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Gone / Mbeki letter

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Embassy of the United States of America

Pretoria, South Africa
July 7, 2000

Mr. B.I.L. Modise
Chief of Protocol
Department of Foreign Affairs
Hatfield Court
Pretoria

Dear Mr. Modise:

I shall be grateful if you would forward the enclosed letter from Vice President Gore to His Excellency Thabo Mbeki.

Sincerely,

Thomas N. Hull
Acting Deputy Chief of Mission

Enclosure

(Signed original will not follow)

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C · SA

JUNE 27, 14:11 EDT

South Africa Leads in HIV Infections

By SUSANNA LOOF
Associated Press Writer

JOHANNESBURG, South Africa (AP) — The stigma and silence surrounding AIDS must be broken if the epidemic is to be controlled in South Africa, now home to more HIV-infected people than any other nation, experts said Tuesday.

According to a new U.N. report on HIV/AIDS, about 4.2 million South Africans — roughly 10 percent of the population — are HIV positive. South Africa's infection rate is even higher among pregnant women: 22 percent of those who visited prenatal clinics last year tested positive for HIV.

But like elsewhere in southern Africa, most infected South Africans are unaware of their status, said Dr. Elhadj Sy, leader for the UNAIDS team for eastern and southern Africa.

African countries need to provide facilities for voluntary tests and counseling so infected people can avoid transmitting the virus, Sy said. But people won't test themselves unless the stigma surrounding the disease is removed, he said.

In South Africa, people who openly say they are HIV positive often are treated as outcasts, fired from their jobs and sometimes even chased from their homes. In 1998, Gugu Dlamini, a woman in KwaZulu-Natal province, was beaten to death after revealing during World AIDS Day that she was infected.

``If people who test positive are kicked out of their homes and their children are discriminated against, and we say come and take a test, I don't think people will do that,'' Sy said.

He spoke at a news conference in advance of the 13th International AIDS Conference, set for July 9-14 in Durban, South Africa. The conference's theme is ``Break the silence.''

HIV-infected people must be recruited to join the battle against AIDS, Sy said.

``This is the way to combat stigma. This is a way to combat exclusion. This is also a way to put a face on this number,'' he said, referring to the 24.5 million people with the HIV virus in sub-Saharan Africa.

South Africa's high infection rate is partly attributable to the migrant labor system under apartheid, said Dr. Hoosen Coovadia, chairman of the International AIDS Conference. He said male workers were forced to live in hostels far from their families, and many turned to prostitutes.

The response from the South African government and communities was initially not as vigorous as it could have been because the country was preoccupied with its transition from apartheid to democracy, Coovadia said.

Critics here have blasted the government for failing to provide drugs that can prolong AIDS sufferers' lives. The government has responded that, like other African nations, it simply cannot afford anti-retroviral AIDS drugs.

Nonetheless, AIDS is a priority for the government, said Thami Skenjana, director of the South African government's AIDS action plan.

Last week, authorities unveiled a five-year plan to combat the epidemic. The plan calls for promoting safe sexual behavior, improving access to testing and counseling and providing treatment and support for HIV positive people, their children and AIDS orphans.

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U.S. - South Africa Understanding on Intellectual Property

United States Trade Representative Charlene Barshefsky today announced that the Governments of the United States and South Africa have come to an understanding with respect to South Africa's urgent need to provide better, more affordable health care while ensuring that intellectual property rights are protected. This understanding was reached working through the mechanism of the Council of the Trade and Investment Framework Agreement (TIFA).

"The Government of South Africa is battling a very serious AIDS pandemic," stated Ambassador Barshefsky. "The United States Government fully supports President Mbeki and his Government in their effort to combat this problem and is committed to do whatever it can to help.

Both Governments also have reaffirmed their shared objective of fully protecting intellectual property rights, including their commitment to comply with the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement). They recognized that this Agreement is designed to ensure high levels of intellectual property protection while enabling governments to address national social needs.

Between these shared commitments, the two governments have identified common ground with respect to South Africa's implementation of its so-called "Medicines Act." "The United States very much appreciates South Africa's assurance that, as it moves vigorously forward to bring improved health care to its citizens, it will do so in a manner consistent with international commitments and that fully protects intellectual property rights," continued Ambassador Barshefsky. "This will enable us to set aside this issue from our bilateral trade agenda. Moreover, once GSP is re-authorized by Congress, new GSP benefits granted to South Africa in June 1998 will be implemented."

Ambassador Barshefsky also welcomed a September 9 announcement by the Pharmaceutical Manufacturers Association of South Africa that it will suspend litigation over the Medicines Act.

Barshefsky observed: "I am hopeful that this suspension, coupled with progress made between our two governments, will enable all interested parties to develop together the best possible approach to addressing this serious situation, while protecting important intellectual property rights."

- 30 -

Understanding

DRAFT

JOINT STATEMENT BETWEEN THE GOVERNMENTS OF SOUTH AFRICA AND THE UNITED STATES OF AMERICA

17 September 1999

Over the past few months, officials of the Governments of South Africa and the United States of America have been exchanging views with the aim of reaching a common understanding on the matter of intellectual property as it pertains to the pharmaceutical industry.

We are pleased to announce that a resolution to this matter has now been found. This is premised on the commitment of both Governments to Agreement on Trade Related Intellectual Property Rights (TRIPS), under the auspices of the World Trade Organization, as well as an appreciation of the South African Government's efforts to provide affordable health care to its people.

It is the express position of the South African Government that, in the implementation of the provisions of the Medicines Act - which permits parallel importation and compulsory licensing of patents for pharmaceuticals - it will honour its obligations under the TRIPS Agreement.

We strongly welcome the fact that this matter has been clarified to the satisfaction of both Governments. Indeed, our two countries can now move forward to strengthen our co-operation on matter of common interest, without the distraction that this issue had become.

The Governments of the United States of America and South Africa hope that the resolution of this matter will open the way for South Africa to pursue its much-needed health reforms in the interests of its people.

HIV/AIDS & STD

Strategic Plan for South Africa 2000-2005

foreword

The HIV/AIDS epidemic is the most important challenge facing South Africa since the birth of our new democracy. This challenge therefore, comes at a time when the country is faced with many other competing needs; redressing the imbalances of the past, transformation of our society, as well as integrating our country in the global economy are some of the many challenges.

Failure to respond to this epidemic however, will reverse all the developmental gains, made in the last five years. The Government has therefore made the fight against this scourge a top priority. In so doing, it has chosen a multi-sectoral approach as a lead strategy in combating the HIV/AIDS epidemic.

Many organisations, communities and individuals have contributed a lot in the country's response and their efforts are applauded. There is however, an urgent need to bring in more partners and to consolidate our efforts for maximum impact. This Strategic Plan has been developed with the participation of many stakeholders. Key priority areas have been identified and sectors are expected to plan their interventions in line with these priorities.

The implementation of this Strategic Plan will require enormous resources. Therefore, all sectors including Government Ministries, Non-Governmental Organisations, the private sector, religious organisations, People Living with AIDS and donor organisations are urged to devote resources towards the fight against HIV/AIDS.

South Africans have fought and won many difficult wars before. We have the ability as a country to do the same with this epidemic. Let us 'Break the Silence' around HIV/AIDS. Let us break the AIDS chain.

Dr M Tshabalala-Msimang
MINISTER OF HEALTH

table of contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ATIC	AIDS Training and Information Centre
ART	Anti-Retroviral Therapy
BHF	Board of Health Care Funders
CBOs	Community-based Organisations
CGE	Commission on Gender Equality
CMA	Civil Military Alliance
DENOSA	Democratic Nursing Organisation of South Africa
DOE	Department of Education
DOF	Department of Finance
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labour
DOME	Department of Minerals and Energy
DOT	Department of Transport
DOTS	Direct Observed Therapy Short Course
DOW	Department of Welfare
EDL	Essential Drug List
GCIS	Government Communication and Information System
IDC	Interdepartmental Committee on AIDS
IMC	Inter-Ministerial Committee on AIDS
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
IEC	Information, Education, and Communication
IMC	Inter-Ministerial Committee on AIDS
MOH	Ministry of Health
MEC	Member of Executive Committee
MRC	Medical Research Council
MTCT	Mother-to-child transmission
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Council
NACOSA	National AIDS Co-ordinating Committee of South Africa
NGOs	Non-Government Organisations
NPPHCN	National Progressive Primary Health Care Network
PEP	Post-exposure prophylaxis
PWA	People living with HIV infection or AIDS
PHRC	Provincial Health Restructuring Committee
SAIMR	South African Institute of Medical Research
SALC	South African Law Commission
SAMA	South African Medical Association
SAPS	South Africa Police Service
SADC	Southern Africa Development Community
SANDF	South African National Defence Force
STDs	Sexually Transmitted Diseases
SM	Syndromic Management
TB	Tuberculosis
THs	Traditional Healers
UNAIDS	Joint United Nations Programme on HIV/AIDS
VTC	Voluntary HIV Testing and Counselling
WHO	World Health Organisation

Dr M Tshabalala-Msimang

"South Africans has fought and won many difficult wars before. We have the ability as a country to do the same with this epidemic"

" South Africans has fought and won many difficult wars before.

We have the ability as a country

to do the same with this epidemic"

introduction

During the last two decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV/AIDS has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy.

According to recent statistics by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), the number of people living with HIV was estimated to be 33,4 million by the end of 1998, a 100% increase compared to 1997. In Sub-Saharan Africa, more than a quarter of young adults are infected with HIV.

Assuming that no cure is found, it is estimated that more than 40 million people globally will be living with HIV by 2000. The impact of the epidemic on the economy is already being felt in most countries. Life expectancy has been significantly reduced as many people in the 15-49 year age group are now dying of AIDS.

Many countries, both in Africa and Asia, have taken urgent steps to curb the epidemic with varying degrees of success. In South Africa, despite our efforts, the HIV infection rate has increased significantly over the past 5 years. This increase in the infection rate calls for a renewed commitment from all South Africans.

1.1 The Purpose of the Strategic Plan

This document is a broad national strategic plan designed to guide the country's response to the epidemic. It is not a plan for the health sector specifically, but a statement of intent for the whole country, both within and outside government. It is recognised that no single sector, ministry, department or organisation is by itself responsible for addressing the HIV epidemic. It is envisaged that all government departments, organisations and stakeholders will use this document as a basis to develop their own strategic and operational plans so that all our initiatives as a country can be harmonised to maximise efficiency and effectiveness.

1.2 The Development of the Strategic Plan

The development of the Strategic Plan was initiated by the Minister of Health, Dr. Manto Tshabalala-Msimang, in July 1999. This was in response to the President, Mr Thabo Mbeki's challenge to all sectors of society to become actively involved in initiatives designed to address the HIV/AIDS epidemic.

It began with a meeting in July 1999 to review the current HIV/AIDS prevention, treatment, and care efforts in South Africa. The meeting was attended by representatives of faith-based organisations, people living with HIV infection and AIDS (PWAs), human rights organisations, academic institutions, the civil military alliance(CMA), the Salvation Army, the media, organised labour, organised sports, organised business, insurance companies, women's organisations, youth organisations, international donor organisations, health professionals and health consulting organisations, political parties, and relevant government departments.

After priority areas for future efforts were discussed and agreed upon, a committee was charged with developing a five-year HIV/AIDS & STDs Strategic Plan. Task teams were

established to review current goals and objectives for the designated priority areas. The priority areas are prevention; treatment, care and support; legal and human rights; and monitoring, research and evaluation.

In addition, the Minister of Health held bilateral meetings with several important sectors including traditional leaders, faith-based organisations and the business sector to obtain their views and to discuss ways to facilitate their active participation.

In September 1999, the Minister of Health and the nine provincial MECs for Health reconfirmed the previous priority areas. This was followed, in October 1999, by a two-day National AIDS Meeting where Provincial AIDS Co-ordinators, the National DOH HIV/AIDS & STDs Directorate, representatives of the AIDS Training and Information Centres (ATICs) and representatives of several other organisations discussed progress in the five-year HIV/AIDS & STDs Strategic Plan.

In October and November 1999 the task teams met to further develop their goals and objectives. They reviewed the National AIDS Plan for South Africa, 1994; the Department of Health White Paper for the Transformation of the Health System; the 1997 Annual HIV/AIDS & STDs review, and reports from the September meeting of the Provincial MECs for Health, and the National AIDS meeting.

In November 1999 a draft document was presented to the Inter-Ministerial Committee (IMC) on AIDS, and additional comments were solicited from all government ministers. The final document was completed in January 2000.

background

2.1 Situation Analysis

The South African picture of the epidemic
The Sub-Saharan and Southern Africa is suffering severely from the HIV/AIDS pandemic. Recent estimate suggest that of all people living with HIV in the world, 6 out of every 10 men, 8 out of every 10 women, and 9 out of every 10 children are in Sub-Saharan Africa. These figures provide sufficient evidence to make HIV/AIDS both a regional and a national priority. Data from the DOH's Annual National HIV Seroprevalence Surveys of women attending Antenatal Clinics (ANC) for the past 9 years provides a good estimate of HIV prevalence and trends over time in South Africa (See figure 1).

Figure 1: The National HIV survey of women attending antenatal clinics of the public health services in South Africa, 1990 - 1999

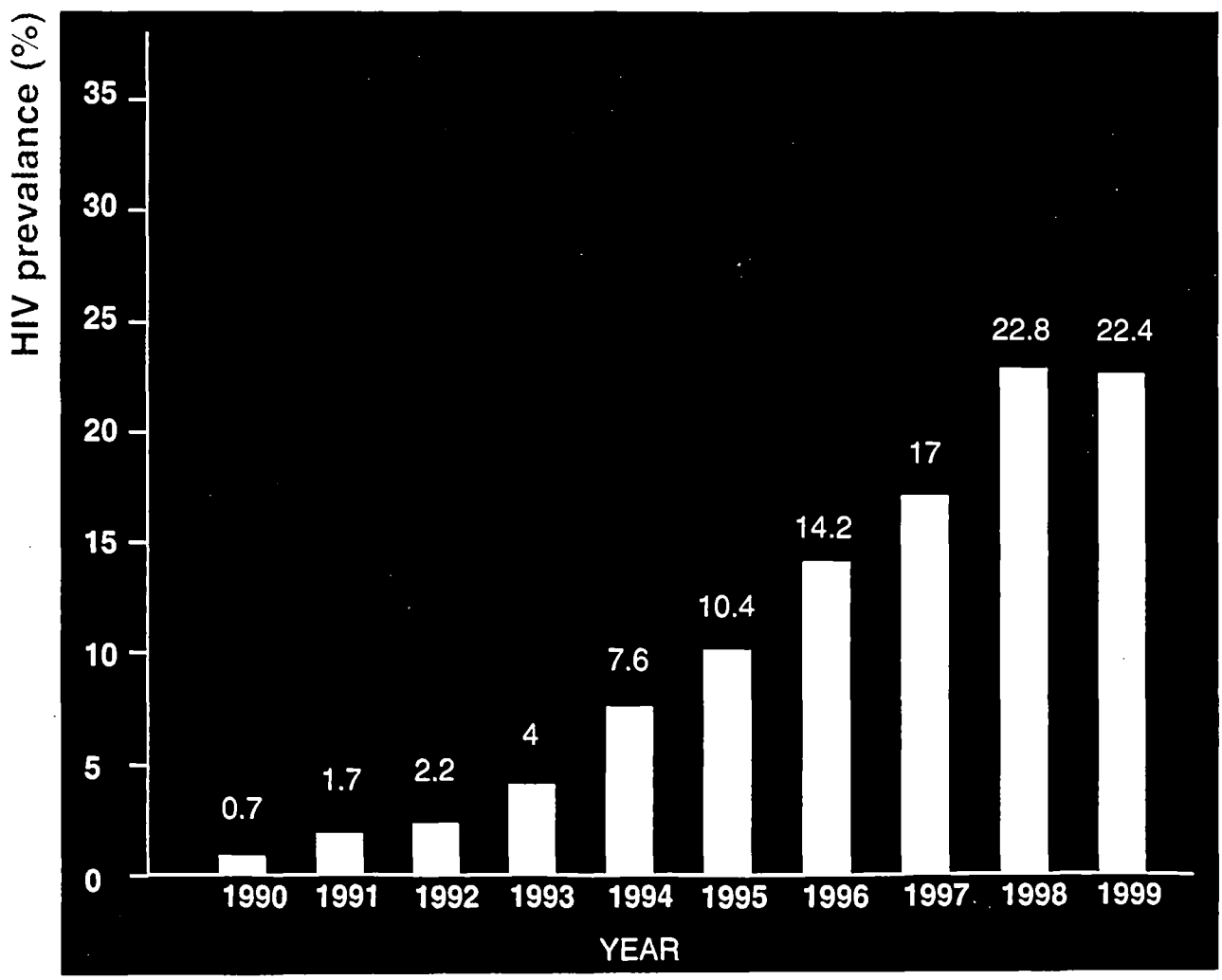
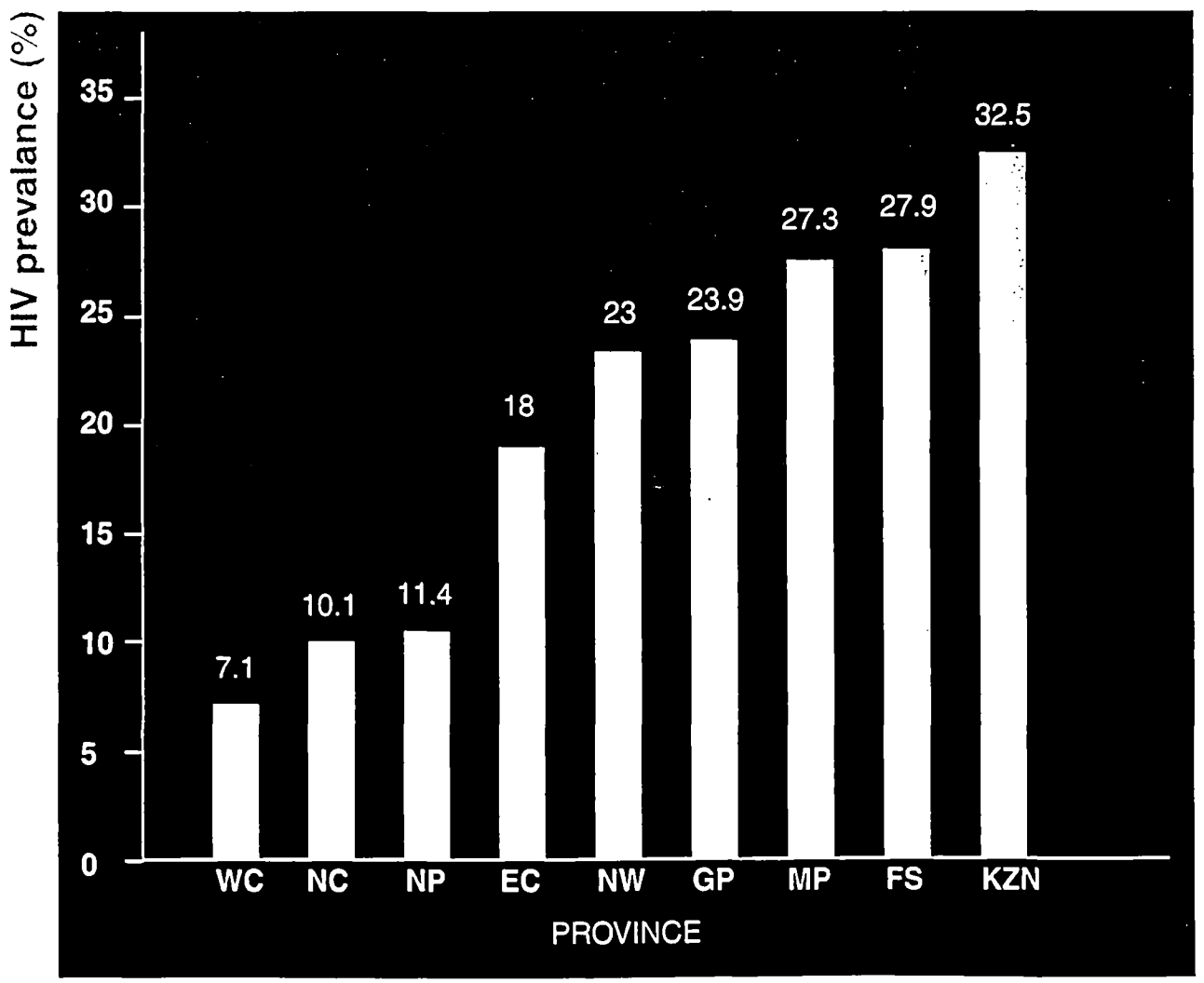


