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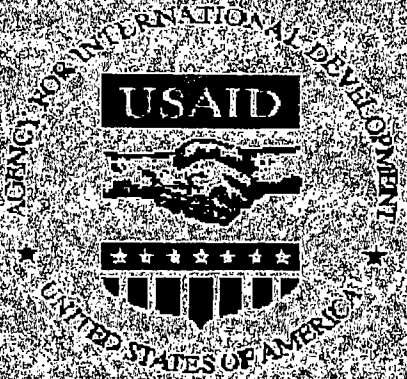
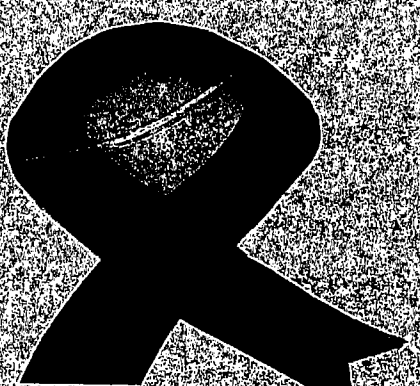
082-858-2034 Ida Ngumshuta
082-858-2304 Adam Ogumba
012-362-0264 Pretoria



USAID PRETORIA

WELCOMES

ALL OUR HONOURED GUESTS



McCORD HOSPITAL

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Durban 4001.
P.O. Box 37587, Overport 4067 KZN,
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Senior Administrator :
David Agates
Dip. MKTG MGT

Vision 2001 and Beyond

HIV/AIDS in Lesotho

Introduction

Lesotho is a small, mountainous, landlocked country completely surrounded by South Africa. Among the social ills of Lesotho's highly mobile workforce are a high incidence of sexually transmitted diseases (STD's) and a high risk of exposure to HIV. The estimated potential workforce is 800,000 out of a population of roughly 2 million. Approximately 100,000 are working in the mines in South Africa. In Lesotho, multiple sexual partners, as well as early sexual experience, are the norm. In one survey, 73% of men and 31% of women reported having multiple sexual partners. Most teenagers have had a sexual experience by the age of fourteen.

The reluctance of the older and more traditional Basotho to discuss sex and sexuality exacerbates the difficulty of reaching the youth through such formal channels as the public health system, churches or schools. Effective mechanisms are still lacking within these institutions to inform and encourage sexual behaviour change among Basotho Youth.

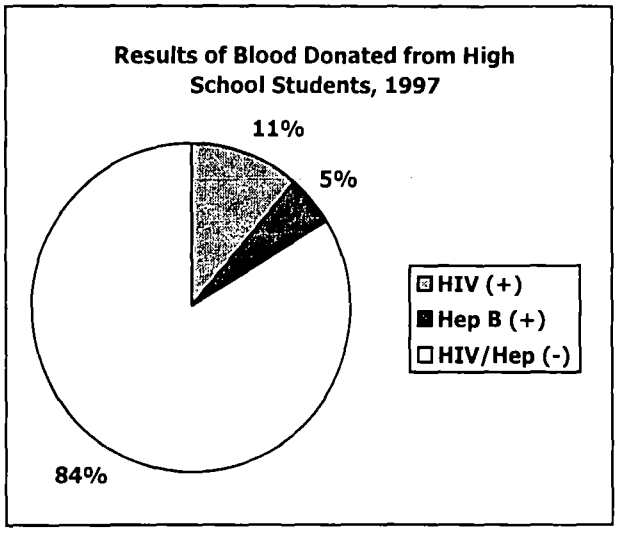
Epidemiology

The first case of AIDS in Lesotho was identified in 1986. Since that time the number of cases has been steadily increasing, with a more dramatic increase in recent years.

Recent HIV/AIDS Sentinel Surveillance data is alarming. Data shows that teenage pregnancy is increasing at dramatic rates, from 6.9% of ante-natal clinic (ANC) attenders in 1992 to 20.1% in 1993. In addition, among ANC patients under the age of 24 who were part of the study, nearly 12% were HIV+. They constituted 58.2% of all the HIV+ results of the study. These results are particularly alarming because the women attending ante-natal clinics are considered a 'low-risk' population, since they are accessing health information and services. Though clear and up-to-date statistics are not available, public health officials believe that this trend has continued to intensify.

Figure 1

Results of Blood Donated from High School Students 1997

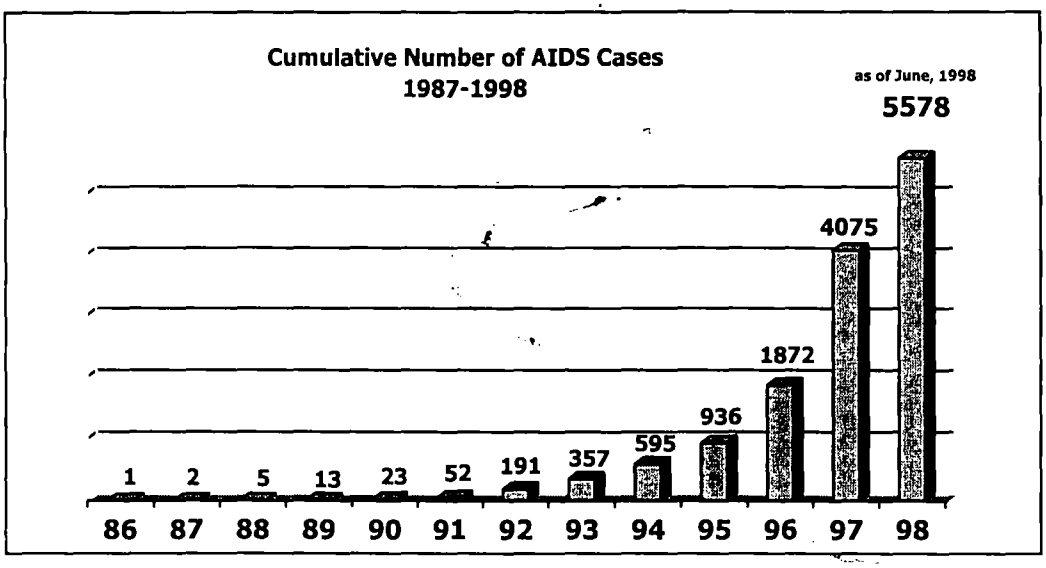


This is illustrated in Figure 1, where we can see that in 1997, 16% of high school students donating blood were either HIV positive or had the antibodies for Hepatitis B. These figures are particularly alarming when one considers that the students who would volunteer to donate blood are generally the students who have more

access to health educational materials. If the figures are so high among this population, one can only imagine what the figures are like among youth who do not have the same advantages.

Figure 2

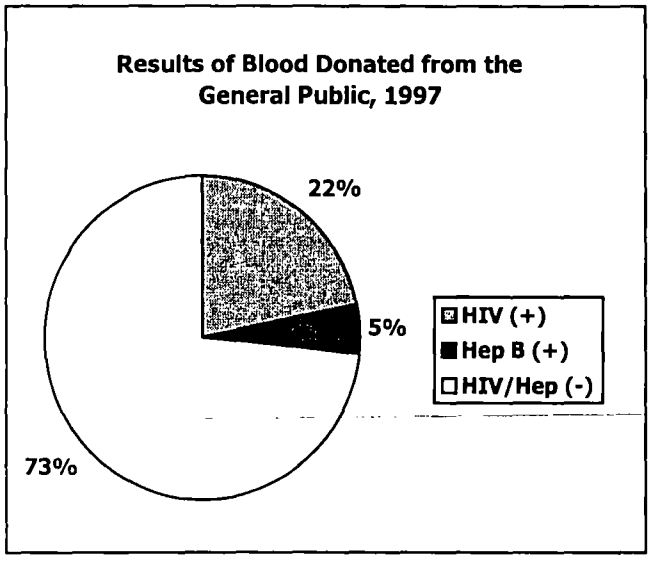
Cumulative Number of AIDS Cases 1987-1998



In June of 1998, the Government of Lesotho's Ministry of Health reported 5,578 cases of AIDS - this is up from the reported 4,075 cases in December of 1997; a 37% increase in just 6 months. It is likely that reported cases vastly understate the actual progress of the disease.

Figure 3

Results of Blood Donated From the General Public 1997

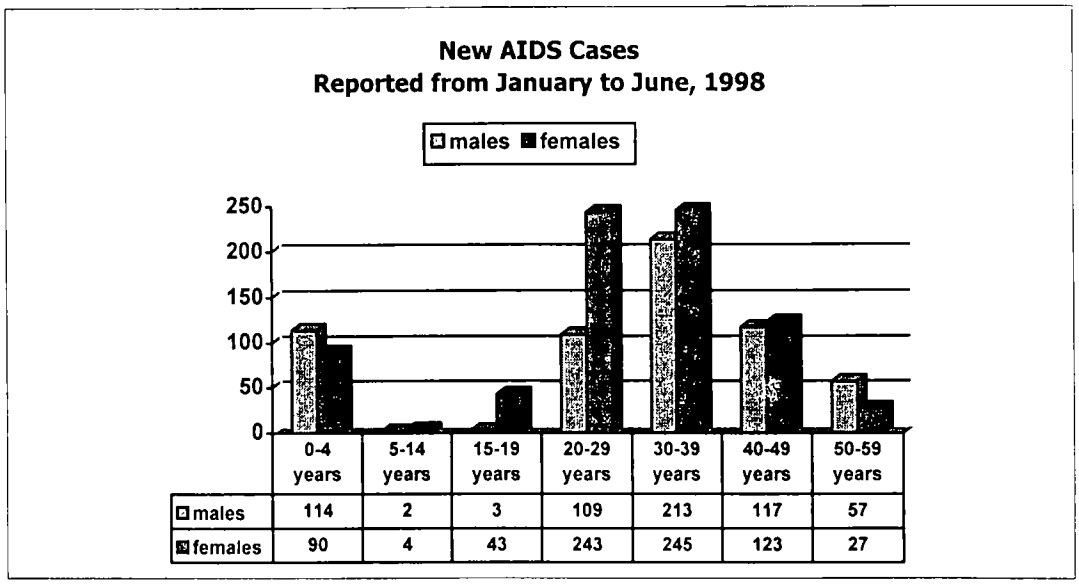


This is evident in the results of the blood donated by the general public; 22% of the blood was HIV+. Again, those who volunteer to donate blood are most likely from 'low-risk' groups.

In Figure 4 we can see the age and gender composition of new AIDS cases, reported between January and June, 1998. Significantly, there are more females in the 15-29 age group and roughly equal numbers in the older age groups. This supports the theory that older men are often infecting both their 'regular' partners and younger women.

