AIDS IN THE THIRD WORLD

A global disaster

PIETERMARITZBURG, HARARE, KAMPALA

The AIDS virus has infected 47m people, and shows no signs of slowing. It cannot be cured. Can it be curbed?

IN RICH countries AIDS is no longer a death sentence. Expensive drugs keep HIV-positive patients alive and healthy, perhaps indefinitely. Loud public-awareness campaigns keep the number of infected Americans, Japanese and West Europeans to relatively low levels. The sense of crisis is past.

In developing countries, by contrast, the disease is spreading like nerve gas in a gentle breeze. The poor cannot afford to spend $10,000 a year on wonder-pills. Millions of Africans are dying. In the longer term, even greater numbers of Asians are at risk. For many poor countries, there is no greater or more immediate threat to public health and economic growth. Yet few political leaders treat it as a priority.

Since HIV was first identified in the 1970s, over 47m people have been infected, of whom 14m have died. Last year saw the biggest annual death toll yet: 2.5m. The disease now ranks fourth among the world's big killers, after respiratory infections, diarrhoeal disorders and tuberculosis. It now claims many more lives each year than malaria, a growing menace, and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", says Peter Piot, head of the UN's AIDS programme.

The human immuno-deficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS), is thought to have crossed from chimpanzees to humans in the late 1940s or early 1950s in Congo. It took several years for the virus to break out of Congo's dense and sparsely populated jungles but, once it did, it marched with rebel armies through the continent's numerous war zones, rode with truckers from one rest-stop brothel to the next, and eventually flew, perhaps with an air steward, to America, where it was discovered in the early 1980s. As American homosexuals and drug injectors started to wake up to the dangers of bath-houses and needle-sharing, AIDS was already devastating Africa.

So far, the worst-hit areas are east and southern Africa. In Botswana, Namibia, Swaziland and Zimbabwe, between a fifth and a quarter of people aged 15-49 are afflicted with HIV or AIDS. In Botswana, children born early in the next decade will have a life expectancy of 40; without AIDS, it would have been nearer 70. Of the 25 monitoring sites in Zimbabwe where pregnant women are tested for HIV, only two in 1997 showed prevalence below 10%. At the remaining 23 sites, 20-50% of women were infected. About a third of these women will pass the virus on to their babies.

The region's giant, South Africa, was largely protected by its isolation from the rest of the world during the apartheid years. Now it is host to one in ten of the world's new infections—more than any other country. In the country's most populous province, KwaZulu-Natal, perhaps a third of sexually active adults are HIV-positive.

Asia is the next disaster-in-waiting. Already, 7m Asians are infected. India's 930m people look increasingly vulnerable. The Indian countryside, which most people imagined relatively AIDS-free, turns out not to be. A recent study in Tamil Nadu found over 2% of rural people to be HIV-positive: 500,000 people in one of India's smallest states. Since 10% had other sexually transmitted diseases (STDs), the avenue for further infections is clearly open. A survey of female STD patients in Poona, in Maharashtra, found that over 90% had never had sex with anyone but their husband; and yet 13.6% had HIV. China is not far behind.

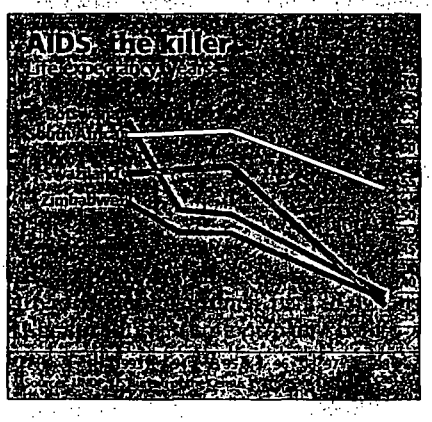
No one knows what AIDS will do to poor countries' economies, for nowhere has the epidemic run its course. An optimistic assessment, by Alan Whiteside of the University of Natal, suggests that the effect of AIDS on measurable GDP will be slight. Even at high prevalence, Mr Whiteside thinks it will slow growth by no more than 0.6% a year. This is because so many people in poor countries do not contribute much to the formal economy. To put it even more crudely, where there is a huge oversupply of unskilled labour, the dead can easily be replaced. Some people argue that those who survive the epidemic will benefit from a tighter job market. After the Black Death killed a third of the population of medieval Europe, labour scarcity forced landowners to pay their workers better.

Other researchers are more pessimistic. AIDS takes longer to kill than did the plague, so the cost of caring for the sick will be more crippling. Modern governments, unlike medieval ones, tax the healthy to

help look after the ailing, so the burden will fall on everyone. And AIDS, because it is sexually transmitted, tends to hit the most energetic and productive members of society. A recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GDP will be 14.5% smaller in 2005 than it would have been without AIDS, and that income per person will be 10% lower.

The cost of the disease

In general, the more advanced the economy, the worse it will be affected by a large number of AIDS deaths. South Africa, with its advanced industries, already suffers a shortage of skilled manpower, and cannot afford to lose more. In better-off developing countries, people have more savings to fall



back on when they need to pay medical bills. Where people have health and life insurance, those industries will be hit by bigger claims. Insurers protect themselves by charging more or refusing policies to HIV-positive customers. In Zimbabwe, life-insurance premiums quadrupled in two years because of AIDS. Higher premiums force more people to seek treatment in public hospitals: in South Africa, HIV and AIDS could account for between 35% and 84% of public-health expenditure by 2005, according to one projection.