Figure 2 presents HIV prevalence in women attending antenatal clinics by province in 1998. This data reveals geographic disparities in the distribution of the HIV/AIDS epidemic in South Africa.

Figure 2: HIV prevalence in pregnant women attending public antenatal clinics by Province, South Africa, 1999



*Key: KZN = KwaZulu-Natal Province; MP = Mpumalanga Province; FS = Free State Province; GP = Gauteng Province; NW = North West Province; NP = Northern Province; EC = Eastern Cape Province; NC = Northern Cape Province; WC = Western Cape Province

*See Annexure A for map

Additional information from the survey reveal that:

- The HIV epidemic in South Africa is one of the fastest growing epidemics in the world
- Young women aged 20-30 have the highest prevalence rates
- Young women under age 20 had the highest percentage increase compared to other age groups in 1998 compared to 1997.

This and other data clearly indicate that the HIV epidemic is severely affecting the young, black, and economically poor populations of South Africa.

Currently there are approximately 4.2 million South Africans living with HIV. It is estimated that in 1998 over 1,600 people were infected with HIV each day – this translates to more than 550,000 people infected each year. It is estimated that by the year 2005, there will be 6 million South Africans infected with HIV and almost 1 million orphans under the age of 15 whose mothers will have died of AIDS.

AIDS is currently not a notifiable disease in South Africa and voluntary reporting seriously underestimates the number of people with AIDS. It is estimated that there were approximately 165,000 people living with AIDS and 120,000 AIDS deaths in 1998. Projections indicate that by 2002 a quarter of a million South Africans will die of AIDS, and that this figure will rise to more than a million by 2008. Average life expectancy is expected to fall from approximately 60 years to 40 years between 1998 and 2008.

Major causes and determinants of the epidemic in South Africa

The immediate determinants of the epidemic include behavioural factors such as unprotected sexual intercourse, multiple sexual partners, and biological factors such as the high prevalence of sexually transmitted diseases.

The underlying causes include socio-economic factors such as poverty, migrant labour, commercial sex workers, the low status of women, illiteracy, the lack of formal education, stigma and discrimination. The national HIV/AIDS & STD Strategic Plan must address all these immediate determinants and underlying causes.

Tuberculosis and HIV/AIDS

Closely linked to the HIV/AIDS epidemic, is Tuberculosis (TB) which is fuelled by HIV infection. TB is also the most frequent cause of death in people living with HIV. In South Africa, approximately 40-50% of TB patients are infected with HIV. In some hospitals in South Africa, the HIV prevalence in TB patients has been recorded as over 70%.

Sexually Transmitted Diseases

There is compelling evidence of the importance of STDs as a major determinant of HIV transmission. There are approximately 11 million STD episodes treated annually in South Africa, with approximately 5 million of these managed by private general practitioners. Even without the HIV epidemic, STDs pose an important public health problem.

2.2 Response Analysis

A detailed description of the country's response to the HIV/AIDS epidemic is beyond the scope of this plan. However, a summary of the key responses and constraints include the following:

- In 1992 the National AIDS Co-ordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV/AIDS. Cabinet endorsed this strategy in 1994. The goals of this plan were to (a) prevent HIV transmission; (b) reduce the personal and social impact of HIV infection, and (c) mobilise and unify, provincial, international and local resources.
- South African National STD&HIV/AIDS Review was conducted in 1997 in line with the goals outlined in the NACOSA plan. This review indicated the following strengths in South Africa's response to the epidemic:

- There is a high level of commitment from the Health Ministry
- Collaboration initiated by the DOH at various levels to ensure an interdepartmental and inter-sectoral response
- NGOs and CBOs have been highly motivated and active *albeit* operating with limited resources
- Adequate drug supply and accessibility for STD management is good in most clinics
- Improvements in TB services.

The following constraints were noted:

- Major restructuring of national and provincial departments has delayed the appointments of personnel. Both human and financial resources at all levels were limited.
- District structures have not been established.
- Lack of structured referral systems and continuity of care, home based care, and terminal care facilities.
- Lack of integration of STD & HIV/AIDS and TB care.
- Lack of visible commitment outside the DOH to effective interdepartmental implementation of the programme.
- There is continued high levels of discrimination and human rights abuses of people affected by and infected with HIV/AIDS.
- Lack of provincial policies, guidelines or management protocols for comprehensive care and counselling.
- Health promotion materials are not always available in the vernacular and are not client sensitive or user friendly.

Following this review of both the strengths and weaknesses in addressing the HIV/AIDS epidemic, the following recommendations were made:

- Increase resources and build capacity at provincial and district levels to manage, organise, and implement the HIV/AIDS & STD Programme. Provincial authorities should designate co-ordinators responsible for STD & HIV/AIDS in every province and district
- Ensure secure political leadership from the Deputy President and to increase political commitment and public leadership
- Strengthen interdepartmental and intersectoral response to the epidemic
- A concerted effort by all stakeholders needs to be made to protect human rights, counter discrimination and reduce stigmatisation
- Support and strengthen People living with HIV infection or AIDS (PWA) initiatives and increase full involvement of PWAs in programme design, implementation, and evaluation
- Increase collaboration between the HIV/AIDS & STD and TB programmes.

Subsequent to the 1997 Review, some of the recommendations have been addressed by the following actions:

- Appointing HIV/AIDS Coordinators in each province and supporting regular training and meetings to facilitate programme implementation
- Establishing an Inter-Ministerial Committee on AIDS. This Committee consists of Ministers and Deputy Ministers and meets on a monthly basis to discuss HIV/AIDS and provide political direction and policy guidance to the HIV/AIDS & STD Directorate
- The launch of the Partnership against AIDS by the President in 1998 to broaden and formalise the participation by all sectors in response to the epidemic
- The development of an HIV/AIDS policy by the Department of Education (DOE) for learners and educators. This makes HIV/AIDS education a component in the curricula of all secondary schools
- The development of other national policies including, the Syndromic Management of STDs and post-exposure prophylaxis (PEP) following occupational exposure to HIV
- The establishment the South African AIDS Vaccine Initiative in 1998. This initiative seeks to develop an effective, affordable preventive vaccine for universal use in South Africa and SADC countries by 2005
- The establishment of the South African National AIDS Council (SANAC), a multi-sec-

toral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan. The SANAC facilitates collaboration between government and all other sectors
- The establishment of a national interdepartmental HIV/AIDS committee that developed HIV/AIDS workplace policies and minimum HIV/AIDS programmes for all government departments
- The development of a Strategic Framework for a South African AIDS Youth Programme
- Improved collaboration between HIV/AIDS & STD and TB programmes in the area of policy formulation and advocacy.

This Strategic Plan aims to address the recommendations that have not been adequately addressed since 1997, and provides a strategic framework for the country's response to the HIV/AIDS & STD epidemic.

Initiatives in the Southern African Development Community (SADC) Countries

South Africa is the current chair and host of the Health Desk of SADC, which currently has 14 member states: Angola, Botswana, the Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, the Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

A regional response to HIV/AIDS & STDs is essential in curbing the spread, and to this end a SADC HIV/AIDS & STD task force has been formed and has prepared an HIV/AIDS & STD plan for 1999 - 2003. The three broad goals of the programme are to achieve:
- A better co-ordinated and harmonised response to HIV/AIDS & STD among Member States
- A multi-sectoral response to HIV/AIDS & STD
- Improved quality and coverage of the response to HIV/AIDS & STD both at national and regional level.

These initiatives will be important in ensuring that South Africa and its regional partners have a more co-ordinated response to the HIV/AIDS epidemic. SADC thus forms an important link in the mechanisms and structures available to the country.

structures in south africa to address HIV/AIDS

The expanded national response will be managed by different structures at various levels. It is envisaged that each government ministry will have a focal person and team with a responsibility will be to plan, budget, implement and monitor HIV/AIDS interventions. It is also recommended that all other sectors including parastatals, NGOs, the private sector, faith-based organisations, youth, and women will also have dedicated HIV/AIDS focal persons. (See diagram 1 on page 9).

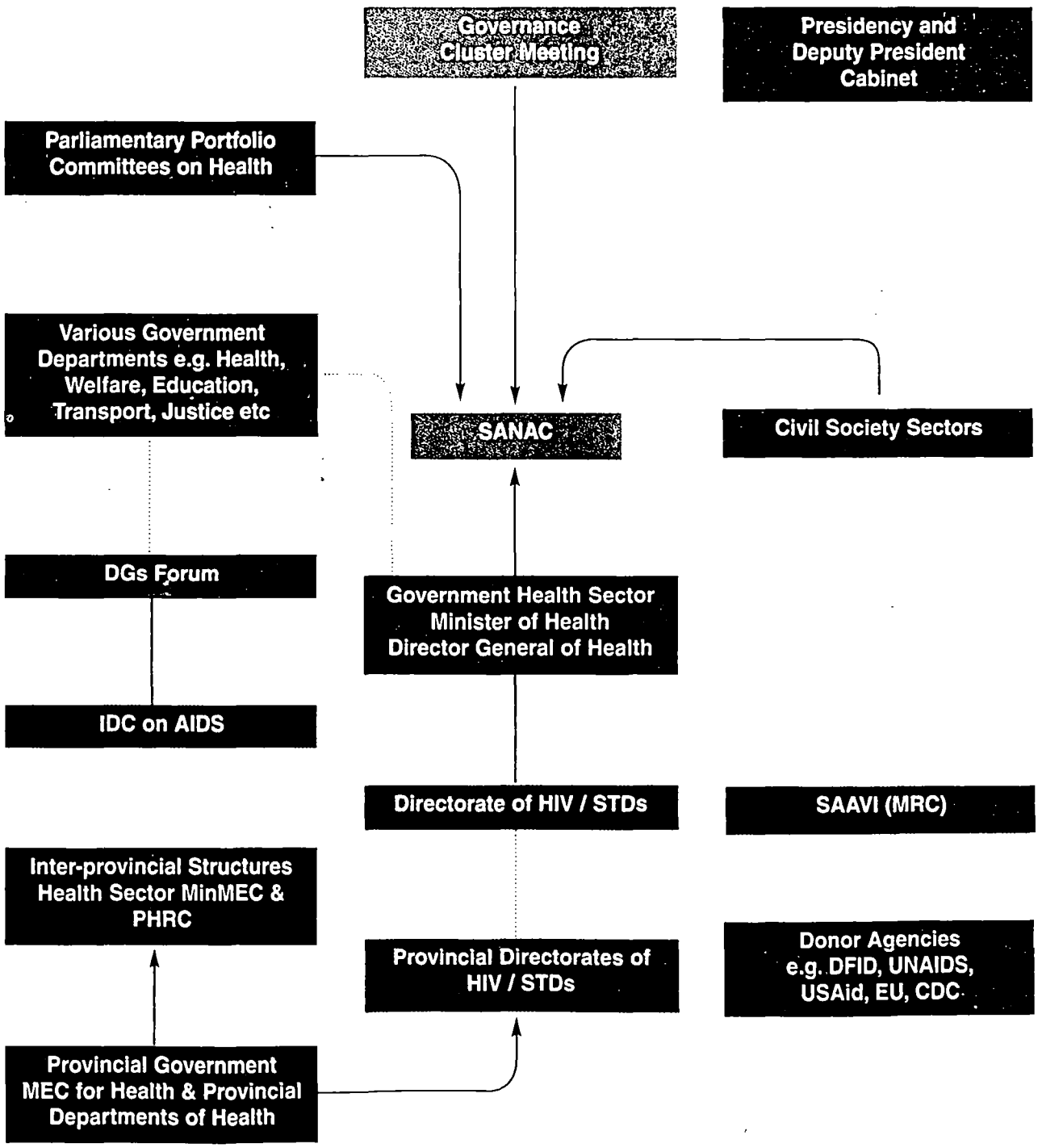
The following presents a brief overview of important structures at national and provincial levels and their specific role and functions relating to HIV/AIDS.

- **Cabinet**
  The Cabinet is the highest political authority in the country. The Cabinet meets weekly, but HIV/AIDS issues are not regularly discussed at this level, as all Cabinet members plus all Deputy Ministers and members of the Department of Health meet monthly in the Inter-Ministerial Committee on AIDS (see page 10).

- **South African National AIDS Council (SANAC)**
  SANAC is the highest body that advises government on all matters relating to HIV/AIDS. Its major functions are to: (a) advise government on HIV/AIDS & STD policy, (b) advocate for the effective involvement of sectors and organisations in implementing programmes and strategies, (c) monitor the implementation of the Strategic Plan in all sectors of society, (d) create and strengthen partnerships for an expanded national response among all sectors, (e) mobilise resources for the implementation of the AIDS programmes, and (f) recommend appropriate research.

This body is chaired by the Deputy President, and consists of 15 government representatives and 16 civil society representatives (see list on page 10).

Diagram 1: Relevant National and Provincial Structures



- **Government**
  Ministers of Health; Education; Welfare and Population Development; Agriculture; Arts, Culture, Science and Technology; Transport; Labour; Finance; Provincial and Local Government; Defence; Minerals and Energy; Correctional Services; the Deputy CEO of the Government Communication and Information Systems; the Chairperson of the Portfolio Committee on Health; and the Chairperson of the Select Committee on Social Services.

- **Sectors to be represented**
  One representative from each of the following sectors: Business; People living with HIV/AIDS; Non-government organisations; Faith-based organisations; Trade Unions; Women; Youth; Traditional healers; Traditional leaders; Legal and Human Rights; Disabled People; Celebrities; Sport; Media; Hospitality Industry; and Local Government.

- **Technical Task Teams**
  The Technical Task Teams, established by the Ministry of Health, will assist SANAC in its deliberations and decisions. These teams comprise experts in the following five areas: a) Prevention; b) Care and Support, c) Information Education and Communications (IEC) and Social Mobilisation, d) Research, Monitoring, Surveillance and Evaluation; and e) Legal issues and Human Rights.