Figure 4

New AIDS Cases Jan - June 1998

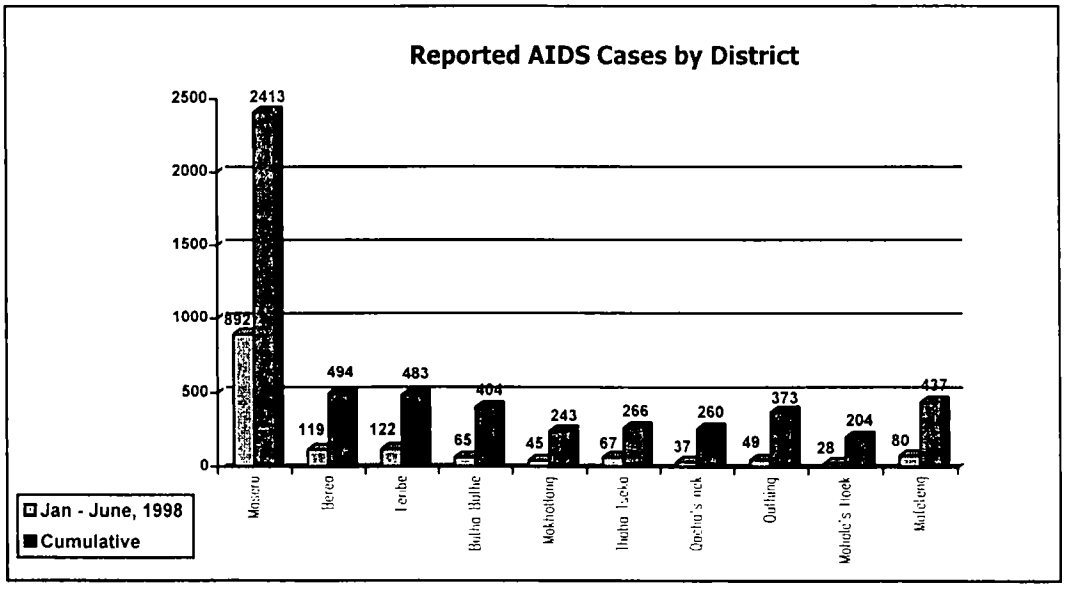


	0-4 years	5-14 years	15-19 years	20-29 years	30-39 years	40-49 years	50-59 years
males	114	2	3	109	213	117	57
females	90	4	43	243	245	123	27

Figure 5 illustrates that while there are reported cases all over the country, the largest numbers are still in the Maseru District. This may in part be due to the fact that many people come to the capital for serious medical attention and thus are recorded in that district. In addition, there has been a marked urban migration in the population.

Figure 5

New Reported AIDS Cases by District



As Figure 6 shows, the great majority of AIDS cases are among married individuals. These figures highlight a problem particular to Lesotho; many among Lesotho's highly mobile work force were employed in South Africa as miners and because of the long periods of separation, had a family in each country. If an individual became infected, two families were effected. In addition, miners often patronise commercial sex workers near their camps and/or near the Maseru border, providing another opportunity for transmission.

Figure 6

New Reported AIDS Cases by Marital Status Jan - June 1998

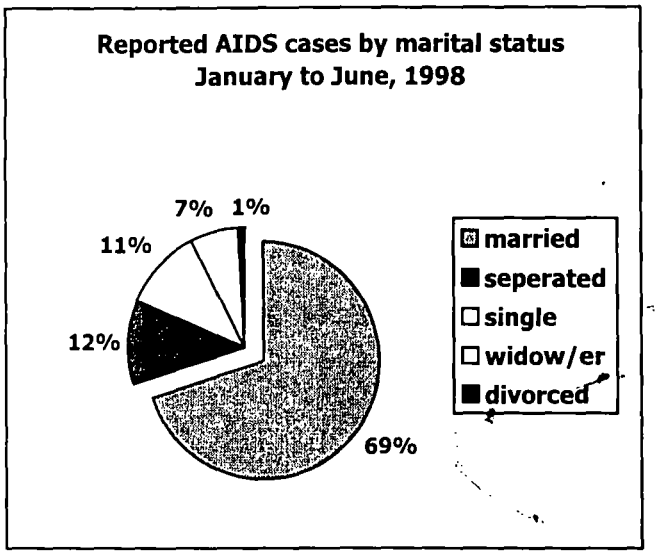
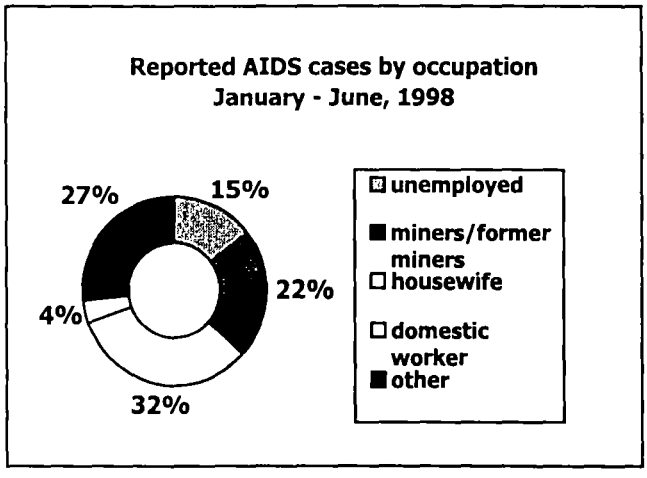


Figure 7 illustrates the gender and occupational breakdown of reported HIV/AIDS cases with 32% being housewives, 22% miners or former miners and 27% being otherwise employed (including the security and police forces).

One of the most important points to be made about the HIV/AIDS statistics in Lesotho is that they present an grossly inaccurate picture of the situation. Due to extreme under-reporting and a climate of denial, many people die from AIDS and go unacknowledged or uncounted. Until testing services are improved and the stigma removed, it will be unclear how HIV/AIDS has truly impacted Lesotho.

Figure 7

New Reported AIDS Cases by Occupation Jan - June 1998



Currently, statistics are collected and reported bi-annually by the Ministry of Health, with a minimum 6 month lag time in the availability of current figures. In the process of trying to compile this report, numerous attempts were made before assistance was given by the appropriate sources. There is a marked lack of accountability and/or responsibility for providing the public with accurate information on how to protect themselves and on the extent of the epidemic in Lesotho.

Local Response

Government of Lesotho

The Government of Lesotho has made a concerted effort to formalise its commitment to the fight against HIV/AIDS. In 1998, an all Ministry workshop was held with the assistance of the World Health Organization.

Government of Lesotho Continued

Thus far, the following steps have been taken:

- The Government has required each line Ministry to identify 'focal persons' who will be responsible for HIV/AIDS issues
- Each line Ministry has committed to train 2-4 persons in counselling, education and referral procedures
- In the Districts, the Heads of Department in each line Ministry are required to establish District HIV/AIDS Committees responsible for integrating HIV/AIDS issues into activities and to form structures to address specific HIV/AIDS related problems.
- The formulation of a Draft HIV/AIDS policy is underway and due to be presented in early-to-mid 1999.
- The Ministry of Health and Social Welfare has promised to install condom machines in public places.
- During the World AIDS Day ceremonies in 1998, the Prime Minister gave a speech highlighting the importance of HIV/AIDS education and stressing that HIV/AIDS is a threat to the economically productive groups in Lesotho. He appealed to the whole nation to increase awareness about the disease and to learn how about protection. It is encouraging that he continues to demonstate a committment to fight HIV/AIDS.

The National AIDS Prevention and Control Programme (NAPCP) has been in existence since the late 1980's. However, their impact remains minimal. Lack of trained staff, poor location and lack of institutional commitment have led to an ineffectual and often non-existent presence.

NGO's

Christian Council of Lesotho AIDS Education Unit (CCL/AEU)

As one of the longest running and most active HIV/AIDS education programmes in Lesotho, the CCL/AEU is currently working primarily in two districts; Quthing and Qacha's Nek. Due to a reduction in funding, their operations have been greatly reduced and many trained staff have been let go.

CARE, Sports Health and Footballers Education Programme (SAFE)

Started as a peer education program with Lesotho's many football teams, SAFE targets the youth by educating young men and having them in turn train their team-mates and the general public. They utilise football

NGO's Continued

matches and tournaments to popularize the message of 'Footballers Against AIDS' and produce related Information, Education, Communication (IEC) materials to educate 'hard to reach' youth.

Lesotho Planned Parenthood Association (LPPA)
While not having HIV/AIDS specific programming, LPPA includes educational messages in their normal activities. In addition, they are planning to implement a research initiative into the effectiveness and usability of the Femadom (the female condom).

Lesotho Red Cross Society (LRC)
Like LPPA, Lesotho Red Cross does not have any HIV/AIDS specific programming, but does include educational messages in their routine work. They have been involved in the Lesotho Network of AIDS Service Organizations (LENASO) from its inception in 1991.

Save the Children (UK)
SCF (UK) is in the process of exploring programming options. They plan to focus mainly on how HIV/AIDS effects children in Lesotho.

National University of Lesotho (NUL)
NUL has implemented a peer education programme with the student body.

A variety of other organizations include HIV/AIDS informational messages in their on-going activities. These organizations include: Lesotho Catholic Secretariate, Lesotho Girl Guides Association, Scripture Union, Christian Health Association of Lesotho (CHAL), Peace Corps, World Vision, Lesotho Save the Children and Lesotho Youth Federation.

UNAIDS

The United Nations Joint Programme on HIV/AIDS was started in Lesotho in 1996 with the formation of the UN Theme Group (TG) on HIV/AIDS. Consisting of all of the represented UN agencies, the Theme Group has drawn up a Terms of Reference and developed a Joint Workplan, but as of yet have not actually taken any action. As the World Health Organization did previously, they continue to support the Government of Lesotho by sharing information and providing advise and support on resource mobilization to the NAPCP. Since February,1998, the TG has been assisting the Government to adopt the above-mentioned multi-sectoral approach, with the intention of developing a National AIDS Policy.

Conclusions

In general, the response to the epidemic in Lesotho has been minimal. While the reported figures continue to climb, the actual number of individuals effected is staggering. It is quickly approaching the time when

Conclusions Conintued

all Basotho will personally know someone who has died from AIDS or someone who is currently infected with HIV. Unfortunately, experience from other countries has shown that only then do people realise the extent of the epidemic and begin to change their own behaviour - but for many it is too late.

The medical and care-giving infrastructure in Lesotho is ill-prepared to accommodate the impact of this epidemic. It will be necessary for patients to receive community care - a task which needs education, training and support. Again, Lesotho is ill-prepared for this.

As the number of AIDS patients increase, the problem of orphans will become increasingly desperate. Lesotho does not currently have a effective formal mechanism to deal with abandoned or orphaned children and thus will be faced with great difficulties as their numbers grow.

The labour unions and business community have yet to recognise the implications of such an epidemic on their productive work force. While some businesses have made token efforts at education campaigns, there will soon be a marked decline in work force productivity and attendance which will need attention. Instead of being pro-active and trying to educate their employee's about prevention, employers are instead ignoring the threat.

Although little is being done in Lesotho, there is a concerted regional effort from a variety of organizations including UNAIDS and SANASO (Southern African Network of AIDS Service Organizations). Due to the high amount of cross-border traffic, participation by Lesotho in regional initiatives would be advisable. However, there has been little concrete action taken to pursue this option.

Because it will be many years before the average Basotho can affford the expensive 'combination cocktails' now available as effective treatment, education and conciousness raising activities are still the strongest weapon in the fight. Support groups promoting positive lifestyles and information on how to live with HIV need to be made available, in a non-judgemental and supportive manner, to those people who are already infected.

While it is encouraging that the Government of Lesotho is beginning to formally address the issue of HIV/AIDS, effective and expedient **action** is necessary. Until the stigma and fear are eliminated and concrete action is taken towards prevention and support, HIV/AIDS will remain the silent killer.