Little research has been done into the effects of AIDS on private business, but the anecdotal evidence is scary. In some countries, firms have had to limit the number of days employees may take off to attend funerals. Zambia is suffering power shortages because so many engineers have died. Farmers in Zimbabwe are finding it hard to irrigate their fields because the brass fittings on their water pipes are stolen for coffin handles. In South Africa, where employers above a certain size are obliged to offer generous benefits and paid sick leave, companies will find many of their staff, as they sicken, becoming more expensive and less productive. Yet few firms are trying to raise awareness of AIDS among their workers, or considering how they will cope.

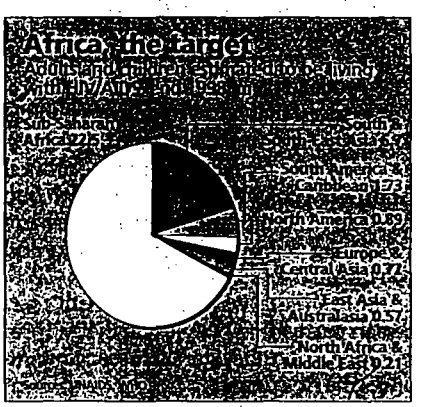
In the public sector, where pensions and health benefits are often more generous, AIDS could break budgets and hobble the provision of services. In South Africa, an estimated 15% of civil servants are HIV-positive, but government departments have made little effort to plan for the coming surge in sickness. Education, too, will suffer. In Botswana, 2-5% of teachers die each year from AIDS. Many more take extended sick leave.

At a macro level, the impact of AIDS is felt gradually. But at a household level, the blow is sudden and catastrophic. When a breadwinner develops AIDS, his (or her) family is impoverished twice over: his income vanishes, and his relations must devote time and money to nursing him. Daughters are often forced to drop out of school to help. Worse, HIV tends not to strike just one member of a family. Husbands give it to wives, mothers to babies. This correspondent's driver in Kampala lost his mother, his father, two brothers and their wives to AIDS. His story is not rare.

Obstacles to prevention

The best hope for halting the epidemic is a cheap vaccine. Efforts are under way, but a vaccine for a virus that mutates as rapidly as HIV will be hugely difficult and expensive to invent. For poor countries, the only practical course is to concentrate on prevention. But this, too, will be hard, for a plethora of reasons.

- Sex is fun... Many feel that condoms make it less so. Zimbabweans ask: "Would you eat a sweet with its wrapper on?"
- ... and discussion of it often taboo. In Kenya, Christian and Islamic groups have publicly burned anti-AIDS leaflets and condoms, as a protest against what they see as the encouragement of promiscuity. A study in Thailand found that infected women were only a fifth as likely to have discussed sex openly with their partners as were uninfected women.
- Myths abound. Some young African women believe that without regular infusions of sperm, they will not grow up to be beautiful. Ugandan men use this myth to seduce schoolgirls. In much of southern Africa, HIV-infected men believe that they can rid themselves of the virus by passing it on to a virgin.
- Poverty. Those who cannot afford television find other ways of passing the evening. People cannot afford antibiotics, so the untreated sores from STDs provide easy openings for HIV.
- Migrant labour. Since wages are much higher in South Africa than in the surrounding region, outsiders flock in to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories surrounded by prostitutes. Living with a one-in-40 chance of being killed by a rockfall, they are inured to risk. When they go home, they often infect their wives.
- War. Refugees, whether from genocide in Rwanda or state persecution in Myanmar, spread HIV as they flee. Soldiers, with their regular pay and disdain for risk, are more likely than civilians to contract HIV from prostitutes. When they go to war, they infect others. In Africa the problem is dire. In Congo, where no fewer than seven armies are embroiled, the government has accused Ugandan troops (which are helping the Congolese rebels) of deliberately spreading AIDS. Unlikely, but with estimated HIV prevalence in the seven armies ranging from 50% for the Angolans to an incredible 80% for the Zimbabweans, the effect is much the same.
- Sexism. In most poor countries, it is hard for a woman to ask her partner to use a condom. Wives who insist risk being beaten



up. Rape is common, especially where wars rage. Forced sex is a particularly effective means of HIV transmission, because of the extra blood.
- Drinking. Asia and Africa make many excellent beers. They are also home to a lot of people for whom alcohol is the quickest escape from the stresses of acute poverty. Drunken lovers are less likely to remember to use condoms.

How to fight the virus

Pessimists look at that list and despair. But three success stories show that the hurdles to prevention are not impossibly high.

First, **Thailand**. One secret of Thailand's success has been timely, accurate information-gathering. HIV was first detected in Thailand in the mid-1980s, among male homosexuals. The health ministry immediately began to monitor other high-risk groups, particularly the country's many heroin addicts and prostitutes. In the first half of 1988, HIV prevalence among drug injectors tested at one Bangkok hospital leapt from 1% to 30%. Shortly afterwards, infections soared among prostitutes.

The response was swift. A survey of Thai sexual behaviour was conducted. The results, which showed men indulging in a phenomenal amount of unprotected commercial sex, were publicised. Thais were warned that a major epidemic would strike

if their habits did not change. A "100% condom use" campaign persuaded prostitutes to insist on protection 90% of the time with non-regular customers.