- **Inter-Ministerial Committee on AIDS (IMC)**
  In 1997, the South African Cabinet formed the IMC. The IMC consists of all Ministers and Deputy Ministers and is chaired by the Deputy President. This committee meets on a monthly basis to review the country's response to the HIV/AIDS epidemic. Issues of strategic importance are discussed and political guidance is given to the HIV/AIDS and STD Directorate and the IDC.

- **Interdepartmental Committee on AIDS (IDC)**
  This committee consists of representatives from all government departments who co-ordinate HIV/AIDS activities. The IDC meets monthly to review government programmess and to fulfil requests from the IMC. Goals of the IDC include facilitating the development of HIV/AIDS workplace policies in all government departments, ensuring that all departments allocate financial resources to HIV/AIDS; and developing minimum HIV/AIDS programmess for all the departments.

- **MinMEC**
  The MinMEC consists of all Provincial Health MECs and the national Minister of Health. The MinMEC meets every six weeks, and is the body that approves national policies and guidelines. HIV/AIDS is a standing item where reports on national and provincial programmes are discussed.

- **Provincial Health Restructuring Committee (PHRC)**
  This committee consists of all Provincial Heads of Health and meets on a monthly basis to discuss the strategic issues of national and provincial importance. HIV/AIDS is a standing agenda item where reports from the IMC, National HIV/AIDS & STD Directorate and Provincial HIV/AIDS Co-ordinators are discussed. Once the PHRC has discussed and approved documentation, it is referred to the MinMEC for political approval.

- **Directors-General Forum**
  This forum consists of Directors General from all the National Government Departments and meets regularly. HIV/AIDS is a standing agenda item where reports from the IMC are discussed.

- **HIV/AIDS and STD Directorate, Department of Health**
  HIV/AIDS issues are brought to the attention of the above national bodies by the Department of Health's Directorate of HIV/AIDS & STDs. This Directorate prepares briefing documents for these national forums, and attends meetings to provide further information to assist decision-making in these national committees and bodies.

guiding principles

The following principles for HIV/AIDS and STD prevention, treatment and care efforts for South Africa were previously adopted in the National AIDS Plan for South Africa, 1994 - 1995, and the Department of Health's White Paper for the Transformation of the Health System in South Africa, 1997. They are reaffirmed.

- People with HIV and AIDS shall be involved in all prevention, intervention and care strategies
- People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination
- The vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection
- Confidentiality and informed consent with regard to HIV testing and test results shall be protected
- Education, counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times
- The Government has a crucial responsibility with regard to the provision of education, care and welfare of all people of South Africa
- Full community participation in prevention and care shall be developed and fostered
- All intervention and care strategies shall be subject to critical evaluation and assessment
- Both government and civil society shall be involved in the fight against HIV/AIDS
- A holistic approach to education and care shall be developed and sustained
- Capacity building will be emphasised to accelerate HIV/AIDS prevention and control measures
- STDs prevention and control are central elements in the response to HIV/AIDS.

The primary goals are to:
- Reduce the number of new HIV infections (especially among youth)
- Reduce the impact of HIV/AIDS on individuals, families and communities.

The following general strategies will be stressed:
- An effective and culturally appropriate information, education and communications (IEC) strategy
- Increase access and acceptability to voluntary HIV testing and counselling
- Improve STDs management and promote increased condom use to reduce STD and HIV transmission
- Improve the care and treatment of HIV positive persons and persons living with AIDS to promote a better quality of life and limit the need for hospital care.

The Strategic Plan is structured according to the following four areas:
- Prevention
- Treatment, care and support
- Human and legal rights
- Monitoring, research and surveillance.

In addition, the youth will be broadly targeted as a priority population group, especially for prevention efforts.

A national set of primary indicators and surveillance data for the country

South Africa needs a set of key indicators that can be used to track the overall response of the country to the epidemic. This means not only tracking the course of the epidemic over the next five years, but also tracking changes in attitudes, social values, health care practices, socio-economic conditions and behaviours that act as predisposing factors of the epidemic.

The following list of indicators is proposed as a combination of various indicators, that collectively can be used to judge how well the country is doing in terms of tackling the HIV epidemic.

Where necessary, mechanisms to collect the required data will be developed.

General trends of the epidemic
- Prevalence of HIV amongst antenatal clinic attendees (using national sentinel surveillance procedure)

Youth
- Prevalence of HIV amongst antenatal clinic attendees below the age of 18 years (using national sentinel surveillance procedure)
- Teenage pregnancy incidence and rate

Prevention
- Proportion of STD cases effectively managed using syndromic treatment in a) the public sector; b) the private sector
- Percentage of sexually active women using condoms
- Proportion of children leaving primary school who are fully informed of the causes and methods of transmission of HIV

Socio-economic indicators predisposing to HIV transmission
- Proportion of household living below the minimum poverty line
- Unemployment rate

Abuse of women
- The number of reported rape cases
- The number of cases of workplace legislation abuse related to employees contracting HIV

Social values, human rights and acceptance in the community
- The number of VTC clients
- The number of homeless children, as a proxy indicator of the capacity of society to care for
- AIDS orphans
- The number of people "coming out" as people living with AIDS

Goals, objectives, strategies and lead agencies

PRIORITY AREA 1: Prevention

- Goal 1: Promote safe and healthy sexual behaviour
- Goal 2: Improve the management and control of STDs
- Goal 3: Reduce mother-to-child transmission (MTCT)
- Goal 4: Address issues relating to blood transfusion and HIV
- Goal 5: Provide appropriate post-exposure services
- Goal 6: Improve access to Voluntary HIV Testing and Counselling (VTC)

PRIORITY AREA 2: Treatment, care and support

- Goal 7: Provide treatment, care and support services in health-care facilities
- Goal 8: and Provide adequate treatment, care support services in communities
- Goal 9: Develop and expand the provision of care to children and orphans

PRIORITY AREA 3: Research, monitoring and evaluation

- Goal 10: Ensure AIDS vaccine development
- Goal 11: Investigate treatment and care options
- Goal 12: Conduct policy research
- Goal 13: Conduct regular surveillance

PRIORITY AREA 4: Human and legal rights

- Goal 14: Create a supportive and caring social environment
- Goal 14: Develop an appropriate legal and policy environment

5.1 PRIORITY AREA 1: Prevention

GOAL 1:PROMOTE SAFE AND HEALTHY SEXUAL BEHAVIOUR

Objective	Selected Strategies	Lead Agencies
Promote improved health seeking behaviour and adoption of safe sex practices	a) Produce and disseminate IEC material and messages to different stakeholders b) Implement life skills education in all primary and secondary schools c) Increase the number of trade unions who have implemented HIV/AIDS & STD policies and programmes d) Facilitate and support the trucking industry's AIDS High Transmission project	DOE, DOH, NGOs, Trade Unions, DOL, DOH Youth Sector
Broaden responsibility for the prevention of HIV to all sectors of government and civil society	a) Develop sector-specific policies and plans for the prevention of HIV/AIDS & STDs, focussing specially on the following sectors: the Government sector: Health; Education; Welfare; Local Government; Transport; Justice; Police; Correctional Services; Home Affairs; Civil society sectors: Traditional leaders; Youth; Faith-Based Organisations; Business; Entertainment and Media.	DOH, NAC, All Sectors
Implement HIV/AIDS prevention for migrants	a) Develop an health programme with an HIV focus as part of the Maputo corridor project b) Facilitate cross-border interventions c) Work in partnership with other SADC countries	DOH, SADC, UNAIDS
Develop and implement counselling and care programmes for all national government departments	a) Create public awareness of HIV/AIDS & STDs in all government departments b) Identify, train, and support peer educators c) Distribute condoms in all government department buildings	DOH and other government departments
Improve access to and use of male and female condoms, especially amongst 15-25 year olds	a) Expand condom distribution through non-traditional outlets b) Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels) c) Increase acceptance, positive attitudes and perceptions, efficacy and use of condoms as a form of contraception among the youth	DOH, All Sectors

GOAL 2:IMPROVE THE MANAGEMENT AND CONTROL OF STDS

Objective	Basic Strategies	Lead Agencies
Ensure effective Syndromic Management (SM) of STDs in the private sector	a) Investigate the dispensing of licences to nurses for STD treatment b) Monitor and regulate the quality of care in the private sector c) Training on SM within the private sector d) Review Medical Schemes regulations to ensure minimum reimbursement for treatment of STDs	DOH, SAMA, Board for Health-care Funders, Health Professions Council of SA
Ensure effective Syndromic Management (SM) of STDs in the public sector	a) Training in syndromic management under-graduate / basic curricula of all nurses, doctors and pharmacists b) Regular in-service training of HCWs	DOH, SANC, Nurse training institutions, Medical Schools
Collaborate with traditional healers to improve health seeking behaviour for STD treatment	a) Develop, print and distribute training manuals in various languages b) Conduct capacity building workshops with THs c) Sensitise the health sector regarding traditional medicine d) Consider referral systems between traditional and Western medicine	DOH, Traditional Healer Organisations; CONTRALESA
Increase access to youth friendly reproductive health services - including STD management, VTC and rapid HIV testing facilities (special focus on youth, women, and migrant workers)	a) Make clinics and HCWs "youth friendly" b) Make schools places where youth can access friendly and supportive counselling services	DOH, DOE, Youth Sector

GOAL 3:REDUCE MOTHER-TO-CHILD HIV TRANSMISSION (MTCT)

Objective	Selected Strategies	Lead Agencies
Improve access to HIV testing and counselling in ANC clinics	a) Develop counselling guidelines b) Train counsellors	DOH, Women's Sector, NGOs
Improve family planning services to known HIV positive women	a) Train reproductive health providers on HIV/AIDS counselling b) Improve access to comprehensive reproductive health services for HIV positive women	DOH, Women's Sector, NGOs, NPPHCN
Implement clinical guide-lines to reduce the trans-mission of HIV during childbirth and labour	a) Train all relevant midwives and medical practitioners	DOH, Nursing Training Institutions, Medical Schools

GOAL 4:ADDRESS ISSUES RELATING TO BLOOD TRANSFUSION AND HIV

Objective	Selected Strategies	Lead Agencies
Maintain a safe blood transfusion service	a) Monitor implementation of current guidelines on blood transfusion b) Develop national guidelines on HIV and blood transfusion c) Improve the recruitment of low-risk blood donors	DOH, SA Blood Transfusion Service

GOAL 5:PROVIDE APPROPRIATE POST-EXPOSURE SERVICES

Objective	Selected Strategies	Lead Agencies
Provide services for needlestick injuries and occupational exposure	a) Ensure appropriate policies for needlestick exposure in the private sector b) Ensure the supply of anti-retroviral drugs to treat occupational exposure in public health facilities c) Reduce exposure to occupational exposure through the appropriate disposal of medical waste	DOH, DOL
Investigate options to reduce HIV/STD transmission and pregnancies resulting from sexual assault	a) Review research on use of Anti-Retroviral Therapy (ART) to prevent HIV transmission following sexual assault b) Assess services for women and men following sexual assault	DOH, Research Institutions

GOAL 6:IMPROVE ACCESS TO VOLUNTARY TESTING AND COUNSELLING

Objective	Selected Strategies	Lead Agencies
Increase the number of voluntary HIV testing and counselling sites	a) Introduce counselling service in all new testing sites b) Expand use of rapid testing methods Increase the proportion of workplaces that have on-site counselling and testing services	DOH
Increase the number of persons seeking VTC	a) Promote access to VTC services, especially for the youth	DOH, All Sector

5.2 PRIORITY AREA 2: Treatment, care and support

GOAL 7:PROVIDE TREATMENT, CARE AND SUPPORT SERVICES IN HEALTH FACILITIES

Objective	Selected Strategies	Lead Agencies
Improve treatment, care and support for people living with and affected by HIV/AIDS	a) Develop guidelines for the treatment and care of HIV/AIDS patients in health-care facilities and the community b) Ensure uninterrupted supply of appropriate drugs for the treatment of opportunistic infections and other related conditions c) Build capacity of health professionals to provide comprehensive HIV/AIDS, STD & TB treatment, care and support d) Establish strong links between health facilities and community-based support programmes e) Improve prevention and treatment of TB and other opportunistic infections	DOH, Training Institutions, PWAs
Establish poverty alleviation projects to address the root causes of HIV/AIDS, STDs and TB	a) Incorporate HIV/AIDS, STDs and TB as indicators of poverty b) Involve relevant government departments and the private sector in poverty alleviation projects	Agricultural sector, Government departments, NGOs, Business
Ensure appropriate practices in the private sector and medical insurance industry for the care and treatment of HIV positive clients	a) Review international and regional practices relating to HIV and medical insurance b) Lobby the medical schemes industry to review benefits and coverage for HIV positive clients c) Standardise a minimum package of treatment and care for people living with HIV/AIDS in the public and private sector	DOH, BHF

GOAL 8:PROVIDE ADEQUATE TREATMENT, CARE AND SUPPORT SERVICES IN COMMUNITIES

Objective	Selected Strategies	Lead Agencies
Develop and implement models of community/ home-based care in all provinces	a) Develop appropriate home-based care implementation guidelines b) Promote the establishment of intersectoral task teams at community level to develop community/home-based care c) Reduce stigma of HIV/AIDS in communities and develop IEC materials targeted at communities	DOH, DOW, NGOs
Increase acceptability to community/home-based care	a) Use media for more exposure to the issues of home-based care in communities	DOH, DOW, NGOs, Media, all

GOAL 9:DEVELOP AND EXPAND THE PROVISION OF CARE TO CHILDREN AND ORPHANS

Objective	Selected Strategies	Lead Agencies
Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS	a) Promote advocacy of all relevant issues that affect children b) Mobilise financial and material resources for orphans and child-headed households c) Investigate the legal protection of child-headed households d) Provide social welfare, legal and human rights support to protect educational and constitutional rights	DOH, DOW, DOJ, NGOs, Business
Implement measures to facilitate adoption of AIDS orphans	a) Investigate the use of welfare benefits to assist children and families living with HIV/AIDS b) Subsidise adoption of AIDS orphans	DOW, DOE

5.3 PRIORITY AREA 3: Research, monotoring and surveillance

GOAL 10:ENSURE AIDS VACCINE DEVELOPMENT

Objective	Selected Strategies	Lead Agencies
Support efforts to develop a Clade C HIV vaccine	b) Conduct biological and behavioural research to support the development of an AIDS vaccine b) Support the South African AIDS Vaccine Initiative c) Develop South African ethical guidelines for vaccine research	DOH, MRC, Research Institutions

GOAL 11:INVESTIGATE TREATMENT AND CARE OPTIONS

Objective	Selected Strategies	Lead Agencies
Review and revise policy on anti-retroviral use for reducing mother-to-child HIV transmission	a) Review, monitor and evaluate current research on the use of anti-retroviral therapy to reduce mother to child HIV transmission b) Identify and implement additional areas of research c) Review and update national policies to reduce MTCT	DOH, Academic Institutions, Research Institutions, Women's Sector
Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis	a) Review international research b) Facilitate local research	MRC, DOH, Research Institutions
Conduct research on the effectiveness of traditional medicines	a) Conduct clinical trials b) Review international research c) Collaborate with traditional healers	Traditional Healers, MRC, DOH

GOAL 12:CONDUCT POLICY RESEARCH

Objective	Selected Strategies	Lead Agencies
Conduct HIV/AIDS studies in selected departments and provinces	a) Commission research	DOH, DOF, government departments
Conduct research to determine HIV incidence	a) Conduct HIV incidence surveys in narrow age groups to approximate incidence	MRC, DOH

GOAL 13:CONDUCT REGULAR SURVEILLANCE

Objective	Selected Strategies	Lead Agencies
Develop mechanisms for long and short-term training to improve the capacities of provincial and district staff to conduct HIV/AIDS&STD related operations research and surveillance.	a) Training for provincial and district staff on research and surveillance in collaboration with research and training institutions	DOH, Academic Institutions
Conduct national surveillance on HIV and STD risk behaviours, especially among youth	a) Conduct behavioural sentinel surveys, with a focus on youth b) Conduct routine STD surveillance c) Conduct surveillance of AIDS morbidity and mortality d) Conduct national HIV infections surveillance in selected populations and groups, including STD and TB clients, hospitalised patients, men, and youth	DOH, HSRC, GCIS, MRC, Youth Sector

5.4 PRIORITY AREA 4: Human and legal rights

GOAL 14:CREATE AN APPROPRIATE SOCIAL ENVIRONMENT

Objective	Selected Strategies	Lead Agencies
Develop a National Inter-Sectoral Campaign on Openness and Acceptance of People Living with HIV/AIDS	a) Promote open discussion of sexual practices in various sectors of society b) Promote VTC c) Target awareness regarding rights and responsibilities of people living with HIV/AIDS in 4 key areas: employment rights, education, health care and social service rights	SANAC, Government Departments, NGOs, all Sectors, SABC
Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS by 2005	a) Review existing legislation and ensure the protection of rights of people living with HIV/AIDS b) Develop policy on the management of mentally challenged HIV positive persons c) Review and enact new Children's Law to take into account the needs of children infected and affected by HIV/AIDS	DOJ, DOH, SALC
Monitor human rights abuses and develop enforcement mechanisms for redress	a) Statutory commissions (HRC and CGE) to set up a discrimination database to collect information on the nature and extent of discrimination against people affected by HIV/AIDS b) Improve access to justice for people infected / affected by HIV/AIDS	DOJ, HRC, CGE

GOAL 15:DEVELOP AN APPROPRIATE LEGAL AND POLICY ENVIRONMENT

Objective	Selected Strategies	Lead Agencies
Develop policy and legislation relating to HIV/AIDS and employment	a) Finalise the code of Good Practice on HIV/AIDS in the Workplace, and accompanying regulations, to enforce workplace HIV/AIDS policies b) Support the development of workplace HIV/AIDS policies	DOL, DOH
Develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault	a) Develop criminal law mechanisms which protect the rights of victims of sexual violence b) Investigate the provision of Post-exposure prophylaxis PEP to the victims of sexual violence c) Investigate decriminalising commercial sex work	DOJ, DOH, SALC

youth as a target group

As indicated earlier in this document, youth is a specific focus area in the fight against HIV/AIDS as people between the ages of 14 -35 are the most vulnerable to HIV infection. In addition, the youth are an important target group to protect against future HIV infection as they represent both the present and future economic power-house of the country.