Resources Used

Baffoe, Frank; Pholo, Rethabile, HIV/AIDS is a Threat to the Economically Productive Age Groups in Lesotho, Southern Star Newspaper, Maseru, Lesotho, December, 1998.

Human Development Report, Lesotho, 1998, United Nations Development Programme, Maseru, Lesotho, 1998.

Maw, Dr. Moe Aung, AIDS Epidemiology in Lesotho, 1997, Disease Control and Environmental Health Division, Ministry of Health and Social Welfare, Maseru, Lesotho, 1997.

Maw, Dr. Moe Aung, Update on AIDS in Lesotho, June 1998, Disease Control and Environmental Health Division, Ministry of Health and Social Welfare, Maseru, Lesotho, June 1998.

Various interviews with NGO's and related organizations

Background information from interviews with Lesotho Network of AIDS Service Organizations (LENASO) officers

Written by Jennifer Anderson-Bähr, Self Help Coordinator, US Embassy - Maseru

Welcome to Durban

Consulate General

of the

United States of America

Visitor's Guide

U.S. Consulate General
2901 Durban Bay House
333 Smith Street

Welcome

I hope your visit to our consular district, which comprises the entire province of KwaZulu-Natal, is safe and productive. As you conduct your business here, whether in Durban or further afield, please drive safely and call on my staff if you encounter major or unusual difficulties. If you are on official business and your travel plans change from your cabled itinerary, please notify us.

Frederic C. Hassani, Consul General

Security
Visitors in Durban should exercise the same level of caution as in any large city. Travel in groups when possible. Avoid wearing good jewelry and carrying expensive camera equipment or valuables.

Avoid driving secondary rural highways after nightfall.

Remember that traffic travels on the left-hand side of the road: look carefully before crossing streets.

Brief History of the Province
Portuguese explorer Vasco Da Gama first sighted this lush, green section of the African coast on Christmas Day 1497; in honor of the occasion he named the area *Natalia* ("birth"). Made a British colony in 1844, this region retains perhaps the strongest English flavor of all of South Africa. Natal merged with the former KwaZulu homeland in 1994 to form KwaZulu-Natal.

Durban is the largest city in the province and the second largest in South Africa. It acquired its name in 1843 when Port Natal was renamed after Sir Benjamin D'Urban, a governor of the Cape Colony.

Shaka proclaimed the establishment of the Zulu nation in 1817 and ruled until he was murdered in 1828. His military and political expansionism led to the rise of a cohesive nation with a single language and social system. Cetshwayo, the last of the independent Zulu kings, was defeated by the British Army in the Anglo-Zulu war of 1879. Zululand was annexed to Natal in 1887.

Reflecting the history of bringing indentured laborers from India to work in agriculture, which began around 1860, Durban is the center of Asian life and culture in South Africa. In a migration that largely ended by 1913, many traders and professionals also came to Natal from India; for example, Mohandas Gandhi arrived here in 1896 and practiced law for many years. Today numerous temples and mosques are found throughout the city; bazaars occupy entire blocks of the compact city center.

Climate, Flora, and Fauna
KwaZulu-Natal is sub-tropical. Coastal summers are humid and hot, winters are warm with cool evenings. The province is home to the elephant, both black and white rhino, lion, leopard, and buffalo. The northern rivers abound with hippos and crocodiles. Plant life is exuberant and endangered species such as stinkwood and yellowwood are preserved and propagated in the superb forests.

Entertainment
Durban's center of attraction is the Golden Mile, a 6-kilometer stretch of beaches, parks, shops, restaurants, and amusement centers. The Jumah mosque in Grey St. downtown is well worth a visit, as is the modern Hare Krishna temple in the suburb of Chatsworth.

Museums include:

- **Durban Natural Science and Art Museums** City Hall Building, Smith St. (telephone 300-6212)
- **Local History Museum** Aliwal St., adjacent to City Hall (telephone 300-6241)
- **KwaMuhle Museum** Ordnance Road (telephone 300-6310)
- **Natal Maritime Museum** harborside, near the small craft basin (telephone 300-6320)
- **Old House Museum** 31 St. Andrews St. (telephone 300-6250)

revised October 1997

RESTAURANTS

call for hours, directions, and security notes before you go

-Central Business District-

La Dolce Vita (Italian)
301-8161, Durban Club Place, Durban Club

Press Club (lunch)
304-9748, Old Mutual Arcade (across from ConGen)

Royal Hotel: Ulundi (curry); Royal Grill (buffet and a la carte); Coffee Shop; 304-0331, 267 Smith St.

Adéga (Portuguese)
304-6476, 26 Parry Rd., one-half block from ConGen

-Esplanade and Harbor-

Café Fish (Seafood)
305-5062, yacht basin

Roma Revolving Restaurant (Italian)
376-707, Victoria Embankment

Famous Fish Company (Seafood)
368-1060, The Point—Durban Harbor Entrance

-Beachfront-

Saagries (Curry)
327-922, 47 West St., 1st floor

Daruma (Japanese)
337-1321, Holiday Inn Crowne Plaza

Jewel of India (Indian)
337-1321, Holiday Inn Crowne Plaza

Orient Restaurant (Chinese)
337-2083, 191 Marine Parade

Joe Kool's Bar and Grill
332-9697, Marine Parade/137 North Beach

-Suburbs (10 minute taxi ride)-

Upstairs (Thai/Vietnamese)
239-134, Avondale Centre, Berea

El Turko (Middle Eastern)
237-893, 413 Windermere Rd.

The Keg and Thistle (traditional pub lunch)
235-315, 140 Florida Road, Morningside

El Cubano (Cuban-Caribbean)
202-9197, Silverton & Vause Rds. Berea

Squire's Loft (South African, esp. game)
303-1110, 295 Florida Rd.

Eat Greek (Greek)
83-8546, 12 Broadway, Durban North

Gulzar (Indian)
309-6379, 71 Stamford Hill Rd., Greyville

TELEPHONES

Access numbers for AT&T, SPRINT, or MCI credit-card or collect calls:

AT&T:	0800-99-0123
Sprint:	0800-99-0001
MCI:	0800-99-0011

Useful Numbers

U.S. Consulate General	304-4737
Police Emergency	10111
Ambulance	10177
Crowne Plaza Holiday Inn	337-1321
Edward Hotel	337-3681
Hilton Hotel	336-8100
Marine Parade Holiday Inn	337-3341
North Beach Holiday Inn	332-7361
Royal Hotel	304-0331
British Airways	304-4741
Concorde Peltours	304-5104
South African Airlines	361-1111
Sun Air	469-3444
Eagle Taxis	337-8333
Entabeni Hospital	81-1344
St. Augustine's Hospital	268-5000
Umhlanga Hospital	560-5500
Tourism Durban	304-4934
American Express	301-5551
Rennies	305-5722
Local Directory Information	1023

Temperature Scales

°F	100	90	80	70	60	50	
°C	40	35	30	25	20	15	10

Further afield are the Natal and Voortrekker Museums in Pietermaritzburg, Talana Museum in Dundee, the Art and Cultural History Museum in Empangeni, and the KwaZulu Cultural Museum in Ulundi.

The Natal Playhouse offers top class theater, symphony concerts, ballet, and opera year-round. The botanic gardens feature a world-class collection of rare cycads. Self-guided walking trails have been established within the metropolis and at nature reserves.

KwaZulu-Natal is widely noted for its numerous parks and game reserves, both enjoyable ways to take in the prolific scenic beauty of the province.

Languages
The primary languages of KwaZulu-Natal are English and Zulu. Xhosa and Afrikaans are also spoken.

Shopping in Durban
Downtown Durban and numerous suburban malls offer up-market stores; flea markets operate in various sites on weekends. Some local arts and crafts may be found among the numerous items sold by traders along the beachfront.

Also of note:

- *Victoria Market*, corner of Victoria and Russell streets. A distinctly oriental flavor. We strongly advise that you travel only in groups in this area.
- *The African Art Centre*, in the Station Building, 160 Pine Street, has an excellent selection of prints, baskets, tapestries, carvings and more.

The *What's on in Durban* brochure produced by Tourism Durban has maps and is an excellent source of information on shopping, touring, and entertainment. Pine St.—one block north of City Hall.

For more on regional attractions and to make bookings, visit Tourist Junction in the Old Station Building, 160

HISTORY

From 1985 to 1994, USAID supported numerous NGOs and other civil society organisations. Partnership with the South African government started after the 1994 democratic elections.

PARTNERSHIP WITH THE SOUTH AFRICAN GOVERNMENT

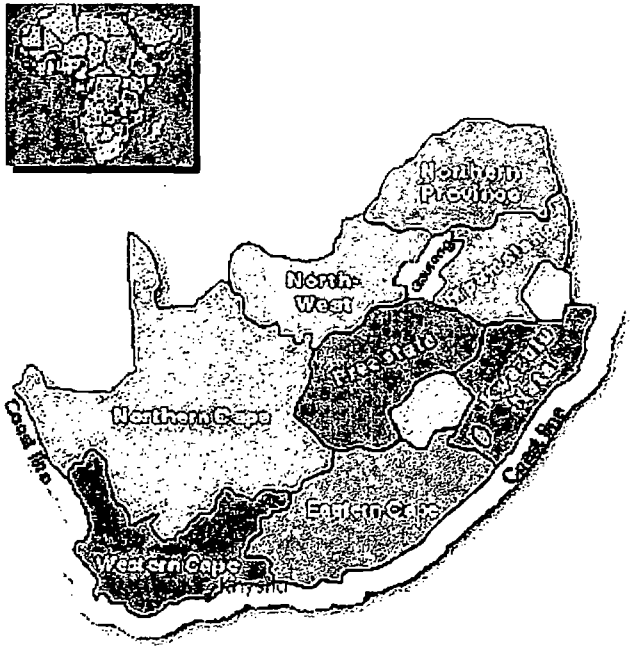
USAID/South Africa provides support through a series of project agreements with key government ministries and departments focusing on the following activities:

* Expanding the capacity of government departments at all levels: national, provincial and local;

* Applying the lessons learned from successful NGO (non-governmental organisations) programs.

ROLE OF NGOs

Prior to the democratic election in 1994, most of USAID's assistance flowed through NGOs. NGOs have historically been an important part of the transformation process in South Africa. These important organisations continue to be pivotal to USAID's involvement.



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Website: http://www.sn.apc.org/usaidsa
Email: web@usaid.gov

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UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

MAKING A DIFFERENCE

The United States Agency for International Development (USAID) manages the U.S government's development assistance throughout the world. USAID's mission is to support people's efforts to develop themselves and their countries. By partnering with governments and communities, we work together to find effective development solutions.

