem onto an agenda, providing a solution to the problem and building support for action.

Purpose:
The purpose of an advocacy presentation on HIV/AIDS is to:

- Raise awareness of the issue
- Suggest appropriate actions and what is necessary for these to occur
- Obtain consensus and support for action

In this instance advocacy is aimed at obtaining commitment to and support for a LG response to HIV/AIDS.

Process:
The steps which should be followed relate to the elements or building blocks of a successful advocacy initiative. These are:

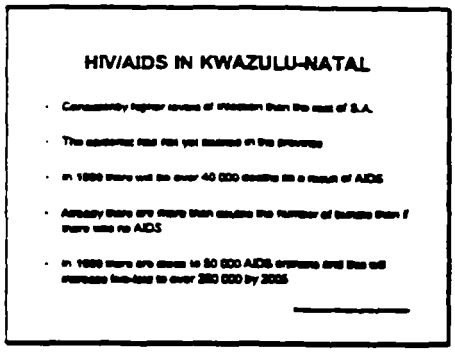


Notes:

MODEL ADVOCACY PRESENTATION

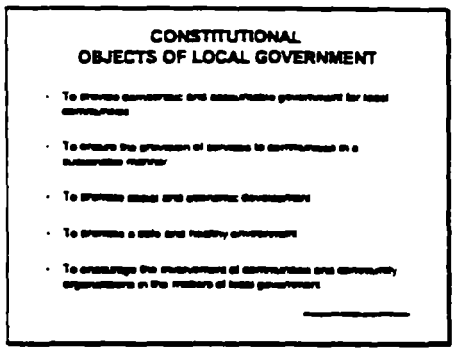
Use the model slides as a basis for generating an advocacy presentation which will be effective for your LGA.

Slide 1



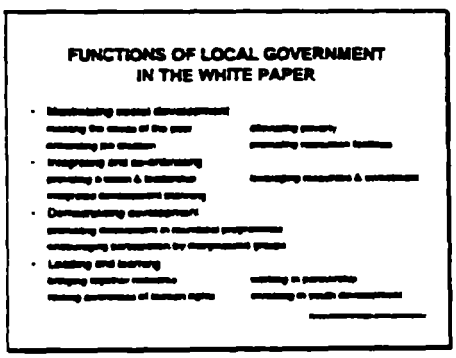
Link to impact (see pg 3) and add any data specific to your LGA

Slide 2



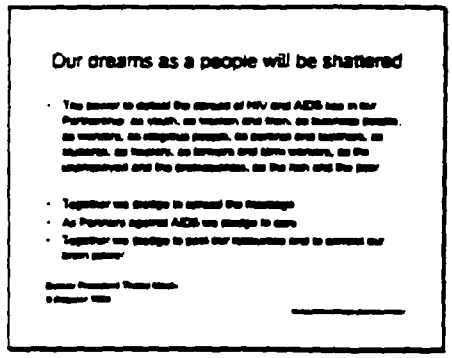
Provide examples specific to your LGA to contextualise the Constitutional roles

Slide 3



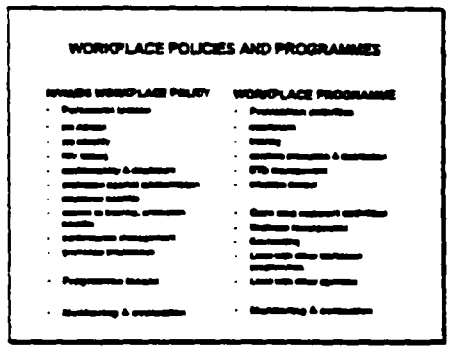
Then refer to the "pillars" of a LGA response (see pg 5)

Slide 4



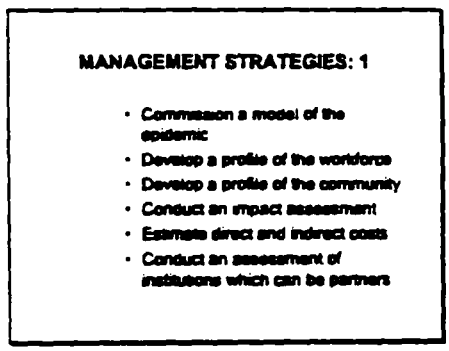
Emphasise the importance of joining the *Partnership Against AIDS*

Slide 5



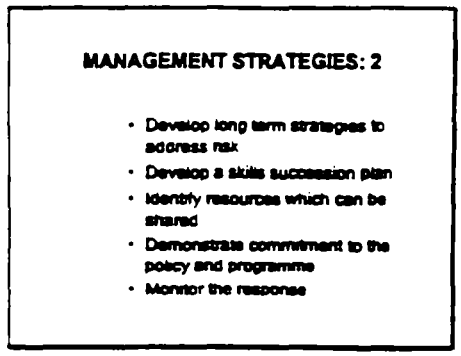
This is an area where the LGA can "lead by example"

Slide 6

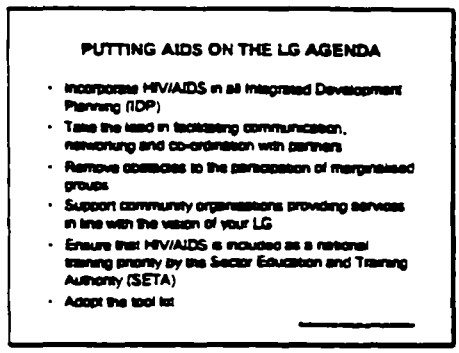


Use as a checklist of the sort of management strategies which are important for effective planning and a sustainable response

Slide 7

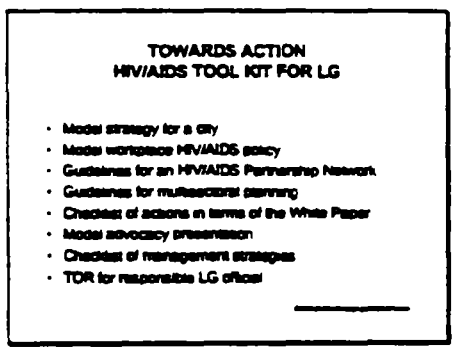


Slide 8



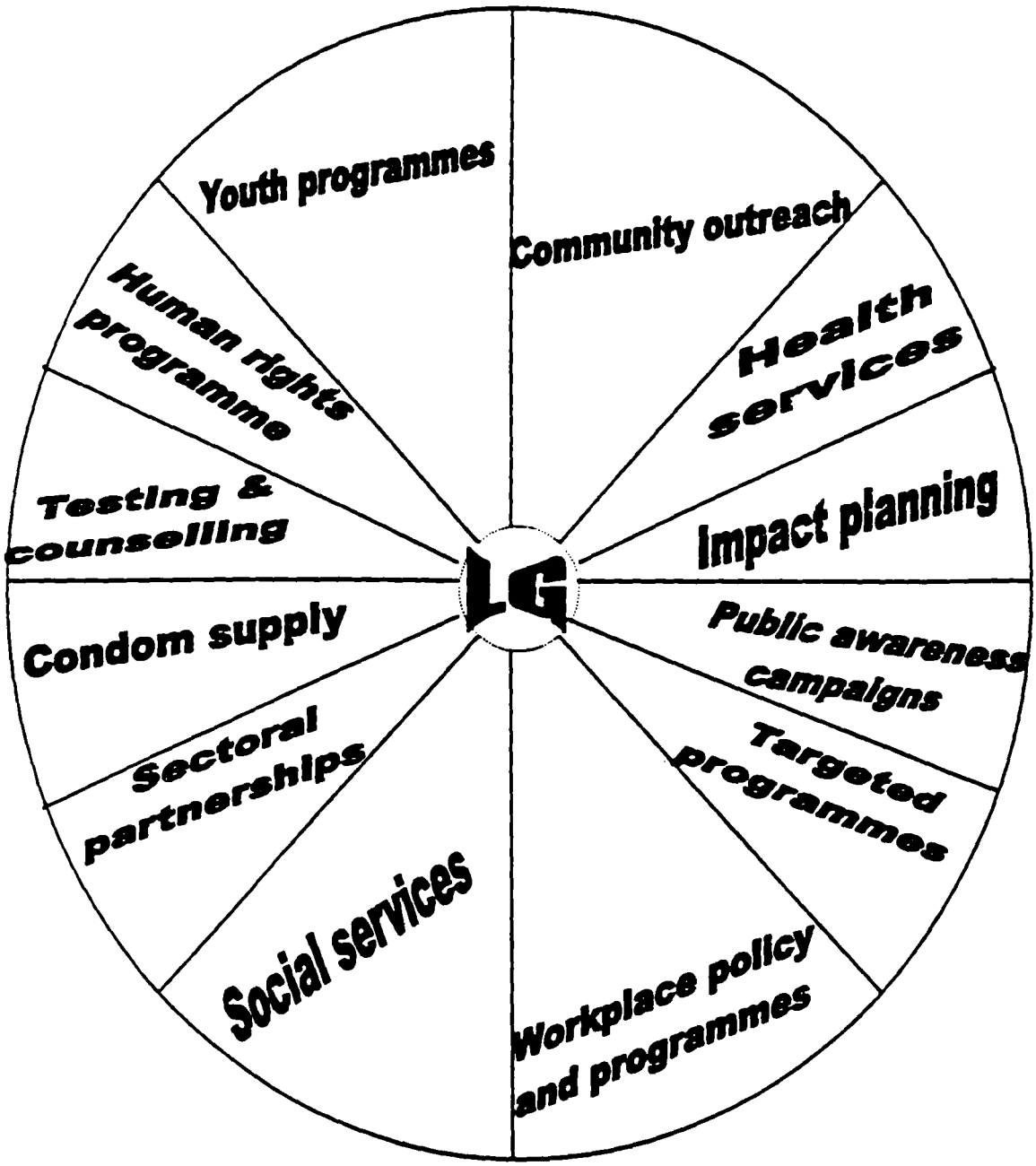
Provide concrete examples of how commitment and support can be demonstrated and where possible get agreement/consensus

Slide 9



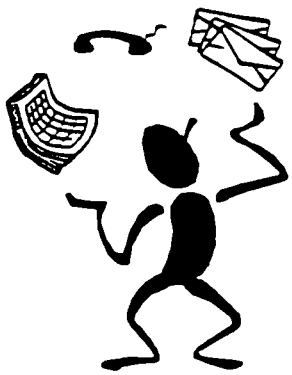
Use the opportunity to popularise the Toolkit as a means to achieve the overall objective of an LGA response to HIV/AIDS

The final slide shows the range of areas in which an LGA response could be developed. It can be used to generate discussion about what is appropriate for your LGA.


Youth programmes
Community outreach
Human rights programme
Health services
Testing & counselling
Impact planning
LG
Condom supply
Public awareness campaigns
Sectoral partnerships
Targeted programmes
Social services
Workplace policy and programmes

LG RESPONSE

WHAT NEXT?



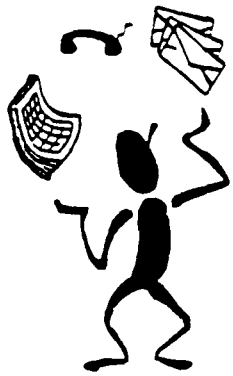
TRAINING

USEFUL RESOURCES AND CONTACTS

APPENDICES

- Checklist of management strategies
- Terms of reference for nominated official and HIV/AIDS Working Group
- Extract from Report on Stakeholder Interviews conducted in July 1999
- Examples of Agendas for Action
- Abidjan Declaration

WHAT NEXT?



TRAINING - WHY?

For a Toolkit such as the one for Local Government to be of optimal use, those who will use it should have the opportunity to attend training.

TRAINING - WHAT?

A five-day course is planned which will hopefully eventually become a standard course available to Local Government officials.

Day One
What you need to know about HIV/AIDS

Day Two
The political, social, economic and legal context of an LGA response to HIV/AIDS

Day Three
Getting to know the Toolkit

Day Four
Developing skills for:

- Data collection
- Planning
- Advocacy

Day Five
Where to from here?

- Tomorrow's tasks
- Needs analysis
- Review of resources
- Support structure

USEFUL RESOURCES AND CONTACTS

The Toolkit should be seen as part of a larger "Tool box" which contains tools or instruments which you may need to use from time to time.

The following is a list of additional tools and of organisations you may need to contact.

TOOLS

Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs - available from the Directorate: HIV/AIDS and STDs, National Department of Health

UNAIDS Guide to the strategic planning process for a national response to HIV/AIDS - available from UNAIDS

South African AIDS Network (National AIDS Database) - available from the Directorate: HIV/AIDS and STDs, National Department of Health

Tool Box for building strong and healthy community organisations working in the area of HIV/AIDS and Sexual Health - available from the Directorate: HIV/AIDS and STDs, National Department of Health

The White Paper on Local Government - available from the Department of Provincial and Local Government

SADC Code on HIV/AIDS and Employment for SADC Member States

South African Code of good practice on HIV/AIDS and employment (currently being developed by the Departments of Health and Labour)

ORGANISATIONS

Directorate: HIV/AIDS and STDs, National Department of Health		(012) 3120121
Department of Provincial and Local Government		(012) 3340600
AIDS Programme, KwaZulu-Natal Department of Health		(0331) 952729
ATICCs:	Pietermaritzburg	(0331) 951612
	Durban	(031) 3003104

APPENDIX ONE: CHECKLIST OF MANAGEMENT STRATEGIES

✓	Commission a model of the epidemic within: (i) the company (ii) the surrounding community
✓	Develop a profile of the workforce, identifying risk factors for HIV infection, such as: (i) separation from primary partnerships (ii) use of condoms (iii) basic knowledge and awareness of HIV/AIDS (iv) cultural practices (such as circumcision) (v) drinking patterns
✓	Develop a profile of the community, describing sexual networking patterns
✓	Conduct an impact assessment to: (i) serve as the base-line information for management/worker consultations (ii) inform the content and focus of the workplace programme (iii) guide medium and long-term strategic planning
✓	Estimate direct and indirect costs attributable to HIV/AIDS including: - absenteeism and sick leave - morbidity → reduced production - replacement recruitment - retraining - medical costs - disability and ill health retirement - pensions and dependent benefits - funeral costs
✓	Conduct an assessment of the institutions that may be involved in any interventions, including: (i) Company medical facilities: hospitals, clinics, outreach teams (ii) Company social services: social welfare, church and recreational services (iii) Union services: (iv) Extra-company health services: (v) Extra-company social services:
✓	Develop long term strategies to address risk factors such as single sex hostels and migrancy
✓	Develop a skills succession plan and initiate a multi-skilling programme for positions identified as critical to production
✓	Identify company resources which can be shared such as: (i) skills in marketing (ii) advertising and public relations (iii) information technology (iv) market research
✓	Demonstrate commitment to the workplace policy and programme from: (i) management (ii) trade unions
✓	Monitor the response by: (i) documenting ill-health data (ii) analysing absenteeism data to indicate trends

APPENDIX TWO: TERMS OF REFERENCE FOR NOMINATED OFFICIAL AND HIV/AIDS WORKING GROUP

The success of a LGA response to the HIV/AIDS epidemic will be greatly enhanced if there is a person nominated with specific responsibility for the various components of the response.

These include:

- the development and implementation of a **Workplace HIV/AIDS Policy**
- the development and implementation of a **LGA Strategy on HIV/AIDS**
- the establishment of an **HIV/AIDS Partnership Network**

It is proposed that an official be nominated and mandated to lead the LGA HIV/AIDS response. He/she should be supported by a small, representative HIV/AIDS Working Group.

TOR FOR THE NOMINATED OFFICIAL

1. The person should be a full-time employee of the LGA with an existing portfolio in the area of social and economic development, planning, health, education or community/social services

2. The person should be formally designated as the nominated HIV/AIDS focal point person, preferably by the LGA Executive/Management Committee. His/her job description should reflect the following responsibilities:

   Internal functions:
   - Co-ordinate the development, implementation, monitoring and evaluation of the Workplace HIV/AIDS Policy and Programme.
   - Report to management (the Executive/Management Committee) regarding Programme implementation and progress.

   External functions:
   - Co-ordinate the development, implementation, monitoring and evaluation of the LGA Strategy on HIV/AIDS
   - Co-ordinate the participatory planning process
   - Conduct an analysis of potential partnerships
   - Facilitate the creation of the LGA HIV/AIDS Partnership Network and support its functions.

   In instances where the nominated person has not received training in HIV/AIDS, he/she should undergo training.

3. The ideal person would therefore:
   - Have seniority (preferably with a development or management portfolio)
   - Have a clear mandate from senior management
   - Have an interest in HIV/AIDS and an understanding of the issues
   - Have an understanding of development issues and of Local and Provincial Government
   - Have credibility with key sectors and with local communities
   - Have leadership qualities
   - Have good inter-personal, negotiation, facilitation and communication skills
   - Have good organisational abilities
   - Have experience (at management level) of planning and financial control.

TOR FOR THE HIV/AIDS WORKING GROUP

1. The HIV/AIDS Working Group would consist of +- 5 persons representing key Departments in the LGA.

2. The members of the HIV/AIDS Working Group would be officially appointed to serve on the Group.

3. The members of the HIV/AIDS Working Group would also serve as members of the HIV/AIDS Partnership Network.

4. The HIV/AIDS Working Group would support the HIV/AIDS Focal Point Person in all the identified tasks.

5. The HIV/AIDS Working Group would have the authority to call on expertise from non-LGA employees should the need arise.