In this section the strategies that relate to youth will be replicated to emphasise the need for all sectors of society to focus a significant amount of their resources and energies on this age group.

Objective: Promote improved health seeking behaviour and adoption of safe sex practices

- Produce and disseminate IEC material and messages to different stakeholders
- Implement life skills education in all primary and secondary schools

Objective: Broaden responsibility for the prevention of HIV to all sectors of government and civil society

- Develop sector-specific policies and plans for the prevention of HIV/AIDS & STDs, focussing specially on the following sectors: ... youth, women and children.

Objective: Improve access to and use of male and female condoms, especially amongst 15 - 25 year olds

- Expand condom distribution through non-traditional outlets
- Improve access to condoms in high transmission areas (e.g. truck stops, borders, mines and brothels)
- Increase acceptance, positive attitudes and perceptions, efficacy and use of condoms as a form of contraception among the youth

Objective: Increase access to youth friendly reproductive health services - including STD management, VTC and rapid HIV testing facilities

- Make clinics and HCWs "youth friendly"
- Make schools places where youth can access friendly and supportive counselling services

Objective: Increase the number of persons seeking voluntary HIV testing and counselling services

- Promote access to VTC services, especially for the youth

Objective: Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS

- Promote advocacy of all relevant issues that affect children
- Mobilise financial and material resources for orphans and child-headed households
- Investigate the legal protection of child-headed households
- Provide social welfare, legal and human rights support to protect educational and constitutional rights

Objective: Implement measures to facilitate adoption of AIDS orphans

- Investigate the use of welfare benefits to assist children and families living with HIV/AIDS
- Subsidise adoption of AIDS orphans

Objective: Conduct a national surveillance on HIV and STD risk behaviours, especially among youth

- Conduct behavioural sentinel surveys, with a focus on youth
- Conduct national HIV infections surveillance in selected populations and groups, including youth

way forward

Implementing the HIV/AIDS & STD Strategic Plan is essential to ensure the achievement of the national goals. Broad principles for implementation include appropriate activities and practices and cost effective for South Africa. Activities should be based on known evidence based practices.

Key critical areas for effective delivery include:

A. Authority and political will at all levels

B. Structures:
- Delivery and implementation
- Co-ordination

C.Resources:
- Financial Resources
- Human Resources
- Technical Resources

D.Capacity:
- HIV AIDS & STD understanding
- Management
- Monitoring and evaluation

E.Communication:
- National = Provincial & Provincial = National
- Provincial = Provincial
- Provincial = District = Community
- Government = Civil society

7.1 Effective implementation of the HIV/AIDS & STD Strategic Plan

To achieve this, the following issues will be addressed:

- **Approval of the HIV/AIDS & STD Strategic Plan by national bodies such as the Inter-Ministerial Committee on AIDS (IMC), SANAC and National HIV/AIDS & STDs Directorate, followed by provincial and local structures**
  The HIV/AIDS & STD Strategic Plan should be used in developing national, provincial and district operational plans. Yearly operational plans have to be based on realistic objectives. These should be developed taking into consideration existing financial and human resources, the capacity thereof, the process of recruitment as well as the political commitment in each of the provinces. The setting of national goals will allow for inter-provincial comparisons and ensure a measure of unity regardless of the relative autonomy of the

provinces. The provinces should then take these national goals and objectives and present them to key role players within each province to ensure that all buy into what would be a Provincial Strategic AIDS Plan.

- **Improve structures for delivery**
  This involves reviewing and developing where necessary structures at all levels, from national to community. The concept of appropriate national structures such as the IMC, IDC and NAC should be considered for duplication within provinces, keeping in mind the importance of delivery within communities.

The most important structures to create to guide the implementation of the Strategic Plan are:

- SANAC, with duplicate bodies in each province
- Interdepartmental Committees on HIV/AIDS in every province. One of the functions of the Interdepartmental Committees within provinces would be to define each government department's unique and generic responsibility within the HIV/AIDS & STD Strategic Plan.

Equally important is the establishment of appropriate structures at district level to ensure the implementation of the HIV/AIDS & STD Strategic Plan. It is thus recommended that District HIV/AIDS Committees be established. The district structures should include community-based committees that represent major role-players within the relevant community in the field of HIV/AIDS.

These committees should include local government to ensure the integration of HIV/AIDS & STDs and TB issues and development plans. It is vital that this include non-health issues as part of HIV/AIDS & STD planning, such as transport and poverty alleviation.

- **Establish acceptable standards for provinces with respect to resources**
  Financial Resources
  It is important to ensure that adequate funding is available at national and provincial levels within the healthcare environment to ensure delivery. One method is to establish an agreed resource standard for all provinces to directly place financial resources into HIV/AIDS. This is currently (in 1999/2000 prices) set as R10 per person per year or a total of R400 million per year for the whole country.

  Related activities include:
  - Audit financial resources for HIV/AIDS activities within Provinces over the preceding three years
  - Compare resources between provinces on a per capita and per HIV infected population
  - Agree on standards or conditions by national bodies such as MinMEC, PHRC for allocating dedicated HIV/AIDS funding from national bodies
  - Cost the HIV/AIDS & STD Strategic Plan and Programmes
  - Agree on the continued funding by the national DoH of activities and products - such as condoms - that have a major cross provincial impact.

  Funds for HIV/AIDS should be devolved to provinces from the national government only on condition that certain standards are met. These include the:
  - Presence of an Interdepartmental Committee on HIV/AIDS
  - Commitment to "ringfence" funds for direct HIV/AIDS activities within provinces
  - Commitment to distribute funds according to the HIV/AIDS & STD Strategic Plan
  - Commitment to spend over 80% of the funds in one financial year
  - Commitment to roll funds over into the new financial year without risk of penalty
  - Commitment to prioritise the process of HIV/AIDS spending within the provinces
  - Commitment to ongoing national and provincial communication
  - Regular review of the implementation of HIV/AIDS Plans

- Establishment of realistic goals and objectives that can be implemented within provinces and districts

- **Human Resources**
  It is vital for the success of the Strategic Plan that adequate human resources are available to ensure delivery. The constraint on action is arguably capacity rather than funding. The current ratio suggested is one dedicated employee per 100,000 population. To evaluate the availability of human resources, it will be necessary to audit the existing human resources at national, provincial, regional and district levels. This audit should assist in establishing standards of personnel at district, regional and provincial levels of management.

- **Regularly review the implementation of the Strategic Plan**
  The HIV/AIDS Strategic Plan must be reviewed every 12 months at national and provincial levels, with quarterly reports to be submitted to provincial and national structures.

  The National DOH has overall responsibility for the implementation of the Strategic Plan within the provincial structures. Specific measurable targets and indicators will be developed for each objective and reported in annual operational plans. The Strategic Plan will be monitored by these objectives and supplemented with additional monitoring including national, provincial and local behavioural surveys. These surveys will measure changes in HIV related risk behaviours including condom use, delay of sexual initiation among youth, HIV incidence, and the number of sexual partners.

  Establish a mechanism of constant and consistent reporting by provinces to national structures and vice versa. Information from the regular review should be used to serve as a communication tool between provinces of successes, as well as to other stakeholders to provide guidelines on activities to be involved in.

7.2 The Role of Sectors

The HIV/AIDS & STD Strategic Plan provides a broad framework for government, NGOs, business, labour, women and all sectors of society. Each sector should develop more specific plans based on their role, activities and their specific strengths. Sectors are encouraged to establish technical AIDS committees. These committees will advocate, manage and co-ordinate, the implementation of HIV/AIDS activities within that sector.

The sectoral AIDS committees will also be responsible for liaison with other sectors and the Directorate: HIV/AIDS & STDs. The recommended role of the sectors will be as follows:

- Identify determinants of the spread of HIV/AIDS & STDs specific to the sector
- Identify strengths and weaknesses with respect to HIV/AIDS & STDs
- Identify obstacles to the response within the sector
- Integrate HIV/AIDS & STD's activities in their yearly plans
- Formulate specific HIV/AIDS sectoral plans and budget for their implementation
- Mobilise resources for interventions
  Document best practice within the sectors and share information
- Prepare and submit quarterly reports to SANAC

All Ministries, including the MOH, will submit quarterly reports to SANAC on their HIV/AIDS activities.

7.3 Monitoring and Evaluation

The effective implementation of the activities outlined in the Strategic Plan will largely depend on the availability of human, financial and institutional resources. The sustainability of the response will depend on an efficient monitoring process in the areas of policy development, institutional strengthening and service delivery.

Monitoring will ensure that activities are being implemented according to the plan and that each implementing agency and all partners contribute to the accomplishment of policy aims. This activity should be seen as mutually beneficial for the implementing agencies to assess their performance and seek corrective measures, and for government to formulate appropriate policy.

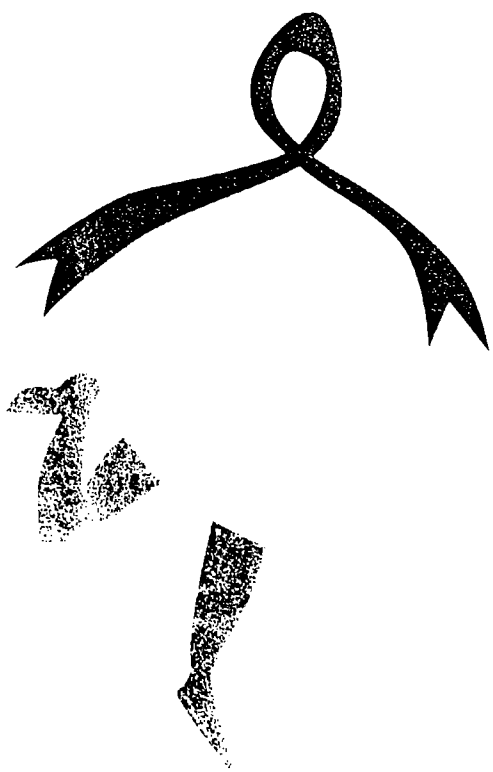
Effective monitoring and evaluation tools will be developed and customised for each intervention. These tools will identify strengths and weaknesses in the response programmes and activities, and areas that need the redirection of resources. The cost effectiveness of selected interventions will be determined through special operational research.

7.4 Concluding Remarks

The HIV/AIDS & STD Strategic Plan is a living document and will be subjected to regular critical review. This will be undertaken at the national, provincial and district levels with input from all stakeholders. A mid-term review will be conducted and the Strategic Plan modified in accordance with the findings.

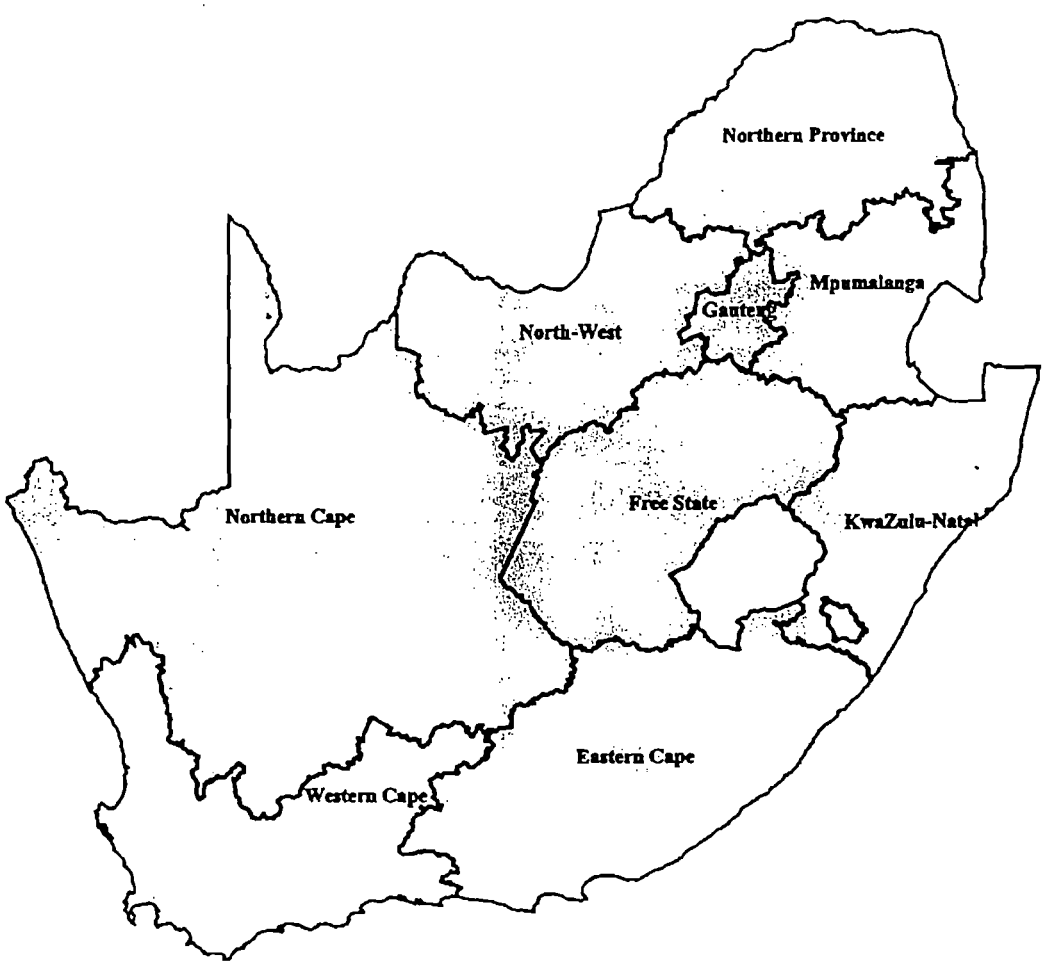
Acknowledgements

The development of this "HIV/AIDS & STD Strategic Plan for South Africa: 2000 - 2005" would not have been possible without the immeasurable assistance from countless individuals and organisations. Our thanks goes to every individual who took the time and effort to assist in the development of the document, be it through drafting sections or reading and commenting several times to improve the quality.



Annexure A: Map of South Africa

The following map represents the nine provinces that make up South Africa.



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DEPARTMENT OF HEALTH

AIDS HELPLINE
0800-0123-22

SOUTH AFRICA AND HIV/AIDS

Country Profile

South Africa is the fourth most populous nation and has the largest and most developed economy in sub-Saharan Africa. It plays a key role in the region's political stability and generates 45 percent of sub-Saharan Africa's gross domestic product (GDP).

The country is struggling to overcome the vestiges of apartheid, including its legacy of racial disparities in education, housing, employment, and healthcare. The Reconstruction and Development Program sets specific targets for service provision.

> *"AIDS is eroding the fabric of our society and jeopardizing the reconstruction and development of our country."*
>
> President Nelson Mandela

Water, electricity, and health care access are improving, but progress has not yet matched earlier hopes.

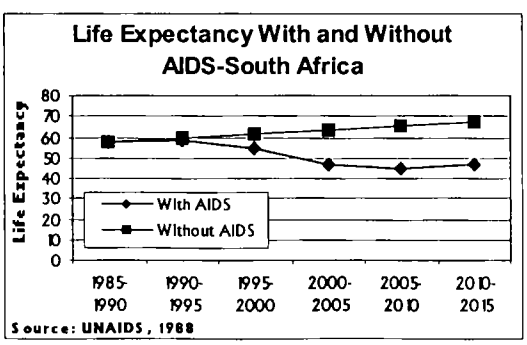
Gender equality is a constitutional right, but in practice many women do not possess equal rights in community decision making, land allocation, access to finance, inheritance, marriage and divorce, and they are often subject to high levels of violence.

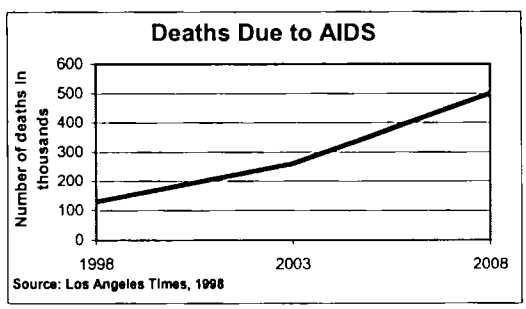
South Africa has an established trend of rural migration to urban settlements with inadequate infrastructure. Social problems, such as poor housing, street children, youth unemployment, drugs, child abuse, violence against women, and commercial sex, appear to be on the increase. Unemployment is estimated at 23 percent and rising.