PRIORITIES

USAID/South Africa's goal is to assist the South African government and non-government organisations (NGOs) to realise the political, social and economic empowerment of the disadvantaged majority. Our current ten-year plan (1995-2005) sets out the development of managerial and technical capacity in six important areas:

Democracy and Good Governance—to strengthen democratic institutions through civil society participation

Education—to assist in developing an education system that provides all South Africans with access to high quality, relevant education and training that prepares learners at all levels to contribute to a prosperous, peaceful South Africa

Health—to assist the government in combating HIV/AIDS and improving primary health care to provide services that are patient-focused in a caring environment

Economic Policy Capacity—to strengthen the capacity of key government and non-government entities to formulate, evaluate and implement sound economic policies

Private Sector Development—to assist in creating jobs and increasing opportunities to financial markets for people denied access under apartheid

Housing and Urban Environmental Services—to support access to housing, urban and environmental services for the majority population

BENEFITING SOUTH AFRICANS

USAID/South Africa's activities are designed to benef the historically disadvantaged. Their victory over d cades of racial oppression has been noted as one of th great changes in the 20th Century. Transformation co tinues as they exert their fundamental rights as citizen economically-active individuals and builders of Sou Africa's future. People participate with USAID activ ties through numerous ways:

* National, provincial and local governments
* Civil society
* Educators and students
* Primary health care providers and users
* Economic policy makers
* Micro-, small- and medium-sized enterprises
* Communities requiring houses and services
* Environmental organizations
* Non-governmental organisations
* Community-based organisations

SOWETAN Dec. 23, 1998

United States Ambassador James A. Joseph says his country supports South Africa's Partnership Against Aids campaign.
PIC: US EMBASSY

Aids campaign unites us to fight pandemic

By James A Joseph

THE national Partnership Against AIDS campaign is a new initiative focused on South Africa but it reminds all of us from widely different parts of the world that the pandemic of Aids knows no boundaries.

Aids is not confined to a particular community or country. It is as much an issue for foreign affairs as it is for domestic health. It is an issue that affects all areas of the world and all sectors of a society – government, civil society, labour and business.

The need is crucial for all of us to join forces and find common ground so that, together, we can make a difference.

In a recent letter to Deputy President Thabo Mbeki, United States vice president Al Gore pledged his support for South Africa's Partnership Against AIDS Campaign, launched by Mbeki on October 9.

Gore also expressed his shared concern over the HIV/Aids epidemic and how it has affected both our countries, our communities, and our families.

Gore's pledge of support for the campaign will be carried out in the following ways:

US community

First, the official US community in South Africa (the embassy, consulates, and all US government agencies) will establish for its staff a workplace programme on HIV/Aids that will include awareness, counselling and education, as well as a re-affirmation of our non-discriminatory practices.

Second, we will support the South African Government's HIV/Aids programme by providing funding support of R59,2 million over five years, through the US Agency for International Development (USAid).

This programmatic support will augment ongoing initiatives of the US Centres for Disease Control and Prevention (CDC) in areas of education in the fight against sexually transmitted diseases, tuberculosis, and surveillance; the US National Institutes of Health in clinical research and international networks; and a variety of non-governmental collaborative efforts.

The shared concerns expressed by Gore are a reflection of the investments and lessons which we have learned in the US over the past 15 years.

Research on treatment, improved counselling, vaccine development and, most importantly, encouraging and enabling preventive behaviour have been among the hallmarks of the American government's response to the epidemic.

We have also worked diligently with labour, business, universities, and non-governmental organisations to promote workplace policies, to encourage a better understanding of the epidemic, to demystify the disease, and to promote acceptance of people living with Aids as full and productive partners of society.

Getting the attention of the myriad publics that must be mobilised against Aids requires a continuing reminder that the victims of AIDS are rarely strangers.

Our colleagues

They are our colleagues in the workplace; they are our neighbours; they are our children; they are our immediate family; they are the global families of humankind.

In helping them, we are helping ourselves.

Though the science and epidemiology of the disease differs between our two countries, the concerns and the impact are similar. Mbeki's call for a Partnership Against Aids is an inspiration for all of us to redouble our efforts to combat the epidemic.

Although not all of us are infected with HIV, we are all affected by it. As the Deputy President stated: "HIV/Aids is not someone else's problem, it is my problem. It is your problem."

Reiterating the words of vice president Gore, the US government is pleased to pledge its support for the Partnership Against Aids Campaign.

The American people join in solidarity with the South African people in mourning the lives of so many who have already been lost to Aids.

We vow to continue our work together to protect those who remain at risk.

(The writer James A Joseph is the United States ambassador to South Africa.)

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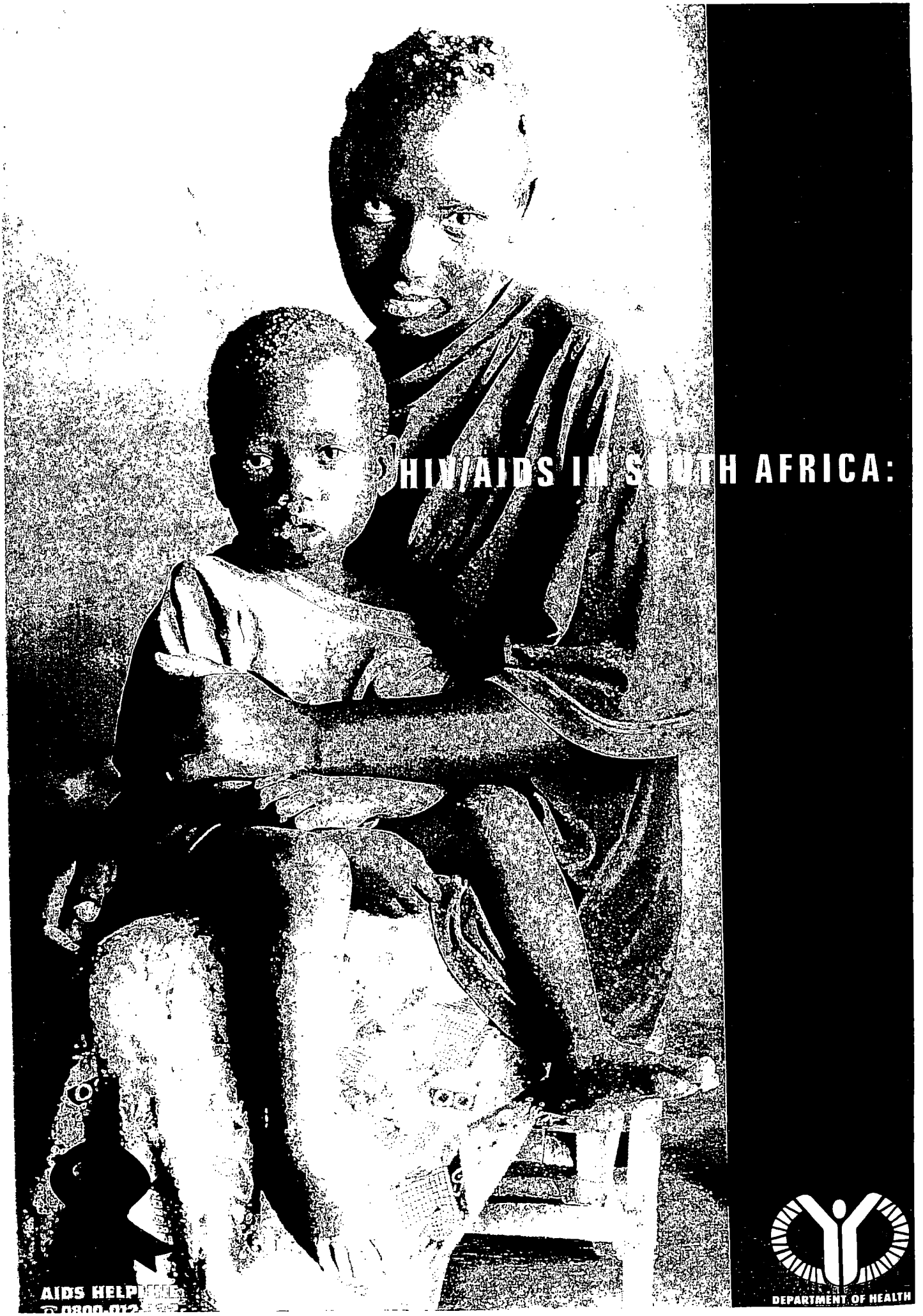
HIV/AIDS IN SOUTH AFRICA:
AIDS HELP
0800 012
DEPARTMENT OF HEALTH

Sandy Thurman
by DKL

USAID PRETORIA

WELCOMES

SANDY THURMAN

AND ALL OUR HONOURED GUESTS

USAID South Africa

Welcomes You

United States Agency for International Development

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

CONTENTS

TABLES

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I. INTRODUCTION

Less than ten years ago, South Africa was in the throes of political struggle and domestic unrest which prompted most countries of the world to impose economic sanctions to encourage the end of apartheid. U.S. sanctions were accompanied by expansion of U.S. foreign assistance to South Africa, which grew from $7 million in FY 85 to $80 million in FY 93. This assistance was focused on strengthening the majority population to assume leadership roles in a democratic South Africa.

TABLE 1: USAID/SOUTH AFRICA FUNDING LEVELS (1985 - 1999)

FISCAL YEAR*	GRANT	GUARANTEE	TOTAL OBLIGATIONS**
1999(estimated)	$47.0 million	-	$47.0 million
1998	$ 70.6 million		$ 70.6 million
1997	$ 86.5 million	$ 24.0 million	$110.5 million
1996	$ 120.6 million	$ 42.9 million	$ 163.5 million (actual)
1995	$ 122.9 million (Includes $ 2.9 million from Global Bureau)	$ 64.0 million	$ 186.9 million (actual)
1994	$ 131.0 million	$ 81.0 million	$ 212.0 million
1993	$ 80.0 million		$ 80.0 million
1992	$ 80.0 million		$ 80.0 million
1991	$ 50.0 million		$ 50.0 million
1990	$ 32.9 million		$ 32.9 million
1989	$ 32.8 million		$ 32.8 million
1988	$ 25.4 million		$ 25.4 million
1987	$ 15.5 million		$ 15.5 million
1986	$ 14.1 million		$ 14.1 million
1985	$ 7.0 million		$ 7.0 million
Total	**$ 869.3 million**	**$ 211.9 million**	**$ 1051.2 million**

* U.S. fiscal year: October 1 - September 30.
** Funds obligated in one year are used to implement activities in that year in and in subsequent years

In April 1994, South Africa entered a new stage of nonracial democracy with the election of Nelson Mandela as President. To support that change and to help redress the social and economic legacies of apartheid, President Clinton committed the U.S. to an approximate doubling of U.S. assistance over the period FY 94 - FY 96. All funds for this pledge period have been obligated and implementation of program activities is continuing. This program, carried out in close consultation with other members of the U.S. Mission such as United States Information Service (USIS) and the Department of State, is now fully funded. The Mission is now working under a ten-year strategy for sustainable transformation in South Africa (See Section V).

II. SOUTH AFRICAN CONTEXT

South Africa's new political leaders are working hard to establish a culture of participation and to build political consensus within South Africa on policy and development goals. They have achieved remarkable success in allaying the fears of the minority population and building cooperation across political party lines at the national, provincial, and local levels. This progress has not been without problems, however, especially over issues of provincial powers. In addition to maintaining a broad political coalition, the Republic of South Africa (RSA) has been widely applauded for instituting market-oriented and fiscally-conservative economic policies and looking to long-term growth as the main vehicle for majority upliftment.