APPENDIX THREE: EXTRACT FROM REPORT ON STAKEHOLDER INTERVIEWS CONDUCTED IN JULY 1999

INTRODUCTION

In July 1999, stakeholders from Business, Trade Unions, NGOs, Provincial and Local Government in two Local Government Authorities in KwaZulu-Natal were interviewed:

- To develop a picture of the role of Local Government in the context of the White Paper on Local Government
- To understand if and how this includes responsibilities to address the HIV/AIDS epidemic
- To define what resources Local Government will need to develop their responses to the HIV/AIDS epidemic and to meet their responsibilities
- To identify potential partners to participate in a multisectoral response
- To agree on the contents of the HIV/AIDS Toolkit for Local Government.

THE CONTEXT OF LOCAL GOVERNMENT IN KWAZULU-NATAL

Examples provided by interviewees of the situation in the two Local Government Authorities (LG1 and LG2) describe the context within which Local Government is currently functioning.

Constraints	Opportunities
In LG1 only two-thirds of the potential rate payers are paying rates	LG2 is engaged in poverty alleviation, promoting food security through community gardens, improving access to water and housing; and job creation
In LG2 commercial rates were increased by 100% 1998 but no additional services have been provided	LG1 is planning to out-source certain non-core functions - this will result in funding becoming available for other purposes
In LG1 50% of the population live in a previously disadvantaged area and over 50% of these people are unemployed	LG1 has successfully called into being a number of fora with multisectoral representation such as the Economic Partnership Action Team to address major issues affected the city
LG appointments have become laborious and difficult and have constrained the capacity of HR officials to undertake new functions	The integrated development planning process has been launched involving sectoral representatives. Catalytic projects in line with the overall vision for the city have been identified
LG has little potential to raise funds other than from the traditional sources (rates, services and allocations from national and provincial government)	LG1 has created an AIDS Forum with multisectoral representation
There is resistance to assuming any new activities which are seen as unfunded mandates.	

PERCEPTIONS OF LOCAL GOVERNMENT'S ROLE AND RELATIONSHIPS

Those interviewed unanimously agreed on the following points:

- Local Government has an enormous amount to do with limited resources
- The 'core business' of Local Government is development – AIDS should be part of this core business
- Local Government is the most appropriate agent to call together partners to address issues of importance to the city and to its communities.

Differing opinions which were articulated included:

- There are problems with Local Government's credibility and concerns about corruption, capacity to deliver and wastage of limited resources
- Particularly in the more rural areas, there is a perception that Local Government is not present
- There is a need for capacity building amongst Councillors
- There is a need for in-service training on attitude change in relation to HIV/AIDS and on gender sensitisation for Local Government officials
- Resistance by some Councillors to confronting and accepting data on the actual HIV/AIDS situation has resulted in denial of the extent of the problem and delays in taking action
- It is naive to think that Local Government, with its existing staff, can undertake the developmental functions described in the White Paper.

LOCAL GOVERNMENT'S POTENTIAL RESPONSE TO HIV/AIDS

Actions identified by the interviewees provide a sense of the range of possible appropriate responses.

- Councillors have a critical leadership role to play to communicate with communities, to open the debate about AIDS and confront the denial which exists, to disseminate consistent, important messages about HIV/AIDS and to demonstrate a non-discriminatory, supportive role to those who are HIV infected.
- Every Council should have a Standing Committee on AIDS, a Sub-committee on AIDS or a standing item on AIDS on every Joint Management Committee agenda.
- Local Government has opportunities to mobilise communities or to access social mobilisation skills from partners (such as Labour) and use these to mobilise sectors and communities around AIDS.
- There are numerous opportunities in the interactions which occur between the city and its citizens to provide AIDS information eg at locations where rates and service accounts are paid.
- Staff working in communities, such as in informal settlements, have opportunities to engage people on the subject of HIV/AIDS.
- Local Chambers of Commerce and Industry do not have the potential to reach the informal business sector and small business. Local Government does have mechanisms to do this.
- Local Government as an employer should lead by example in matters of workplace policies and programmes.
- Local Government has a budgetary allocation for training. All training conducted could incorporate HIV/AIDS.

EXAMPLES OF POSSIBLE ACTIONS

Local radio stations could become the "voice of Local Government" on HIV/AIDS

Local Government could call together parents to discuss AIDS programmes in schools

Venues under the control of Local Government could be made available free or at low cost for AIDS activities

A question on AIDS could be included in every interview for new staff

Procurement of supplies for Local Government could be made conditional on the suppliers providing evidence that they have workplace policies and programmes in place for their staff

Messages about AIDS could be printed on rates accounts

The forum of Mayoresses could prioritise AIDS issues, eg youth initiatives

APPENDIX FOUR: EXAMPLES OF AGENDAS FOR ACTION

EXAMPLE NO.1

	INTERNAL[3]			EXTERNAL
✔	Establish an HIV/AIDS working group		✔	Identify networks and processes to prioritise HIV/AIDS as an on-going issue
✔	Develop and adopt a workplace policy on HIV/AIDS, STDs and TB		✔	Demonstrate leadership commitment
✔	Conduct a needs assessment and an impact assessment		✔	Mobilise community leaders and the private sector to participate in the *Partnership Against AIDS*
✔	Implement an awareness and prevention programme		✔	Increase awareness, support debate and encourage action in prevention, care and support
✔	Improve access to voluntary counselling and testing and to the treatment of STDs		✔	Promote and improve access to services such as STD treatment and voluntary counselling and testing
✔	Implement a programme for the management of infected employees		✔	Establish risk reduction programmes for groups at high risk
✔	Protect the rights of employees with HIV/AIDS		✔	Provide care and support services within an enabling, non-discriminatory environment
✔	Monitor the policy and programmes regularly		✔	Monitor the Local Government's response regularly

Whilst the overall goal must remain the reduction of new HIV infections and the provision of enabling care and support to those infected and affected, the indicators which will demonstrate progress and/or success in a Local Government are:

the establishment of an "HIV/AIDS Action Team"
joint planning to create a common understanding by all role-players of the problem (ideally within the context of integrated development planning)
the creation of partnerships with civil society, community organisations and the private sector
the development or expansion of services such as HIV/AIDS information points, counselling centres and community-based care services
the development or expansion of services for citizens in high risk situations such as the youth, sex workers and migrant/mobile workers

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[3] Adapted from Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs, Department of Health (1997)

EXAMPLE NO.2[4]

The LGA is committed to an Agenda for Action that includes seven priorities. Each Agenda point is supported by one Statement of Intent that gives expression to the Agenda point.

Secure political and leadership support

We must emphasise the gravity and urgency of the epidemic, and announce to our people that the country's stability and survival are at stake

Create an enabling environment for effective responses

We must overcome any sensitivities and speak out frankly about how to prevent AIDS; no taboo should be allowed to interfere with the saving of millions of lives

Challenge discrimination

We must counter the impression that AIDS is a disease that only attacks certain groups or populations, and show by our personal example that people with HIV or AIDS are to be treated with respect and compassion, in keeping with Africa's age-old tradition of tolerance

Mobilise communities to join the ***Partnership Against AIDS***

We must encourage traditional and religious leaders to exercise moral leadership to bring about life-saving changes in individual and collective behaviour

Reduce transmission of HIV

We must seize this opportunity and ensure that today's girls and boys, who will be the mothers and fathers of tomorrow's children – are safe from HIV

Plan for the care of people with HIV infection and AIDS

We must ensure links and collaboration between the formal health sector and community structures, including religious, charitable and other non-governmental organisations

Support families and survivors

We must anticipate the family and community disruption that will result from AIDS deaths and plan now for ways of caring for and supporting the survivors

MODUS OPERANDI

1. Strategies to achieve each of the seven priorities will be developed through a joint, participatory, inclusive planning process

2. Those strategies that meet certain criteria will form the basis of the LGA work plan – wherever possible, integrating activities into existing projects and programmes, particularly development projects and programmes, to ensure full ownership and responsibility

3. An analysis of potential partnerships will be conducted

4. Mechanisms for consultation, communication and collaboration will be established

5. All services offered by the LGA will be examined to determine the potential impact of the HIV/AIDS epidemic on these services

6. Development projects and programmes which, by their nature, address the underlying factors which fuel the epidemic will be prioritised for support

7. Financial, material and human resources will be identified

8. Short-term (process) indicators and longer-term (progress) indicators will be developed and utilised to monitor the LGA Strategy on HIV/AIDS

4 Adapted from the Organisation of African Unity **Declaration on the AIDS epidemic in Africa**, July 1992

APPENDIX FIVE

Xth International Conference on STD/AIDS in Africa

Abidjan Declaration

By African Mayors and Municipal Leaders

We, Mayors and Municipal Leaders of Africa, meeting December 9, 1997 in Abidjan, Côte d'Ivoire, on the occasion of the Xth International Conference on STD/AIDS in Africa, have adopted the following declaration, called the "ABIDJAN DECLARATION".

Aware that precarious economic conditions in our cities intensify the impact of HIV/AIDS on vulnerable communities, in particular women and youth, and jeopardise our long term local development plans;

Recognising that our cities are increasingly becoming centres of demographic growth in our countries and that, given the powers invested in them, our municipalities have an important role to play in responding to the many challenges posed by the HIV/AIDS epidemic;

We hereby commit ourselves to search for solutions relevant to local needs and realities, in accordance with the goals and principles of the United Nations and our own laws and regulations, in order to respond more effectively to HIV/AIDS in our communities.

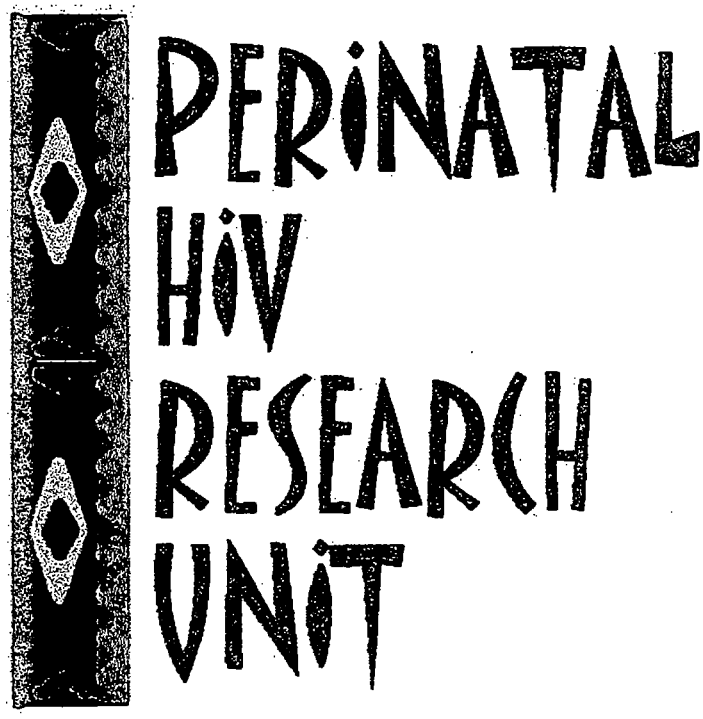
To this end we have agreed to:

- Aim to reduce the socio-economic impact of HIV/AIDS in our communities by implementing effective measures to reduce HIV transmission.
- Promote and co-ordinate local multisectoral approaches for HIV prevention and the care of infected and affected people.
- Participate in efforts to mobilise the human and financial resources necessary to implement local strategies.
- Ensure the active involvement of people infected and affected by the HIV epidemic in designing and implementing local strategies.
- Strengthen solidarity amongst our cities and develop an effective partnership with national and international, public and private stakeholders.

We therefore commit ourselves to:

- Ensure that the search for effective solutions to HIV/AIDS is a public policy priority
- Effectively involve our citizens in designing action plans, defining local strategies, and implementing activities.
- Provide the necessary institutional support to our cities and communities and strengthen their capacity to intervene.
- Guarantee transparency and accountability in programme management.
- Create an ALLIANCE OF MAYORS AND MUNICIPAL LEADERS to maximize commitment, participation, leadership, capacity and experience at community level in response to the challenge of the HIV/AIDS epidemic in Africa.

Abidjan, 9 December 1997



THE PERINATAL HIV RESEARCH UNIT

Departments of Obstetrics & Gynaecology and Paediatrics

Chris Hani Baragwanath Hospital and the University of the Witwatersrand
Soweto
South Africa

January 1999

BACKGROUND TO THE PERINATAL HIV RESEARCH UNIT

History

The Perinatal HIV Research Unit is a joint project of the Department of Obstetrics and Gynaecology and the Department of Paediatrics of the University of the Witwatersrand at Chris Hani Baragwanath Hospital.

The Unit was formed as a joint Research Unit in 1996, developing from the Perinatal HIV Clinic at the hospital, which has functioned since 1991. The Co-Directors, Dr James McIntyre (Obstetrician) and Dr Glenda Gray (Paediatrician) have worked in the field of HIV/AIDS in women and children for over ten years, and have been at the forefront of this field in South Africa. The Perinatal HIV Research Unit has been involved in research, training, policy formation and advocacy in issues concerning HIV-positive women and their children.

Objectives:

The objectives of the Perinatal HIV Research Unit are:

- To undertake research into mother to child transmission of HIV
- To provide appropriate, high-standard medical care for HIV infected women, their HIV infected partners and children at the CHBH
- To undertake prevention research in HIV
- To undertake clinical research in HIV in adults and children
- To promote awareness of the rights of HIV-positive women and children
- To train others in the management of HIV-positive women and children
- To make policy regarding the minimum standard of care in pregnancy and childhood for HIV infected women and children
- To set minimum standards of counselling in the antenatal setting
- To develop innovative models for rapid on site testing and counselling in midwifery units in Soweto

RESEARCH WORK:

The Perinatal HIV Research Unit has undertaken several major research projects over the past three years and is in the process of developing new projects relevant to the South African setting. The unit is recognised nationally and internationally as a leader in the field of research and policy in the area of mother-to-child transmission of HIV. It is also developing a reputation as a leading African research unit for clinical trials in adults and children with HIV, with one of the largest cohorts of adults enrolled in HIV drug trials in the world. The Co-Directors of the Unit have contributed to the international development of the research and guidelines in perinatal HIV and are regarded as international experts in this field.

The Unit, together with the Reproductive Health Research Unit, is one of eleven international HIVNET sites for HIV prevention research, awarded after an international competition that received over twenty applications. As one of the partners in the Soweto HIVNET site, the unit is also at the forefront of HIV vaccine development research in South Africa, which has been identified as a priority by the government and which is likely to grow in importance in the years to come.

CURRENT ACTIVITIES

The Perinatal HIV clinic at the Chris Hani Baragwanath Hospital (CHBH) provides obstetric care for mothers and paediatric follow up of children born to HIV-positive women in one setting with nurse counselling, group education, peer counselling and social support, including income generation projects, undertaken by community organisations and a group of HIV-positive workers. This combined approach to the care of HIV infected women and their children has been very successful and has been cited as a model for other African settings.

The Research Unit works from this clinical base to undertake research on mother-to child transmission (MTCT) of HIV, obstetrical and gynaecological aspects of HIV infection, social and psychological factors associated with fertility in HIV infected women, growth and development of HIV infected children, medical problems of HIV infected children and trials on drug therapy for both adults and children. Over 30% of paediatric admissions to Baragwanath Hospital at present are HIV-related, and the Unit is promoting and assisting research in the field of paediatric HIV, in addition to the perinatal issues.

The Unit is conducting clinical trials of new antiretroviral drugs for both adult and children, in association with international researchers and pharmaceutical companies. These trials include Phase 1 and 2 work as well as extensive Phase 3 clinical trials.

The Perinatal HIV Research unit, together with the Reproductive Health Research Unit at Chris Hani Baragwanath, is one of eleven international sites funded for HIV prevention research projects by the US National Institutes of Health in the HIVNET programme. This funding was awarded after a worldwide competition for new HIVNET sites in 1997, and the research programme includes perinatal transmission work and preparation for vaccine trials.

The Perinatal HIV research Unit has been awarded a contract to conduct operational research in providing antiretroviral access in Soweto by the International Solidarity Fund spearheaded by the French Government.

Clinical activities

The Perinatal HIV Research Unit is based in and linked to the Perinatal HIV Clinic a the CHBH. Dr McIntyre and Dr Gray formed the Perinatal HIV Clinic in 1991, to co-ordinat : the care and counselling of pregnant women identified as HIV-positive. All pregnant women who receive antenatal care at Baragwanath Hospital are offered routine HIV testing. Uptake o' the test is over 90%, and the HIV seroprevalence in mid 1998 was over 20%. Identified HIV-positive women are then referred through to the Perinatal HIV Clinic for counselling and further management.

The Clinic provides antenatal and postnatal care for women, follow up for gynaecological problems, family planning advice and provision, counselling at all stages of the disease, peer group counselling and access to community organisations and support groups. Counselling and testing is provided for male partners of HIV-positive women and women are encouraged to bring partners in for couple counselling. The children born to infected mothers are followed up at the clinic to 18 months, and have repeat HIV tests during this period to determine their serostatus. Children that are identified as being HIV infected are part of a long-term follow-up programme to determine the natural history of HIV disease in this perinatal cohort.

Dr Gray is the Honorary Paediatrician for an AIDS Home for abandoned children (Bethesda House, Soweto) and the only children's AIDS Hospice in South Africa (Cotlands). She has helped develop guidelines for terminally ill patients into the hospice and treatment guidelines for the management of HIV infected children in the institution.