By the mid-1990s, the government was spending $80m a year on AIDS education and palliative care. In 1990-93, the proportion of adult men reporting non-marital sex was halved, from 28% to 15%; for women, it fell from 1.7% to 0.4%. Brothel visits slumped. Only 10% of men reported seeing a prostitute in 1993, down from 22% in 1990. Among army conscripts in northern Thailand, a group both highly sexed and well-monitored, the proportion admitting to paying for sex fell from 57% in 1991 to 24% in 1995. The proportion claiming to have used condoms at their last commercial entanglement rose from 61% in 1991 to 93% in 1995.

People lie about sex, so reported good behaviour does not necessarily mean actual good behaviour. But tumbling infections suggest that not everyone was fibbing. The number of sexually transmitted diseases reported from government clinics fell from over 400,000 in 1986 to under 50,000 in 1995. Among northern conscripts, HIV prevalence fell by half between 1993 and 1995, from over 7% to under 3.5%.

Most striking was the government's success in persuading people that they were at risk long before they started to see acquaintances die from AIDS. There was no attempt to play down the spread of HIV to avoid scaring off tourists, as happened in Kenya. Thais were repeatedly warned of the dangers, told how to avoid them, and left to make their own choices. Most decided that a long life was preferable to a fast one.

Second, **Uganda**. Thailand shows what is possible in a well-educated, fairly prosperous country. Uganda shows that there is hope even for countries that are poor and barely literate. President Yoweri Museveni recognised the threat shortly after becoming president in 1986, and deluged the country with anti-AIDS warnings.

The key to Uganda's success is twofold. First, Mr Museveni made every government department take the problem seriously, and implement its own plan to fight the virus. Accurate surveys of sexual behaviour were done for only $20,000-30,000 each. Second, he recognised that his government could do only a limited amount, so he gave free rein to scores of non-governmental organisations (NGOs), usually foreign-financed, to do whatever it took to educate people about risky sex.

The Straight Talk Foundation, for example, goes beyond simple warnings about AIDS and deals with the confusing complexities of sex. Its staff run role-playing exercises in Uganda's schools to teach adolescents how to deal with romantic situations. Its newsletter, distributed free, covers everything from nocturnal emissions to what to do if raped. Visiting AIDS workers from South Africa and Zimbabwe asked the foundation's director, Catharine Watson, how she won government permission to hand out such explicit material, and were astonished to hear that she had not felt the need to ask.

The climate of free debate has led Ugandans to delay their sexual activity, to have fewer partners, and to use more condoms. Between 1991 and 1996, HIV prevalence among women in urban ante-natal clinics fell by half, from roughly 30% to 15%.

Third, **Senegal**. If Uganda shows how a poor country can reverse the track of an epidemic, Senegal shows how to stop it from taking off in the first place. This West African country was fortunate to be several thousand miles from HIV's origin. In the mid-1980s, when other parts of Africa were already blighted, Senegal was still relatively AIDS-free. In concert with non-governmental organisations and the press and broadcasters, the government set up a national AIDS-control programme to keep it that way.

In Senegal's brothels, which had been regulated since the early 1970s, condom use was firmly encouraged. The country's blood supply was screened early and effectively. Vigorous education resulted in 95% of Senegalese adults knowing how to avoid the virus. Condom sales soared from 800,000 in 1988 to 7m in 1997. Senegalese levels of infection have remained stable and low for a decade—at around 1.2% among pregnant women.

Contrast these three with South Africa. On December 1st, World AIDS Day, President Nelson Mandela told the people of KwaZulu-Natal that HIV would devastate their communities if not checked. The speech was remarkable not for its quality—Mr Mandela is always able to move audiences—but for its rarity. Unlike Mr Museveni, South Africa's leader seldom uses his authority to encourage safer sex. It is a tragic omission. Whereas the potholed streets of Kampala are lined with signs promoting fidelity and condoms, this correspondent has, in eight months in South Africa, seen only two anti-AIDS posters, both in the UN's AIDS office in Pretoria.

How to dither and die

South Africa has resources and skills on a scale that Uganda can only marvel at. It even has an excellent AIDS prevention plan, accepted by the new cabinet in 1994. But the plan was never implemented. The government likes to consult every conceivable "stakeholder", so new plans are eternally drafted and redrafted. Local authorities cannot act without orders from the central government. NGOs, many of them dependent on the powers-that-be for their finance, waste months making sure that enough of their senior management posts are filled with blacks to satisfy the ruling African National Congress. And they have minimal freedom to experiment.

"There's an idea that if you disagree with the government, you are betraying the liberation struggle," says Mary Crewe, head of the Greater Johannesburg AIDS project. As a result, soldiers in the South African army are so ignorant that they snip the tips off their free condoms, and HIV has spread through South Africa as fast, according to Dr Neil McKerrow of Grey's Hospital in Pietermaritzburg, as if no preventive measures at all had been taken.

Such bungling is not unique to South Africa. Most governments have been slow to recognise the threat from AIDS. From Bulawayo to Beijing, apathy and embarrassment have hamstrung preventive efforts.

In anarchic countries, such as Congo and Angola, there have been almost no preventive efforts. Many people believe that the cause—a bid to restrain one of the most basic human instincts—is hopeless. As a Zimbabwean novelist, Chenjerai Hove, puts it with disturbing fatalism: "Since our women dress to kill, we are all going to die." But if the sexual drive is basic, so is the desire to live. If governments in poor countries wake up to the need to persuade their citizens that unprotected sex is Russian roulette, Mr Hove could be proved wrong.

This article is indebted to a number of UNAIDS reports, including AIDS epidemic update (December 1998), AIDS in Africa (November 1998), and "A measure of success in Uganda" (May 1998).