Goals of the South African government include:

* Consolidating democracy and reforming civil society

* Spurring economic growth and job creation through policies which are conducive to growth and the private sector while maintaining fiscal discipline

* Meeting the tremendous needs of the majority population in education, housing, health and other areas within the constraints of a responsible economic policy

This represents the RSA's national vision for catalyzing popular participation in South Africa's transformation to sustainable development. It aims to help the poor and to involve them in their own development. The government puts a premium on community involvement and grassroots participation. It also calls for cooperative efforts by the various branches of government, civil society, business, and labor.

III. CURRENT USAID PROGRAM

Since the democratically held elections, USAID/South Africa has worked to ensure that its assistance is supportive of the South African government's developmental priorities. Based on (a) dialogue with the RSA at various levels, (b) coordination with other international donors in various sectors, and (c) joint review and assessment of our past assistance activities with non-governmental organizations and the private sector, the overall goal of the USAID program through 2005 is sustainable transformation. Sustainable transformation means:

> Assisting South Africa through the point where democracy is sufficiently consolidated; basic systems and policies for social service delivery are in place; processes of institutional change and the development of management and technical capacity are far enough along so that there is reasonable confidence that South Africa's majority population is on a course to sustainable political, economic, and social development.

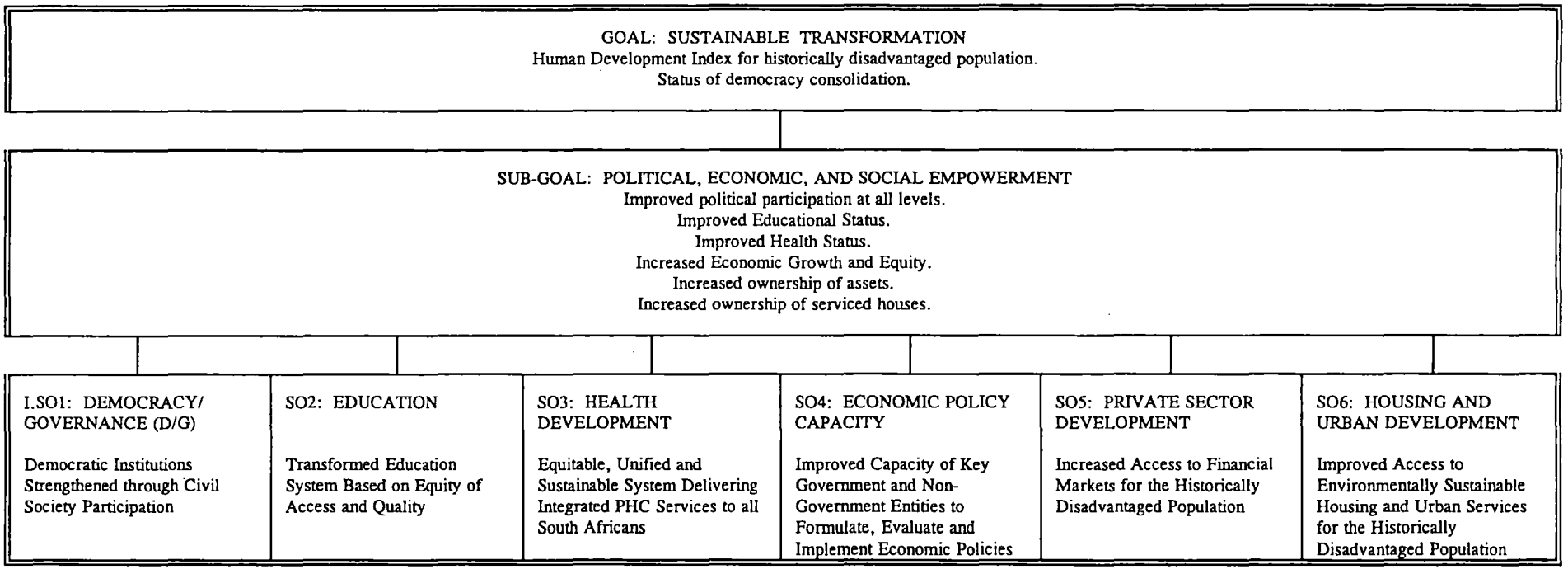
A vital element of transformation is increasing participation and empowerment of the majority population -- the sub-goal of USAID assistance. Apartheid was a top-down system in which most aspects of life of the majority population were decided by the minority government. The present government does not want to merely change the faces of government leaders who are making decisions for the people, but to include the people in decision-making so that they can ensure government programs are responsive to their needs and hold the government accountable for its performance.

The role of foreign assistance is not to become a principal driver of development, but to provide supplementary help that supports internal processes, particularly in developing new policies and systems. In those limited cases in which such assistance supports services delivery, it is as a means to the end of policy or system change.

Program priorities that guide development and implementation of USAID assistance include: (a) participation, (b) sustainability, (c) appropriate linkages with USAID regional and global initiatives, and (d) results orientation. We have applied and will continue to apply various mechanisms to ensure that participation is broad and effective which will help ensure that our program contributes to the development of South Africa.

IV. RESULTS FRAMEWORK

USAID/South Africa COUNTRY STRATEGY PLAN
STRATEGIC OBJECTIVES AND RESULTS FRAMEWORK



V. SIX STRATEGIC OBJECTIVES

In developing proposals for a future program, we considered the government's developmental priorities, areas important for sustainable transformation, the Mission's experience and comparative advantage, and what we thought we could realistically aim to accomplish within reasonable bounds of program duration and funding levels. This led us to focus on six strategic objectives (SOs) in the following areas:

SO1 -- DEMOCRACY AND GOVERNANCE
SO2 -- EDUCATION
SO3 -- PRIMARY HEALTH/HIV/AIDS
SO4 -- ECONOMIC POLICY CAPACITY
SO5 -- PRIVATE SECTOR DEVELOPMENT
SO6 -- SHELTER, URBAN AND ENVIRONMENT SERVICES

SO 1. DEMOCRACY AND GOVERNANCE

The Mission has a long history of promoting civil society and human rights development in South Africa through local NGOs. We plan to build on this experience to support democratic consolidation, a human rights culture, a more equitable justice system, NGO integration into RSA service delivery, and a strong civil society. The Mission's Administration of Justice program relies heavily on NGOs as implementers in direct support of RSA activities.

While many of these areas involve assistance to the RSA, some are directed at supporting civil society as a balance to the government. Examples of the latter are support to NGOs for monitoring government performance, providing information to the public, and protecting human rights. USAID also is supporting civil society participation in the development of new public policies and laws; strengthening of legislatures; improving new government structures at provincial and local levels; creating new partnerships for development that link government, civil society and business, and helping NGO sustainability efforts.

SO 2. EDUCATION

Education is one of the RSA's top priorities and a key to sustainable economic growth and development. One of the lessons of international development experience is the strong linkage between education (especially basic education) and long-term growth. This linkage is particularly strong in South Africa, where shortage of skilled labor and poor basic education standards among the majority population are obstacles to economic growth.

The Mission has experience in this sector--a substantial proportion of past USAID assistance has been in direct support of education, training and human resource development. Key among USAID's objectives in this sector has been the development of models for possible wider application. Much of this past work with NGOs in basic and tertiary education is expected to feed into existing and planned programs with the RSA in two main component areas.

The first component is a program to support policy and systems change, capacity building, and participation/empowerment in basic education, with a focus on four provinces. The second component is a program to strengthen historically disadvantaged institutions (HDIs) in the tertiary education sector (universities and technikons) through the Tertiary Education Linkages Project (TELP). TELP is a ten-year project that began in 1995. It focuses on strengthening HDIs through a combination of training technical assistance in five focus areas and linkages with U.S. universitities and U.S. universities. Workforce development is another aspect of training education being supported.

SO 3. HEALTH

The Equity in Integrated Primary Health Care Project (EQUITY) was the first major USAID/South Africa bilateral project with the RSA. The EQUITY Project takes a capacity-building and systems

development approach in assisting the RSA to change and strengthen its national health system so that quality, essential services are accessible to all South Africans -- especially those who are under-served. To accomplish this, the EQUITY Project concentrates support initially in a single province (Eastern Cape) in order to have sufficient resources both to develop the system and to make it fully operational. The national scope of the project will be achieved by intensive coordination among all nine provinces and the national DOH to ensure that replicating effective systems will proceed rapidly throughout the country.

The RSA has begun the process of consolidating the fragmented health system, redistributing services in an equitable manner, and drastically changing health care priorities to ensure that integrated PHC, with its community orientation and focus on priority health interventions, can be achieved. The EQUITY Project supports the government's efforts and clearly contributes to the shared goal of equitable access to essential health care by all South Africans.

USAID'S FUTURE SUPPORT: USAID/South Africa, in collaboration with the Government of South Africa and civil society organizations (CSOs), is currently developing a new activity to address HIV/AIDS for the public and private sectors. For the coming years (1999-2003), USAID/SA will support South Africa's efforts at reducing the spread and impact of the HIV/AIDS epidemic, including related STD, TB, and Health Reproduction (HR) issues. The $21 million design is in progress to address awareness, prevention, cure/treatment, care/support and mitigation services and practices.

USAID has five priorities in health: (1) increased access to an integrated package of PHC services; (2) an effective health care referral system in operation; (3) improved management of integrated PHC delivery systems at the provincial level; (4) PHC training programs strengthened and institutionalised at the provincial level; and (5) increased capacity for the PHC system to deliver appropriate HIV/STD prevention and treatment. USAID also is planning a new focus on HIV/AIDS/STDs.

SO 4. ECONOMIC POLICY CAPACITY

Structural economic change is required to increase economic growth and job creation, both of which are vitally important for sustainable development. To support the government's efforts in addressing this area, USAID initiated the "Support for Economic Growth and Analysis" (SEGA) activity in FY 1996. SEGA aims to achieve the following results:

1. Strengthened government departments that deal with economic policy matters;
2. Strengthened think tanks to formulate and evaluate economic policy options for all economic policy makers;
3. Individuals trained in economics and policy analysis; and
4. Strengthened centers of economics training (Centers of Excellence in Economics), especially within the historically disadvantaged institutions.

The third activity above represents the "Mandela Scholars Program" under the United States-South Africa Binational Commission. This program will send approximately 50 South Africans from the disadvantaged community to the U.S. for masters and doctoral training in economics. The purpose of this activity is to equip a core group of highly-trained individuals with an education that will help them to formulate growth-promoting policies for the South African economy.

SO 5. PRIVATE SECTOR DEVELOPMENT

Supporting black participation in the private sector is vital for producing sustainable economic gains for the majority population and for reinforcing the political will to rely on private sector-led growth. In the past, USAID's private sector program focused on provision of microenterprise credit through NGOs. Present and future programs will stress broader business development among the previously disadvantaged majority, specific needs of the agricultural sector, the enabling environment for small and medium enterprises (SMEs), and business input to national economic policy-making. The USAID-funded Southern African Enterprise Development Fund is one of capital for South African SMEs. A

cross-cutting theme is empowerment of the majority population through expanded ownership and participation in the formal economy. Job creation is an important outcome of such entrepreneurial development.

SO 6. SHELTER, URBAN AND ENVIRONMENT SERVICES

There is an enormous need for housing and related urban services among South Africa's majority population. Extreme poverty and the unavailability of credit make it difficult for this historically disadvantaged group to obtain adequate shelter.