Teaching:

The Unit is involved in teaching at many different levels. Dr Gray and Dr McIntyre teach fourth and sixth year medical students in lectures and tutorials. The Unit is responsible for a segment of the DTM&H at Wits, which is taught each year. Teaching is provided for registrars if the Obstetrics and Gynaecology and the Paediatric department. In addition to this teaching commitment within the University, both Directors and several other staff members provide in-service teachings sessions for nurses and other disciplines and have give numerous talks to professional bodies on an ongoing basis. Dr McIntyre is co-author of the HIV/AIDS section of the Reproductive Health Education Programme (RHEP) and author of several textbook articles on HIV in pregnancy. Dr Gray was central to the development of management guidelines for HIV in Paediatrics, issued by the Gauteng Health Department and the University.

Policy & Advocacy:

The Unit is also involved in provincial, national and international policy development in HIV issues and in the training of doctors, medical students and nurses in HIV management Both Dr McIntyre and Dr Gray have worked as consultants to the World Health Organisation and UNAIDS on perinatal transmission of HIV. Dr McIntyre is the author of a comprehensive WHO review on the subject of HIV in pregnancy and is a consultant to UNICEF on the implementation of perinatal transmission prevention strategies. The Co-Directors of the unit participate in a number of international working groups on the subject and have presented at many international conferences. Dr McIntyre and Dr Gray are working with UNAIDS, WHO and other collaborators on the development of cost effectiveness models and policy

development for interventions to reduce mother to child transmission of HIV, and on guidelines for policy makers on the issues of pregnancy management in HIV-positive women, breastfeeding and anti-retroviral therapy in pregnancy.

The Unit is working closely with the National AIDS Programme in South Africa on the prevention of mother-to-child transmission of HIV and has co-ordinated a consultative process and national working group on this issue. The directors co-chair a Technical Task Team on the Prevention of Vertical Transmission for the National AIDS Programme The Perinatal HIV Research Unit has been central to the development of a provincial policy for the care of HIV infected children.

The unit has been involved in wider policy development for HIV/AIDS in South Africa. Dr McIntyre was a member of the National AIDS Plan team, which wrote the National AIDS Plan for the country, and both he and Dr Gray contributed the section of the plan on perinatal HIV. Both directors have been members of the AIDS Advisory Committee of the Department of Health and have worked with the provincial national government on policy documents The Unit contributed to the Government's Maternal, Child and Women's Health Policy, in the sections on HIV in women and children. Policy has been developed for the care of children in institutions.

The Unit has close links with the National Association of People Living with AIDS (NAPWA) and has worked with NAPWA on policy and educational media. There are also close links with the AID Consortium (which Dr McIntyre co-chairs), NACOSA and the AIDS Law Project of the Centre for Applied Legal Studies at the University of the Witwatersrand, reflecting the Unit's policy of working on the human rights and individual needs issues around AIDS as well as research and clinical care.

International links:

The Perinatal HIV Research Unit has links with other researchers and organisations involved in HIV internationally. These include:

- UNAIDS,
- WHO,
- UNICEF,
- HIVNET,
- Intramural AIDS Research Division and DAIDS, NIH;
- IAS;
- INSERM, France
- Society for AIDS in Africa,
- NARESA,
- The European Collaborative Study of Children Born to HIV-positive Mothers,
- The Ghent Working Group on Mother to Child Transmission,
- The Hughes Research Foundation, University of California, San Francisco,
- Columbia University,
- University of New South Wales and the
- Centres for Disease Control and Prevention, USA.

CURRENT RESEARCH

PERINATAL HIV RESEARCH

- **Factors Affecting HIV transmission from Mother-to-Child**: This study started in May 1993 and looked at the role of HIV-1 transmission through breastfeeding
- **PETRA study**: The Perinatal HIV Research Unit is one of 5 multicentered sites for the PETRA (perinatal transmission study) which is sponsored by UNAIDS. Our site is the largest site and has enrolled the largest number of mother-infant pairs. The site has been commended for its high standard of clinical research and good clinical practice. We have retained this cohort of mother-infant pairs over a period of eighteen months and have a loss to follow-up of less than 11%. Dr Gray and Dr McIntyre are the Principal Investigators on the study.

  Substudies of PETRA co-ordinated by the Perinatal HIV Research
  - **Cellular Immunity in infants born to HIV infected women**: this is a sub-study of the PETRA study initiated by the investigators to document immune responses of infants born to HIV infected women. Collaborators in this research include Dr Caroline Tiemessen from the National Institute of Virology and Prof. Louise Kuhn from Columbia University, USA.
  - **Immunogenicity to immunisations of infants born to HIV infected women**. This sub-study of the PETRA study will ascertain immune responses to childhood immunisations in infants born to HIV infected women. Dr Gray and Dr Vardas of the National Institute of Virology are the Principal Investigators on the study.
  - **Attitudes and Behaviour of HIV infected women to infant feeding practices.** This study was completed earlier this year and was intended to understand and describe infant feeding practices against the backdrop of HIV disease. Dr Mike Urban, Dr Gray and Prof. Wagstaff were the Principal Investigators in this study.
  - **HHV8: Risk factors for transmission**. This study is being conducted in collaboration with Dr Freddie Sitas (National Cancer Registry), Dr Andrew Grulich (University of New South Wales, Australia) and Dr Gray at the PHRU
  - **Is HHV8 perinatally acquired**? This study is being conducted by Dr F Sitas, Dr Andrew Grulich and Dr Glenda Gray
  - **The Effect of Formula Feeding on Growth and Illness in infants born to HIV infected women in Soweto**. In this study the effects of an intervention of formula feeding are evaluated against the outcomes of growth and illness. Dr Gray and D. Violaris are the Principal Investigators on the study.
  - **Late postnatal transmission of HIV-1 from mother to child through breastfeeding**

- **The Cost-Effectiveness of Interventions to prevent Mother-To-Child Transmission of HIV in middle income countries**. Dr Gray collaborated with Drs Soderlund, Kinghorn and Zwi in this study. The aim of the study was to assess the affordability and cost-effectiveness of certain interventions for middle income countries.
- **A study of the effect of maternal Vitamin A supplementation on mother-to-child transmission of HIV-1 infection.**
- **An open label study to evaluate the pharmacokinetics and safety of MKC-442 in HIV-1 infected pregnant women and their offspring**. (MKC-204) Dr Gray is the Principal Investigator on the study, Dr McIntyre and Violaris are co-investigators. The study has almost been completed. The results of the study will help direct future research in this arena.

Proposed Research in Perinatal Transmission of HIV

- **Phase II study if Nelfinavir in pregnancy:** Dr Gray as Principal Investigator has submitted a phase II protocol to Roche Pharmaceuticals to investigate Nelfinivir in pregnant HIV infected women and their infants. This protocol is investigator driven. Presently the protocol is being reviewed in Basal, the headquarters of Roche.
- **Phase II/III study of d4T/ddi in pregnancy**: Dr Gray as Principal Investigator has submitted at protocol to investigate d4T and ddI in pregnancy to Bristol Myers Squibb. The protocol has been accepted by BMS and the protocol is undergoing development by BMS and the Perinatal HIV Research unit.
- **Innovative concepts to reduce MTCT with new drug combinations**. The Unit is negotiating with Triangle Pharmaceuticals to look at innovative concepts of reducing mother-to-child transmission of HIV-1 with the use of new drug combinations in late pregnancy.
- **An innovative model for voluntary testing and counselling in an antenatal setting** Dr McIntyre and Gray submitted a proposal to the National Institute of Health in the USA to develop. They will be investigating rapid on site testing and models of counselling that will facilitate future implementation of intervention s to reduce vertical transmission This proposal has been approved for funding.
- **A pilot project looking at providing expanded access to antiretroviral therapy to pregnant women** developed by Dr McIntyre and Gray has just received approval by the Internal Solidarity Fund for Treatment (FSTI).
- **HIVNET Perinatal Working Group**. Dr McIntyre and Gray have been asked to submit a Trial Concept Plan for innovative research in vertical transmission for HIVNET. They will be investigating new concepts for affordable options to reduce vertical transmission of HIV.

PAEDIATRIC RESEARCH:

- **Diarrhoeal diseases in HIV infected children**: Dr Saul Johnson (PHRU) and Dr Wildy Hendon (Paediatric dept) were co-investigators on this study.
- **TB co-infection with HIV in children**. Dr Shabir Madhi was the Principal Investigator (Paediatric Dept) and Dr Gray was a co-investigator.
- **Seroprevalence and disease profile of HIV infection in paediatric admissions at Baragwanath Hospital, Soweto.** Dr Gray who was also a co-investigator supervised this study undertaken by Dr Tammy Meyers.
- **A study of micronutrient levels in human immunodeficiency virus type 1 infected children at Baragwanath Hospital** Dr Alison Baxter was the principal investigator on this study and Dr Gray supervised this study.
- **An open label study of MKC-442 in combination with nucleoside reverse transcriptase inhibitors in HIV-1 infected paediatric patients to evaluate its pharmacokinetics, preliminary safety and antiviral efficacy**.(MKC-203)
- **Cellular immunity of children**

Future paediatric research:

- **A phase I study investigating TXU-PAP in paediatrics**. This study has received MCC approval.

HIV VACCINE DEVELOPMENT RESEARCH

- **HIVNET**: The PHRU is part of a Southern African HIV Vaccine Initiative of HIVNET.
- **Acute seroconvertor study** The PHRU, together with the other Southern African HIVNET sites of Malawi, Zimbabwe, Zambia and Hlabisa will conduct a study to map out subtype C viral sequences and immune responses to acute HIV infection in an attempt to develop a subtype C vaccine.
- **Attitudes to vaccine trials**. An interview based study of attitudes of people in Soweto to HIV vaccine trials has recently been completed
- **Vaccine trials:** Through the link to HIVNET and the South African AIDS Vaccine Initiative, the PHRU will be one of the first sites in South Africa to test a candidate HIV vaccine.

ADULT CLINICAL TRIALS:

The unit is involved in Phase III clinical trials in the field of antiretroviral therapy:

- **A study on the tolerance and efficacy of a combination of Delavirdine Mesylate and nucleoside therapy in the treatment of HIV infected patients**. Our site is the second largest site in the world. Dr Alan Karstaedt is the Principal Investigator with Dr Saul Johnson and Dr Gray as co-investigators.
- **A randomised, double blind, comparison of MKC-442 Vs placebo in antiretroviral naïve patients with HIV-1 RNA greater than 5000 and less than or equal to 50000 copies/ml and CD4+ > 300 cells/mm^3 who are initiating therapy with Zerit and Epivir**. The Triangle 301 study Dr McIntyre is the Principal Investigator with Dr Lerato Mohapi and Dr Gray as co-investigators
- **A randomised, double blind, comparison of MKC-442 vs. placebo in antiretroviral naïve patients with HIV-1 RNA greater than 50000 copies/ml and CD4+ > 300 cells/mm^3 who are initiating therapy with Zerit and Videx.** The Triangle 302 study: Dr McIntyre is PI with Dr Mohapi and Dr Gray as co investigators

PREVENTION & SOCIAL SCIENCE RESEARCH:

- **A study on dilemmas facing HIV-positive women attending antenatal care and postnatal clinics at Chris Hani Baragwanath Hospital regarding partner notification**
- **A Phase II study of the safety and toxicity of Pro 2000, a vaginal microbicide, in HIV-positive women.** This is a HIVNET Study that will be undertaken with the Reproductive Health Research Unit.
- **Contraceptive use and fertility decisions of HIV-positive women.** This study is complete and data are being analysed. Dr Manuel Bareiro of the Department of Obstetrics and Gynaecology is the principal investigator.

RECENT PUBLICATIONS

1. Chapters in books for the specialist:

1. McIntyre JA. *HIV Infection and AIDS*, in: *Topics in Obstetrics & Gynaecology*, Bassin J (Ed), Julmar Communications, Johannesburg, 1994: 72-77
2. McIntyre JA *HIV Infection and AIDS*, (major revision) in: *Topics in Obstetrics & Gynaecology, Fourth Edition*, Bassin J (Ed), Julmar Communications, Johannesburg, 1994: 102 - 107
3. McIntyre JA *HIV and AIDS in Pregnancy* In O'Brien PMS (Ed). *Yearbook of the Royal College of Obstetrics and Gynaecology, Volume 6,* 1998; Royal College of Obstetrics and Gynaecology, London: 126-136
4. McIntyre JA. *HIV in Africa* in Hudson C, Jeffries D, (Eds) *Viral infections in Obstetrics and Gynaecology.* Chapman & Hall, London, (In press)
5. Fleming A, McIntyre JA., Johnson F *AIDS.* in Bergstrom S, Lawson JB, Harrison K (eds) *Obstetrics and Gynaecology for the Tropics*, Churchill Livingstone, London, Second edition. (in press)
6. McIntyre JA *HIV in pregnancy* in Pattinson RC, Pistorius L, Mantel G (Eds) *Manual of Pregnancy Management* (in press)
7. McIntyre JA, Crewe M *Introduction to HIV/AIDS* in Rees H et al (eds) *Reproductive Health Education Programme: STD and HIV/AIDS Manual,* Reproductive Health Research Unit, Johannesburg (In press)
8. Crewe M, McIntyre JA *Counselling and Testing* in Rees H et al (eds) *Reproductive Health Education Programme: STD and HIV/AIDS Manual,* Reproductive Health Research Unit, Johannesburg (In press)
9. McIntyre JA, Crewe M *Management of Common HIV/AIDS related conditions* in Rees H et al (eds) Reproductive Health Education Programme: STD and HIV/AIDS Manual, Reproductive Health Research Unit, Johannesburg (In press)
10. McIntyre JA, Crewe M *Women and HIV/AIDS* in Rees H et al (eds) *Reproductive Health Education Programme: STD and HIV/AIDS Manual*, Reproductive Health Research Unit, Johannesburg (In press)
11. McIntyre JA, Crewe M *HIV/AIDS in pregnancy* in Rees H et al (eds) *Reproductive Health Education Programme: STD and HIV/AIDS Manual*, Reproductive Health Research Unit, Johannesburg (In press)
12. McIntyre JA, Crewe M *Education, Prevention and Interventions* in Rees H et al (eds) *Reproductive Health Education Programme: STD and HIV/AIDS Manual*, Reproductive Health Research Unit, Johannesburg (In press)

2. Published conference proceedings:

1. McIntyre JA, Gray GE. Lyons SF *Maternal and obstetrical factors in mother-to-child transmission of HIV in Soweto, South Africa.* Proceedings of the 15th Conference on Priorities in Perinatal Care in Southern Africa, University of Pretoria, 1996: 79-80
2. Cooper PA, Saloojee H, Hauptfleisch CJ, McIntyre JA *Are there measurable effects of the introduction of free antenatal care?* Proceedings of the 15th Conference on Priorities in Perinatal Care in Southern Africa, University of Pretoria, 1996: 67-68
3. McIntyre JA, Gray GE *Transmission of HIV from mother to child: strategies for prevention.* Proceedings of the 16th Conference on Priorities in Perinatal Care in Southern Africa, University of Pretoria, 1997: 58-62
4. McIntyre JA, Govender M, Pillay P, Madikane C. *The Northern Cape Safe Motherhood Needs Assessment.* Proceedings of the 16th Conference on Priorities in Perinatal Care in Southern Africa, University of Pretoria, 1997: 75-77
5. Roussot D, Buchmann E, McIntyre JA, Russell JM *Women who book late in pregnancy.* Proceedings of the 16th Conference on Priorities in Perinatal Care in Southern Africa, University of Pretoria, 1997: 81-83

3. Papers in academic journals:

1. McIntyre JA. *HIV/AIDS in South Africa - a relentless progression? (Editorial)* S Afr Med J 1996; **86(1)**: 27-28
2. Taylor MB, Parker SP, Crewe-Brown HH, McIntyre JA, Cubitt WD. *Seroepidemiology of HTLV-1 in relation to that of HIV-1 in the Gauteng region, South Africa, using dried blood spots in filter papers.* Epidemiol Infect 1996, 117: 343-348
3. Westerway MS, Viljoen E, Wessels GM, McIntyre J, Cooper PA *Determining the barriers to utilisation of free antenatal care. The perspective of South African Black pregnant women and community members.* CHASA J Compr Health 1996; 7: 137-140
4. Rees H, Katzenellenbogen J, Shabodien R, Jewkes R, Fawcus S, McIntyre J, Lombard C, Truter H , & Reference Group: *The Epidemiology of Incomplete Abortion In South Africa.* S Afr Med J 1997; 87(4):432-7
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6. Ellison GT; Matshidze KP; Richter LM; Levin J; McIntyre J. *Medical aid and racial bias in caesarean section rates [letter]* S Afr Med J 1996; 86(6):696, 698
7. Ellison GTH, Richter LM, De Wet T, Harris HE, Griesel RD, McIntyre JA. *The reliability of hand written and computerised records of birth data collected at Baragwanath Hospital in Soweto.* Curationis 1997; 20(1): 35-40