AIDS Stalking Africa's Struggling Economies

By DONALD G. McNEIL Jr.

LUSAKA, Zambia -- At one time, Barclay's Bank here was losing 36 of its 1,600 employees a year, 10 times the death rate at most U.S. companies.

At the private Minbank Clinic, where the senior managers of Zambia's biggest mining houses, banks and industrial companies are treated, about half of all appointments are AIDS-related.

In nearby Zimbabwe, a personnel officer confesses that he has hired three people for each semiskilled job, expecting two to die in training. Half the executives at another company refuse promotions because an HIV test is required.

In the mines, where one sick driller can cripple a whole crew, some South African shafts are reporting 25 percent HIV infection rates, and even higher rates of tuberculosis, which blooms in weakened immune systems.

As the AIDS epidemic sweeps the continent, the underpinnings of many already shaky economies are becoming riddled with cracks. As one economist put it, the problems right now are merely insidious, "but one day you'll wake up and they'll be catastrophic."

In Africa, the disease attacks educated urban professionals -- the backbone of economic expansion -- first. The loss of those people can rob the continent of much of its potential. The damage is immeasurable, economists say, because it appears in ways that cannot be seen — businesses that will never be founded, ideas that will never be pitched, university departments that will never be created.

In eastern and southern Africa, where the epidemic is worst, the economically strongest countries -- South Africa, Botswana, Zimbabwe, Kenya, Uganda and Zambia -- have infection rates between 10 percent and 25 percent. Virtually all of those infected will die within 10 years. West Africa's strongest economies, like those of Nigeria, Ghana and the Ivory

Coast, have lower, but still scary, infection rates.

AIDS here, spread mostly by heterosexual encounters, hits the economically productive hardest. "It's men who may come from poor areas, but now have social mobility, can travel, can afford prostitutes," said Wayne Myslik, chief consultant for Lifeworks, a South African AIDS-management consultancy, who has studied the problem at companies all over Africa.

A well-known 1987 study in Rwanda showed that a pregnant woman had a 9 percent chance of infection if her husband was a farmer, a 22 percent chance if he was a soldier, a 32 percent chance if he was a white-collar worker and a 38 percent chance if he was a government official.

Companies and governments may find ways to avoid bankruptcy, but the choices they make to survive will be cruel -- laying off the sick, sending others home to die.

For Westerners used to a system in which insurers and governments pay for top-quality medical care, it is hard to grasp the kinds of cuts already being made here. Never mind $15,000 AIDS cocktails and costly cures for rare brain infections. Companies that once calmly paid for coffins, hearses and funeral meals for employees are now begrudging even that.

Accurately gauging the impact of the epidemic is difficult. Few companies know how many of their workers are infected. And no one admits having AIDS, so experts must guess how many of the deaths of young working people from tuberculosis, malaria and vague complaints like "bad chest" are really AIDS-related.

But the indications are that the disease is devastating to family finances, widely variable in the damage it inflicts on individual companies and government health budgets, and -- so far, anyway -- surprisingly minor in its statistical effects on national economies.

But because so many industries in Africa rely on cheap unskilled labor from the almost limitless pools of the unemployed, damage to overall economies may be relatively slight, economists said.

In one of the cruel ironies of epidemiology, the survivors may benefit economically, just as the survivors of the 14th-century bubonic plague did when wages skyrocketed and farmland became free.

The damage at the family level is easy to grasp. The typical breadwinner in Africa has 10 dependents, and outside South Africa there are no welfare systems. Poor families are devastated even by a child's death, because the cost of medicine and a funeral means they often have to eat less, sell land or cattle, or take healthy children out of school.

That returns a once-ambitious family directly into the hopeless cycle of poverty at its nadir -- illiterate, ill-nourished children hoeing small plots of corn to avoid starvation.

Health Systems: Strained Budgets Bring Rationing

The next greatest threat is to medical budgets, both public and private.

Most African countries have annual health budgets of less than $6 per citizen. Zimbabwe, for example, allocated $3.68 per person in 1995, while the hospitalization of a privately insured AIDS patient that year cost $18,000.

Faced with bankruptcy, governments respond by rationing.

The $15,000-a-year protease-inhibitor "cocktails" that prolong so many American lives are out of the question -- the World Bank estimates that one patient's dosage would keep 400 children in school for a year. Most patients get the most common malaria drugs, TB drugs and antibiotics. When their immune systems are so weak that those stop working, they simply die.

Even relatively rich South Africa says it cannot afford to offer $80 courses of AZT routinely to pregnant and nursing women to prevent transmission to their children.

Workers for corporations face similar rationing, but the more generous

employers buy them more months of life. Worker health insurance is rare; far more common are clinics on the grounds of the mine, factory or farm. They offer as much as the company decides it can afford.

Small companies cope by simply dismissing sick workers; rich ones cap their health benefits. Even Eskom, the South African power company known for its generous benefits, recently cut its medical benefits for HIV-infected employees from $18,000 a year to $2,600.

"The employees didn't scream," said Liz Thebe, Eskom's AIDS-education administrator. Since South Africa's press is unsophisticated about AIDS, protease-inhibitor "cocktails" are seldom mentioned and few people are aware of them. Only a handful of Eskom workers, most of them white, take them, Ms. Thebe said. Others, who have heard that such treatment involves 60 pills a day and harsh side effects, simply declined. Some "prefer to go to traditional healers," she said.