USAID's goal is to improve access to environmentally sustainable urban services for disadvantaged South Africans by working collaboratively with all major stakeholders in the shelter sector. USAID supports the efforts of all tiers of government to improve the shelter and urban infrastructure policy environment. It works with private financial institutions to increase access to credit for low-income households and to develop effective lending models. It also assists NGOs and community-based groups to develop viable projects and to constructively interact with the public and private sector in order to improve their shelter conditions. Finally, USAID is supporting initiatives to increase the environmental management capacity of local authorities and to enhance the participation of communities in urban development.

TABLE 2: PLANNED OBLIGATION LEVELS BY STRATEGIC OBJECTIVE, 1999

STRATEGIC OBJECTIVE	PROJECT	FUNDING LEVEL	% OF TOTAL
SO 1:DEMOCRACY AND GOVERNANCE		**$ 14.70 million**	**30.00%**
	Democratic Institution Strengthening	$ 14.20 million	
	Self-Help	$ 0.50 million	
SO 2: EDUCATION TRANSFORMATION		**$ 10.30 million**	**21.021%**
	Support for Tertiary Education	$ 0.74 million	
	Transformed Education System	$ 4.80million	
	Tertiary Education Linkages Project	$ 4.26 million	
	Transition Support Fund	$ 0.50 million	
SO 3:UNIFIED HEALTH SYSTEM		***$ 11.50 million**	**23.47 %**
	Equity in Health	$ 11.50 million	
SO 4:ECONOMIC POLICY CAPACITY		--	--
	Support for Economic Growth and Analysis	--	--
SO 5:PRIVATE SECTOR DEVELOPMENT		**$ 3.83 million**	**7.82%**
	Black Private Enterprise Support	$ 0.75 million	
	SAEDF	$ 2.5 million	
	Transition Support Fund	$ 0.58 million	
SO 6:HOUSING AND URBAN DEVELOPMENT		**$ 8.67 million**	**17.69%**
	Environmental Sustainable Housing and Urban Development	$ 8.57 million	
	Transition Support Fund	$ 0.10 million	
TOTAL		***$ 49.0 million**	**100%**

*Includes FY98 carryover of $2.0 million

VI. PROGRAM IMPLEMENTATION

USAID/South Africa is implementing a comprehensive program to assist the goal of sustainable transformation (See Table 4).

Program areas represent USAID's technical strength and complement other donors' programs in South Africa. The activities are implemented in a participative manner that has proven effective, blends with South African consultative traditions and maximizes opportunity for success. Activities are selected from advertised and solicited proposals from South African and U.S. PVOs, NGOs, CBOs, and private contractors. Activities implemented under agreements with the South African government are selected cooperatively.

Our strategic principles are consistent with USAID's New Partnerships Initiative (NPI), announced by Vice-President Gore. This initiative stresses cooperation, empowerment, and non-dependence through partnerships among donors, NGOs and host country governments. Key principles embodied in the USAID/South Africa program fit directly with NPI:

* focus on empowerment through citizen participation and ownership;
* emphasize the role of local NGOs, universities, foundations, small businesses, and decentralized government in sustainable development;
* mobilize U.S. nongovernmental resources to support local capacity building;
* improve the enabling environment for NGOs and small business; and
* a goal of graduating from U.S. assistance.

NGO PARTNERSHIPS: Program expansion since FY94 has effectively enabled USAID/South Africa to continue its broad support to the important NGO community while concurrently providing considerable government-to-government assistance. An integral part of the Mission's strategy is to help build bridges where appropriate between the government at national, provincial and municipal levels, and the NGO community. The objective is to build on key, successful NGO programs, many of which were funded by USAID in the past.

THE U.S. SOUTH AFRICA BINATIONAL COMMISSION (BNC): BNC meetings have taken place annually since 1995. BNC, core-chaired by Vice President Gore and Deputy President Mbeki, was formed to facilitate bilateral cooperation on key issues of mutual concern. USAID/South Africa supports the objectives of the BNC in many substantive areas. Particular emphasis is placed on support to the Human Resource Development and Education Committee. Other assistance supports the objectives of the Agriculture Committee; Conservation, Environment and Water Committee; Energy Committee; Housing Working Group and Health Working Group. Finally, USAID/South Africa, in cooperation with the U.S. Information Service/South Africa, provides broad assistance to facilitate exchanges and internships recommended by the various BNC Committees.

COORDINATION WITH THE SOUTH AFRICAN GOVERNMENT: USAID/South Africa annually proposes, in partnership with government ministries, new projects and activities (See Table 3) to be developed and implemented under the government's bilateral project agreements. These proposals are jointly reviewed and negotiated with relevant South African partners prior to funding commitments. USAID also cooperates with the Department of Finance on annual progress reviews of the overall program.

TABLE 3: BILATERAL AGREEMENTS FY 1994 - 1999 ($ millions)

MINISTRY	PROJECT	TOTAL PLANNED	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999 Planned
MINISTRY OF JUSTICE	ADMINISTRATION OF JUSTICE	15.5	1.5	3.0	4.0	1.8	4.2	1.0
	CONSTITUTIONAL DEVELOPMENT & PROVINCIAL AFFAIRS	5.2	-	-	-	-	2.8	2.4
MINISTRY OF EDUCATION	SOUTH AFRICAN BASIC EDUCATION RECONSTRUCTION	31.8	--	3.9	10.9	17.0		-
	TRANSFORMED EDUCATION SYSTEM	8.6	--	--	--	--	5.0	3.6
	SOUTH AFRICA EDUCATION SUPPORT AND TRAINING	8.0	--	1.5	6.5	--	--	--
	SUPPORT TO TERTIARY EDUCATION PROJECT	9.7	--	--	3.0	6.3	--	0.4
	TERTIARY EDUCATION LINKAGES PROJECT	28.6	--	7.8	7.8	3.0	5.7	4.3
OFFICE OF THE DEPUTY PRESIDENT (SIGNED BY MINISTRY OF EDUCATION)	YOUTH DEVELOPMENT SUPPORT FOR TERTIARY EDUCATION	3.5	--	3.0	0.5	--	--	--
MINISTRY OF HEALTH	EQUITY IN INTEGRATED PRIMARY HEALTH CARE	42.7	--	8.0	10.9	14.7	9.1	-
	*HIV/AIDS/STDS CAPACITY BUILDING	--	--	--	--	--	-	-
MINISTRY OF FINANCE	SUPPORT FOR ECONOMIC GROWTH AND ANALYSIS/ MANDELA ECONOMICS SCHOLARS PROGRAM	16.4	--	--	3.9	4.0	8.5	--
MINISTRY OF TRADE AND INDUSTRY	BLACK PRIVATE ENTERPRISE DEV.	2.5	--	2.5	--	--	--	--
DEPARTMENT OF PUBLIC ENTERPRISES	BLACK PRIVATE ENTERPRISE DEV.	4.1	--	--	1.5	--	2.6	--
DEPARTMENT OF WATER AFFAIRS & FORESTRY	INSTITUTIONAL DEV. PROJECT	2.7	--	--	0.5	0.5	0.2	1.5
MINISTRY OF CONSTITUTIONAL DEVELOPMENT & PROVINCIAL AFFAIRS	MUNICIPAL INFRASTRUCTURE INVESTMENT FRAMEWORK	10.3	--	--	1.8	5.3	3.2	--
	MUNICIPAL INFRASTRUCTURE PROVISION SUPPORT (PREVIOUSLY IN RDP)	0.3	--	0.3	--	--	--	--
MINISTRY OF HOUSING	SHELTER ACCESS FACILITATION PROGRAM	5.5	--	--	3.0	1.0	1.0	0.5
	BASIC SHELTER SUPPORT	1.6	0.5	1.1	--	--	--	-
DEPT. OF ENVIRONMENT AND TOURISM	GLOBAL CLIMATE CHANGE	5.0	--	--	--	--	2.0	3.0
TOTAL		202.0	2.0	34.1	57.6	47.3	44.3	16.7

TABLE 4: USAID/SOUTH AFRICA

LIFE OF PROJECT DATA SHEET

STRATEGIC OBJECTIVE	PROJECT NAME	START DATE	END DATE	Authorized Funding (Million)
SO1: DEMOCRACY AND GOVERNANCE	Democracy Institutional Strengthening	1997	2005	$ 98.7
	Labor Union Training	1983	1997	$ 25.0
	Community Outreach and Leadership Development	1986	2001	$ 149.3
SO2: EDUCATION TRANSFORMATION	Education Support and Training	1986	1999	$ 50.0
	Support for Tertiary Education	1990	2003	$ 137.0
	South African Basic Education Reconstruction	1992	2000	$ 55.3
	Tertiary Education Linkages Project	1995	2004	$ 50.0
	Transformation Education System	1997	2005	$ 95.0
SO3: UNIFIED HEALTH SYSTEM	Equity in Health	1995	2005	$ 71.0
SO4: ECONOMIC POLICY CAPACITY	Support for Economic Growth Analysis / Mandela Economic Scholars Program	1996	2005	$ 30.0
SO5: PRIVATE SECTOR DEVELOPMENT	Southern African Enterprise Development Fund	1997	2005	$ 50.0
	Black Private Enterprise Development	1987	2001	$ 83.0
SO6: HOUSING & URBAN DEVELOPMENT	Shelter and Urban Development Support	1993	2003	$ 70.0
	Environmentally Sustainable Shelter and Urban Development	1998	2005	$ 27.0
	Basic Shelter and Housing Guarantee*	1995	1999	($ 94.9)
	Private Sector Housing Guarantee*	1994	2001	($ 75.0)
OTHER SUPPORT	Self-Help	1980	1998	$ 9.0
	Transitional Support Fund	1995	2005	$ 50.0
TOTAL				**$ 1050.3**

*Guarantees not included in total

ACRONYMS

AOJ	Administration of Justice
BNC	Binational Commission
CBO	Community Based Organization
DOH	Department of Health
HBCU	Historically Black Colleges and Universities
HDI	Historically Disadvantaged Institutions
HG	Housing Guarantee
MOJ	Ministry of Justice
NGO	Non-Governmental Organization
NPI	New Partnership Initiative
ODA	Overseas Development Assistance
PHC	Primary Health Care
PVO	Private Voluntary Organization
RSA	Republic of South Africa
SAEDF	Southern African Enterprise Development Fund
SBLG	Small Business Loan Guarantee
SME	Small and Medium Enterprises
SO	Strategic Objective
USAID	United States Agency for International Development
USIS	United States Information Service

PROJECTS

BPED	Black Private Enterprise Development
COLD	Community Outreach/Leadership Development
EQUITY	Equity in Integrated Primary Health Care Project
LUT	Labor Union Training
SABP	South African Bursaries Program
SABER	South African Basic Education Reconstruction
SEGA	Support for Economic Growth and Analysis
SELF HELP	Self Help Support Community Dev. Fund
STEP	Support for Tertiary Education
SUDS	Shelter and Urban Development Support
TELP	Tertiary Education Linkages Project
TSF	Transition Support Fund

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

SUPPORTING HEALTH DEVELOPMENT IN SOUTH AFRICA

OVERVIEW OF USAID

USAID/South Africa supports the process of change underway in South Africa with sustainable development. The government and non-government institutions (NGOs) are assisted to contribute to the political, economic and social empowerment of the disadvantaged majority population. The following development priorities shape USAID/South Africa's program:

- *Consolidate democracy;*
- *Improve access to high quality education and* ***health care;***
- *Enhance economic policy capacity; and*
- *Broaden asset ownership, including housing and urban environment services*

SUPPORTING A UNIFIED HEALTH SYSTEM

The major health care challenge for the new South Africa is to provide equity in basic health care to all South Africans and, in the process, to rectify the underlying inequities in health services provision brought about by apartheid. South Africa has had a highly fragmented public health system designed to serve the different population groups separately. Fragmentation, curative focus, and lack of community participation resulted in a large, majority population which was deprived of even basic primary health care. The rationale for supporting the development of an integrated primary health care system rather than the delivery of specific health services is based on the Republic of South Africa's identification of such a system as the cornerstone of its new health system.