8. Ellison GTH, Richter LM, De Wet T, Harris HE, Griesel RD, McIntyre JA. *Improving the accuracy of birth notification data: lessons from the Birth to Ten study.* South Afr J Epidemiol Infect 1997; 12(3): 91-96
9. Hofmeyr GJ, McIntyre JA. *Preventing perinatal infections* (Editorial) Br Med J 1997, 315(7102), 199-200
10. Newell M-L, Gray GE, Bryson Y *Interventions to reduce mother-to-child transmission of HIV-1.* AIDS, 199
11. Gray GE *Antiretrovirals and their role in preventing mother-to-child transmission of HIV-1.* In Van Praag E, Fernyak S, Katz AM (Eds) *The implications of antiretroviral treatments. Informal Consultation April 1997,* World Health Organisation, Geneva: 79-87
12. Lyons S, Bowers ET, McGillivray GM, Blackburn N, Gray GE. *Evaluation of the MUREX ICE HIV-1.0.2 capture enzyme immunoassay for early identification of HIV-1 seroreverting infants in a developing country.* Clinical and Diagnostic Virology, April 1997.
13. Matshidze KP, Richter LM, Ellison GTH, Levin JB, McIntyre JA *Caesarean section rates in South Africa: evidence of bias among different population groups.* Ethnicity and Health 1998; 3(1-2): 71-79
14. McIntyre J, Gray G, Johnson S *Paediatric AIDS--is now not the right time to act? [Letter]* S Afr Med J 1998 Apr;88(4):466-467
15. McIntyre JA *Roundtable: AZT Trials to reduce perinatal HIV transmission: a debate about science, ethics and resources: Introduction* Reproductive Health Matters 1998; 6(11): 129-130
16. McIntyre JA *Roundtable: AZT Trials to reduce perinatal HIV transmission: a debate about science, ethics and resources: Caught in the crossfire: the ethics of perinatal transmission trials in South Africa.* Reproductive Health Matters 1998; 6(11): 136-139
17. Roussot D, Buchmann EJ, McIntyre JA, Russell JM *Women who book late in pregnancy.* S Afr Med J, 1998; **88**: 905-908
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19. Gray GE, McIntyre JA, Lyons S, Levin J, Cooper PA, Pettifor J: *The Effect Of Breastfeeding on transmission of HIV from Mother-to-Child* (Submitted Lancet)
20. Soderlund N, Kinghorn A, Zwi K, Gray G *The cost-effectiveness of interventions to reduce mother-to-child transmission of HIV* (Submitted to British Medical Journal)
21. Meyers TA, Gray GE, Pettifor J: *HIV seroprevalence amongst paediatric admissions at the Chris Hani Baragwanath Hospital* : (submitted to Infectious Diseases)

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1. Rees H, McIntyre JA *Women's sexual and reproductive rights and HIV/AIDS.* Aids Bulletin 1995; 4(2): 8 -
2. McIntyre JA. *Transmission of HIV from mother to child: strategies for prevention.* Postgraduate Doctor Middle East 1996; 19(3): 68 – 72
3. McIntyre JA. *Management of HIV positive pregnant women.* CME 1996; 14(6): 781-788
4. McIntyre JA *Transmission of HIV from mother to child.* Maternal and Child Health 1996; 21(5): 116-118.
5. Gray GE, McIntyre JA. *Factors affecting vertical transmission of HIV-1.* Leech, February 1996
6. McIntyre JA, Gray GE. *Ethical issues in mother-to-child transmission of HIV.* AIDS Bulletin November 1997
7. Gray GE *Affordable options in the prevention of mother-to-child transmission of HIV-1 in Africa* Pedmed, August 1997
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9. McIntyre JA *HIV in women.* Cont Med Educ 1998 (In press)

5. Reports

1. McIntyre JA. *Second Report on Research and Research Training in Human Reproduction in South Africa.* Department of Obstetrics and Gynaecology, University of the Witwatersrand, 1995
2. Griesel RD. McIntyre JA, Van Zyl BA, Wege JW. South *African Research on HIV/AIDS 1980-1994.* Institute for Behavioural Sciences, University of South Africa, Pretoria, 1996

6. Documents prepared for publication by the World Health Organisation:

1. World Health Organisation *HIV in pregnancy: a review.* World Health Organisation, Geneva 1998. WHO/RHT/98.24 I (J McIntyre)
2. World Health Organisation & UNAIDS. *Guidance modules on antiretroviral treatments: Module 6: The use of antiretroviral drugs to reduce mother to child transmission of HIV.* World Health Organisation & UNAIDS, Geneva, 1998. WHO/ASD/98.1 (UNAIDS/98.7) (J McIntyre, G Gray)
3. World Health organisation: Guidelines on Voluntary Testing and Counselling for HIV in Pregnancy (In press) (G Gray, J McIntyre)
4. World Health Organisation: Guidelines on antenatal care for HIV-positive women (In press) (J McIntyre, G Gray)

5. World Health organisation: Guidelines on Labour and Delivery Care for HIV-positive women (In press) (J McIntyre, G Gray)
6. World Health Organisation: Guidelines on Postpartum care of HIV positive women (In press) (G Gray, J McIntyre)
7. World Health Organisation : A review of HIV and contraception (in press) (J McIntyre)

Videos:

1. McIntyre JA. *HIV Infection and AIDS in pregnancy: a teaching video.* Video, Edition 2. University of the Witwatersrand Central Television Service, 1994/5

STAFFING

Directors:
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Dr James McIntyre MBChB MCROG

Research Co-ordinators:
Dr Saul Johnson BSc MBBCH DOH: Clinical Epidemiological Studies
Dr Lerato Mohapi BSc MBBCH: Adult Clinical Trials
Dr Avyi Violaris MD

Biostatistician and Epidemiologist:
Ms Gill Nelson MSc (Med)

HIV Treatment Consultant:
Dr Dave Johnson BSc MBBCH

Part time Medical staff and fellows:
The following medical staff are involved in research projects with the unit or assist with some of the clinical work:

Dr Manual Bareiro
Dr Mike Urban
Dr Shamima Dawood
Dr Karen Zwi
Dr Mbulelo Mtoba
Dr Shabir Madhi
Dr Thandi Mtsi

Clinical Research Associates:
Mr Jacob Moetle: PETRA study co-ordinator: RN
Ms Karen James: Adult Clinical studies
Ms Evelyn Kheswa: Adult Clinical studies
Ms Mirriam Tshabalala: Paediatric Trials

Assistant Research Associates:
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Ms Wilhelmina Saba
Ms Gloria Tshabalala
Mr Pascort Khela
Ms Gloria Ngakane

Laboratory Assistant:
Mr Amstrong Makhofola

Field Worker:
Mr Tlhoriso Phutheho

Counsellor and Community Outreach Associate:
Ms Florence Ngobeni

Administrator:
Ms Nomahlubi Radebe

Messenger:
Ms Zenneth Nhlapo

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

March 24, 1999

NOTE TO SANDY THURMAN

Subject: Latest South African Antenatal HIV/AIDS Survey Data (1998): INFORMATION

Attached are the latest data from the 1998 South African antenatal HIV/AIDS survey. These data are very disturbing. They represent significant increases in both the national average of HIV prevalence among antenatal clinic visitors, as well as for specific provinces.

HIV+ 2/3 under 20 in SA 1500 per day 1000 teenagers

The national average increased from 17.04% to 22.8%, an increase of 33.8%.

The increase among youth is particularly grave: national average for 15-19 year olds (antenatal clinics) went up from 12.7% in 1997 to 21.0% in 1998 – a 65.4% increase in one year!

All provincial rates, with the exception of the Western Cape, increased. The rate of increase varied (highest rate of increase was in the Northern Province which borders on Botswana). However, the highest provincial average for HIV/AIDS among women visiting antenatal clinics in 1998 was in Kwazulu Natal where the HIV positive average rate increased from 26.9% in 1997 to 32.5% in 1998 – a third of all the women attending the clinics!

Given these increases, and the particularly high rates among youth nationally as well as in provinces with large populations, the situation in South Africa is nearing catastrophic proportions.

It is important to note that the overall national adult population average for HIV/AIDS is not equivalent to the 22.8% figure cited above. The overall figure tends to be slightly lower and requires extrapolation from the antenatal clinic data (the only national survey).

Ken Yamashita, USAID/South Africa, is taking an active planning role to assist the Government of South Africa. However, we need to do more. Let's discuss.

Thank you.

Alex Ross

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

Relative risk of HIV infection amongst young women and men in a South African township

Figure 1 shows the age prevalence of HIV-infection for men and women in Khutsong (excluding sex workers and mine workers) fitted to log-normal curves.[1] Not only are the infection rates among women significantly higher than among men, but the rate of increase, which is a measure of the incidence of infection, is very much greater among young women than it is among young men. At age fifteen, for example, an estimated 0.1% of men and 7% of women are HIV-positive, at age twenty the figures are 9% and 43%, respectively. Two obvious biological factors that might serve to explain this difference are the age at first sex and the age difference between sexual partners since it is generally the case that women generally have sexual partners who are older than they are.

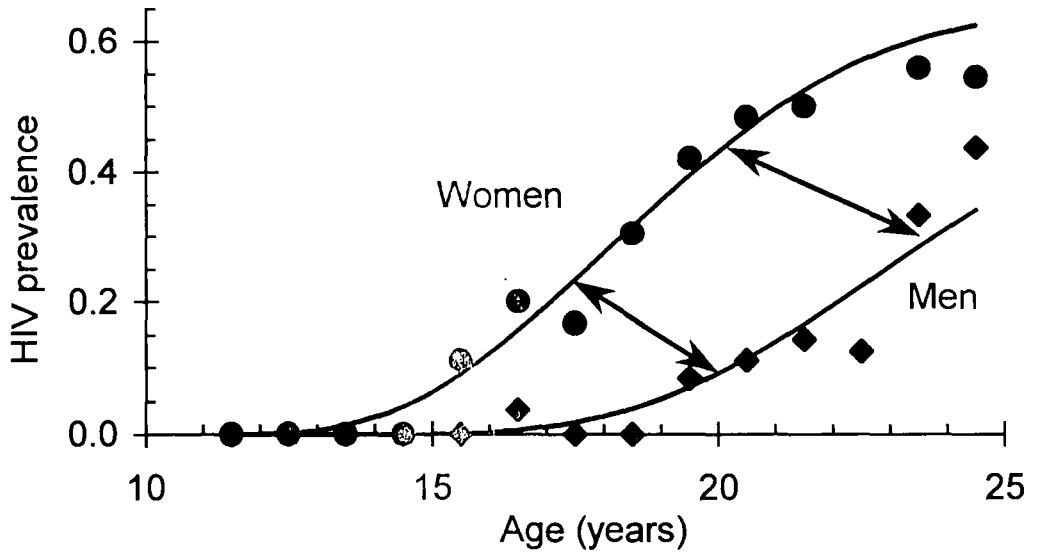

Figure 1. Prevalence of HIV infection among 13 to 25 year old men and women. The fitted curves are log-normal functions with the parameter values given in the text. The arrows indicate the mean age differences between casual partners.

Figure 2 shows the cumulative distribution of the age at first sex for men and women, determined in two ways. Respondents were asked firstly if they had ever had sex.[2] Plotting

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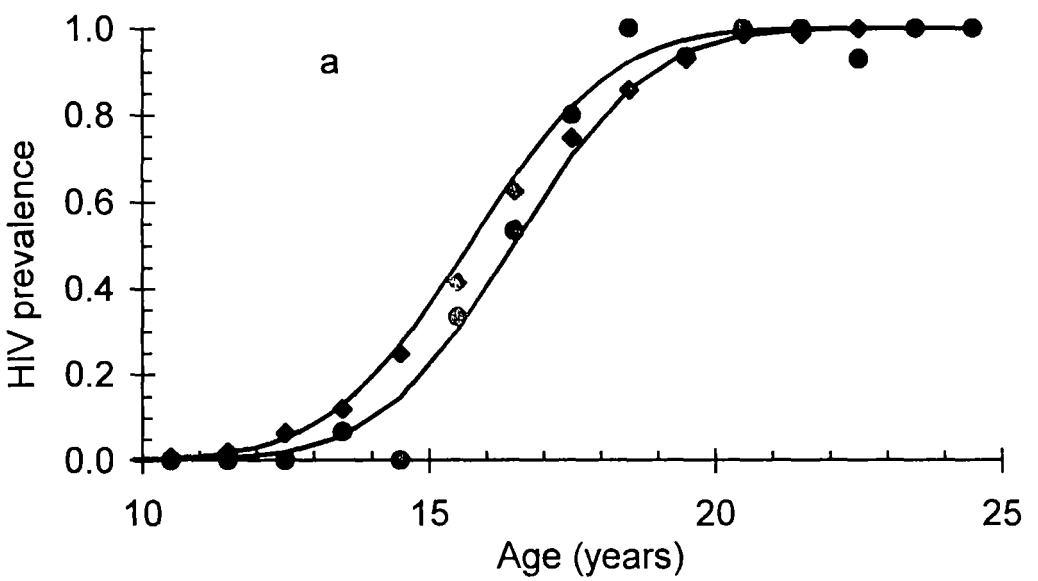
1 For men: Off-set = 9.5 years, $N = 0.480$, $m = 20.502$ years, $s = 0.372$. For women: Off-set = 9.5 years, $N = 0.817$, $m = 15.987$ years, $s = 0.511$. The fitted curve is then

$$p = \frac{N}{s\sqrt{2\pi}} e^{-\ln((a-O)/m)/(2s^2)}$$

2 "Have you ever had penetrative sexual intercourse? By penetrative sex I mean when the penis enters the vagina, anus or mouth."

the proportion who answered yes as a function of age gives the red dots in Figures 2a and b. The red line is the maximum likelihood fit to the data using a cumulative normal distribution function. Respondents were also asked the age at first sex.[3] This gives a probability density function (*p.d.f.*) from which the cumulative distribution is readily obtained and is given by the diamonds in Figure 2. (It is important to ensure that the right denominators are used since the number of people sampled who are less than a given age increased with age.) The blue line is cumulative distribution obtained from the maximum likelihood fit to the *p.d.f.* Since there are two independent estimates of the same function they should give the same values, unless of course there has been a shift in the age at first sex over the last five to ten years. It is important to note however, that the first (red) curve is likely to be less biased, given the nature of the question, than the second (blue) curve since the second curve relies on recall. However, the number of people indicating that they first had sex at an early age will be greater than the number of young people of that age in the sample so that the second curve will be statistically more precise than the first. From the curves given in Figure 2a it seems likely that when asked how old they were when they first had sex, men exaggerate downwards by about one year.

Figure 2b presents the same analysis for women. For women we see that there is much closer agreement between the two estimates and indeed there is no evidence that they exaggerate in either direction.



3 "How old were you when you had penetrative sexual intercourse for the first time?"

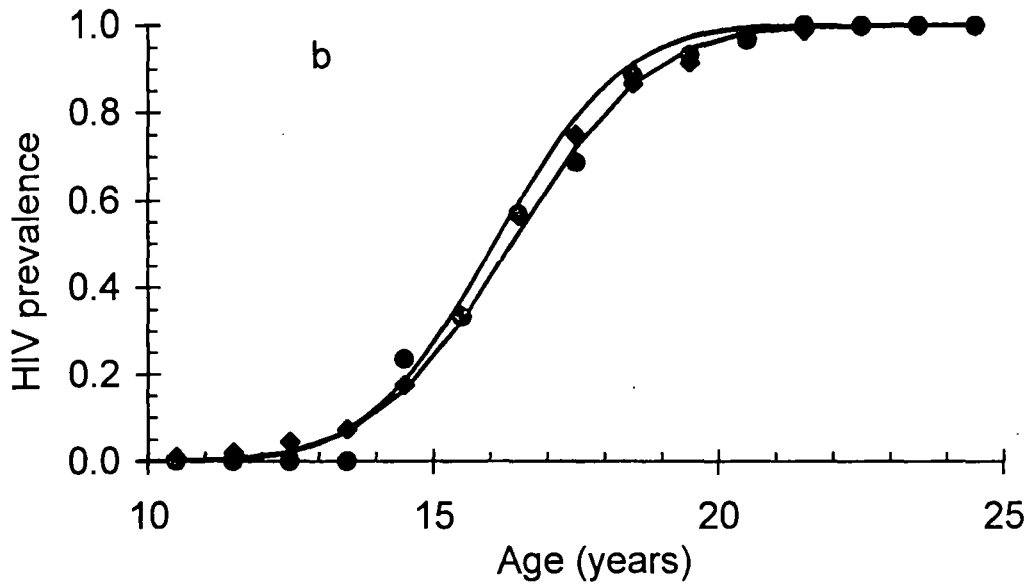


Figure 2. Cumulative distributions of reported age at first sex for (a) men and (b) women. The red dots are in answer to the question "Have you had sex?" and the blue triangles in answer to the question "How old were you when you first had sex?" The fitted curves are cumulative normal distributions with the parameter values given in the text.

From the fits to the cumulative distribution functions in answer to the first question, the mean age at first sex is then 16.5 years for men and 16.4 years for women. The standard deviations of the density functions are 1.88 years for men and 1.91 years for women so that 95% confidence limits for the age at first sex are 12.8 to 20.1 years for men and 12.6 to 20.1 for women. There is therefore no evidence that men and women in Khutsong differ significantly in the age at first sex.

To investigate the age difference between sexual partners Figure 3 gives the ages of men and women plotted against the reported age of their casual sexual partners.[4] The upper line gives equal ages and, as expected, men are generally older, women younger, than their sexual partners. The lower line is the best fit to the observed data[5] which happens, by chance, to go through the point at which both men and women are ten years old.

4 "Think of the last casual partner that you had sex with. ... How old is he/she?"

5 Age of female partner = 19.338 + (Age of male partner - 22.599)*0.7425. Ages in years. Principle axis regression.

Figure 3. Ages of male and female sexual partners. The upper line gives equal ages, the lower line is the best fit to the data.

We can now indicate on Figure 1 the infection rates among men and women matching them for the ages of their partners. For example, 20 year old men have partners who are on average 17.4 years old and 20 year old women have partners who are on average 23.5 years old. This is then indicated by the arrows in Figure 1 so that the prevalence of infection among women is higher than among their sexual partners and among men is lower than among their sexual partners. This indicates that part, but not all, of the difference in infection rates among men and women can be attributed to the age difference between partners.