Insurance companies react to the disease's heavy toll by writing policies that require repeated blood tests. If a country outlaws such requirements, they stop doing business there.

In dirt-poor Malawi, Myslik said, there are only two insurers left: the state-owned National Insurance Co., which is insolvent, and Old Mutual, which insures only expatriate workers, not Malawians.

The Companies: Some Cut Costs, Others Stress Help

The third-greatest economic damage done by AIDS is to corporate profits. Few companies will talk about AIDS in their work force and some hide the problem even from their shareholders, so analyses of losses are relatively rare.

At Indeni, Zambia's only oil refinery, AIDS costs doubled from 1991 to 1993 and surpassed the company's meager profits the next year.

A study of Botswana Diamond Valuing Co., whose 525 highly trained sorters pick diamonds off conveyor belts full of mine gravel, estimated that AIDS cost it $237 per employee, or 6 percent of profits, in 1994.

The Botswana Meat Commission, which slaughters the country's beef, its second-biggest export after diamonds, was losing $268 per employee, or 8 percent of profits.

At Muhoroni Sugar, a huge sugar plantation in Kenya, costs in 1994 were only $49 per employee, but they were expected to double while the company kept losing money. (To keep this in perspective, one must remember how low wages are in Africa. A typical Muhoroni worker earned about $1,200 a year.)

AIDS bleeds profits from companies in many ways: medical and death expenses, funeral payments, the costs of recruiting and training new employees; work hours lost because employees are off sick.

Interestingly, in companies that keep statistics, more work-hours are lost to funeral attendance than to illness. Since most Africans are buried in their rural home villages, attending a relative's funeral means asking for up to a week off.

"In my tradition, I can have three or four mothers," said Mulenga Kapwepwe, an executive at Project Concern, an AIDS-monitoring group here, explaining that Africans consider aunts, uncles and cousins to be immediate family. "Before the epidemic, things were loose -- I could go bury anyone in my extended family. Now companies are tightening up."

And there are the potentially huge costs of accidents. "I had a guy collapse at the airport the other day," said an executive who spoke on condition his company not be named. "What if he'd been driving his truck and hit a 727?"

With brutally hard-nosed management, some companies can contain costs. Although 20 to 25 of the 900 employees of Chilanga Cement die each year, the effect on the bottom line is "almost negligible," said chief executive Patrick Gorman. The disease does not even rate a mention in the annual report.

The Lusaka-area company, which owns Zambia's biggest cement plant,

was sold by the government to Britain's Commonwealth Development Corp. in 1994.

Most of its deaths are among laborers, who are easily replaced, and the company is laying men off anyway, Gorman said. "To put it callously, it's achieving what we want," he said. "Natural wastage is letting us reach our manning levels."

Absenteeism for funerals had increased 15-fold between 1992 and 1995, but "we've stamped on that," he added. A worker may leave only for the funeral of a wife, parent or child without losing the day's pay.

White-collar deaths are "surprisingly low," Gorman said, though he had to hire back a marketing director because the two successors he hired have both died.

At the company's on-site clinic, costs are "down to about $15 per head per annum," he said. "We draw the line at AZT and all these high-powered expensive drugs."

For each worker who died, the company used to pay for the coffin, hearse, buses for mourners, food for the funeral meal and a cash grant to the family. "When I first got here, I tried to do away with the whole thing and ended up in a three-month firefight with the union," Gorman said. Ultimately, they settled for a grant worth about $200.

At the other end of the spectrum in Zambia is Barclay's Bank, the country's biggest. Its employees are overwhelmingly white-collar and high school or college graduates. With subsidiaries across Africa, Barclay's is widely admired for its AIDS plans, of which Zambia's was the first.

The bank has never calculated exactly how much the disease costs it, said Bright Nyirenda, who started the program. But its startling wake-up call came in the late 1980s when it was legal to give blood tests to job applicants: eight of the 10 interviewed in the small city of Kabwe proved HIV-positive.

Meanwhile, inside the company's ranks, "young men ready for promotion

were dying," said Sylvester Mubengwa, Nyirenda's successor as health and safety manager.

Between 1987 and 1992, the bank's annual mortality rate rose from 0.4 percent to 2.23 percent. In the United States about 0.25 percent is typical. It has since leveled off a bit lower, with 85 percent of the deaths AIDS-related.

Making matters worse, many are middle managers. The typical death comes after six years of service; the bank lost eight supervisory or managerial rank employees last year and 11 in 1996.

Others who have been hard-hit are the secretaries to those men. "The managers travel a lot, and so are ... exposed to temptation," said Nyirenda, straining to speak delicately. "Back at work, they prevail over their juniors, and get favors from them. With secretaries, it can turn out quite viciously." The bank has a sexual-harassment policy, he said, but workers in impoverished Zambia are desperate to keep their jobs.

Because the bank pays relatively well, it can fill its depleted ranks by raiding other companies. Small firms cannot compete for executive talent.

Barclay's does not merely offer health lectures and free condoms, as some companies do. "It's bank policy to show compassion," Mubengwa said, sitting under a poster of the Barclay's eagle with a red AIDS ribbon on its wing.

When an employee begins to show signs of sickness -- slackening concentration, growing absenteeism -- Mubengwa tries to work out a plan that eases the work burden, oversees medical care and suggests disability retirement. Employees are prodded to prolong their lives by living in healthy ways -- quitting smoking, taking vitamins, avoiding new infections.