Another major public health challenge facing South Africa is the epidemic of HIV/AIDS. Recent estimates suggest that over 20% pregnant women are HIV positive, with rates ranging as high as 30% in Kwa-Zulu/Natal province. The Government of South Africa has responded with a comprehensive national plan of action. The Deputy President launched a Partnership Against AIDS campaign in October 1998, which will be the cornerstone of the national plan of action.

The goal for USAID is to work with the Republic of South Africa (RSA) in combating HIV/AIDs and improving primary health care (PHC) to provide services that are patient-focused in a caring environment. This will be achieved through the following emphasis areas:

- Increased equitable access to integrated primary health care services in the Eastern Cape;
- Increased quality of integrated PHC services in the Eastern Cape;
- Improving the sustainability of the district health system in the Eastern Cape;
- Increasing the adoption of lessons learned from the Eastern Cape by other provinces and the National Department of Health (DOH);
- Increasing access to, demand for, and quality of prevention practices and services for HIV/AIDS, sexually transmitted diseases (STDs), tuberculosis (TB), and Reproduction Health (RH);
- Carrying out mitigation strategies for HIV/AIDS, STDs, and (TB) programs and services.

EQUITY IN INTEGRATED PRIMARY HEALTH CARE PROJECT

The EQUITY grant agreement was signed by the Minister of Health and the USAID Director in September 1995. The EQUITY Project will assist the South African government to change and strengthen its health service delivery system so that high quality essential services can be made available to all South Africans, especially those currently under-served.

Equity is a seven-year, $50 million project, of which $11.5 million was allocated in FY97. The South African Government demonstrated its strong support for this project by providing counterpart funds of 34% of the total project budget.

The ultimate beneficiaries of the improved health systems are those individuals previously denied adequate health care, particularly mothers and children in the rural areas, who will soon have access to adequate, integrated PHC services. The

intermediate beneficiaries will be the provincial and local government health departments and health training institutions.

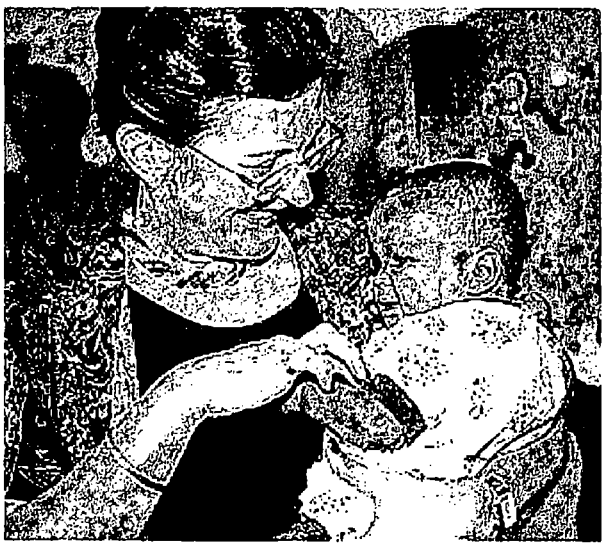
Two years into the full implementation of this project, the National Department of Health (NDOH) and the Eastern Cape Department of Health (ECDOH), supported by Management Sciences for Health (MSH), have made significant progress towards the goal of improving the access and quality of primary health care services to historically disadvantaged population groups:

- A unified drug logistics system has been fully implemented in the Eastern Cape and is being scaled up nationally.
- A simple and useful health information system is being developed in the Eastern Cape and will be scaled up nationally.
- Implementation of the health care referral system has started in the Eastern Cape.
- The Directly Observed Treatment System (DOTS) methodology for diagnosis and treatment of tuberculosis is being implemented for the first time in multiple sites in the Eastern Cape
- Condoms are widely and freely available in public sector institutions of the Eastern Cape for the first time without need for prior consultation with a medical official.
- Public/private partnerships involving the administration and management of small hospitals has been successfully initiated in the Eastern Cape.

Mitigating the Impact of HIV/AIDS -- from 1992 to present, USAID/SA's HIV/AIDS strategy has been to support educational and prevention efforts. Focus areas include:

- Education and training of community leaders, AIDS workers and counselors in prevention and counseling techniques;
- Community outreach and AIDS awareness activities for those "at risk", such as youth and women;
- Prevention workshops provided for youth in urban, rural and informal settlement areas;
- Capacity building and technical assistance support to NGOs in program design, implementation and design of education materials;
- Policy development assistance, such as the national AIDS strategy, for national and provincial health departments; and
- Legal and ethical issues dealing with anti-discriminatory practices/policies against HIV-infected individuals.

A new, five year, $10 million HIV/AIDS grant agreement is currently being developed in partnership with the DOH. This new project will be in direct support of the government's "A Partnerships Against AIDS" campaign, and will focus largely on raising awareness and building capacity of provincial and local organizations. In addition, a smaller component of the project will support activities to establish a national reference center for sexually transmitted infections (STI), and activities which will be supportive of the national initiative for vaccine development.



Further information is available from USAID/SA's Health Development Team Leader, Dr. Ken Yamashita: (Tel) 012-323-8869 or (Fax) 012-323-6443.

P.O. Box 55380, Arcadia, 0007.
Website: http://www.sn.apc.org/usaidsa

for Sandy Thurman's Review and Approval

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

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PRETORIA, South Africa
April 6, 1999
PHOTOS AVAILABLE ON REQUEST

DRAFT

U.S. Presidential AIDS Delegation in South Africa

President Bill Clinton's fact-finding delegation to South Africa, Zambia and Uganda, organised by the United States Agency for International Development (USAID), has visited AIDS orphans and abandoned babies to assess the impact of HIV/AIDS on children, families and communities in these three hard-hit countries.

Presidential White House advisor for AIDS, Ms. Sandra Thurman, led the team of congressional representatives to the sub-Saharan countries to see a wide variety of activities addressing AIDS orphans.

"We've seen a broad spectrum of projects," said Thurman. A hospital in Atteridgeville, for instance, assists people with AIDS to find jobs; staff and volunteers at an orphan care centre in Durban hug babies daily in addition to administering medical care. Thurman described these coping mechanisms as progressive.

She said it was disheartening to see superstitions and stigmas affecting the lives of some people with AIDS. Thurman said that the U.S. had reacted similarly in the last decade, but was learning to deal with the challenges. Thurman was deeply moved by the human consequence of the epidemic and encouraged by the remarkable response of individuals and organisations in the communities who were working tirelessly to make a difference in the lives of AIDS orphans and abandoned babies.

Thurman has said that the disease was no longer just a health problem; it is a development issue. She said the epidemic detrimentally affects finances, economics, trade, security and other elements of developing societies like the three countries she has just toured.

The Presidential AIDS group visited South Africa as an extension of the binational support forged between Vice-President Gore and Deputy President Mbeki on national AIDS day late last year. American Ambassador to South Africa, Mr. James Joseph, announced in December 1998 that the U.S. government will provide funding support of R59,2 million over five years through USAID in South Africa. Thurman's visit with members of Congress will result in a further R8.8 million through USAID to help community efforts underway in South Africa to address the specific needs of AIDS orphans.

Further information is available from USAID Information Officer, Reverie Zurba: Tel: (012) 323-8869 or Fax: (012) 323-6443

BRIEF

Results of the Ninth National HIV Survey of women attending antenatal clinics of the public health services in South Africa, October/November 1998.

Background

During October/November 1998, the Department of Health conducted the ninth national annual survey in a series of unlinked anonymous surveys in women attending antenatal clinics in public health facilities. These surveys were made possible by the cooperation and support of Provincial Health Department coordinators and a number of laboratories.

The trend in the annual point HIV prevalence rates determined in the pregnant population is a good indicator for the progress of the HIV epidemic in the general South African population.

Results

Based on the 15 301 blood samples screened for HIV antibodies, it is estimated that **22.8 %** of the women attending antenatal clinics of the public health services nationally were infected with HIV by the end of 1998. This represents a **33.8%** rate of increase in the prevalence level of HIV infection since 1997. Table 1 shows the 1998 HIV prevalence rates in relation to prevalence rates obtained in 1997. Of concern is the increase in the rate amongst 15-19 year old girls from 12.7% in 1997 to 21.0% in 1998.

HIV prevalence by Age

HIV prevalence has increased among women in their twenties, who have the highest rates of HIV infection at 26.1% and 26.9% for the 20-24 and 25-29 year old groups respectively (Table 2). The rates in the older groups are slightly lower at 19.1% (30-34 year group) and 13.4% (35-39 year group). As seen before, HIV infection is clearly present in older women with rates of 10.5% and 10.2% found in 40-44 and 45-49 year groups respectively. It is a concern to note the increasingly higher HIV prevalence rate amongst teenage girls which has risen form 12.7% in 1997 to 21.0% in 1998.

Provincial HIV rates

When provincial estimates were examined, the following were found. HIV infection in the provinces has in the main continued to rise. Point prevalence rates were estimated as follows: KwaZulu/Natal 32.5%, Mpumalanga 30.0%, Free State 22.8%, Gauteng 22.5%, North West 21.3%, Eastern Cape 15.9%, Northern Province 11.5%, Northern Cape 9.9% and Western Cape 5.2%.

Rates of Increase

The rate of increase amongst teenagers is very high. From 1997 to 1998 we observe a 65.4 % rate of increase (HIV prevalence rate of 12.7% in 1997 to 21.0% in 1998) in comparison to percentage increases in other age groups which are all below 48%.

By province the Northern province has the highest percentage rate of increase of 40.2%, Gauteng 31.6%, Mpumalanga 32.8%, Eastern Cape 26.2%, KwaZulu Natal 20.8%, North West 17.7%, none in the Western Cape, 15.1% in the Northern Cape and 14.0% in the Free State.

General Discussion

The findings are generally indicative of a growing HIV epidemic throughout the country and in all age groups. The findings in the Western Cape require specific comment. The Western Cape HIV estimate seems not to have increased. It should however not be read as a decrease. The true value, if we were not sampling but taking the entire population, could lie anywhere within the range of the confidence limits provided. We can see here that the 1998 HIV estimate for the Western Cape lies within similar confidence intervals as the estimates for last year. Whilst sampling considerations need to be taken into account, this does not fully explain the emerging pattern in the development of the epidemic in that province. More investigations will need to take place to examine for instance whether the epidemic amongst non-public facility users is perhaps growing faster. Further in-depth studies are being pursued to better understand epidemiologic patterns in the Western Cape and elsewhere.