Another factor which could affect the relative prevalence of HIV infection among men and women is the rate at which they acquire partners with age. Figure 4 shows the proportion of men and women who have different numbers of partners for people aged 15 to 19 (Figure 4a) and 20 to 24 (Figure 4b). With increasing age the mean number of partners increases as expected but the differences are small although statistically significant. For the younger age group men are less likely than women to have no sexual partners but more likely to have one sexual partner. For the older age group men are more likely to have more than eight sexual partners.

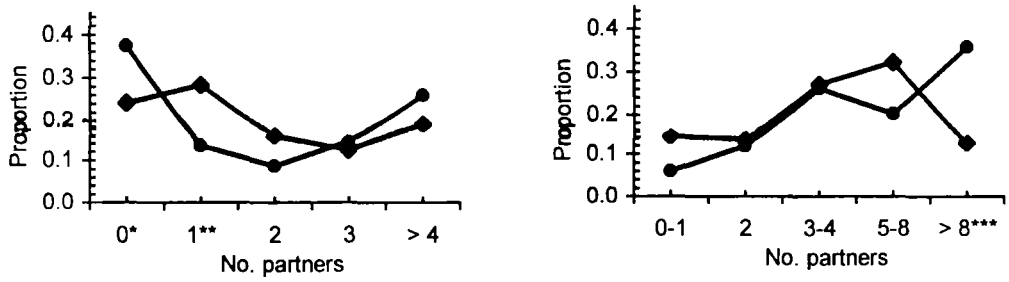


Figure 4. The proportion of men and women who have different numbers of sexual partners. (a) People aged 15–19, (b) people aged 20–24. (χ^2 test of significance: (a) p = 0.013 (b) p = 0.001. The significance levels for comparisons of individual proportions are indicated on the horizontal axes.

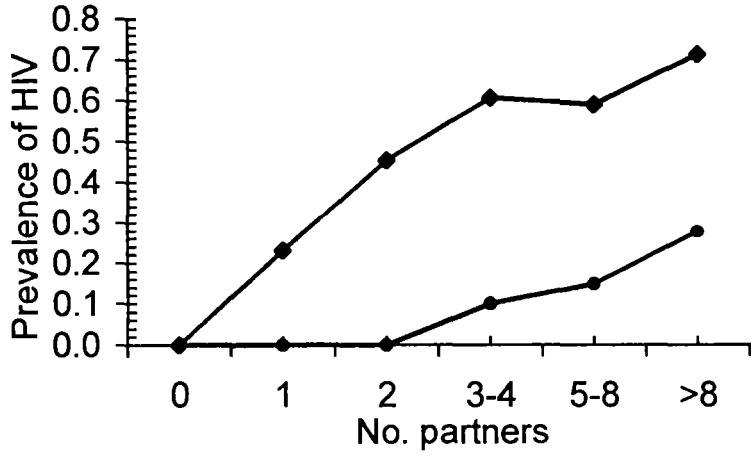


Figure 5. The prevalence of HIV infection among men and women aged 13 to 24 years as a function of the number of sexual partners that they have. Upper line men, lower line women.

Finally we consider the risk of infection as a function of the number of sexual partners. For women the risk of infection increases by about 25% per sexual partner, for men the risk is essentially zero if they have had zero, one or two partners and then increases by about 8% per partnership thereafter.

Discussion

1. The incidence of HIV infection among young boys and girls is extremely high and in excess of 8% per year among 20 year old girls and 6% year among 24 year old boys.

2. In particular, young girls are infected much earlier and more rapidly than young boys: at age fifteen, for example, an estimated 0.1% of men and 7% of women are HIV-positive, at age twenty the figures are 9% and 43%, respectively.
3. There are a range of possible biomedical and social explanations for the dramatic difference between boys and girls including: the age of sexual debut, the age difference between partners, the difference in susceptibility to infection among boys and girls, the extent to which coercive sex is a feature of the society....
4. Age of sexual debut not significantly different.
5. Age difference between partners explains some but not all of the difference.
6. The rate at which girls acquire new partners with age does not seem to be much greater than it is for boys.
7. Risk per partnership much greater among girls than among boys.
8. Future work needed: better stats (19909 survey), duration of partnerships, coercive sex, relative infectivity, STDs, frequency of sexual contact.
9. Dynamical models needed.

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The Condom Conundrum: Barriers to Condom Use Among Commercial Sex Workers in Durban, South Africa

Christine A. Varga

ABSTRACT

We examined socio-cultural and economic determinants of condom use among 100 female South African commercial sex workers. The symbolism and dynamics of condom use between sex workers and their clientele were explored. These issues were also investigated when sex workers negotiated sex with their personal partners. An additional focus was the extent to which HIV/AIDS influences women's condom use in these situations. Results demonstrate considerable contrast between factors influencing condom use in professional versus private sex situations. With clients, practical issues such as financial strain were the major obstacles to condom use. With personal sex partners, sex workers avoided condoms due to their negative symbolism. Condoms were seen as suggestive of filth, disease, infidelity, and mistrust. HIV/AIDS awareness had minimal impact on condom use. HIV/AIDS was viewed as a remote threat, overridden by immediate practical and emotional concerns. The intervention implications of condom symbolism and differential barriers to condom use are discussed. (*Afr J Reprod Health* 1997;1(1):74–88)

RÉSUMÉ

Le préservatif: Les barrières à l'utilisation du préservatif chez les prostituées de Durban en Afrique du Sud

Nous avons examiné les déterminants socio-culturels de l'utilisation du préservatif chez 100 prostituées Sud Africaines. Le symbolisme et la dynamique de leur utilisation ont été étudiés chez les prostituées et leur clientèle. Ces éléments ont été également appréciés au moment de la négociation pour l'acte sexuel entre les prostituées et leurs partenaires intimes. Un autre point d'intérêt a été l'importance de l'influence du VIH/SIDA sur l'utilisation des préservatifs chez les femmes dans ces situations. Les résultats montrent un contraste considérable entre les facteurs favorisant l'utilisation de préservatifs dans les situations professionnelles et ceux des situations intimes. Avec les clients, des problèmes pratiques tels que la contrainte financière constituaient les obstacles majeurs à l'utilisation des préservatifs. Avec leurs partenaires intimes, les prostituées évitaient les préservatifs du fait de leur connotation péjorative. Leur utilisation était percue comme un signe d'obscénité, de maladie, d'infidélité et de méfiance. La connaissance du VIH/SIDA avait peu d'impact sur l'utilisation du préservatif. Le VIH/SIDA était percu comme une menace lointaine masquée par des inquiétudes immédiates et émotionnelles. Les implications du rôle du symbolisme et des barrières différentielles sur l'utilisation des préservatifs ont été discutées. (*Afr J Reprod Health* 1997;1(1):74–88)

KEY WORDS: Condom use, commercial sex workers, risk, HIV/AIDS prevention, South Africa, Africa

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Introduction

This paper examines the dynamics of condom use among female commercial sex workers (CSWs) in Durban, a large coastal city in KwaZulu-Natal province. Our objectives were to explore the socio-behavioural determinants of condom use between CSWs and their partners, both in professional sexual relations with clients and in personal relationships with domestic partners. We also sought to examine the extent to which HIV/AIDS influences CSWs' condom use in these situations.

Reported here are the results from in-depth interviews with two groups of young black African CSWs. Our data illustrate the pivotal influence socio-cultural, conceptual, ideological, and economic factors have on condom use. These results also reinforce the necessity of considering such elements in the design—and ultimate success—of HIV intervention programs.

The state of HIV/AIDS in sub-Saharan Africa

Worldwide, an estimated 21.8 million individuals are currently living with HIV/AIDS.[1] The vast majority live in sub-Saharan Africa. HIV/AIDS figures for the region illustrate the situation in grim detail. By mid-1996, this region contained 63 percent (13.3 million individuals) of the total number of adult cases of HIV infection. Recent estimates suggest that 5.1 percent of sub-Saharan Africa's population is HIV positive. Moreover, the epidemic has not affected all members of the population equally; women account for more than half of all infected adults in Africa.[1]

In recent years, South Africa has witnessed a dramatic increase in HIV infection rates. Between 1990 and 1995, seroprevalence in the country rose from 0.76 to 10.4 percent.[2,3] In KwaZulu-Natal province, where this study was undertaken, the rate of increase is cause for even greater concern. During the same period, provincial seroprevalence underwent an eleven-fold increase, from 1.6 to 18.2 percent.[2,3] This most recent provincial figure (18.2% seropositivity in 1995) reflects a 27 percent increase over the previous year's figures (14.4% in 1994).[4] Presently, KwaZulu-Natal has the highest (and rapidly increasing) prevalence of HIV infection in South Africa.

The commercial sex industry and HIV/AIDS

The commercial sex industry has long been associated with disease. In the early 20th century, U.S. social reformers and physicians attributed the spread of sexually transmitted diseases (STDs) almost solely to prostitution, and prostitutes[a] were commonly known as "plague spots."[5] The evidence used to support such claims was the high prevalence of STDs among women arrested for soliciting male clients. In addition to physical ailments, prostitution was frequently associated with mental and social afflictions. In 1911, the Vice Commission of Chicago published a report describing prostitution as "a disease scattering misery...leaving in its wake sterility, insanity, paralysis, blinded eyes of babes, the twisted limbs of deformed children, degradation, physical rot, and mental decay."[5] Moreover, it appears that many of prostitution's negative associations have persisted well into the present.[5–12]

In medical and epidemiological research, CSWs are frequently targeted as a "high risk group" for STD and HIV acquisition and transmission. The picture portrayed is that of members of the commercial sex industry posing a significant public health threat through their professional (high risk) sexual behaviour. This threatening image is enhanced by the frequency with which CSWs are referred to either as a "reservoir" of infection or as a potential "bridge of infectivity" for STDs and HIV/AIDS.[6,8,11,13–17]

What exactly is the general population's risk of HIV infection from the commercial sex industry? Two patterns of HIV infection among CSWs seem prevalent. In the developed world (North America, Europe, and parts of Latin America), studies have revealed low HIV seropositivity (less than 10%) among non-drug injecting CSWs.[14,15,18–20] This is consistent with so-called Pattern I transmission of HIV/AIDS in which male homosexuals, intrave-

nous drug users (IVDUs), and their sex partners are those most affected.[21] With Pattern I transmission there is generally a low (though increasing) female to male seropositivity ratio, and relatively few cases of vertical transmission of HIV.

In contrast, CSWs in developing countries in sub-Saharan Africa, the Caribbean, and most recently Asia have demonstrated extremely high seroprevalence (greater than 25%).[6,20,22-24] These rates occur among CSWs who are *not* IVDUs and where intravenous drug use is uncommon in the general population. Such a profile conforms to Pattern II transmission of HIV/AIDS, characterised by heterosexual transmission, a nearly equal sex ratio of infection (or slightly higher female to male ratio), and high frequency of paediatric HIV/AIDS.[2]

African sex workers have received considerable attention in connection with the HIV/AIDS epidemic. Many researchers emphasise the increased risk of HIV acquisition and transmission specifically among African CSWs, their clients, and others in their sexual networks.[10,19-29,b] There appears to be a certain amount of justification for such claims. Studies with African CSWs have revealed some of the highest recorded seroprevalence rates anywhere in the world.[23,26,33]

Interpretation of variation in HIV patterns among CSWs must be undertaken cautiously. Lower seroprevalence in some areas may reflect the later introduction of HIV, not necessarily decreased risk for infection.[20] In addition, many seroprevalence studies among CSWs are clinic-based, decreasing the generalizability of results to the commercial sex industry as a whole. Plant cites research findings from work with European and Indian CSWs which defy expected trends and bring into question the strength of geographically-based associations between intravenous drug use and HIV.[6] Moreover, Gillies and Parker point out that HIV seroprevalence among non-drug injecting female CSWs is consistently higher than among childbearing women in the general population in *both* Pattern I and Pattern II areas.[34] At the very least, this finding suggests that the link between HIV and commercial sex work must be explored more carefully among CSWs in Pattern I regions and among those that are IVDUs.

Despite—and in some cases due to—variation in HIV seroprevalence patterns, there is ample reason for examining sexual behaviour and sexuality related issues among members of the commercial sex industry.[14] By definition, CSWs have multiple sex partners who may themselves have many partners. Commercial sex often takes place under risky circumstances (anally, without protection, in the presence of genital lesions, without access to adequate health care). Finally, it is well known that the most common mode of HIV transmission is through sexual intercourse, responsible for 86 percent of HIV infections. The majority of these infections (71%) are through heterosexual relations.[35]

Africa, in particular, appears to merit close attention in exploring the link between commercial sex work and HIV/AIDS. Not only does the continent bear the majority of HIV/AIDS cases worldwide, but its commercial sex industry appears to be strongly associated with HIV infection. In the South African context, KwaZulu-Natal has a similar profile to much of the rest of sub-Saharan Africa, with its skyrocketing HIV seroprevalence rates. Although prostitution is illegal in South Africa[3], those providing commercial sex services have by various means succeeded in circumventing the law, and a thriving industry exists throughout the country. For CSWs on the streets of Durban, extortion, incarceration, rape, and other forms of violence from police are daily threats. Most women in this study had been arrested or experienced violence from local law enforcement officers at some point during their working lives. However, such repercussions appear to have little long-term deterrent effect on CSWs, who view them as job hazards. Thus, focusing on HIV/AIDS related issues in Durban's com mercial sex industry is certainly timely and necessary.

Condom use patterns and changing sexual behaviour

With no cure on the horizon and ineffective therapeutic measures available against HIV/AIDS, emphasising sexual behaviour change is one of the few potentially viable intervention options.[36–38] A major focus of many intervention efforts—both in the commercial sex industry and in the general populace—has been the promotion of condom use as an effective means of protection against HIV infection. Within the commercial sex industry, however, condom use is a complex issue, dictated by multiple—and often conflicting—factors.

The frequency of condom use among CSWs varies considerably, and appears to follow a largely geographic pattern.[d] Recent research has revealed the highest condom use rates are among CSWs in European countries and the United States[6,20,23]. Studies in Scotland,[10,11] England,[17,39] Germany,[40] the Netherlands,[41] Greece,[42] Italy,[19] and the United States[28,43] have confirmed this trend.[e,f] Financial gain (particularly among those CSWs using drugs), client refusal, and avoidance of physical abuse from clients appear to be the primary reasons for waiving condom use.[10,11,20,39]

By comparison, the frequency of condom use between CSWs and their clients in developing countries is generally much lower.[8] Most studies from African countries reveal low condom use rates between sex workers and their partners. Abdool Karim et al. discovered condom use to be a rarity among South African sex workers.[24] Working with CSWs in Kinshasa, Zaire, Mann et al. found that two percent of women reported "frequent" use of condoms with clients.[28] Fischbacher and Njeru reported a 23 percent use rate among CSWs in an intervention study in Kenya.[46]

Wilson et al. recorded low condom use rates among sex workers in Bulawayo.[29] In another study among CSWs in Harare, they found just over half of the CSWs in the study reported consistent condom use with clients.[27] Finally, Pickering et al. found varying condom use rates among Gambian CSWs (53–80%).[22] The primary reasons that CSWs engaged in unprotected sex with clients included limited access to condoms, financial incentive, clients' objections and physical abuse, and low self-perceived risk for HIV infection.[22,24,27,29,46,47]

Patterns of condom use in sexual relations between CSWs and their personal partners appear far more uniform than in commercial sex situations. Studies which have addressed this aspect of sex workers' sexual behaviour have found a nearly universal avoidance of condoms.[8,10,15,19,23,28,34,39,48] The primary obstacles to condom use in personal sex situations appear to be a perceived violation of trust and intimacy connected with requesting condom use, and sex workers' need to disassociate themselves with professional (i.e., protected) sexual behaviour. Among African sex workers, little research has focused upon issues related to personal sex situations. Instead, available studies focus almost exclusively on CSWs' professional sexual behaviour.

Intervention efforts frequently rely on education and heightened HIV/AIDS awareness as a means of effecting behavioural change among CSWs and their partners. The assumption underlying such approaches appears to be that provision of information about HIV/AIDS and its consequences is sufficient for individuals to make informed, rational, and ultimately safe choices regarding their sexual behaviour. Several studies cited here undertook surveys to establish a baseline of HIV/AIDS knowledge or emphasised HIV/AIDS education as part of intervention strategies.[11,15,16,27,28,34,39,47] In most cases, HIV/AIDS related knowledge regarding means of avoiding HIV infection and the health consequences of risky behaviour appeared to be sufficient. However, a common finding was a minimal relationship between HIV/AIDS awareness and CSWs' (high risk) sexual practices.[8,10,16,29,39] Condom use rates remained low or erratic, particularly among African sex workers and in CSWs' personal sexual relationships.

Though armed with the facts regarding HIV/AIDS risk, African CSWs use condoms inconsis-

tently, especially within personal sexual relationships. Two questions then arise. What factors *are* influencing CSWs' condom use? How—if at all—*does* HIV/AIDS fit into decisions concerning condom use? There is a pressing need for research aimed at answering such questions and identifying contextual and socio-cultural factors which influence sexual behaviour.[48–54] Such an approach may shed light on the dynamics influencing sex workers' decisions to use (or not use) condoms both on the job and in personal relationships. It may also be a crucial step toward sustainable HIV/AIDS interventions in the commercial sex industry.