However, as is frequently the case here, the employees often deny they are sick, refuse HIV tests and try to work until they die. In a legacy of mining-based economies, African companies typically pay two to four times annual salary to the family of a worker who dies on the job, while

disability retirements are pittances.

The Economies: Loss So Far Slight, but Potential Fades

Perhaps surprisingly enough, the least catastrophic damage from the epidemic is at the macroeconomic level. Most of the 610 million people in Africa south of the Sahara are subsistence farmers, herders or fishermen. Those with formal jobs are usually laborers, crop pickers or miners. Although they suffer and die, the economy marches on indifferently. There are so many desperate job-seekers that they are quickly replaced.

Mead Over, a World Bank economist, estimates that in Africa's 10 worst-hit countries, through the year 2025, the disease will reduce growth of gross domestic product per capita by only 0.3 percent.

Although total GDP goes down when the sick do not grow crops or produce goods, he explained, so many people die that those who are left own greater slices of the economic pie. And he is quick to point out that an 0.3 percent drop in growth is significant in countries struggling to grow even 1 percent a year.

Some economists almost apologetically compare AIDS in Africa to the 14th century's Black Death. That great scythe of bubonic plague killed nearly a third of Europe's people in three years, but from a cold-bloodedly financial point of view, the survivors did nicely. With labor scarce, wages climbed, and "a lot of people suddenly had a lot more land," Over said.

And, as Alan Whiteside, an economist at the University of Natal, in South Africa, noted, many African economies are shrinking, while governments are selling state enterprises and trimming public payrolls. "Being cynical about it," he said, "They think, 'If you're going to lose people anyway, do you mind how they go?'"

The impact of deaths in the civil service has yet to be calculated. Business in Africa is intertwined with government, which usually owns the telephone system and electric company. Infection rates in the civil service are high -- in South Africa, as many as one in seven are thought to be infected. In some countries, civil servants, who have job security, may

legally be home sick for a year before being replaced.

That is a crisis in the making, said Whiteside. "You can't run a company without electricity," he said. "If the power company loses its technicians, you can't generate electricity."

Although most companies have been slow to respond, or are still in denial, a few prescient ones saw the problem coming.

That did not always help.

Jenny Rogers runs South Africa's best-known AIDS program for the Billiton aluminum company in the province of KwaZulu-Natal. It hands out condoms and brochures in every bathroom, gives health lectures and aggressively treats workers for venereal diseases, which increase the risk of HIV infection.

Mrs. Rogers even took a whole museum exhibit on AIDS from Pretoria to Richards Bay, the little city around the smelters, and found friendly HIV-infected guides to take 20,000 visitors through and talk to them about their fears of the disease.

In a way, she was lucky. AIDS came late to South Africa because anti-apartheid sanctions kept the borders closed -- though not airtight -- until 1990. She might have had time to head off the disease.

But, she said, "for years, the unions blocked it."

"There was a belief that the disease didn't exist, because no one had seen it. And some feeling that it was a plot by the old government or the United States to keep the black population down by getting people to use condoms. And there were objections that condoms aren't part of African culture. And there are traditional practices here that spread the disease -- such as when a man dies, his wives become his brother's property so the land isn't split up, and he is expected to sleep with them."

She slowly overcame a lot of that resistance, she said. Shop stewards now double as AIDS educators, and the company hands out so many

condoms that at one point employees were taking an average of 6.2 per day each. "I think I'm supporting a lot of small entrepreneurs," she said, laughing.

Nonetheless, it may all be too late. The infection rate in surrounding KwaZulu-Natal is now 30 percent, higher even than in Zimbabwe or Botswana, Africa's worst-hit countries. Those deaths are yet to come.

Sunday, November 15, 1998

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

FAX CORRESPONDENCE

DUFF G. GILLESPIE
DEPUTY ASSISTANT ADMINISTRATOR
POPULATION, HEALTH AND NUTRITION
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

MAIL: 320 TWENTY-FIRST ST., N.W.
WASHINGTON, DC 20523-3600
INTERNET: dgillespie@usaid.gov

STREET: 1300 Penn. Ave. NW
Wash. DC 20004
PH: (202) 712-4120
FAX: (202) 216-3046

DATE: 11-14-97

TO: Ms. Sandy Thurman

ORGANIZATION: C/O Sapori Park Hotel

FAX PHONE: _____ OFFICE PHONE: _____

FROM: Duff Gillespie

ORGANIZATION: _____

FAX PHONE: _____ OFFICE PHONE: _____

SUBJECT: _____

NUMBER OF PAGES (including this cover sheet): 2

COMMENTS: Please pass to Ms. Sandy Thurman.

November 13, 1997

FOR MS. SANDY THURMAN Who Arrives the afternoon of November 14

Sandy,

I just received a telephone call from Dr. David Nabarro, UK, who had some very important observations about what may or may not go into an opening statement. I can't go into details here, but he feels that this meeting is not an appropriate venue for major and sensitive issues. If it were possible to hold off on a major statement until I get there, I can fully brief you. If not, maybe you could informally discuss our statement with the UK delegation.

Sorry I couldn't get there earlier. Looking forward to seeing you and the crew, Duff

United States Information Agency

WASHINGTON DC 20547-0001

USIA

December 3, 1997

MEMORANDUM TO: Victoria and Alfred Hotel
27-21-419-89-55

FROM: Tom Stillitano Tom Stillitano

ATTENTION: Minette - Reservations

This is to confirm the reservation of Sandra Thurman for a single room for December 13 and December 14 at a rate of R540 per night. Please send confirmation of this reservation and rate to Tom Stillitano at fax (USA) 202-401-5785. This reservation can be guaranteed on VISA card #4800-1201-1934-8100, expiration 9-30-99, name THOMAS A STILLITANO, Jr.