Acknowledgements

The participation of the Provincial Health Departments, especially the project co-ordinators, participating laboratories; South African Institute of Medical Research, South African Blood Transfusion Services, Virology Departments of Natal and Cape Town universities, Medical University of South Africa, Mankweng Provincial Laboratory of the Northern Province, National Institute for Virology of the Department of Health, and the Medical Research Council Statistician, is greatly appreciated.

Source. HSR & Epidemiology Directorate
Department of Health, 1999 (18 Feb.)

Table 1: HIV prevalence by province, comparing 1997 and 1998 antenatal survey findings

PROVINCE	Est (HIV+) 95% CI	Est (HIV+) 95% CI
	1998	1997
KwaZulu/Natal (KZN)	32.5 (29.3 - 35.7)	26.9 (24.9 - 29.0)
Mpumalanga (MP)	30.0 (24.3 - 35.8)	22.6 (20.5 - 24.8)
Free State (FS)	22.8 (20.2 - 25.3)	20.0 (17.1 - 22.2)
Gauteng (GP)	22.5 (19.2 - 25.7)	17.1 (15.1 - 19.2)
North West (NW)	21.3 (19.1 - 23.4)	18.1 (16.2 - 20.1)
Northern Province (NP)	11.5 (9.2 - 13.7)	8.2 (6.9 - 9.7)
Eastern Cape (EC)	15.9 (11.8 - 20.0)	12.6 (11.0 - 14.4)
Northern Cape (NC)	9.9 (6.4 - 13.4)	8.6 (6.4 - 11.3)
Western Cape (WC)	5.2 (3.2 - 7.2)	6.3 (5.2 - 7.5)
National	*22.8*	*17.04*

NB: The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.

Table 2: HIV prevalence by age comparing 1997 and 1998 antenatal survey findings.

AGE GROUP	Est (HIV+) 95% CI	Est (HIV+) 95% CI
	1998	1997
<20	21.0 (18.4 - 23.8)	12.7 (11.3 - 14.2)
20-24	26.1 (24.1 - 28.1)	19.7 (18.4 - 21.0)
25-29	26.9 (24.7 - 29.0)	18.2 (16.8 - 19.6)
30-34	19.1 (17.1 - 21.1)	14.5 (12.9 - 16.2)
35-39	13.4 (11.2 - 15.6)	9.5 (7.7 - 11.5)
40-44*	10.5 (6.8 - 14.1)	7.5 (4.4 - 11.8)
45-49*	10.2 (0.4 - 20.0)	8.8 (1.9 - 23.7)

* Note that the wide confidence intervals (CI) are a result of the smaller numbers of women who participated in the study.

Source: HSR & Epidemiology Directorate, DOH, 1999.

THE CURRENT STATUS OF ORPHANS

REVIEW FOR THE KWAZULU NATAL AIDS CLINICAL ADVISORY COMMITTEE

N H McKERROW
January 1999

At present there is no National body looking into the status of children orphaned by HIV/AIDS nor has a national policy been developed. However a number of individuals and organisations are developing responses to the anticipated problem locally, nationally and in southern Africa.

1 The extent of the problem

There are two recognised ways of estimating the number of orphaned children:

- Enumeration surveys.
- Mathematical models based on basic demographic characteristics of a given society including fertility rates, mortality rates, HIV seroprevalence levels in pregnant women, the rate of progression from HIV to AIDS and local vertical transmission rates.

The first step in estimating the extent of the problem is to define an orphan. There are three categories of orphans - maternal, paternal and double. General consensus considers that as the role of the father in childrearing in the sub-Saharan African setting is extremely limited only children who have lost their mother, ie maternal or double orphans, require our consideration. Furthermore most authorities only include children under 15 years of age in their definition and consider older children as adults.

Enumeration

In sub-Saharan Africa enumeration studies have been undertaken in cities and provinces in a number of countries since the late 1980s. Due to varying demographic features and different stages of the HIV epidemic in the different countries the findings of these studies vary considerably but tend, in general, support projected estimates derived from mathematical models.

I am only aware of one such enumeration study in South Africa done by myself in the Midlands region of KwaZulu-Natal at the end of 1994 when the provincial HIV seroprevalence level in pregnant women was 14,35%. As the epidemic was fairly immature at that stage this study provided a baseline for further projections. The finding showed that 6% of all children under 16 years of age had already lost their mother as a result of AIDS and other causes. Mathematical models project that by 1994 1% of all children in KZN had been orphaned by AIDS.

Mathematical Models

Although a number of different models exist a few basic principles hold true for most.

The peak national HIV seroprevalence amongst pregnant women should stabilise between 25 - 30 % after at least five years of the epidemic.

The number of orphaned children will peak 10 - 15 years the HIV seroprevalence peak and then plateau off at a slightly lower level.

The more rapid the progression from HIV to AIDS the earlier the peak and the lower the plateau.

Twenty years into the epidemic over 25% of all children will be maternal orphans.

If we consider a maternal HIV seroprevalence peak of 25%, a vertical transmission rate of 35% and a 4 year interval between infection to the development of AIDS the following scenario emerges:

Orphan numbers will peak 10 years after the HIV seroprevalence peak.

This peak estimates that 12 - 13% of the total population will be maternal or double orphans from all causes, not just AIDS.

Thereafter the curve will plateau off with these orphans accounting for 9 - 11% of the total population.

The mean age of these orphans will drop by up to 2 years from the pre-AIDS mean age.

At present I am only aware of two mathematical projections of orphan numbers from South Africa, both looked specifically at the position of KZN. The first done by Alan Whiteside et al estimated that by 2 000 197 000 - 250 000 children in the province under the age of 15 will have lost their mother as a result of AIDS. This works out to be 5,8 - 7,4% of children in the province and 2,3 - 2,9% of the entire population of the province. The second by Mason and Wood obtained a higher estimate of 8,86%.

These figures are similar to the projections for Uganda (2,1 - 4,9%), lower than those for Zambia (4,0 - 7,1%), but higher than those for both Tanzania and Kenya (1,5 - 2,5%).

South Africa

To produce an overall estimate for this country is extremely difficult as I'm not sure when we can consider the type 2 HIV epidemic to have started, each province is at a different stage of the epidemic and each province has its own demographic characteristics with respect to degrees of urbanisation, fertility and age distributions.

Based on the last three national antenatal seroprevalence studies it appears that Mpumalanga and KwaZulu-Natal are nearing their peak HIV seroprevalence level, Northern Cape and Gauteng are not far behind whilst the other provinces are all still a long way off. In light of all this we can probably assume that individual provinces will begin to experience their peak numbers of orphans between 2005 and 2010 before falling slightly and that by 2015 the country as a whole should have reached its peak. Thereafter we can expect that maternal orphans will comprise 9 - 12% of the total population. This projects to 3,5 - 4,8 million children under 15 years of age.

2 Responses to the problem

Locally a number of isolated responses have emerged to cater to the needs of orphaned children in specific settings. These responses include traditional models of surrogate care including children's homes - both HIV specific and integrated - various forms of foster care as well as adoption.

In the Midlands of KZN CINDI, a networking forum partly funded by the Nelson Mandela Children's Fund, is co-ordinating a holistic response to the problem. This programme consists of a number of pilot programmes operated by independent NGOs addressing the following needs:

home based care and the early recognition of children at risk
temporary shelters
alternative models of community based care of children

income generating activities for surrogate families
programmes for street children

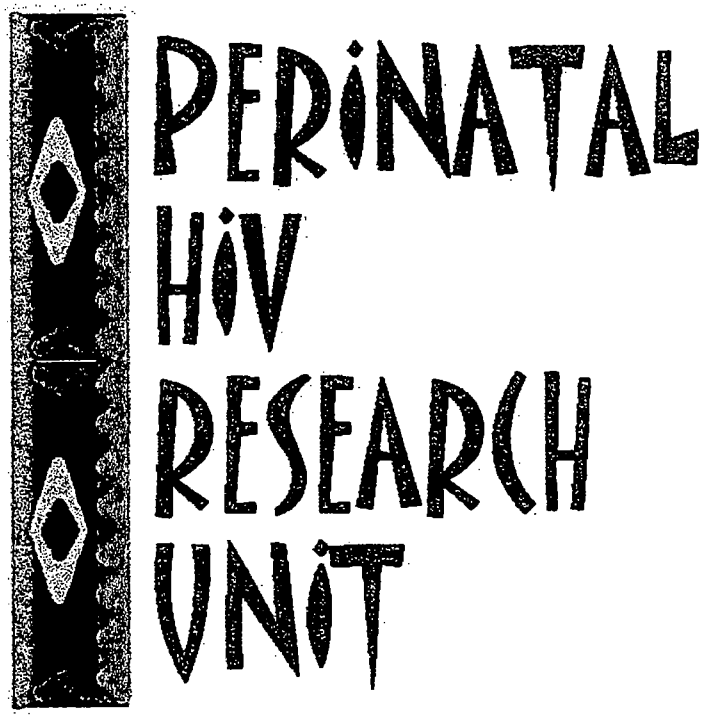
The aim is to develop these pilots programmes to a point where they could act as blue prints for replication in other regions.

CINDI was responsible for organising the first Southern African conference on the issue of caring for orphaned children. This was held in Pietermaritzburg in the middle of 1998 with participants from east, west and southern Africa as well as the UK and USA.

At a national level the South African Law Commission is reviewing the Child Care Act and has commissioned a position paper on HIV/AIDS and children from Kitty Barrett, Ann Strode and myself. This is long term process as the paper will be circulated for discussion in February and the White Paper of the new Child Care Act will only be available in about a year. In addition the National Council of Child and Family Welfare is in the process of developing a handbook on various models of care for orphaned children.

In southern Africa, noticeably Malawi, Zambia and Zimbabwe, a few South Africans are involved in a number of initiatives looking at legal reform, identification and registration of orphans, alternative models of surrogate care and targeting support to children in distress.

The bottom line is that we have a long way to go before effective measures will be in place to cater to the needs of orphaned children. Fortunately people are beginning to work together at local, national and international levels.



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 mother 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 Wiley 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
5. Fawcus S, McIntyre J, Jewkes R, Rees H, Katzenellenbogen J, R, Shabodien R, Lombard C, Truter H , & Reference Group: *Management of incomplete abortions by South African public hospitals.* S Afr Med J 1997; 87(4):438-42
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 Benig 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
18. Beksinska ME, Rees VH, Nkonyane T, McIntyre JA *Compliance and use behaviour, an issue in injectable as well as oral contraceptive use? A study of injectable and oral contraceptive users in Johannesburg.* Br J Fam Plan, **24**, April 1998 (in press)
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)

4. Papers in other journals

1. Rees H, McIntyre JA *Women's sexual and reproductive rights and HIV/AIDS.* Aids Bulletin 1995; 4(2): 8 - 1
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
8. McIntyre JA *Caught in the Crossfire: the Ethics of HIV prevention studies.* AIDS Scan 1998, 9(4): 4-6
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 1 (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:
Dr Glenda Gray MBBCh FCPaeds
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

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