HIV/AIDS in South Africa

The Joint United Nations Programme on AIDS (UNAIDS) reports that half of all HIV-positive people in the nine southern African countries hardest hit by the pandemic live in South Africa.

- The government estimates that 3.6 million people—8 percent of the population—are infected with HIV.
- The number of reported AIDS cases has risen 33 percent since the end of 1997.
- Every day an estimated 1,500 people acquire new HIV infections. Two-thirds of them are 15 to 20 years old.





- By 2010 adult HIV prevalence is projected to reach 25 percent, on par with that of neighboring Zimbabwe and Botswana.

More than 360,000 people have already died of AIDS-related illnesses. Of all African countries, South Africa is projected to have the highest number of AIDS deaths from 1995 to 2015.

- About 130,000 people died of AIDS in 1998.
- In 2005 the population is expected to be 16 percent lower than it would have been in the absence of AIDS. By 2015 population loss to AIDS-related deaths will be 4.4 million.

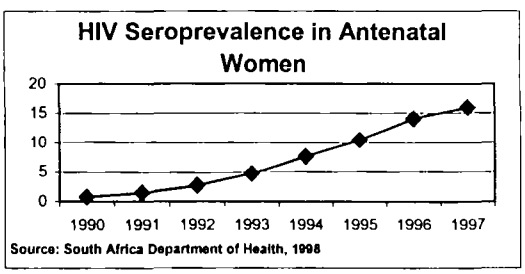
In October 1998 a $12-million awareness campaign was launched by Deputy President Thabo Mbeki. But until then, few HIV/AIDS prevention measures had been undertaken in South Africa and the resulting information gap was filled with myth and stigma. Many South Africans, for example, believe that bewitchings are the cause of AIDS or that tribal ancestors are displeased and are wreaking havoc on the living. Vengeful coworkers and jealous lovers are often blamed.

Personal denial of HIV risk is widespread. In a 1998 survey of 1,000 people in the township of Soweto, 90 percent of respondents identified AIDS as deadly, but 70 percent believed they were at little or no risk of becoming infected with HIV. Nearly two-thirds said they had never used a condom, and half did not even know where to get one. "It's this ignorance that's so difficult to break through," said Dr. Nono Simelela, national director of the government's HIV/AIDS and sexually transmitted infection (STI) program.

HIV/AIDS and Women

Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at high risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, exacerbate this vulnerability. Spousal separation due to male labor migration encourages high-risk sexual behavior among men and women.

UNAIDS reports that during the last eight years, the prevalence of HIV infection at prenatal clinics has increased more than 21-fold. The 1997 Eighth National HIV/AIDS Surveillance Survey found an HIV prevalence rate of 27 percent among pregnant women tested at clinics in the province of KwaZulu/Natal, and a national average of 16 percent. In 1998 this number rose to 33 percent in KwaZulu and national average of 23 percent.



"We have to recognize that the imbalances in basic human relations, prejudices and taboos, lack of equal opportunities and socio-economic conditions have left women less protected against the disease."

Geraldine Fraser-Moleketi,
Minster of Welfare and Population Development

Women bear the brunt of the deep stigma that has grown up around HIV/AIDS. They fear that their men will leave them, their families will shun them, and their neighbors will ostracize them and call them prostitutes. A KwaZulu/Natal woman, Gugu Dlamini, publicly acknowledged her HIV-positive status on World AIDS Day in 1998, only to be beaten to death for revealing something that her community felt brought it into disrepute.

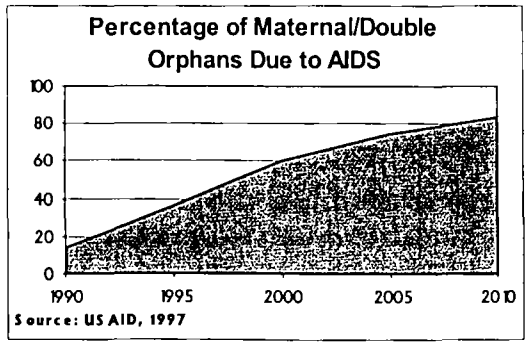
According to the DFID, South Africa has the highest level of reported rape in the world. Roving gangs of young men—many infected with HIV—are engaging in what is known as "catch and rape."

Children and HIV/AIDS

Thirty-five percent of South Africa's population is under age 15. The HIV pandemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV, and most of them will develop AIDS and die within two years.

- AIDS will increase the infant mortality rate in the next five years by 26 percent. By 2010 it will have increased by 40 percent.

- In 1998 South Africa had approximately 100,000 AIDS orphans.
- By 2008, 1.6 million children will have been orphaned by AIDS.
- In the year 2000, 61 percent of all orphans will have lost parents to AIDS. By 2010 that proportion will rise to 83 percent.



Youth and HIV/AIDS

The age group once thought to be most receptive to HIV/AIDS prevention messages—15- to 20-year-olds—is already heavily infected. Young women are at particularly high risk of HIV infection.

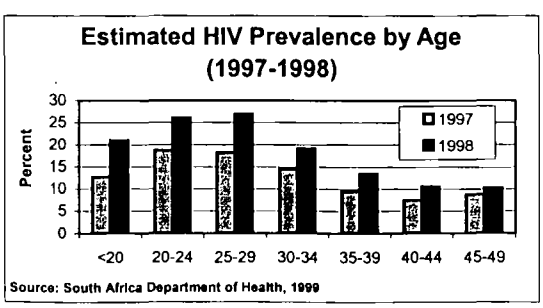
> *"The time has come to teach our children to have safe sex, to have one partner and use a condom."*
>
> President Nelson Mandela

- Two-thirds of new infections are in 15- to 20-year-olds.
- Data from antenatal clinics show that from 1997 to 1998, HIV prevalence rose from 12.7 percent to 21 percent among teenage girls.
- More than half the reported AIDS cases in women through 1996 were in the 15- to 29-year-old age group.
- New awareness campaigns are targeting youth ages 12 to 30.

Socioeconomic Effects Of HIV/AIDS

The HIV/AIDS pandemic threatens South Africa's reconstruction and development, as well as the health and well-being of its people. The death and illness it causes among people in their most productive years affects economic prosperity, foreign investment, and sustainable development.

The direct costs alone of caring for millions of people living with HIV/AIDS (PLWHA) are overburdening an inadequate health care system. The cost of AIDS care to South Africa in 1996 was $12.6 million. In a country with a GNP per capita of $3,040, the cost per AIDS case was $4,560.



A tuberculosis (TB) epidemic fueled by HIV/AIDS will further strain health care resources.

- South Africa has one of the highest incidences of TB in the world. There are 243 new cases for every 100,000 South Africans.
- In 1996 HIV was responsible for a 27 percent increase in the TB caseload, or 42,000 additional TB cases.

The migrant labor system in the trucking and mining sectors fuels the HIV/AIDS pandemic; HIV/AIDS, in turn, is a key factor in their loss of labor and profits. Since wages are much higher in South Africa than in the surrounding region, men from neighboring countries flock there to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories where having multiple sex partners is part of the lifestyle. When they go home, they often take HIV with them.

"Most vulnerable will be the health and education sectors, along with industries dependent on manual or unskilled labor. Mostly they have the least access to medical care, a poor financial infrastructure to fight the disease, and poor employment packages."

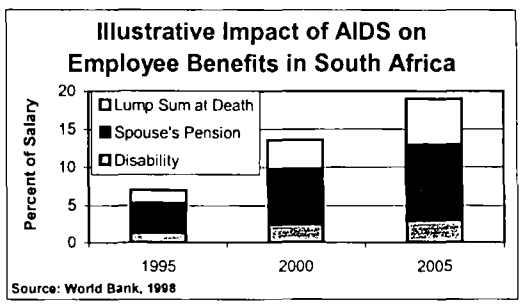
Bruce Hodkinson, medical adviser to insurer Sanlam

A survey in Carltonville, a gold mining area near Johannesburg, revealed that:

- Sixty percent of the 88,000 miners were migrants from other parts of South Africa or from the nearby countries of Lesotho, Malawi, and Mozambique.
- One-fifth of mineworkers were HIV-positive.
- Three-quarters of the 400 to 500 sex workers who service the miners were HIV-positive.

KwaZulu/Natal, the province that serves as the source for many of South Africa's migrant workers, has the highest HIV prevalence rate (as measured by testing of women at antenatal clinics). Surveillance data from 1997 to 1998 show that 61 percent of female sex workers at truck stops in this province were HIV-positive. Virtually the entire provincial health budget is being used to treat AIDS-related diseases, particularly opportunistic infections such as pneumonia and TB.

Other businesses are beginning to feel the effects of HIV. Eskom, the South African power company, estimates that if HIV continues to spread at the current rate, sickness and absenteeism will cost the company $773 million by 2012.



Interventions

The National Response

The African National Congress organized the National AIDS Convention of South Africa (NACOSA) in 1992, ten years after the first AIDS case was reported. In 1994 South Africa became the first sub-Saharan country to develop and gain Cabinet approval for a comprehensive HIV/AIDS policy.

Components of the national plan include education and prevention, counseling, care, welfare, human rights, and research. Those identified to engage in partnership in the national campaign were the media, labor and industry representatives, religious leaders, women, youth, and sports and entertainment figures.

"There is no longer any time on our side to continue the luxury of both denial and of stigmatization of this pandemic."

Geraldine Fraser-Moleketi, Minister of Welfare and Population Development

The leadership silence has been broken, with Nelson Mandela speaking out publicly on HIV/AIDS and Archbishop Desmond Tutu appearing on national television promoting condom use and safe sex.

The government has recently reinvigorated the national strategy with its "Partnership Against AIDS" campaign. The Interministerial Committee on AIDS was formed in 1997, chaired by Deputy President Mbeki, to provide senior leadership and build partnerships with all sectors of society.

In February 1998 the Cabinet adopted the Government AIDS Action Plan. Under this plan, the National AIDS Directorate designs HIV/AIDS and STI projects and programs for implementation at the provincial level, with a proposed 1999-2000 budget of about $8.9 million. With intersectoral structures now in place, all ministries are either

developing or implementing policies and programs. The Department of Health recently renewed its "Beyond Awareness Campaign" to encourage behavior change among the general population.

The number of condoms distributed by the government increased from 90 million in 1996 to 150 million in 1998. In many clinics, however, condoms are only accessible through consultation. The government's Health Portfolio Committee is considering whether the female condom should be provided to the public free of charge.

Nine provincial AIDS Training, Information, and Counseling Centers (ATICC), funded by the Department of Health and the provinces, provide information, voluntary HIV counseling and testing (VCT) services, and training workshops.

Businesses are beginning to become more involved in the national response to HIV/AIDS. Some mines, factories, and farms provide STI services at their employee clinics. Since 1993, the South African power company Eskom has guaranteed full ill-health and pension benefits to employees with AIDS and their families. It also provides HIV/AIDS and STI clinical services, including counseling and therapy, and supports a peer education program and educational radio broadcasts. The company is also funding a vaccine feasibility study predicted to cost $25 million over the next five years.

Greater private sector involvement in HIV/AIDS programs is now being mobilized through the South African Business Council on AIDS, the Council of South African Trade Unions, and the American Center for International Labor Solidarity.

A group of leading South African scientists are putting together a five-year, $8-million project to develop a vaccine to counteract subtype C, the form of the HIV virus dominant in Southern Africa and Asia. The Department of Health has set up a task group to evaluate the initiative.

Donors

USAID's HIV/AIDS funding for FY 1998 was $2 million, and $3.3 million was requested for integrated primary health care (PHC) services in FY1999.

USAID forms part of the health working group of the Gore-Mbeki Binational Commission. The mission's strategic objective in health supports the increased use of essential Primary Health Care and HIV/AIDS services and practices. Responding to the HIV/AIDS epidemic includes:

- Increasing access to prevention services.
- Increasing demand for prevention and mitigation services and practices.
- Improving the quality of services and mitigation strategies.
- Improving the enabling environment for programs and services.

With USAID funding, the Center for Disease Control (CDC) has, since 1992, provided technical assistance in epidemiology and surveillance; institutional and capacity building; STI prevention and control; HIV/AIDS counseling and testing; partner notification and referral; and policy development. Other cooperating agencies that have helped implement USAID's HIV/AIDS programs include Family Health International, Population Services International, and The Futures Group.

Mission initiatives in HIV/AIDS have focused on training, advocacy, community outreach, and institutional capacity building, with the following results:

- NGOs have made a substantial contribution to community outreach and HIV/AIDS awareness activities in rural and informal settlement areas.
- A nationwide demographic and health survey was conducted in 1998.
- An improved referral system reduced hospitals' outpatient loads.

An innovative approach to HIV prevention treated sex partners of miners (Harmony Mine) based on risk. STI prevalence among the women declined dramatically, by 70 to 85 percent. The miners (for whom services were not changed) showed a 33 percent reduction in gonococcal and chlamydial infections and a 75 percent reduction in genital ulcers.

- A National AIDS Strategy was developed at a USAID-supported national AIDS convention.
- The Department of Health, in collaboration with The Futures Group, held training workshops to build skills in advocating for leadership support for strong multisectoral HIV/AIDS programs at both national and provincial levels.
- An in-service management training program was developed for health managers at the provincial level and below.
- A legal charter to prevent discrimination against PLWHA was developed.
- The major labor unions drafted a consensus position document on workplace policies and guidelines on HIV/AIDS.
- The American Center for International Labor Solidarity will be implementing more HIV prevention and care activities in the workplace.

The Department For International Development (DFID) supported the National AIDS Control Project; prevention and care of HIV/AIDS and STIs; development and implementation of a national AIDS strategy; and increasing the availability of condoms outside health services via social marketing (1995-1998, about $10.5 million).

DFID supports South Africa in its lead responsibility for health within the Southern African Development Community (SADC) to promote effective regional action in fighting HIV/AIDS.

The European Union supports the implementation of the SADC Plan of Action for HIV/AIDS to minimize the spread of HIV and mitigate its impact (1999-2002, about $3.2 million).

UNAIDS has a coordinating theme group based in South Africa. The group, chaired by WHO, includes representatives from UNDP, WHO, UNFPA, UNICEF, UNESCO, and the World Bank. Support from the UN includes:

Organization	US$ Amount 1996-97	US$ Amount 1998-99
WHO	10,000	80,000
UNDP	17,000	200,000
UNFPA	15,000	10,000
ILO	5,000	
UNESCO	5,000	5,000
UNAIDS	1,058,306	683,450
Total	1,110,306	978,450

UNAIDS cosponsor support 1996-1999

UNAIDS-supported activities include:

- Research on the female condom.
- Research on the role of traditional healers in HIV/AIDS prevention and treatment.
- A multimedia campaign promoting condoms and safer sex in the southern Africa region.
- Inclusion of gender and HIV/AIDS in the new constitution.

- HIV vaccine development, including preparing a national AIDS vaccine strategy, organizing national workshop on vaccines, and providing seed money for an AIDS vaccine office.

Private Voluntary Organizations (PVOs,) Nongovernmental Organizations (NGOs) and Research Institutions

A number of PVOs implement activities in South Africa, funded by multilateral and bilateral donors. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of activities in HIV/AIDS. This list is evolving and changes periodically.*

There are also a large number of organizations working in all aspects of HIV/AIDS. The South Africa AIDS Network has published a directory of the National AIDS Database that contains over 600 entries.

Two South African institutions, the Center for Epidemiological Research in South Africa (CERSA/MRC) in Durban and the Chris Hani Baragwanath Hospital in Soweto, serve as research sites for the HIV Network for Prevention Trials (HIVNET). HIVNET was established in 1993 by the U.S. National Institute of Allergies and Infectious Disease (NIAID) to conduct trials of promising HIV prevention strategies in the United States and abroad. The two HIVNET sites in South Africa are part of a Southern African group of countries that will be studying the virology and immunology of newly infected individuals to evaluate immune responses to clade C HIV-1 infection in order to facilitate the design of a relevant vaccine candidate. Other HIVNET research includes a trial to evaluate the safety and efficacy of a microbicide, and an intervention to prevent perinatal transmission of HIV.

Challenges

Major constraints to HIV/AIDS control in South Africa include:

- Overcoming the historical inequity in distribution of education and basic health care.
- A late start in responding to the epidemic, with public awareness campaigns beginning after many people—particularly adolescents—have already been infected.
- Migrant labor patterns both inside South Africa and across borders with neighboring countries.
- Denial: fear of retaliation due to the stigma associated with HIV/AIDS prevents people from revealing their status—even to their sexual partners.
- The subservient role of women in South African society.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in South Africa.

- HIV/AIDS and STI information and counseling need to be integrated into basic community-level health services.
- Collaboration between health and other sectors remains weak at both central and provincial levels.
- Decentralization of program planning and management still requires considerable capacity building at provincial levels.
- Sufficient resources need to be allocated for planned activities in non-health sectors.
- Industry and labor need to play a more active role.