Confirmation American Airlines # TONFXQ

Dec 12

depart WASH NAT 12[59] ARRIVE Miami 336 P.M.
AA # 1791

depart Miami 5 PM ARRIVE Capetown 140 PM Dec 13
AA # 6004

overnight Capetown Dec 13, Dec 14

Dec 15

depart Capetown 8[00] AM ARRIVE Joberg 9[55] AM
SA # 306 COACH

overnight Joberg Dec 15 and Dec 16

Dec 17 depart Joberg 1[30] PM ARRIVE Port Elizabeth 3[10] P.M.
SA # 449

pick up by Dr Woods for 1 hr drive to Rhodes
PROGRAM/OVERNIGHT Rhodes Dec 17, Dec 18

Dec 19 Shamori
Dr Woods will drive you to Shamori early morning
overnight Shamori

Dec 20 car will take you to Port Elizabeth Airport for 3[55] PM
departure on SA # 425 for Joberg
Depart Joberg 9 PM on AA # 6001 ARRIVE JFK 7[30] AM (21st)

Dec 21 American Eagle # 4944 10[15] AM to WASH NAT ARRIVE 11[40] AM

NOTE TO SANDY THURMAN

Subject: Update on South Africa

This is an informal note Sandy. I apologize for being persistent--I had no idea (until last Friday) that the President's Commission was in town last week and over the weekend. As you know, I recently returned from South Africa where I was the team leader to develop the design for the new USAID HIV/AIDS program. There are issues and details which I would like to share with you on this new program when you have a less busy moment.

What is of greater importance from a timing point of view is your possible visit to South Africa. I had heard that you would possibly be visiting South Africa later this week and staying into next (with the dates fluctuating). However, I am also aware that no information has been circulating inside of South Africa regarding a possible trip, including from the USIS side. I became very concerned about this which is why I was trying to get hold of you so much last week. I don't know the details regarding your trip: whether you are indeed still planning a trip, what you intend to accomplish, who you would like to meet with, and so on. If you are planning a trip later this week, then I offer the following items and issues:

- USIS and USAID are not aware of your trip. At USIS, Dan Whitman has been and will continue to be on leave until January 2. His stand-in, Ben Lovejoy, is not aware of any details of a visit (I don't know if this is the person your office was working with, but it's the information I get back from the USAID office in South Africa). USAID is also unaware. Whereas they do not have responsibility for your trip, the Mission Director Aaron Williams would undoubtedly like to meet with you, and USAID can help identify sites for visits as well as key national individuals to meet with. At this point, however, it is late to set these up. Within the USAID mission, the health officer Alan Foose is on leave until this Wednesday and the HIV/AIDS technical advisor Renee Saunders is available to help.

- Rose Smart will be in Abidjan for the Africa AIDS Conference this week, returns on Dec 15 and goes on leave until the 29th--hence, she will not be available to meet with you. Also, Rose will not be available to help set up appointments for you within the Department of Health or with other interested parties. What concerns me here is that the DOH's staff is very limited and there may not be others who can help at the last minute.

- Many key individuals involved in HIV/AIDS in South Africa will be at the Africa AIDS meeting this week. If you go next week, then many should have returned, but appointments may not have been taken with them.

- December 16th is an official holiday in South Africa. In addition, Parliament has adjourned which means that many of the Parliamentarians will not be accessible.

There are also two sensitive issues involving the Minister of Health and HIV/AIDS that you should be aware of. The first is that the Minister announced in September her plan to have

mandatory anonymous AIDS case reporting in South Africa by the end of this year. This has been very controversial, with NAPWA and other advocacy groups being critical. In addition, there are serious public health issues involved such as the legal/human rights side (including confidentiality) as well as technical data collection issues. The second issue involves the Minister's announcement on World AIDS Day that all South Africans with AIDS should have access to Viridine (spelling?), a drug that a South African researcher has made multiple claims of cure etc, but has been discredited by the medical community (sort of like the Kemron case in Kenya a number of years ago). You could be asked to comment on either of these issues by the media or others if you are in South Africa.

I hope this helps and please let me know if you would like any other information or help.

Sincrely,

Alex

703-235-4453 -- w
301-585-1867 -- h

RHODES UNIVERSITY

MARKETING AND COMMUNICATIONS • Tel: (0461) 31 8513 • Fax: (0461) 31 1902 • e-mail: adjm@giraffe.ru.ac.za

Programme for the visit to Rhodes University and Grahamstown area, Eastern Cape, as the guest of the Vice-Chancellor of Rhodes University, of

Ms Sandy Thurman, Director of the Office of the United States of America National AIDS Policy and Presidential Advisor on AIDS issues

Wednesday 17 December 1997

15.10
Arrive Port Elizabeth airport, collected by Ms Aletta de Villiers, Director of Marketing at Rhodes University, and taken to The Lodge, Grahamstown, the home of her hosts Dr David and Mrs Charlotte Woods. Private informal braai evening with invited guests.