An anthropological approach

Anthropology offers an important alternative perspective in finding solutions to problematic HIV/AIDS-related issues such as condom use. An anthropological approach is significant for at least two distinct but inter-related reasons. First, it can provide an understanding of socio-cultural reactions to HIV/AIDS; that is, how societies conceptualise aetiology, symptoms, and treatment, and these factors' potential impact upon behaviours surrounding HIV/AIDS. Research by Farmer on Haitians' reactions to AIDS and AIDS victims,[55,56] Green's work on African traditional healers' roles in dealing with AIDS-related issues and on local conceptions regarding STDs and AIDS,[57–60] and research conducted by Schoepf[61] among Zairian women at high risk for HIV infection are only a few excellent examples in this regard.[52,62–64] All these works illustrate the potential health impact of socio-cultural responses to HIV/AIDS.

Second, qualitative anthropological studies are a vital complement to quantitative survey methodologies often employed in research on health-related issues.[65,66] In many cases surveys provide a necessary descriptive baseline for understanding *what* people know and do with regard to sexual relations. Anthropology can be instrumental in elucidating *why* people behave they way they do, and why adequate knowledge of potential negative health consequences appears to have little impact on reducing risky sexual behaviour. Given its characteristic holistic and ecological approach to the study of the human condition, anthropology is ideally suited to this purpose.[67–76] In the case of HIV/AIDS, understanding the "whys" of human behaviour could be the key to the difference between life and death.

Anthropological studies of condom use

Anthropologists have recently begun exploring socio-cultural and ideological factors influencing condom use in the context of HIV/AIDS. Several recent studies have focused on condom use among American women considered at increased risk for HIV infection.[48,77–79] Some research has also examined condom use in an African context.[61,80–83]

Sobo explored risk denial for HIV infection and the self-perceived benefits of unprotected sex among impoverished urban African-American women.[77] Women's avoidance of condoms was interpreted as a psycho-social and economic strategy to maintain self-esteem and domestic economic stability. By denying risk for HIV infection and shunning protected sex, women created both a public and personal image of monogamous, secure, trustworthy sexual relationships. Admission of the necessity for condoms would require acknowledgment of steady partners' infidelity, leading to women's personal humiliation and loss of dignity.

Studies by Worth,[48] Sibthorpe,[79] and Pivnick[78] with intravenous drug users revealed similar conceptual and socio-cultural obstacles to condom use. Despite acknowledgment of their high risk for HIV infection, many women made a deliberate decision *not* to use condoms. Condoms threatened trust, intimacy, sexual satisfaction of both partners, and domestic and economic stability. Condom use also presented a barrier to fertility and childbearing, a practice contrary to the cultural value placed on motherhood.[48,78] Due to these negative associations, protected sex was appropriate only in

casual sex situations and strictly avoided with personal partners.[79]

In Pivnick's study, the bonding associated with unprotected sex was so important that condoms were avoided even within relationships where one partner was a suspected or confirmed HIV carrier. Men and women judged the emotional benefits of unprotected sex as more important than the risk of infection. HIV was viewed as a potential, and in some cases unavoidable, cost incurred when entering into an intimate sexual relationship; risk was part of the commitment made in what the author described as "conjugal bonding."[78]

Anthropological studies have also begun to examine socio-cultural factors influencing condom use in an African setting. According to Taylor, Rwandan women's resistance to condom use was related to cultural notions of fulfilling personhood and social cohesion through the mixing of bodily fluids.[80] Condoms represented a polluting "blockage" to Rwandan men and women.[80] Thus, protected sex was an obstacle to the reciprocity necessary to maintain social stability.

Schoepf examined cultural barriers to condom use in Zaire.[61] Among these were the value placed on fertility and polygyny, and men having multiple sex partners as a culturally sanctioned means of achieving status and gender superiority. In another study, Schoepf examined the potential role of involving Zairian traditional healers in promotion of HIV awareness and safe sex practices.[81] By virtue of their respected status in the community, and being "legitimate interpreters of customary rules of conduct," traditional healers' advocacy of condom use could be a culturally appropriate means of effecting behaviour change.[81]

In South Africa, anthropological research has revealed condom use to be a problematic aspect of sexual negotiation among adolescent sex partners.[82,83] Adolescent females avoided discussion of or attempts to use condoms out of fear of emotional rejection or physical abuse from partners, or of being branded promiscuous or HIV positive.[82] Adolescent males refused condoms due to the belief that they interfere with male control in a relationship. The need for condoms was also seen as a reflection of the *female* partner's status: untrustworthy, uncommitted, "dirty" (promiscuous and a carrier of sexually transmitted diseases).[83] These insights can be helpful in understanding the dynamics behind condom use among Durban commercial sex workers.

Methods

Fieldwork was undertaken in two sites. The first was an inner city section of Durban known to be frequented by commercial sex workers. The area was near the central business district, recreational areas, and hotels on the beachfront and Durban harbour.

The second venue was an industrialised suburb approximately 15 kilometres from the city centre. The area was characterised by a large truck depot, serving as the endpoint and way-station for truck routes from throughout southern Africa. Several hotels and bars frequented by locals, truckers, and CSWs were located near the truck depot.

Participants were black African, female, self-identified CSWs. The majority were Zulu or Xhosa-speakers. All women worked independently, either on the street or frequenting bars or nightclubs. The snowballing technique was used for selection of study participants.[h]

Data were gathered using in-depth interviews (45), semi-structured questionnaires (100; 50 per venue),[i] focus groups (2), and participant observation. Questionnaire topics included HIV/AIDS-related knowledge and attitudes, and frequency of condom use. In-depth interviews and focus groups concerned issues related to condom use in professional and personal sexual relationships.

Study objectives were explained to each prospective participant and verbal consent obtained before enrolment. Questionnaires and interviews were conducted in Zulu or Xhosa with the aid of a young, black African male fieldworker.

Analysis of questionnaire data was undertaken using D-base and Epi-Info 6 statistical programs.[j]

Transcripts from in-depth interviews and fieldnotes were examined and interpreted.

Results

Socio-demographic characteristics

One hundred women participated in the study (50 per venue). Mean subject age was 25.5 years. In the central city group, 73 percent were Zulu and 26 percent were Xhosa-speakers. In the suburban group, 56 percent were Zulu and 36 percent Xhosa-speakers.[k]

Study participants had a mean of 6.4 years of schooling. Among central city CSWs, 90.2 percent identified sex work as their main income source. Seventy-six percent of suburban CSWs derived their income from sex work.[l] Mean daily income was 148 Rand ($32.30) for central city CSWs and 96 Rand ($21.00) for suburban CSWs.[m]

HIV-AIDS awareness and risk behaviour

All study participants knew of HIV/AIDS and were well-versed in means of acquisition, transmission, and prevention. Unprotected sexual intercourse was most frequently cited as a behaviour likely to facilitate HIV infection. Significantly, the vast majority (87%) of CSWs described AIDS as lethal, incurable, and preventable.

Subjects had a mean of 2.7 clients per day. Eighty-six percent of CSWs described themselves as involved in monogamous non-commercial relationships. Nearly the same number (85%) suspected or had proof that their steady boyfriend had multiple sex partners.[n] Intravenous drug use was not practised by any study participants.[o]

Condom dynamics and symbolism

Most CSWs in both venues viewed condom use as a rule to be enforced whenever possible. Several CSWs noted their personal partners encouraged and even monitored their condom use with clients. One central city CSW described how her boyfriend counted the number of condoms missing from her purse and the amount of money brought home each night in an attempt to monitor the consistency with which she used condoms during working hours.

Structured questionnaire data revealed low condom use rates among both groups. Among central city CSWs, 29 percent described themselves as "always" using condoms with clients; 14 percent of suburban CSWs similarly responded. A further 71 percent of central city and 80 percent of suburban sex workers "usually" used condoms with paying partners.[p]

Several obstacles to consistent condom use were articulated in structured questionnaires. These included: threat of physical violence from clients (4%), clean and trustworthy appearance of prospective clients (8%), and financial incentives for unprotected sex (67%).

In both groups, financial problems appeared to be the primary reason for waiving the condom rule.[q] Most CSWs calculated daily earnings, and many aspects of their finances—food, rent, or transportation—were dependent upon making a certain quota each evening. In the course of a night's work, a sex worker might become increasingly likely to accept an offer of extra payment for unprotected sex if the financial quota had not been achieved. Several women also described steady clients with whom they did not insist upon condom use in fear of losing the regular income.

Finally, in focus groups and in-depth interviews, many women identified high alcohol consumption and frequent use of *dagga* (marijuana) or mandrax as significant impediments to their ability to make decisions and enforce condom use with clients. Questionnaire responses revealed that 98 percent of sex workers in the study used alcohol (usually beer) on a regular basis, with an average 7.7 drinks consumed daily. Twenty percent of study participants reported regular (daily or weekly) use of *dagga* or mandrax. CSWs who used drugs and alcohol described substance use as necessary in order to muster courage to solicit clients and face other unpleasant working conditions.

Unlike professional sexual relationships, sex workers adamantly rejected condom use with per-

sonal partners. Nearly all (96%) study participants reported never using condoms in private sex situations. Avoidance was due both to CSWs' own dislike of condoms and partners' objections.

Sex workers viewed condoms as a means of maintaining the ideological barrier between professional sex with clients and personal sex with private partners. Most women described the conceptual necessity of dividing work and personal life, and of reaffirming their membership in conventional society outside of working hours. Condoms were seen as being in direct opposition to this, and associated with impersonal, professional, and usually unpleasant sexual interactions. A central city sex worker described condom use in the following way:

> When I sleep with a client I use a condom because then I am not an ordinary person but a professional sex worker. There are no feelings or love involved and you don't expect to get any pleasure out of it. The pleasure is when you get money. That is *ukubhebha*;[3] when you [have sex with] a client you are not a full human being. But you cannot be a sex object 24 hours a day. You have to become a full, emotional, loving girlfriend...You have to make love (*ukulala*).[4]

Sex workers from the suburban group reaffirmed this viewpoint. One woman noted, "Condoms were made to keep flesh apart that isn't supposed to mingle." The use of condoms as a symbolic divider between personal and professional life among suburban CSWs was illustrated in yet another way. Many suburban sex workers described becoming personally involved with longtime trucker clients. The transition from client to personal partner was marked by a lapse in condom use. In respect to this, a suburban sex worker whose boyfriend had at one time been her client said, "Once he became my lover, I forgot to use condoms. I felt at home and safe."

The negative symbolism of condoms was clearly demonstrated in reasons provided for the necessity of condom use with clients. Clients were considered "dirty," "untrustworthy," "promiscuous," and suspected carriers of "diseases" (AIDS or other STDs). Professional sex was viewed as undesirable for both personal and health reasons. Clients were assumed to have had multiple sex partners, and as a result to harbour STDs or HIV. In addition, the professional sex act was viewed by CSWs as impersonal and even morally repugnant. Thus CSWs felt it imperative to use condoms as a means of physical and emotional protection against intercourse with clients.[1]

Condoms' negative image was also demonstrated in reasons CSWs provided for the rejection of protected sex in personal relationships. Personal partners were viewed as "clean"[a] and "trustworthy." Condoms were also seen as a threat to intimacy and commitment, in that requesting protected sex would introduce an element of distrust and suspicion into partner dynamics. Regarding condom use, the association between love, trust, cleanliness, and unprotected intercourse was cited in nearly half (46%) of CSWs' questionnaire responses and all in-depth interviews.

Trust in a personal partner was also the primary reason for not fearing AIDS from unprotected sex with personal partners. When asked about the degree to which HIV/AIDS influenced her choice of personal partners, a CSW retorted, "I only sleep with guys who are clean and trustworthy. So why should I be afraid of AIDS?" Such views are also articulated as follows:

> Condoms take the trust away. How do I say to my boyfriend that I do not trust him? How would I feel if he didn't trust me?

> It would be better to die of AIDS from someone you love than lose a loving guy for the sake of a condom.

Another prevalent theme was that requests for condom use with domestic partners suggest infidelity or the possibility of carrying HIV/AIDS.

One young central city CSW noted:

> Because I am a CSW if I asked my boyfriend to start using condoms he would accuse me of having had unprotected sex with clients and say that I have AIDS. Or he might think that I suspect him of having it [AIDS].

CSW study participants were aware of HIV/AIDS, high risk sexual practices associated with it, and the potential consequences of HIV infection. However, this appeared to have limited impact upon sex workers' condom use, particularly in personal sex situations.

In both professional and private sex situations women were resigned to the risk of HIV infection from unprotected sex. The priority in personal sexual relationships was to maintain closeness and domestic stability. A popular sentiment was that the risk of AIDS is a responsibility which must be shouldered in a personal relationship. The cost of HIV risk did not outweigh the benefits of personal intimacy gained through unprotected sex.

Regarding professional sex situations, immediate concerns, such as financial gain, appeared to override any fear of contracting HIV/AIDS. Also, the threat of infection may not have been taken seriously due to the virus' long period of dormancy and AIDS' current lack of visibility in South Africa.[v] The following are comments by central city CSWs in this regard:

> I would rather die of AIDS in ten years' time than die of hunger next week...

> Why should I care about a sickness [AIDS] that will only attack me years in the future? By that time I will be too old to do sex work anyway.

Discussion

This research illustrates the complex dynamics involved in these South African sex workers' condom use and the critical role socio-cultural and economic factors play in determining their sexual behaviour. Thus, we may begin formulating answers to questions surrounding sex workers' condom-related decision-making and the role of HIV/AIDS in this process.

What factors were influencing Durban CSWs' condom use? In professional sex situations, study participants preferred protected sex. The primary barriers to CSWs' condom use with clients were practical and economic ones. Poverty, and thus the financial incentive to engage in unprotected sex, appeared to be the greatest obstacle. In addition, threat of physical abuse from clients and the debilitating effects of substance use were also factors hindering sex workers' ability to successfully negotiate condom use with clients.

Barriers to CSWs' condom use in personal relationships were much more complex. In this context, conceptual and symbolic issues determined (un)safe sex practices. Condoms' ugly connotations were an overwhelming component in women's decisions to avoid condoms. The negative symbolism of condoms was a significant deterrent to their use, and stood in direct opposition to what these women sought from personal sexual relationships. Condoms were associated with disease, infidelity, and impersonal, illicit, professional sexual acts. In stark opposition to such imagery, women looked to personal sex for purification, trust, intimacy, and affirmation of love. Thus, by definition, condoms were excluded from personal sexual relations.

Condom use was also conditioned by the conceptual categories into which sex workers placed their partners. Sex with clients was seen as dirty, illicit, and impersonal. Such interactions warranted the protection of a condom to avoid unwanted and potentially dangerous contact. Personal partners were viewed as clean, intimate, trustworthy, and offering invited physical acts of love and affection. In these situations condoms were anathema. Within such a conceptual framework, it is unsurprising that condoms were used as a logical divider between professional and personal life.[w] Lack of skin contact might make the impersonal,

unclean professional sex act physically, conceptually, and emotionally invisible.

What role did HIV/AIDS play in Durban CSWs' condom-related decision-making? In both personal and professional sex the risk of HIV/AIDS appeared to have little bearing on women's condom use, but for very different reasons. In personal situations, sex workers looked to their relationships to fulfil personal needs crucial in maintaining successful equilibrium between professional and personal life. So strong were these needs that study participants preferred to overlook personal partners' high risk behaviour and maintain their relationships. Given their stressful life circumstances, potentially life-threatening personal sex was a rational cost-benefit analysis for Durban CSWs; the emotional benefits of unprotected sex outweighed the risks of HIV infection.[x]

In contrast, Durban sex workers' views on condom use and HIV/AIDS in professional sex situations were tied to poverty and powerlessness. Despite women's fears of infection from clients and their desire to use condoms during professional intercourse, dire financial circumstances rendered them unable to enforce condom use. As a result of their dependence on sex work as a means of income generation, women approached the risk of HIV infection from professional sex somewhat fatalistically. It was considered an unavoidable job-related hazard, and the risk of infection was subsumed by day-to-day worries. In view of their immediate concerns and constraints, Durban sex workers saw HIV/AIDS as a remote danger which had little bearing on their daily professional or personal lives.

The fact that sex workers were unwilling to use condoms in personal sex relationships has significant ramifications for the progression of the HIV epidemic. It suggests that sex workers are at potentially greater risk for HIV infection from personal sexual behaviour than from professional intercourse. The HIV-related risks of sex workers' personal sexual behaviour have been suggested elsewhere.[8,11,15,19,28,34,39–41] However, this study appears to be among the first to explore the differences between sex workers' personal and professional condom use, and the dynamics behind such contrasting behaviour, in an African context. Most published works concerning African CSWs focus exclusively on HIV risks surrounding sex worker-client relationships.[9,26,27,29,47]

Conclusions

The differences between sex workers' professional and personal sexual relationships have significant ramifications for the structuring of HIV/AIDS intervention efforts focused on the commercial sex industry. In commercial sex, barriers to condom use are practical, environmental ones, external to sex workers' motivation to practice safe sex. Their preferences for condom use and the modifiable nature of barriers to protected sex are important characteristics to be considered in intervention frameworks. Women need not be convinced about the necessity of safe sex with clients, they need only be enabled to practice it. Environmental (political, legal, economic) change is the key.

Condom-related dynamics in sex workers' personal sex lives present a very different scenario. With intimate partners, barriers to condom use are deep-seated socio-cultural and ideological issues. Such obstacles to safe sex practices are likely to be more difficult to overcome than those in professional sex situations. Unprotected intercourse serves an important function both emotionally and in terms of self-esteem; condoms symbolise everything that is the opposite. For the women in this study, the well-being they derived from intimate unprotected sex actually allowed them to function more successfully in their commercial sex roles.