The Future

After a very slow start, South Africa has an opportunity for a new beginning in its response to HIV/AIDS. The now-visible threat of the impact of HIV/AIDS on the country's development has stirred leadership attention and support for more aggressive action. A national plan is in place, outlining a multisectoral approach with the involvement of key government ministries. Now

the country needs to mobilize public and private sector resources to implement the plan, and move quickly to overcome the pervasive denial of HIV risk among South Africans. Special attention must be paid to empowering women and providing effective HIV prevention services for youth. Labor and industry must become key players for prevention and care in the workplace.

Provision of effective STI prevention and treatment services for women at high risk of infection may be an effective interim strategy for reducing community STI prevalence and, in so doing, reducing the efficiency of HIV transmission.

South Africa is unique in its capacity to research and develop AIDS vaccines. With public and private sector support, the country could make a significant contribution to the search for a vaccine appropriate for the virus strain prevalent in sub-Saharan Africa. The development of national AIDS vaccine strategy is a first step in this direction.

Important Links and Contacts

1. UNAIDS Team Leader, Elhadj Sy, Metropark Building, 351 Schoeman Street, Pretoria
2. National AIDS Directorate, Dr. Nothemba Simalela
3. National AIDS Convention of South Africa (NACOSA), Director Pooven Moodley, Tel: 27-21-233277; email nataidc@iafrica.com
4. National Association of People Living with AIDS (NAPWA), Peter Busse, Tel: 11-403-8113; e-mail: napnet@sn.apc.org
5. Council of South Africa Trade Unions (COSATU)
6. The AIDS Legal Network, Ms. Mary Ceasar, Tel: 021-448-3812
7. Centre for Applied Legal Studies/AIDS Law Project, Mr. Mark Heywood, Tel: 011-403-6918; e-mail: 125ma3he@solon.law.wits.ac.za
8. The AIDS Consortium, Gauteng
9. South Africa Business Council on HIV/AIDS
10. American Center for International Labor Solidarity (ACILS), Fisseha Tekie, Tel: 11-403-3246
11. The Medical Research Council, P.O. Box 17120, Congella, Durban 4013, Tel: 27-31-251481
12. HIVNET: Center for Epidemiological Research in South Africa: Principal Investigator, Salim S. Karim, MD
    Chris Hani Baragwanath Hospital, Principal Investigator, James McIntyre, MD

U.S. Agency for International Development

Population, Health and Nutrition Programs
HIV/AIDS Division

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Implementing AIDS Prevention and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516-9779
Fax: (703) 516-9781
URL: www.fhi.org

April 1999

hospitals.[18] Another study showed that, of the 238 hospital visits made by AIDS patients during a three month period, 165 (69.3%) could have been handled at the primary care level. As the illness progresses, however, patients are less able to be treated at the primary care level.[19]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

    - In KwaZulu-Natal, there are two major trucking routes, as well as two major harbor areas. Commercial sex workers are prevalent in this area, as they have clients in both the transport and harbor workers. There is also cross-border traffic among KwaZulu-Natal, Swaziland, and Mozambique; both of these countries have relatively high prevalence rates. KwaZulu-Natal has some of the highest prevalence rates in South Africa.[20] A survey of 213 truck drivers in this area found that 35% had more than one sex partner in the week immediately preceding the survey. Although most of those surveyed had heard of AIDS and knew how to protect themselves, it was not clear whether they were, in fact, doing so.[21]

    - An early, unpublished study of the transport industry in South Africa found that truck drivers frequently engaged in risky sex, and had little knowledge of HIV/AIDS.[22] A later study found that, although knowledge of HIV/AIDS by commercial sex workers was fairly detailed, their need for work meant that they did not have the power to negotiate safer sex.[23]

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[18] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.

[19] Metrikin, AS, M Zwarentstein, MH Steinberg, E Van Der Vyver, G Maartens, R Wood (1995) "Is HIV/AIDS a primary-care disease? Appropriate levels of outpatient care for patients with HIV/AIDS," AIDS; 9(6):619-23.

[20] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.

[21] Suvery cited in Whiteside, A (1998) "How the transport sector drives HIV/AIDS – and how HIV/AIDS drives transport," AIDS Analysis Africa; 8(2): 5-7, April 1998.

[22] Fisher and Associates Management Consultants (1992) "AIDS and Truck Drivers," submitted to the Department of Health.

[23] Karim, QA, and SS Karim (1995) "Reducing the Risk of HIV Infection among South African Sex Workers: Socioeconomic and Gender Barriers," South Afrian Medical Research Council in Durban, cited in Loewenson, R and A Whiteside (1997) "Social and Economic Issues of HIV/AIDS in Southern Africa," SAfAIDS Occasional Paper No. 2, March 1997.

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

  - It is estimated that approximately 284,000 men were employed in the mining sector in 1996, 122,000 of whom were foreigners.[24] These men live in single quarters and are not allowed to bring their families with them, creating a high risk for HIV transmission. Apartheid also made any South African miners migrants once they went beyond the "borders" of the homelands. The National Union of Mineworkers in South Africa introduced an education campaign about HIV/AIDS in the late 1980s, and has advocated the provision of family accommodation.[25] Even with these programs, the Union estimates that there could be between 12,000-14,000 AIDS-related deaths per year by 2010.[26] The table shows the cost of AIDS to the mining industry, estimated for the years 1995 and 2010. The projections indicate that total costs will increase from 114 million Rand in 1995 to 1,509 million Rand in 2010.[27] In KwaZulu-Natal, an area of high HIV prevalence, many miners migrate to employment in the Free State and Gauteng, and are separated from their families for long periods of time.[28]

The Cost of AIDS to the Mining Industry (R million 1992)		
	1995	2010
Prevention	5	10
Treatment	38	600
Compensation	39	480
Research	1	5
Replacement	1	16
Total Direct Costs	**84**	**1,111**
Foregone earnings	19	230
Productivity loss	11	168
Total Opportunity Costs	**30**	**398**
TOTAL COSTS	**114**	**1,509**

[24] The Employment Bureau of Africa Limited, Annual Report 1997, Johannesburg 1997.
[25] A Whiteside, A (1993) "AIDS: Socio-economic Causes and Consequences," Economic Research Unit Occasional Paper No. 29, University of Natal, Durban, 1993; Whiteside, A and D FitzSimons (1992) "The AIDS Epidemic: Economic, Political, and Security Implications," Conflict Studies 251, Research Institute for the Study of Conflict and Terrorism, UK.
[26] King Akerele, O (1997) "Presentation by Ms. Olubank King Akerele," The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, Annex 2, http://www.undp.org/hiv/Mayors/anex2e.htm
[27] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.
[28] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

  - One early study estimated the lost human capital that had been invested in the education of AIDS patients according to three different scenarios. Using the 1991 distribution of educational attainment for various races in the economically active age group, the total lost educational investment was R26.9 million. Depending on the racial mix of the projection, the total lost investment ranged from R14.4 million to R41.3 million.[29]

Total educational human capital invested in AIDS victims, with three educational distributions, 1991

	Amount (R millions)	Index
Current distribution	26.9	100.0
Biased towards uneducated	14.4	53.3
Biased towards educated	41.3	153.9

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance:

[29] Trotter, G (1993) "Some Reflections on a Human Capital Approach to the Analysis of the Impact of AIDS on the South African Economy," in Facing Up to AIDS, The Socio-Economic Impact in Southern Africa, S. Cross and A Whiteside, eds. (Basingstoke, UK: Macmillan Press, 1993).

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

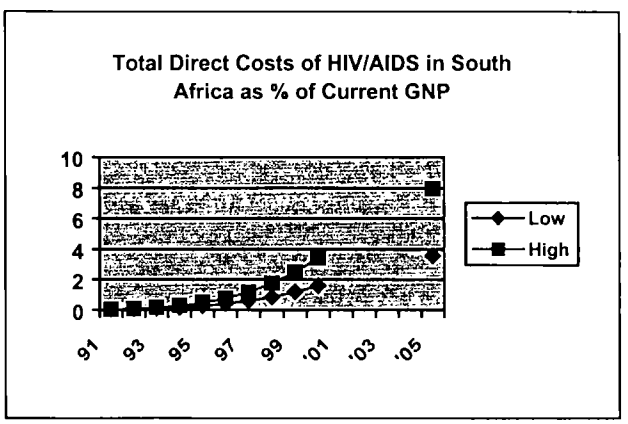
- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

- In South Africa, by the year 2010, child mortality will be 99.5 per 1000 children including the impact of AIDS, while the number would have been 48.5 per 1000 without the effect of HIV/AIDS. Life expectancy will decrease to 47.8 years from the previously expected 67.9 years, due to the impact of HIV/AIDS. Overall, the population growth rate with AIDS will be 0.4% by the year 2010, while the growth rate without AIDS would have been 1.4%.[30]

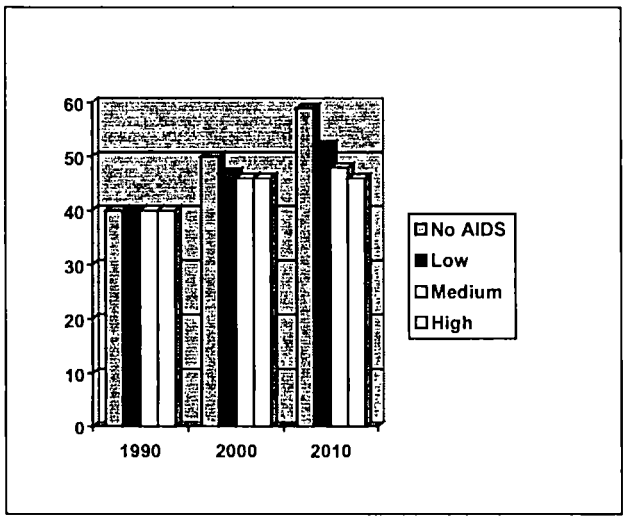


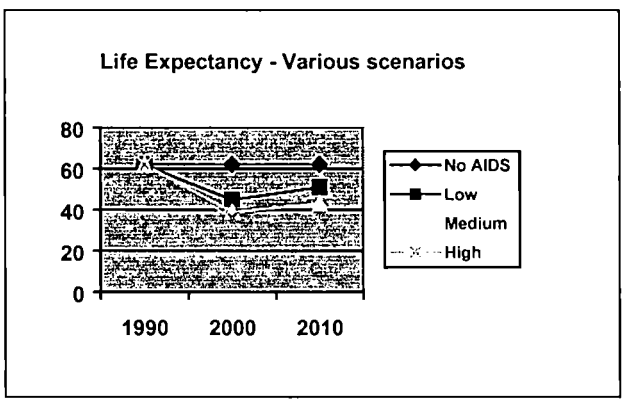
- One study estimated the total direct and indirect costs due to HIV/AIDS through the year 2000, using two different scenarios. In the low scenario, using low hospital costs, the costs rise from US$21.5 million in 1991 to US$1.2 billion in the year 2000, while in the high scenario, using high hospital costs, the costs rise from US$32 million to US$2.9 billion. This translates into an increase from 0.5 percent of total health expenditure in 1991 to 34 percent in 2005 for the low scenario, and from 0.8 percent in 1991 to 75 percent of total health expenditure in 2005 for the high scenario. Total direct costs of HIV/AIDS reach 3.6 percent of current GNP by 2005 for the low scenario, and 8 percent of current GNP by 2005 for the high scenario.

[30] US Bureau of the Census, World Population Profile, 1998, Population Division International Programme Centre, Washington DC, 1998.

The indirect costs, based on assumptions about lost earnings per worker, indicate that total lost work years decline by between 20 and 35 percent, but production decreases only 2.3-3.5 percent. Thus the overall macroeconomic impact, in monetary terms, will be small. This result is due to the disparity between the pay of skilled versus unskilled workers; because a large percentage of the population has relatively low earnings, although years lost is high, total monetary loss to the economy is low.[31]

- A recent set of projections of the macroeconomic impact of HIV/AIDS in South Africa estimated that under the high impact scenario, the population size would be 28% smaller in 2010 than it would have been without AIDS. Without AIDS, the model predicts that the population would be about 59 million people in 2010, while under the high impact scenario, the population would be only 46 million people. The same model predicts that life expectancy will decrease by 82 percent under the high scenario, from 62 years without the impact of AIDS to 34 years under the high impact scenario. In comparison, the model predicts that the population in Zimbabwe decreases by 45 percent by 2010, and by 17 percent for Kenya. Life expectancy is projected to decline by 90 percent for Zimbabwe by 2010, and by 33 percent for Kenya. The projections for both population size and life expectancy for South Africa, for all of the scenarios, are shown in the graphs.[32]





What Can Be Done?

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep

[31] Broomberg, J , M Steinberg, P Masobe, and G Behr (1993) "Economic impact of the AIDS epidemic in South Africa," in Facing Up to AIDS, The Socio-Economic Impact in Southern Africa, S. Cross and A Whiteside, eds. (Basingstoke, UK: Macmillan Press, 1993).

[32] Gregson, S, B Zaba, G Garnet, R Anderson (1997) "Projecting the HIV/AID epidemic in Southern Africa," presented at the Socio-Demographic Impact of AIDS in Africa Conference, 3-6 February 1997.

the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

    - During 1997, South Africa implemented a pilot program to introduce presumptive STD treatment in a mining community. The intervention included free monthly exams, community-based peer education on STD/HIV prevention, counseling, and one dose of an antibiotic for about 400 women over a nine-month period. Over that time period, there was a reduction of 20% in the reported number of clients, and an increase in the use of condoms from 13% to 29% of total sexual contacts. The AVERT model estimated that 237 new HIV infections had been averted through this intervention over a one-year time period, 41 among the women and 196 among the miners.[33] A similar program was followed in KwaZulu-Natal by the African Medical Research Foundation for commercial sex workers and truck firms, including peer education and STD treatment.[34]

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives

[33] Rehle, T, TJ Saidel, SE Hassig, PD Bouey, EM Gaillard, and DC Sokal (1998) "AVERT: a user-friendly model to estimate the impact of HIV/sexually transmitted disease prevention interventions on HIV transmission," AIDS 1998; 12(suppl 2):S27-S35.

[34] Crowe, S (1997) "South Africa revolutionises HIV prevention and education strategies," Lancet; 349(9062):1377.

for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

- South Africa has been in the process of rewriting their employment legislation; part of this process may classify HIV/AIDS as a disability. This classification would protect employees from unfair dismissal and discrimination.[35] Although discrimination against people living with AIDS is not allowed, as stated in the Government White Paper on Health System Transformation, stigma against AIDS is widespread in South Africa.[36]

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

  - A crucial element for the care of orphans in South Africa seems to be some sort of external financial support. One study found that, although 62 percent of families surveyed in KwaZulu were willing to care for orphans, this rose to 78 percent if some sort of external support would be provided. Two other efforts at community-based care did not succeed because external support was not provided.[37]

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

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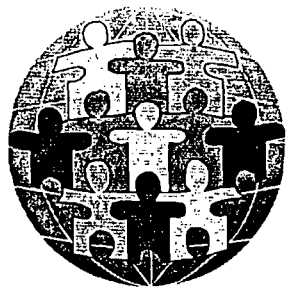
[35] Gresak, GA (1998) "AIDS in the workplace – HIV/AIDS and the law," AIDS Bulletin; 7(1):8-11.
[36] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[37] Cited in Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.



The POLICY Project

The Economic Impact of AIDS in South Africa

by
John Stover
Lori Bollinger

September 1999

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and Population Activities (CEDPA)

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS				
	Economically Active Labor Force: 1995[a]		Employment by Industry: 1993[b]	
Sector	**'000s**	**%**	**'000s**	**%**
AGRICULTURE				
Agriculture, hunting, forestry and fishing	1,295	12.8	n/a	n/a
INDUSTRY				
Mining and quarrying industries	471	4.6	561.7	11.4
Manufacturing industries	1,526	15.1	1,400.5	28.3
SERVICES				
Electricity, gas and water	95	0.9	42.5	0.9
Construction	483	4.7	374.5	7.6
Trade, restaurants and hotels	1,769	17.4	764.4	15.4
Transport, storage and communications	520	5.1	303.1	6.1
Finance, insurance, real estate and business services	654	6.4	191.5	3.9
Community, social and personal services	3,137	30.9	1,312.4	26.5
TOTAL	**10,152**	**100.0**	**4,950.5**	**100.0**
Source: a – Europa World Year Book, 1998; b - United Nations, Statistical Yearbook, 1995, table 29				

In contrast to most of Africa, South Africa has a very small agricultural sector, employing a negligible number of people in the formal sector. It is important to note, however, that in the formal sector, as much as 52% of the people aged 16-30 are unemployed, with half of

those classified as marginalised, that is, with little chance of obtaining formal sector employment due to a lack of education. South Africa has a highly developed mining and manufacturing sector, but much of the labor force in the mining industry is foreign. South Africa is the largest producer of gold in the world, producing about 30% of total world production. The manufactured products are diverse, and include chemicals, petroleum and coal products, food products, and transport equipment. The per capita GNP figure for the country of US$3,400 masks the disparities that exist within the country; 13 percent of the population are very well off, while 53 percent are very poor. Only 50 percent of this very poor group have a primary school education, over 33 percent of these children suffer from malnutrition, and only about 25 percent have electricity and running water.[1] The lowest 20 percent of the households spend only 3 percent of the total expenditure, while the highest 20 percent spends 61 percent of the total.[2]

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from South Africa to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- Over 100,000 children became AIDS orphans in South Africa in1998 alone.[3] One model predicts that there may be as many as 1 million maternal orphans in the country by the year 2005, where orphans are children under 15 years old.[4] Another model projects, for KwaZulu-Natal alone, a total of between 759,700 and 833,520 maternal orphans by 2010.[5]

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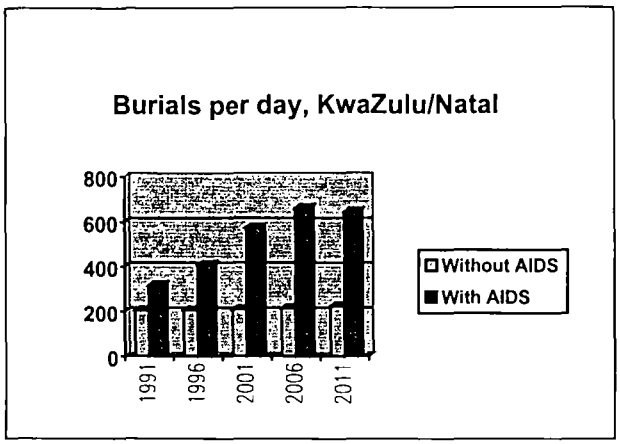
[1] The World Bank. Http://www.worldbank.org/html/extdr/offrep/afr/bw2.htm. 6/10/99; Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (London).
[2] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[3] Kirby, A (1999) "South Africa's Growing HIV Crisis," BBC News (06/07/99).
[4] Kinghorn, A and M Steinberg (1999) "HIV/AIDS in South Africa: The Impacts and the Priorities," Department for International Development in Southern Africa and the Department of Health, South Africa.
[5] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.



- One study for KwaZulu-Natal projects that there will be an increase of 419 burials a day by the year 2011 due to HIV/AIDS, from 224 per day to 643 per day. Not only does this increase the demand for cemetery plots, but costs will increase for the household, including burial costs, transport costs to and from the burial, and lost wages due to taking time off from work to attend funerals.[6]

- A project in Cape Town that works with families who have children with HIV, the Thuthuzela Abantwana project, found that the families were already stretched to their financial limits, and that external support was crucial if the families were to meet the needs of their children with HIV.[7]

- There is an estimated backlog of 3 million housing units to be provided by the government, mostly for Africans; 98 percent of whites live in either a house, flat, or townhouse, while only approximately 54 percent of African households live in this formal housing. The planning process for the government in providing this housing is made more complicated, and thus more lengthy, through the impact of HIV/AIDS. Although fewer units will probably be needed because of AIDS deaths, the structure of households may change, making planning more difficult: households may become headed by children; households may be even poorer than before, and so unable to pay for even the most basic services; and the number of people per household may decrease.[8]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this

[6] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.
[7] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[8] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.

may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops. Because the agricultural sector is a relatively small part of the South African economy, little research has been focussed on the impact of HIV/AIDS on agriculture there.

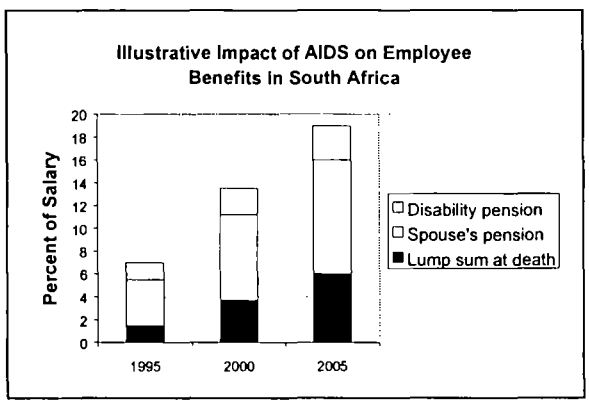
Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

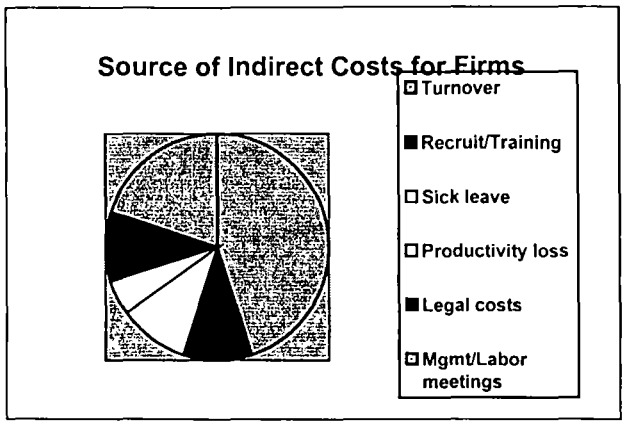
- A survey of 16 firms in South Africa asked whether the company prevalence rate was known, and whether HIV/AIDS had created any problems for the company. Only four companies returned the survey forms. Specifically, neither a major retail company nor a publishing house had felt any impact of HIV/AIDS yet, while a major platinum mining company stated that four employees were dying of AIDS per month. A major industrial company based in KwaZulu-Natal recorded a 31% increase in the number of ill-health retirements between 1995 and 1997; of these retirements, 17% of them were due to AIDS.[9]

- A study in South Africa examined the expected impact of AIDS on employee benefits, and thus on corporate profits. It found that at current levels of benefits per employee, the total costs of benefits would rise from 7 percent of salaries in 1995 to 19 percent by 2005. Since these additional costs will have to be paid at the same time that productivity is declining, due to AIDS, the net impact on profits could be significant.[10]



[9] Galloway, MR and J Stein (1998) "HIV/AIDS in the Workplace: what South African companies are doing," AIDS Bulletin; 7(1):16-9, April 1998.
[10] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.

- Another survey examined the best practices of 18 South Africa companies regarding HIV/AIDS through an UNAIDS project. "The vast majority of companies are not considering HIV and AIDS...AIDS is not currently an issue for the South Africa private sector."[11]



- A recent set of estimates by the Metropolitan Life Insurance Company in South Africa predicted that the impact of HIV/AIDS would double employee benefits costs by 2005, and triple by 2010. Either benefits would be reduced, or the remuneration costs paid by firms would increase by about 15%. Total indirect costs would add a further 10% to the wage bill by 2005, and 15% by 2010. The sources of the total indirect costs are shown in the chart.[12]

- One South African company, Gencor, projected that HIV/AIDS-related health would reach 60 percent of the total by the year 2000, which is 15 times greater than the costs had been in the past.[13]

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other

[11] Cited in Whiteside, A (1998) "The Current and Future Impact of HIV/AIDS in South Africa," HIV/AIDS and Human Development Report, Draft paper prepared for the United Nations Development Programme, Pretoria, 23 August 1998.
[12] Moore, D (1999) "The AIDS threat and the private sector," AIDS Analysis Africa; 9(6):1-2.
[13] Quoted in Curtis Knight, V (1997) "HIV/AIDS threatens size of Southern African market," AIDS Analysis Africa; 7(4):7-8, August 1997.

objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

- Various hospitals report large numbers of HIV/AIDS illnesses; in Durban, 40% of adult medical in-patients at King-Edward VII Hospital were admitted with HIV-related conditions in 1997; the percentage of HIV-related admission in Guateng in 1997 varied between 26% and 70%; and in 1996, the Chris Hani Baragwanath Hospital in Soweto reported that about 30% of children under age 6 were HIV-positive.[14]

- A case study for a rural hospital in Hlabisa province indicated that total admissions had increased dramatically between 1991 and 1997, by 57 percent. About 55 percent of the adult medical patients surveyed were HIV positive, while 42 percent of the gynaecology patients were HIV positive, and 26 percent of the paediatric cases were HIV positive. A cost-effectiveness analysis undertaken there found that the number of maternal transmission cases would be reduced by 11 percent at a cost of US$53,509, and would be reduced by 37 percent at a cost of US$263,510, by following a course of antiretroviral therapy during pregnancy. The study concluded, however, that finding these funds would be very difficult.[15]

- An early, unpublished study estimating the costs of AIDS treatment found that the cost would vary between R150,000 and R300,000 per case on average over 13 years. Furthermore, only a small percentage of the population would be able to afford the most comprehensive treatment: 40-50% of the population, those who are poor and unemployed, would receive no treatment at all; 20-25% of the population, those who are employed in the informal sector, would receive limited treatment; and 12-20% would receive adequate treatment.[16] A recent report estimated the cost of antiretroviral therapy to cost between R400 and R4000 per month, which makes it unavailable to most South Africans.[17]

- A policy paper for KwaZulu-Natal recommended that the needs of HIV/AIDS patients be met through the primary health care network, rather than through hospital care. If this course is followed, the paper estimated that the impact of HIV/AIDS on the demand for neighborhood clinics and community health centres would be high, but would be less expensive than providing care through

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[14] Kinghorn, A and M Steinberg (1999) "HIV/AIDS in South Africa: The Impacts and the Priorities," Department for International Development in Southern Africa and the Department of Health, South Africa.
[15] Cited in Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[16] Taylor, G (!992) "AIDS and Medical Care Costs," uncompleted research, cited in Loewensen, A and A Whiteside (1997) "Social and Economic Issues of HIV/AIDS in Southern Africa," SAfAIDS Occasional Paper Series No. 2, Harare, Zimbabwe.
[17] Kinghorn, A and M Steinberg (1999) "HIV/AIDS in South Africa: The Impacts and the Priorities," Department for International Development in Southern Africa and the Department of Health, South Africa.

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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.

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.

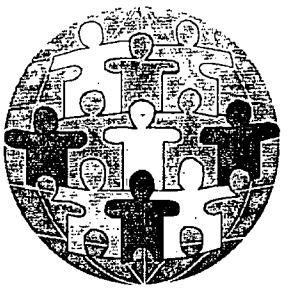
Table 2: HIV prevalence by age comparing 1997 and 1998 antenatal survey findings.

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: HSRC & Epidemiology Directorate, DOH, 1998

C- SA



The POLICY Project

The Economic Impact of AIDS in South Africa

by
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September 1999

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and Population Activities (CEDPA)

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS				
	Economically Active Labor Force: 1995[a]		Employment by Industry: 1993[b]	
Sector	**'000s**	**%**	**'000s**	**%**
AGRICULTURE				
Agriculture, hunting, forestry and fishing	1,295	12.8	n/a	n/a
INDUSTRY				
Mining and quarrying industries	471	4.6	561.7	11.4
Manufacturing industries	1,526	15.1	1,400.5	28.3
SERVICES				
Electricity, gas and water	95	0.9	42.5	0.9
Construction	483	4.7	374.5	7.6
Trade, restaurants and hotels	1,769	17.4	764.4	15.4
Transport, storage and communications	520	5.1	303.1	6.1
Finance, insurance, real estate and business services	654	6.4	191.5	3.9
Community, social and personal services	3,137	30.9	1,312.4	26.5
TOTAL	**10,152**	**100.0**	**4,950.5**	**100.0**
Source: a – Europa World Year Book, 1998; b - United Nations, Statistical Yearbook, 1995, table 29				

In contrast to most of Africa, South Africa has a very small agricultural sector, employing a negligible number of people in the formal sector. It is important to note, however, that in the formal sector, as much as 52% of the people aged 16-30 are unemployed, with half of

those classified as marginalised, that is, with little chance of obtaining formal sector employment due to a lack of education. South Africa has a highly developed mining and manufacturing sector, but much of the labor force in the mining industry is foreign. South Africa is the largest producer of gold in the world, producing about 30% of total world production. The manufactured products are diverse, and include chemicals, petroleum and coal products, food products, and transport equipment. The per capita GNP figure for the country of US$3,400 masks the disparities that exist within the country; 13 percent of the population are very well off, while 53 percent are very poor. Only 50 percent of this very poor group have a primary school education, over 33 percent of these children suffer from malnutrition, and only about 25 percent have electricity and running water.[1] The lowest 20 percent of the households spend only 3 percent of the total expenditure, while the highest 20 percent spends 61 percent of the total.[2]

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from South Africa to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- Over 100,000 children became AIDS orphans in South Africa in1998 alone.[3] One model predicts that there may be as many as 1 million maternal orphans in the country by the year 2005, where orphans are children under 15 years old.[4] Another model projects, for KwaZulu-Natal alone, a total of between 759,700 and 833,520 maternal orphans by 2010.[5]

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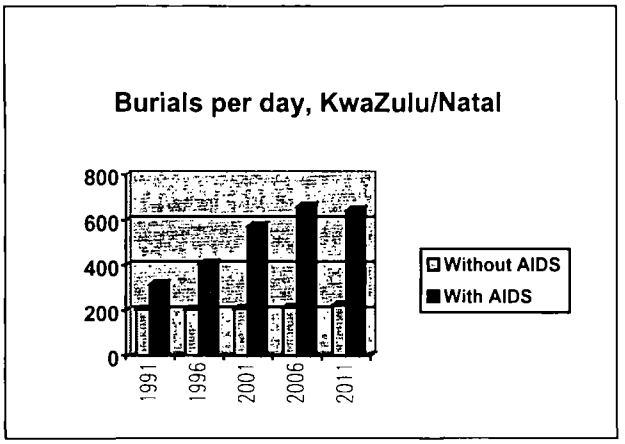
[1] The World Bank. Http://www.worldbank.org/html/extdr/offrep/afr/bw2.htm. 6/10/99; Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (London).
[2] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[3] Kirby, A (1999) "South Africa's Growing HIV Crisis," BBC News (06/07/99).
[4] Kinghorn, A and M Steinberg (1999) "HIV/AIDS in South Africa: The Impacts and the Priorities," Department for International Development in Southern Africa and the Department of Health, South Africa.
[5] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.



- One study for KwaZulu-Natal projects that there will be an increase of 419 burials a day by the year 2011 due to HIV/AIDS, from 224 per day to 643 per day. Not only does this increase the demand for cemetery plots, but costs will increase for the household, including burial costs, transport costs to and from the burial, and lost wages due to taking time off from work to attend funerals.[6]

- A project in Cape Town that works with families who have children with HIV, the Thuthuzela Abantwana project, found that the families were already stretched to their financial limits, and that external support was crucial if the families were to meet the needs of their children with HIV.[7]

- There is an estimated backlog of 3 million housing units to be provided by the government, mostly for Africans; 98 percent of whites live in either a house, flat, or townhouse, while only approximately 54 percent of African households live in this formal housing. The planning process for the government in providing this housing is made more complicated, and thus more lengthy, through the impact of HIV/AIDS. Although fewer units will probably be needed because of AIDS deaths, the structure of households may change, making planning more difficult: households may become headed by children; households may be even poorer than before, and so unable to pay for even the most basic services; and the number of people per household may decrease.[8]

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this

[6] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.
[7] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[8] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.

may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops. Because the agricultural sector is a relatively small part of the South African economy, little research has been focussed on the impact of HIV/AIDS on agriculture there.

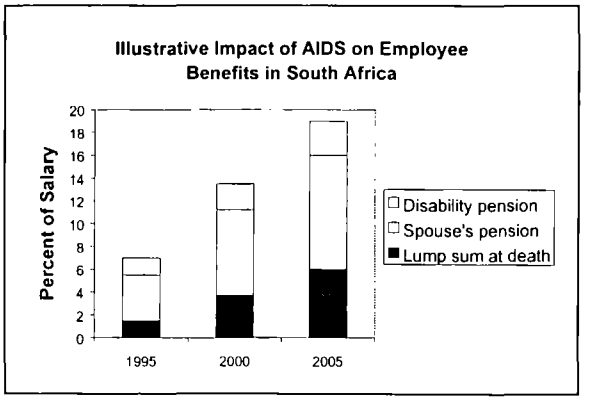
Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

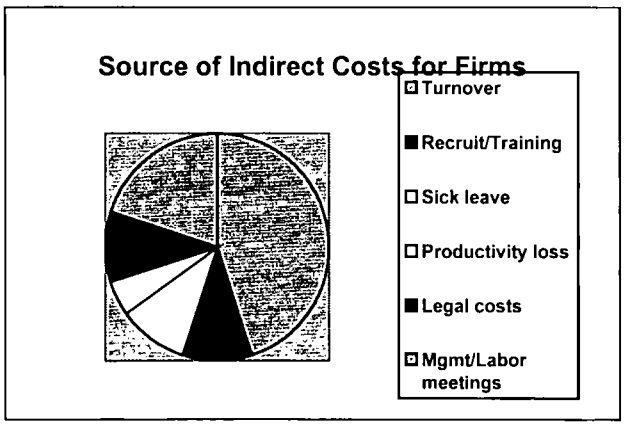
- A survey of 16 firms in South Africa asked whether the company prevalence rate was known, and whether HIV/AIDS had created any problems for the company. Only four companies returned the survey forms. Specifically, neither a major retail company nor a publishing house had felt any impact of HIV/AIDS yet, while a major platinum mining company stated that four employees were dying of AIDS per month. A major industrial company based in KwaZulu-Natal recorded a 31% increase in the number of ill-health retirements between 1995 and 1997; of these retirements, 17% of them were due to AIDS.[9]

- A study in South Africa examined the expected impact of AIDS on employee benefits, and thus on corporate profits. It found that at current levels of benefits per employee, the total costs of benefits would rise from 7 percent of salaries in 1995 to 19 percent by 2005. Since these additional costs will have to be paid at the same time that productivity is declining, due to AIDS, the net impact on profits could be significant.[10]



[9] Galloway, MR and J Stein (1998) "HIV/AIDS in the Workplace: what South African companies are doing," AIDS Bulletin; 7(1):16-9, April 1998.
[10] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.