Given the HIV-related implications of sex workers' condom use with personal partners, intervention programs must begin focusing on the broader aspects of their lives. This means centring on women's personal lives and personal partners. Men (both clients and personal partners) are frequently overlooked in HIV/AIDS intervention programs targeting the commercial sex industry.[y] Moreover,

intervention efforts taking into consideration CSWs' personal situations must adopt an approach centred on socio-cultural and ideological factors, not only practical, environmental ones.

This study among South African commercial sex workers illustrates the importance of examining socio-cultural, ideological, and economic factors influencing sexual dynamics and condom use. The work also demonstrates the significance of an anthropological approach in unravelling the inconsistencies between HIV-related knowledge, attitudes, and behaviour. Given that Africa bears the burden of the HIV epidemic, more qualitative work is needed to identify intervention strategies which reach beyond education and awareness to touch deep-seated socio-cultural and economic factors that influence sexual decision-making.

Acknowledgments

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Notes

a The terms "prostitute" and "prostitution" are used here for historical review purposes only.

b The differences between Pattern I and Pattern II transmission have been attributed to various factors including lack of access to medical care and subsequent increased prevalence of untreated STDs in developing countries, population-specific biological differences, differences in virus sub-types, extreme poverty and poor material conditions, and African cultural patterns which emphasize fertility and sanction multiple sex partners (20–21, 24, 30–32).

c Presently, escort agencies and massage parlours are the only sector of the commercial sex industry operating legally in South Africa. These are classified as "entertainment facilities" and require the same permit as movie houses, theaters, or night clubs. They are subject to periodic visits from health inspectors, and until recently could be raided by police without warrant if covert activities were suspected. Owners of such facilities rarely admit to supplying sex services on the premises, and claim that they have no control over employees during house calls or dates with clients.

d Research by Estebanez et al. (20, 404), Campbell (28), and Jackson et al. (15) suggests CSWs' condom use with clients is positively related to the legalization or public toleration of commercial sex work.

e See Gillies and Parker (34) for exceptions to this pattern in demonstrating high condom use rates among sex workers in Brazil and the Dominican Republic.

f Due to variations in methodology and reliability, comparison of reported use rates is problematic. However, nearly all the European and U.S. studies cited here reported use rates of 80 percent or higher. Note also that some studies have demonstrated questionable reliability of self-reported condom use, with sex workers over-reporting and clients under-reporting frequency of use (22–23, 27).

g See findings from research in India (44), Nicaragua (45), and Indonesia (16).

h Due to the sensitive nature of the subject matter, random sampling was not possible.

i Questionnaire results are reported here selectively, only as they pertain to condom-related topics addressed in in-depth interviews.

j Questionnaire results will be reported as a combined figure from the two field sites unless otherwise noted.

k Significant difference urban vs. suburban ($p < .001$)

l Significant difference urban vs. suburban ($p < .002$)

m Significant difference urban vs. suburban ($p < .002$); 1 US Dollar =R4.58

n Confidential interviews with several boyfriends confirmed this. In the course of this research, 35 personal partners and clients (mostly truckers) were interviewed. These data are currently being analysed.

o Interviews with local police and drug enforcement agents confirm that injectable drugs are currently a rarity in the communities where this research was undertaken.

p Significant differences ($p < .001$)

q Poverty was also the primary reason these women became involved in commercial sex work. Poverty and other reasons related to material circumstances accounted for nearly one half (48%) of study participants becoming involved in the commercial industry.

r *Ukubhebha* is a vulgar Zulu term referring to sexual intercourse.

s *Ukulala* (Zulu), "to make love"; positive, loving connotation.

t Note one reason provided for *waiving* condom use was a client's clean and trustworthy appearance.

u Connotations of "clean" and "dirty" refer both to physical appearance (dress and smell) and disease status (sores on genitals or appearing ill or wasted), and to a more symbolic notion of trustworthiness, intimacy, and purity. They are also related to the manner in which CSWs view their jobs (distasteful, abnormal, sinful, dirty) vs. their personal lives (removed from sex work, conventional, and pure).

v In South Africa, the epidemic has yet to reach the point at which full-blown AIDS cases are a visible (and thus recognized) public phenomenon.

w Jesson et al. have also suggested CSWs' reluctance to use condoms in personal sex is tied to the need to "confirm the demarcation between sex as work and sex as pleasure" (39, 8).

x In this respect, our findings confirm those of Worth (48), Sibthorpe (79), Sobo (77), and Pivnick (78) among American drug users, and of Nataraj (44) among Indian sex workers.

y Results of data collected in this study among male partners (boyfriends and clients) will be available by mid-year 1997.

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Bureau of African Affairs
Economic Policy Staff
(AF/EPS)

FAX COVER

DATE: April 29, 1999
TIME: 3:00 pm

TO: Sandy Thurman
Director of the White House
Office for National AIDS Policy

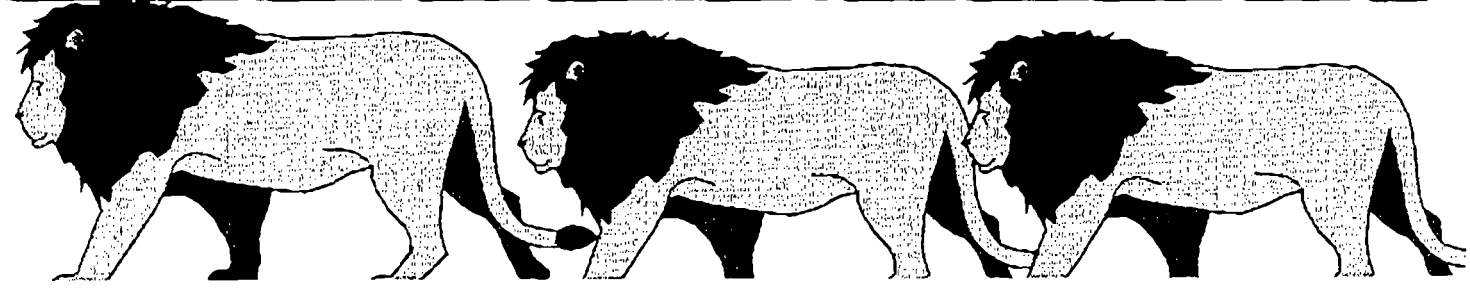
FROM: *AF/EPS Marlene Urbina de Breen*
647-4098

SUBJECT: Article on HIV/AIDS in South Africa

Sandy,

Greetings! It has been a while since we last touch base. I hope both of your recent trips to Africa were successful. When you have the time, I would like to get a copy of your trip reports. I am interested in learning about your findings and recommendations. I also find such reports useful as we are often asked to do briefing papers for our principals on HIV/AIDS. By the way, I wanted to share with you the attached article.

Regards, Marlene



'This is worse than apartheid'

In South Africa black women who admit to being HIV-positive risk death threats, writes **Chris McGreal**

THE MESSAGE stuffed into Prudence Mabele's letterbox was badly written and confused, but the intent was explicit enough. "Dear so-called Aids Activist," it began. "Your days are numbered." It was signed "Anti-Aids Gang."

Mabele is one of only a few among the millions of HIV-positive black women in South Africa to talk openly about her condition. She has served as the public face of a government Aids education campaign, and in 1998 was chosen as one of the South African women of the year.

But the 27-year-old chemist has been shunned by her family, forced to leave her township and repeatedly threatened over her public admission to a disease that many black South Africans believe is best not spoken about.

"This is worse than apartheid because we are rejected by our communities," she says. Last December one of Mabele's friends — Gugu Dlamini, a 36-year-old Zulu woman — was stoned and kicked to death by neighbours in the township of KwaMancinza, near Durban. They said she had brought shame on them with her admission, during broadcasts on World Aids Day, that she carried the Aids virus.

The government estimates that as many as one in five black women in South Africa is HIV-positive. The United Nations says it is the fastest-growing infection rate in the world. The welfare ministry predicts that within five years more than 500,000 children will be orphaned by Aids and life expectancy will fall from 60 to 40 years.

Despite the government's belated education efforts — including warnings by Nelson Mandela that Aids could wreck the progress made since the end of apartheid — there is a culture of silence within large parts of the black population. Mabele says women are the primary victims.

Mabele: shunned by her family.

"It's worse for women because when their men get sick they are left to look after the family even if they are sick themselves. If the men die they are left destitute. The silence means they don't go to doctors, they don't get help. They just pretend it doesn't exist until they die," she says.

Mabele contracted HIV in 1991 from a boyfriend who was a doctor and knew he was carrying the virus. The Cape Town technical college where she was studying chemistry found out and asked her to leave, arguing that she might infect other students if there was a laboratory accident.

Mabele searched for a self-help group, but the only one she found was for HIV-positive gay men.

"These men were rich and white and I was poor, black and a woman. They were very nice to me but they would talk about their jacuzzis when I just wanted to know about HIV," she says.

In desperation, five years ago Mabele helped found the National Association of People Living with Aids. "We had our first meeting and I realised there really was a big problem. Women told how their husbands had given them HIV but wouldn't admit it. Men said they had lost their jobs when people found out. Everyone was afraid their neighbours or employers would find out."

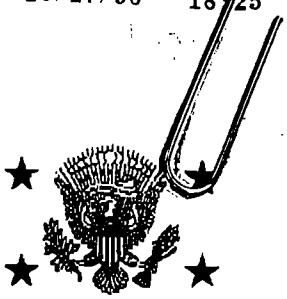
A few months later Mabele attended an Aids conference in Canada. Television pictures of the meeting were relayed to South Africa and her face was spread across the news. Her family was horrified.

"It was scary. Suddenly I was recognised all over the place. People pointed to me on the streets and said: 'She's the one with Aids.' I had to go to my family and neighbours and try and explain what HIV is. But they did not want to know. I was cursed.

"Whites think that it is a black disease. Among blacks there's this legend that it's a white gay disease," she says. "Many black men are so arrogant. They don't want to accept they can be at risk and put their wives at risk. Men from the mines think that if they have anal sex with a man it's not gay. Teenagers say you don't love me if you use a condom. It's really difficult to persuade the women to stand up to the men."

The threats are a regular part of Mabele's life. "I have no money so I'm not getting any medication. But I really want women to know about this, so more don't end up like me."

1. Mabele
2. Mike ——→ a. also see review



THE VICE PRESIDENT
WASHINGTON

October 20,1998

His Excellency
Thabo Mbeki
Executive Deputy President
of the Republic of South Africa
Pretoria

Dear Thabo:

I read with great interest and a sense of shared concern your declaration on the occasion of the launching of the Partnership Against AIDS. Your call to action is not only important for South Africa, but also as an inspiration for all of Africa.

Over the last fifteen years, our nation has worked diligently to stop the spread of this devastating disease, to support research for effective HIV therapeutics and a preventive vaccine, and to remind all citizens that, together, we must combat this epidemic. Educators and activists, members of religious and civic groups, business and labor organizations, and tens of thousands of other men and women with a shared concern have all been part of our response to this disease. I am confident that your address to the people of South Africa helped generate the same broad societal support that has been essential to our own advances.

As you recall, in July 1997, within the framework of the Binational Commission, we announced a $10 million USAID funded project to support the Ministry of Health's AIDS program. It's our hope that this project will significantly contribute to the attainment of the goals of your finalized national AIDS strategy. In addition, the President recently asked Sandra Thurman, our National AIDS Policy Coordinator, to travel to South Africa, at your government's convenience, to discuss the manner in which the United States can further support South Africa's efforts.

I join with you in mourning the lives of so many who have already been lost and look forward to our continued work together to protect those who remain at risk.

Sincerely,

Al Gore

AG:jb

PRINTED ON RECYCLED PAPER

EMBARGOED UNTIL FRIDAY, 9 OCTOBER 1998: 12.15

ADDRESS BY DEPUTY PRESIDENT
THABO MBEKI.

DECLARATION OF PARTNERSHIP AGAINST AIDS.

President Mandela has asked me to address you on his behalf. I am honoured to be able to do so.

DECLARATION

HIV/AIDS is among us.
It is real. It is spreading.
We can only win against HIV/AIDS if we join hands to save our nation.

For too long we have closed our eyes as a nation, hoping the truth was not so real.

For many years, we have allowed the HI Virus to spread, and at a rate in our country which is one of the fastest in the world.

Every single day a further 1 500 people in South Africa get infected. To date, more than 3 million people have been infected.

THE DANGER IS REAL

Many more face the danger of being affected by HIV/AIDS.

Because it is carried and communicated by other human beings, it is with us in our work places, in our classrooms and our lecture halls.

It is there in our church gatherings and other religious functions.

HIV/AIDS walks with us. It travels with us wherever we go. It is there when we play sport. It is there when we sing and dance.

Many of us have grieved for orphans left with no one to fend for them. We have experienced AIDS in the groans of wasting lives. We have carried it in small and big coffins to many graveyards.

At times we did not know that we were burying AIDS victims. At other time we knew, but chose to remain silent.

And when the time comes for each one of us to make a personal precautionary decision, we fall prey to doubt and false confidence. We hope that HIV/AIDS is someone else's problem.

CHANGING OUR WAY OF LIFE

HIV/AIDS is not someone else's problem. It is my problem. It is your problem.

By allowing it to spread, we face the danger that half of our youth will not reach adulthood. Their education will be wasted. The economy will shrink. There will be a large number of sick people whom the healthy will not be able to maintain. Our dreams as a people will be shattered.

HIV spreads mainly through sex.

You have the right to live your life the way you want to.

But I appeal to the young people, who represent our country's future, to abstain from sex for as long as possible. If you decide to engage in sex, use a condom.

In the same way, I appeal to both men and women to be faithful to each other, but otherwise to use condoms.

PARTNERSHIP

The power to defeat the spread of HIV and AIDS lies in our Partnership - as youth, as women and men, as business people, as workers, as religious people, as parents and teachers, as students, as healers, as farmers and farm workers, as the unemployed and the professionals, as the rich and the poor - in fact, all of us.

Today, we join hands in this Partnership Against HIV/AIDS, united in our resolve to save the nation.

As **Partners Against AIDS**, together we pledge to **spread the message!**

Everyday, every night - wherever we are - we shall let our families, friends and peers know that they can save themselves and save the nation, by changing the way we live and how we love. We shall use every opportunity openly to discuss the issue of AIDS.

As **Partners Against AIDS**, together we pledge to **care!**

We shall work together to care for those living with HIV/AIDS and for the orphans. They must not be subjected to discrimination of any kind. They can live productive lives for many years.

They are human beings like you and me. When we lend a hand, we build our own humanity, and when we remind ourselves that, like them, each one of us can become infected.

As **Partners Against AIDS**, together we pledge to **pool our resources** and to **commit our brain power**!

There is still no cure for HIV and AIDS. Nothing can prevent infection except our own behaviour.

We shall work together to support medical institutions to search for a vaccine and a cure. We shall mobilise all possible resources to spread the message of prevention, to offer support to those infected and affected, to destigmatise HIV and AIDS and to continue our search for a medical solution.

And so today we join hands in the Partnership, fully aware that our unity is our strength. The simple but practical action that we take today is tomorrow's insurance for our nation.

Accordingly, we pledge that wherever we meet and study, work and sing, play and enjoy one another's company, we will protect ourselves and our partners against HIV and AIDS.

Together, as Partners Against HIV/AIDS, **we can and shall win**.

I have asked for your time to listen to this urgent message because there is no other moment but the present, to take action!

I thank you for your attention and urge you to **act NOW**!

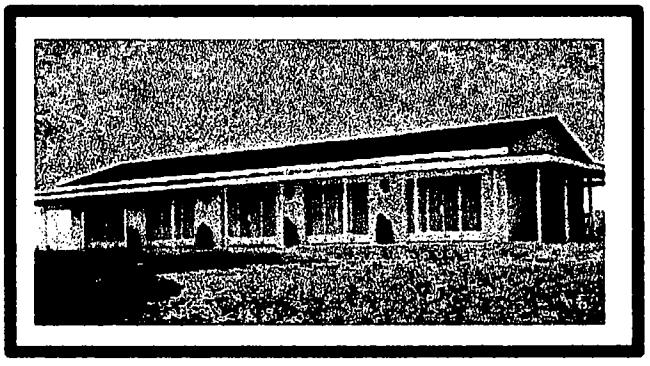
9 October, 1998.

CHRISTIAN CARE CENTRE

comprising

The Lily of the Valley Children's Home

The Lily of the Valley Training Centre
and
The Rose of Sharon Clinic



Submitted by: The Chairman, Mrs. Anita Keyzer
Correspondence: P.O.Box 158 SARNIA 3615
Telephone & Fax (031) 7085127 Office
(0325) 81063 Farm
Banking Details: Nedbank P.O.Box 389
New Germany 3620 South Africa
Account Number: 1311 060812
Fundraising No. 066010390005

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Mission Statement

The Mission of the Christian Care Centre, comprising The Lily if the Valley Children's Home, Training Centre and Rose of Sharon Clinic, is to reflect the compassion of Jesus Christ in providing care, love and support to terminally ill Aids patients and their families, including children abandoned or orphaned due to parental Aids suffering.

The Christian Care Centre operates as a non profit institution of a public and permanent nature, serving the community in KwaZulu-Natal.