- Another survey examined the best practices of 18 South Africa companies regarding HIV/AIDS through an UNAIDS project. "The vast majority of companies are not considering HIV and AIDS...AIDS is not currently an issue for the South Africa private sector."[11]



- A recent set of estimates by the Metropolitan Life Insurance Company in South Africa predicted that the impact of HIV/AIDS would double employee benefits costs by 2005, and triple by 2010. Either benefits would be reduced, or the remuneration costs paid by firms would increase by about 15%. Total indirect costs would add a further 10% to the wage bill by 2005, and 15% by 2010. The sources of the total indirect costs are shown in the chart.[12]

- One South African company, Gencor, projected that HIV/AIDS-related health would reach 60 percent of the total by the year 2000, which is 15 times greater than the costs had been in the past.[13]

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other

[11] Cited in Whiteside, A (1998) "The Current and Future Impact of HIV/AIDS in South Africa," HIV/AIDS and Human Development Report, Draft paper prepared for the United Nations Development Programme, Pretoria, 23 August 1998.
[12] Moore, D (1999) "The AIDS threat and the private sector," AIDS Analysis Africa; 9(6):1-2.
[13] Quoted in Curtis Knight, V (1997) "HIV/AIDS threatens size of Southern African market," AIDS Analysis Africa; 7(4):7-8, August 1997.

objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

- Various hospitals report large numbers of HIV/AIDS illnesses; in Durban, 40% of adult medical in-patients at King-Edward VII Hospital were admitted with HIV-related conditions in 1997; the percentage of HIV-related admission in Guateng in 1997 varied between 26% and 70%; and in 1996, the Chris Hani Baragwanath Hospital in Soweto reported that about 30% of children under age 6 were HIV-positive.[14]

- A case study for a rural hospital in Hlabisa province indicated that total admissions had increased dramatically between 1991 and 1997, by 57 percent. About 55 percent of the adult medical patients surveyed were HIV positive, while 42 percent of the gynaecology patients were HIV positive, and 26 percent of the paediatric cases were HIV positive. A cost-effectiveness analysis undertaken there found that the number of maternal transmission cases would be reduced by 11 percent at a cost of US$53,509, and would be reduced by 37 percent at a cost of US$263,510, by following a course of antiretroviral therapy during pregnancy. The study concluded, however, that finding these funds would be very difficult.[15]

- An early, unpublished study estimating the costs of AIDS treatment found that the cost would vary between R150,000 and R300,000 per case on average over 13 years. Furthermore, only a small percentage of the population would be able to afford the most comprehensive treatment: 40-50% of the population, those who are poor and unemployed, would receive no treatment at all; 20-25% of the population, those who are employed in the informal sector, would receive limited treatment; and 12-20% would receive adequate treatment.[16] A recent report estimated the cost of antiretroviral therapy to cost between R400 and R4000 per month, which makes it unavailable to most South Africans.[17]

- A policy paper for KwaZulu-Natal recommended that the needs of HIV/AIDS patients be met through the primary health care network, rather than through hospital care. If this course is followed, the paper estimated that the impact of HIV/AIDS on the demand for neighborhood clinics and community health centres would be high, but would be less expensive than providing care through

[14] Kinghorn, A and M Steinberg (1999) "HIV/AIDS in South Africa: The Impacts and the Priorities," Department for International Development in Southern Africa and the Department of Health, South Africa.
[15] Cited in Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[16] Taylor, G (1992) "AIDS and Medical Care Costs," uncompleted research, cited in Loewensen, A and A Whiteside (1997) "Social and Economic Issues of HIV/AIDS in Southern Africa," SAfAIDS Occasional Paper Series No. 2, Harare, Zimbabwe.
[17] Kinghorn, A and M Steinberg (1999) "HIV/AIDS in South Africa: The Impacts and the Priorities," Department for International Development in Southern Africa and the Department of Health, South Africa.

hospitals.[18] Another study showed that, of the 238 hospital visits made by AIDS patients during a three month period, 165 (69.3%) could have been handled at the primary care level. As the illness progresses, however, patients are less able to be treated at the primary care level.[19]

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

    - In KwaZulu-Natal, there are two major trucking routes, as well as two major harbor areas. Commercial sex workers are prevalent in this area, as they have clients in both the transport and harbor workers. There is also cross-border traffic among KwaZulu-Natal, Swaziland, and Mozambique; both of these countries have relatively high prevalence rates. KwaZulu-Natal has some of the highest prevalence rates in South Africa.[20] A survey of 213 truck drivers in this area found that 35% had more than one sex partner in the week immediately preceding the survey. Although most of those surveyed had heard of AIDS and knew how to protect themselves, it was not clear whether they were, in fact, doing so.[21]

    - An early, unpublished study of the transport industry in South Africa found that truck drivers frequently engaged in risky sex, and had little knowledge of HIV/AIDS.[22] A later study found that, although knowledge of HIV/AIDS by commercial sex workers was fairly detailed, their need for work meant that they did not have the power to negotiate safer sex.[23]

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[18] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.

[19] Metrikin, AS, M Zwarentstein, MH Steinberg, E Van Der Vyver, G Maartens, R Wood (1995) "Is HIV/AIDS a primary-care disease? Appropriate levels of outpatient care for patients with HIV/AIDS," AIDS; 9(6):619-23.

[20] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.

[21] Suvery cited in Whiteside, A (1998) "How the transport sector drives HIV/AIDS – and how HIV/AIDS drives transport," AIDS Analysis Africa; 8(2): 5-7, April 1998.

[22] Fisher and Associates Management Consultants (1992) "AIDS and Truck Drivers," submitted to the Department of Health.

[23] Karim, QA, and SS Karim (1995) "Reducing the Risk of HIV Infection among South African Sex Workers: Socioeconomic and Gender Barriers," South Afrian Medical Research Council in Durban, cited in Loewenson, R and A Whiteside (1997) "Social and Economic Issues of HIV/AIDS in Southern Africa," SAfAIDS Occasional Paper No. 2, March 1997.

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

  - It is estimated that approximately 284,000 men were employed in the mining sector in 1996, 122,000 of whom were foreigners.[24] These men live in single quarters and are not allowed to bring their families with them, creating a high risk for HIV transmission. Apartheid also made any South African miners migrants once they went beyond the "borders" of the homelands. The National Union of Mineworkers in South Africa introduced an education campaign about HIV/AIDS in the late 1980s, and has advocated the provision of family accommodation.[25] Even with these programs, the Union estimates that there could be between 12,000-14,000 AIDS-related deaths per year by 2010.[26] The table shows the cost of AIDS to the mining industry, estimated for the years 1995 and 2010. The projections indicate that total costs will increase from 114 million Rand in 1995 to 1,509 million Rand in 2010.[27] In KwaZulu-Natal, an area of high HIV prevalence, many miners migrate to employment in the Free State and Gauteng, and are separated from their families for long periods of time.[28]

The Cost of AIDS to the Mining Industry (R million 1992)

	1995	2010
Prevention	5	10
Treatment	38	600
Compensation	39	480
Research	1	5
Replacement	1	16
Total Direct Costs	**84**	**1,111**
Foregone earnings	19	230
Productivity loss	11	168
Total Opportunity Costs	**30**	**398**
TOTAL COSTS	**114**	**1,509**

[24] The Employment Bureau of Africa Limited, Annual Report 1997, Johannesburg 1997.
[25] A Whiteside, A (1993) "AIDS: Socio-economic Causes and Consequences," Economic Research Unit Occasional Paper No. 29, University of Natal, Durban, 1993; Whiteside, A and D FitzSimons (1992) "The AIDS Epidemic: Economic, Political, and Security Implications," Conflict Studies 251, Research Institute for the Study of Conflict and Terrorism, UK.
[26] King Akerele, O (1997) "Presentation by Ms. Olubank King Akerele," The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, Annex 2, http://www.undp.org/hiv/Mayors/anex2e.htm
[27] Southern African Economist, 1997. "AIDS toll on regional economies," April 15-May 15, 1997.
[28] A Whiteside, N Wilkins, B Mason, G Wood (1995) "The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal," prepared for The Town and Regional Planning Commission of KwaZulu-Natal, draft report, 24 March 1995.

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

  - One early study estimated the lost human capital that had been invested in the education of AIDS patients according to three different scenarios. Using the 1991 distribution of educational attainment for various races in the economically active age group, the total lost educational investment was R26.9 million. Depending on the racial mix of the projection, the total lost investment ranged from R14.4 million to R41.3 million.[29]

Total educational human capital invested in AIDS victims, with three educational distributions, 1991

	Amount (R millions)	Index
Current distribution	26.9	100.0
Biased towards uneducated	14.4	53.3
Biased towards educated	41.3	153.9

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance:

[29] Trotter, G (1993) "Some Reflections on a Human Capital Approach to the Analysis of the Impact of AIDS on the South African Economy," in Facing Up to AIDS, The Socio-Economic Impact in Southern Africa, S. Cross and A Whiteside, eds. (Basingstoke, UK: Macmillan Press, 1993).

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

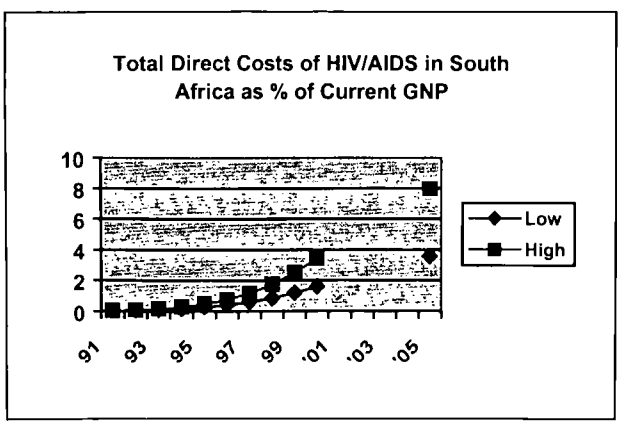
- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

- In South Africa, by the year 2010, child mortality will be 99.5 per 1000 children including the impact of AIDS, while the number would have been 48.5 per 1000 without the effect of HIV/AIDS. Life expectancy will decrease to 47.8 years from the previously expected 67.9 years, due to the impact of HIV/AIDS. Overall, the population growth rate with AIDS will be 0.4% by the year 2010, while the growth rate without AIDS would have been 1.4%.[30]

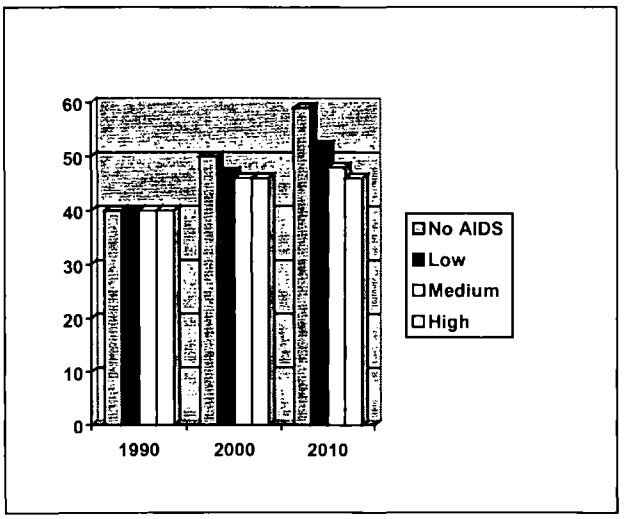


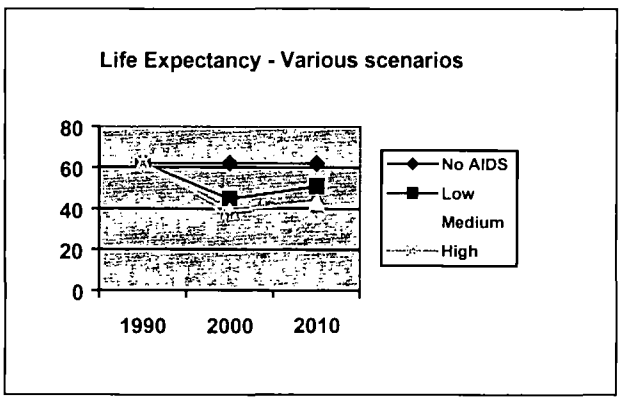
- One study estimated the total direct and indirect costs due to HIV/AIDS through the year 2000, using two different scenarios. In the low scenario, using low hospital costs, the costs rise from US$21.5 million in 1991 to US$1.2 billion in the year 2000, while in the high scenario, using high hospital costs, the costs rise from US$32 million to US$2.9 billion. This translates into an increase from 0.5 percent of total health expenditure in 1991 to 34 percent in 2005 for the low scenario, and from 0.8 percent in 1991 to 75 percent of total health expenditure in 2005 for the high scenario. Total direct costs of HIV/AIDS reach 3.6 percent of current GNP by 2005 for the low scenario, and 8 percent of current GNP by 2005 for the high scenario.

[30] US Bureau of the Census, World Population Profile, 1998, Population Division International Programme Centre, Washington DC, 1998.

The indirect costs, based on assumptions about lost earnings per worker, indicate that total lost work years decline by between 20 and 35 percent, but production decreases only 2.3-3.5 percent. Thus the overall macroeconomic impact, in monetary terms, will be small. This result is due to the disparity between the pay of skilled versus unskilled workers; because a large percentage of the population has relatively low earnings, although years lost is high, total monetary loss to the economy is low.[31]

- A recent set of projections of the macroeconomic impact of HIV/AIDS in South Africa estimated that under the high impact scenario, the population size would be 28% smaller in 2010 than it would have been without AIDS. Without AIDS, the model predicts that the population would be about 59 million people in 2010, while under the high impact scenario, the population would be only 46 million people. The same model predicts that life expectancy will decrease by 82 percent under the high scenario, from 62 years without the impact of AIDS to 34 years under the high impact scenario. In comparison, the model predicts that the population in Zimbabwe decreases by 45 percent by 2010, and by 17 percent for Kenya. Life expectancy is projected to decline by 90 percent for Zimbabwe by 2010, and by 33 percent for Kenya. The projections for both population size and life expectancy for South Africa, for all of the scenarios, are shown in the graphs.[32]





What Can Be Done?

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep

[31] Broomberg, J , M Steinberg, P Masobe, and G Behr (1993) "Economic impact of the AIDS epidemic in South Africa," in Facing Up to AIDS, The Socio-Economic Impact in Southern Africa, S. Cross and A Whiteside, eds. (Basingstoke, UK: Macmillan Press, 1993).

[32] Gregson, S, B Zaba, G Garnet, R Anderson (1997) "Projecting the HIV/AID epidemic in Southern Africa," presented at the Socio-Demographic Impact of AIDS in Africa Conference, 3-6 February 1997.

the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

    - During 1997, South Africa implemented a pilot program to introduce presumptive STD treatment in a mining community. The intervention included free monthly exams, community-based peer education on STD/HIV prevention, counseling, and one dose of an antibiotic for about 400 women over a nine-month period. Over that time period, there was a reduction of 20% in the reported number of clients, and an increase in the use of condoms from 13% to 29% of total sexual contacts. The AVERT model estimated that 237 new HIV infections had been averted through this intervention over a one-year time period, 41 among the women and 196 among the miners.[33] A similar program was followed in KwaZulu-Natal by the African Medical Research Foundation for commercial sex workers and truck firms, including peer education and STD treatment.[34]

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives

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[33] Rehle, T, TJ Saidel, SE Hassig, PD Bouey, EM Gaillard, and DC Sokal (1998) "AVERT: a user-friendly model to estimate the impact of HIV/sexually transmitted disease prevention interventions on HIV transmission," AIDS 1998; 12(suppl 2):S27-S35.

[34] Crowe, S (1997) "South Africa revolutionises HIV prevention and education strategies," Lancet; 349(9062):1377.

for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

  - South Africa has been in the process of rewriting their employment legislation; part of this process may classify HIV/AIDS as a disability. This classification would protect employees from unfair dismissal and discrimination.[35] Although discrimination against people living with AIDS is not allowed, as stated in the Government White Paper on Health System Transformation, stigma against AIDS is widespread in South Africa.[36]

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

  - A crucial element for the care of orphans in South Africa seems to be some sort of external financial support. One study found that, although 62 percent of families surveyed in KwaZulu were willing to care for orphans, this rose to 78 percent if some sort of external support would be provided. Two other efforts at community-based care did not succeed because external support was not provided.[37]

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

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[35] Gresak, GA (1998) "AIDS in the workplace – HIV/AIDS and the law," AIDS Bulletin; 7(1):8-11.
[36] Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.
[37] Cited in Taylor, V (1998) "HIV/AIDS & Human Development: South Africa, 1998," UNDP/UNAIDS.