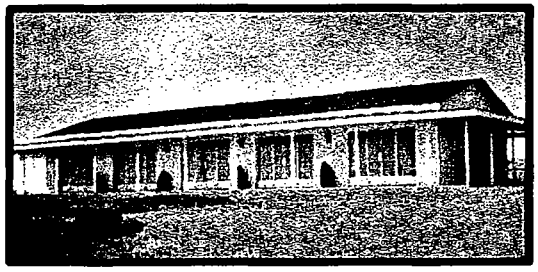
Background

1992	A Pinetown Christian couple, Anita and Kees Keyzer, felt a calling from God to do something practical to relieve the plight of AIDS sufferers and so the idea of a Christian Care Centre was born.
1992	A property was purchased in Pinetown by Kees and Anita Keyzer.
1993	The official opening of the Rose of Sharon House a hospice for Aids patients.
1994	A 59 acre property was purchased in Eston by the Keyzers, which was called the Lily of the Valley Evangelical Care Centre. The 300sq meter barn was rebuilt and converted into a Children's home.
1995	Official opening of the Lily of the Valley Children's Home.
1997	Official opening of Lily of the Valley Training Centre.
1997	Relocation and sale of The Rose of Sharon House in Pinetown to the Lily of the Valley Farm in Eston
1997	Building of Rose of Sharon Clinic for out-patients.
1998	Opening of Rose of Sharon Clinic.
1998	Opening of a Children's Village to provide a home for the children of the Lily of the Valley Children's Home that have sero-converted and are now HIV negative.

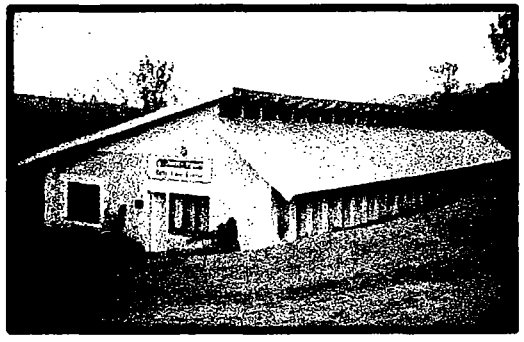
THE CHRISTIAN CARE CENTRE

consisting of the

LILY of the VALLEY



Training Centre



Children's Home

Children's Village

The Lily of the Valley Children's Home

The Lily of the Valley Children's Home is a home for abandoned and orphaned children living with HIV/AIDS who have inherited this disease from their parents.
Their lifespan is on average about 18 months.
This Home was opened in 1995 and is situated on a 59acre farm in Eston near Pietermaritzburg. We are a Government registered Children's Home and can take up to 35 children under the age of six years.
The children come from the various Child Welfare Organisations and are placed with a Court Order from the Children's Court.
Contrary to expectations our little ones with a few exceptions are thriving in this loving environment and we are finding that 65% of our children are sero-converting, and will live a normal healthy life.
We have a compliment of 18 staff members consisting of day and night child carers, domestic, gardening and weekend staff.
In the last year we lost 8 of our precious babies whom the Lord saw fit to take.

Our eldest child is looking forward to going to big school next year.

The Lily of the Valley Children's Village

The Good News. In 1994 while planning the Children's Home we were informed that 1% of babies born to HIV infected mothers would sero-convert, but we are finding that 60% of the children at the Lily of the Valley Children's Home that tested HIV positive on arrival, are now testing HIV negative.
Sero conversion is that a child has just passively aquired the antibodies from the mother and has not aquired the HIV virus. Twelve of our children are now HIV negative. As all our children are abandoned or orphaned this has brought about a new problem.
It is our vision over the next five years to build a Children's Village. We envisage to build one cottage per year. On the 30 September 1998 we opened the first two cottages of our Children's Village. Each cottage will accomodate six children and a housemother. Our first cottage is named "Jabula" meaning Joy or Happiness. Our second cottage is called "Thanda" meaning Love. These cottages will house the children that have sero-converted and will live a normal healthy life. To feed, house, clothe and care for one of these little ones in the Children's Village will cost us R500.00 per month or R6000.00 per year.

Mission Statement

The Mission of the Christian Care Centre, comprising the Lily of the Valley Children's Home,

Lily of the Valley Training Centre and Lily of the Valley Children's Village, is to reflect the compassion of Jesus Christ in providing care, love and support to children abandoned or orphaned due to parental Aids suffering.

The Christian Care Centre operates s a non profit institution of a public and permanent nature, serving the community in KwaZulu Natal.

The Training Centre

The Training Centre was opened on the 17 July 1997
The Centre offers various activities.
Home-based Care Courses which will teach the people in the community Aids awareness, basic Counselling skills and basic Nursing skills. We can accommodate 25 people on each course. The course runs for five consecutive days.

The Sewing School

The aim of the sewing school is to equip the ladies in the community with a sewing skill.In our community 40% of the people are living and dying with Aids and will die over the next few years. When the bread- winners of a family die, leaving their children to the grandparents, the latter will then be able to support themselves and the children.

The Pre-School

All the children from the Lily of the Valley Children's Home over 3 years of age, attend the pre and play school. All the teaching is in English so that the children will grow up to speak Zulu and English.

Thank You for your love and concern for the work among orphaned children living and dying with HIV/AIDS

Our address
The Lily of the Valley
P.O.Box 158
SARNIA
3615

Contact person:
Mrs. Anita Keyzer
Tel .& Fax(031) 7085127
Farm (0325) 81063

THE
CHRISTIAN CARE CENTRE

LILY OF THE VALLEY CHILDREN'S HOME
LILY OF THE VALLEY TRAINING CENTRE
ROSE OF SHARON HOUSE

Fundraising No. 066010390005

3 April 1999

Dear Friend,

WELCOME TO SOUTH AFRICA

On behalf of the Lily of the Valley we want to thank you for coming to our country and giving of your valuable time to visit this project for abandoned and orphaned babies and children living and dying with Aids.

We are most grateful to your President Mr. Bill Clinton for his commitment and offer of assistance towards the Aids pandemic which is sweeping South Africa.

We hope that this visit will serve as a valuable indication of what you can do to help the people of this country and the people in the United States who are suffering with Aids, in particular the women and children.

We give thanks to God for sending you.
May you be blessed in your work.

Yours sincerely

Anita Keyzer

Kees and Anita Keyzer

Office telephone and fax:
(031) 708-5127
(Anita)

P O Box 158
SARNIA
3615
(Association not for gain)

Lily of the Valley Centres:
(0325) 81063
(Anita)

Facts about The Christian Care Centre

The Christian Care Centre, comprising of the:

Lilyof the Valley Children's Home
Lily of the Valley Training Centre
Rose of Sharon Clinic

* ***Is governed by a Board of Trustees, a Management Committee and a Board of Reference which includes members of the medical profession.***
* ***Has a registered Constitution.***
* ***Has a Fundraising Number (066010390005).***
* ***Our Attorneys are Morris Fuller & Associates, Pinetown.***
* ***Our Accountants are Joles & Associates, Pinetown.***

BOARD OF TRUSTEES:

MR. THOMAS SHEARER
MR. KEES KEYZER
REV. REGINALD COURTNEY

MANAGEMENT COMMITTEE:

MR. THOMAS SHEARER	President and Trustee
MRS. ANITA KEYZER	Chairman
MR. DAVID AGATES	Vice Chairman
MRS. LIZ SEED	Hon. Secretary
MRS. MARGE DE LEUR	Member (Fundraising)
MRS CYNTHIA SQUIRES	Member
MRS. DAWN SALZWEDEL	Member
MRS. ETHEL MHLANE	Member
MRS. JEAN MILLER	Member
REV. JEREMIAH ZONDI	Member

Aids - the shocking facts

* 24 million people worldwide are infected with the HIV virus which leads to certain death. (World Health Organisation)

* By the year 2000, 60 million people will be living and dying with Aids.

* 16,000 people in South Africa are infected with the HIV virus every day.

* Much has been spent on Aids Education, however this has not reduced the figures of new infections.

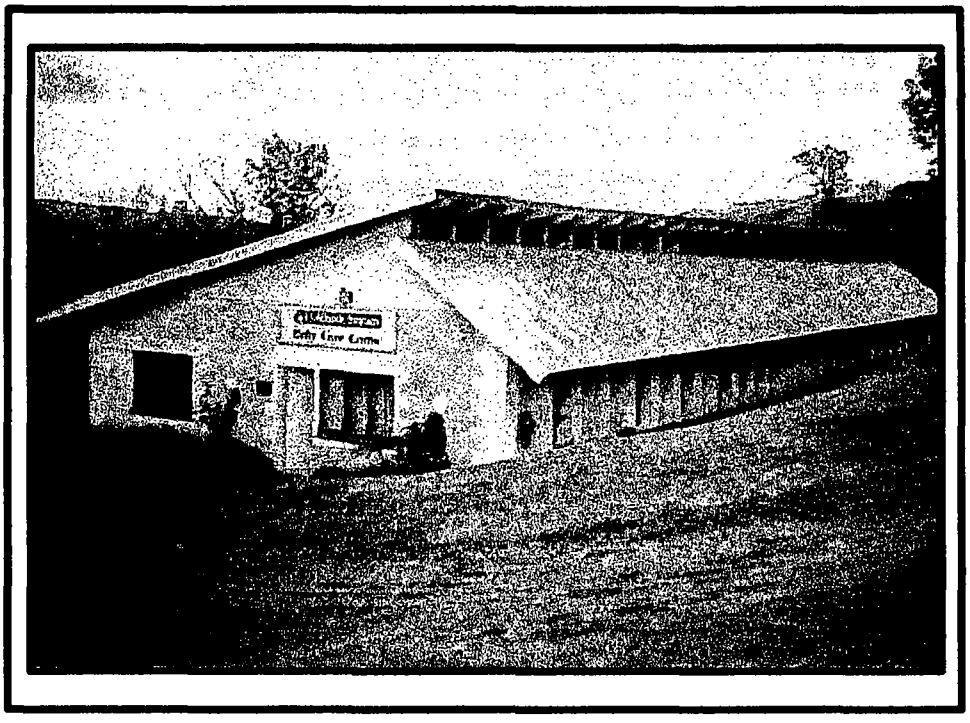
* There will be 500,000 Aids orphans in KwaZulu Natal by the year 2000.

* 6 babies die daily of Aids in KZN.

* 45% of women attending anti-natal clinics in KZN are infected with the Hiv virus.

* There is still no cure or vaccine for Aids.

LILY OF THE VALLEY



The Lily of the Valley Children's Home

The Objective of the Home is to provide a loving, caring home for orphaned and abandoned children living and dying with AIDS, who have inherited the disease from their parents.

Their life span is, on average about 18 months. However our little ones with a few exceptions, contrary to expectations are thriving in this loving environment.

All the children that are admitted to the Home test HIV positive for up to 18 months, some without truly being HIV infected. In other words the child has just passively acquired the antibodies from the mother and has not acquired the HIV virus. It has been discovered that about 60% of the children born to mothers that are HIVpositive will sero-convert and live a normal healthy life. These children are then available for adoption, or alternately be placed in our Children's Village.

The children are placed with us by the Child Welfare Organizations who bring them to us with the authority from the Children's Court. We are a registered Children's Home and have permission to take 35 children. At present we have 30 ranging from 6 months to 5 years. At the Home we have a staff compliment of 18 Child Carers which are day, night and weekend workers.

Background

The Establishment of the Lily of the Valley Evangelical Care Centre (LOVE Care Centre) came about as a result of our work among terminally ill AIDS patients at the Rose of Sharon House . We realized the tremendous need for care of abandoned babies born with AIDS, and for their plight in society.

There will be 500,000 AIDS orphans in KwaZulu Natal by the Year 2000.

Responding to this need, we purchased a 59 acre farm in Eston near Pietermaritzburg, to give these children some quality of life and happiness in their short lives.

The buildings on the property required much renovation, refurbishing and equipping in order to provide the necessary infrastructure to accommodate up to 35 children.

The Children's Home was officially opened in February 1995.

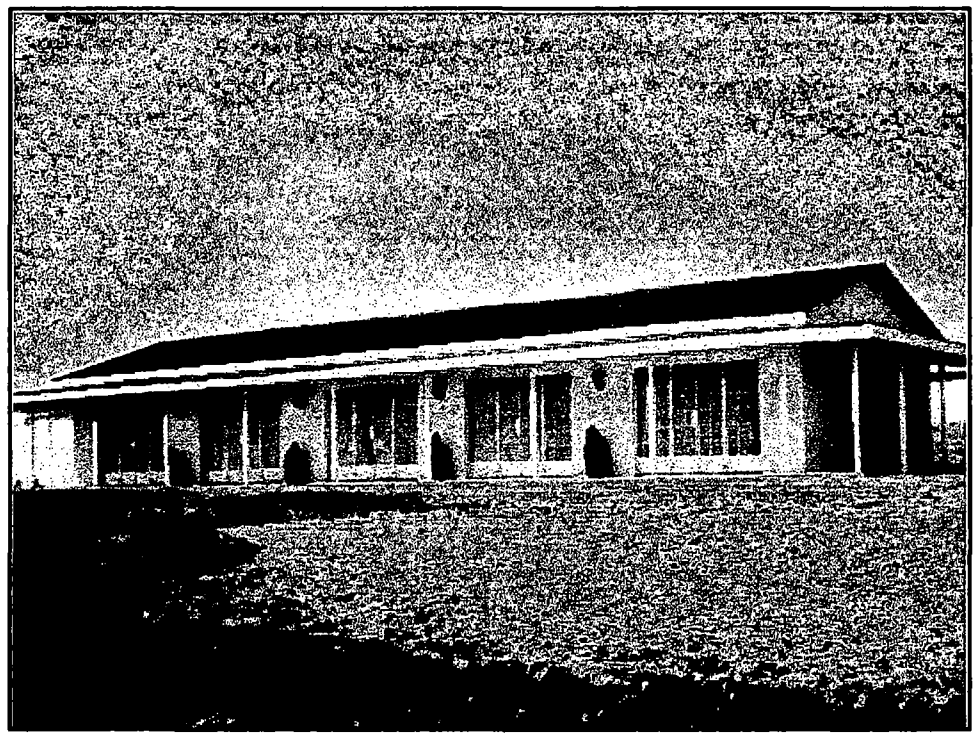
Existing Facilities

A 300-square metre brick building which was converted from a rabbit hatchery to baby nurseries,to house 35 children, including all the necessary facilities for them.

A thatched roof cottage provides accommodation for a management couple. This is fully equipped and furnished

An electric fence protects the property.

LILY OF THE VALLEY
TRAINING CENTRE



Lily of the Valley Training Centre

The Training Centre consists of:

Home-based Care Training

This Centre was opened on the 17. July 1997. The objective of this Centre is to teach the people of the community, Aids awareness, basic counseling skills and basic nursing skills. We envisage training trainers who will go into the community and teach the facts about HIV/AIDS. This will assist in eradicating the fear and discrimination surrounding this disease as well as teaching people to care for their ill and dying family members.

The Training Courses can accommodate 25 trainees per course.

SEWING SCHOOL

Lily of the Valley Sewing School

The ladies in the community are being trained to sew, equipping them with a skill and enabling them to become self-supporting.
We have trained 30 ladies on our first course in 1998.
We will sell the goods they sew to generate funds .

PRE-SCHOOL

Lily of the Valley Pre-School

As the children of the Lily of the Valley Home grow, they will attend the Pre-school. This will provide them with stimulation and prepare them for "Big" school. All the teaching is in English.

Rose of Sharon Clinic

Having trained over 420 trainers , who are now in the community training others and bringing their sick to us at the Training Centre for medical help and counseling.
This has brought to the fore the necessity of proper facilities.
We built a small clinic in 1997 which houses two consulting and two counseling rooms, a waiting room, kitchen and toilets.
This facility was opened to the community in February 1998, which has a qualified nursing sister, counselors and a doctor in attendance one morning per week.
We envisage that we will be able to care for 620 patients every month.
At present the service and medication are free of charge and we hope to be able to continue to do this , by raising enough funds.
We have found that most of the families of the area are unemployed and many do not have enough food to eat...

Future Plans

Our future plans are to build a Children's Village

While planning the Children's Home in 1994 we were informed at that time, that only 1% of the children born to HIV positive mothers would in fact sero-convert and live a healthy normal life.

However we have experienced in our work at the Children's Home, that in fact 60% of the children placed with us, who tested positive on arrival are now HIV negative.

This has brought about a new problem.
What are we going to do with these children?
With this problem in mind we planned to build a Children's Village over a period of 5 years.

We officially opened the first two cottages of the Children's Village in 1998 and are in the process of building two more cottages in 1999.

Our vision and hope for the future is to build 20 cottages to house 120 abandoned children.

Funding

We have received sponsorship from the following Departments and Organisations:

* Department of Welfare of Pietermaritzburg
* Department of Health
* Ithuba Trust
* Transitional National Development Trust

OTHER SUPPORTERS.

* B.P. (Southern Africa)
* Mc Cord Hospital
* Masonite (Africa) Limited
* Aids Foundation of South Africa
* NBS (Pinetown & Kingsmead)
* Adcock Ingram
* Christ Church Pinetown & Queensburgh
* Mrs. H. Englaender
* Mrs. G Antelme
* The D.G. Murray Trust
* T.T. Craddock Trust
* 31 Club
* Bequest of the late Mr.A.J.Sandler
* Different Churches, Women's Auxiliaries, Rotarian Groups and service organisations.
* Fund raising endeavors through appeals, collection of jumble which is sold to raise funds, donations of food, toys and children's clothing.

We owe all supporters a debt of gratitude for their support and caring over the years.