Thursday 18 December 1997

08.00
Social history tour of Grahamstown with Mrs Helen Holleman of the Black Sash.

10.00 - 12.30
Tea and meeting with all interested parties - AIDS educators, researchers, caregivers, action groups etc. While as many groups as possible will have been identified and invited, the short notice for the visit means that some are bound to have been missed out. For this reason, advertisements have been placed in the local East Cape media to allow everyone involved to hear about the meeting. Media coverage will also help ensure participation by all.
Venue: Arts Major Lecture Theatre, Rhodes University Campus

12.30 - 14h00
Finger lunch for all those who attend the meeting and wish to stay on.
Venue: Senior Common Room, Rhodes Main Administration Building

14.00
DRAMAID production excerpts and discussion. DRAMAID is a joint project of Rhodes University and the Grahamstown Foundation, funded by the National Department of Health. This drama production is taken into the rural schools as part of a Youth Education programme on AIDS.
Venue: 1820 Settlers Monument

15.15
Tea and tour of Grahamstown Foundation projects at the Monument, with Janet Buckland.

18.00
Traditional Xhosa evening arranged privately.

Friday 19th December 1997

08.30
Visit to Temba TB hospital in Grahamstown and Marjorie Parrish hospital in Port Alfred with Pastor Mike Lazar, Provincial Manager SANTA, Eastern Cape.

12.00
Private visit to Shamwari Game Reserve. Depart Saturday 20 December.

ORIGINAL
I.M. 61

USA

R

REPUBLIC OF KENYA

D 605235

Department of Immigration (Passport Branch) 15/11/97, 19

Received from Thomas Serena

Address

the sum of Sh. Thirty dollars

Sh. cts. Credit: Revenue/Immigration/Passport Fees

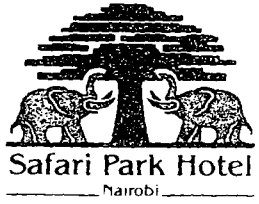
$30

Immigration Officer

SERVICE REQUIRED:		DOCUMENTS REQUIRED:		DISPOSAL:	
Passport	☒	P.P. 1	☐	Post	☒
Passport Renewal	☒	P.P. 2	☐	Calling	☐
Emergency Certificate	☐	Marriage Certificate	☐		
G.I.N.	☒	Birth Certificate	☐		
Visa	☒	Photographs	☐		
Other	☒				

P.O. Box 45038, Nairobi, Kenya.

SANDY THURMAN -



NATIONAL BLOOD TRANSFUSION SERVICE ZIMBABWE

(Registered as a Welfare Organisation No. 54/68)

BULAWAYO: P.O. Box 2010, Bulawayo. **Tel.: 62454 Fax: 65530**

ATTENTION: Ms SANDY THURMAN

Dear Ms Thurman,

REQUEST FOR FINANCIAL ASSISTANCE

We are requesting for financial assistance in the National Blood Transfusion Service of Zimbabwe (NBTS).

BACKGROUND.

The NBTS is a registered welfare organisation, not for profit. We operate on a cost recovery base under a voluntary non-remunerated blood donor policy. It has attained very high standards of blood transfusion practice and safety. Currently it is a World Health Organisation Collaborating Centre. Many African blood transfusion services second their doctors, technologists, nurses, and blood donor promotion staff to this regional training centre.

INFECTIOUS DISEASE SCREENING - HIV, HEPATITIS B AND C.

- Donor education, information and counselling encourage self deferral.
- Each blood donation is screened for all the diseases listed above.
- The current incidence of these diseases in donor blood is very low.
- NBTS is unable to introduce P_{24} antigen testing because of financial constraints.
- Introduction of P_{24} testing would further reduce the ''window period'' risk.

FINANCIAL CONSTRAINTS.

- Devalued Zimbabwe dollar has more than doubled the cost of imported test kits.
- NBTS is unable to adequately raise fees to counter the inflation.

THREATS.

- Present standards of operation are not sustainable due to financial constraints.

- Failure to screen blood will expose patients to HIV and other infections.
- Majority of blood transfusion recipients are mothers and children due to obstetrical, gynaecological and child health problems.

SEROLOGY COSTS.

• Current HIV, hepatitis B and C, screening annual budget	=	US $595 925.00
• Add P_{24} antigen testing	=	150 638.00
TOTAL ANNUAL BUDGET	=	**US $746 563.00**

Our request is for assistance to the tune of seven hundred and fifty United States dollars (US$750 000.00) per year for the next three years, till things get better. We thank you for all the previous aid and hope you will be able to assist as requested.

Yours faithfully,

_____
J Chitsva
MANAGER

cc Mr D A Mvere - Technical Director
Mr D M Connolly - General Manager
Dr M E Chitiyo - Medical Director

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed, Assistant to the President for Domestic Policy
Sandra Thurman, Coordinator for National AIDS Policy

SUBJECT: International Studies on Reducing Maternal-Infant HIV Tranmission

This memorandum will provide background on the controversy over an ongoing group of U.S.-supported international clinical trials studying options to reduce maternal transmission of HIV in developing countries. A brief overview of current knowledge, the rationale for further research, the World Health Organization position, concerns of domestic public interest groups, and the Department of Health and Human Services' position will be covered. Attached separately are talking points and Q&A's prepared by HHS on the issue.

Perinatal Transmission The World Health Organization (WHO) estimates over 1,000 HIV+ infants are born each day. Women with HIV disease have a 15%-40% risk of transmitting HIV to their baby with each pregnancy. The National Institutes of Health demonstrated that this transmission risk can be lowered to 8.3% by the administration of the drug AZT to women orally during pregnancy and intravenously during labor, and to their newborn infants orally for 6 weeks. This NIH study, known as ACTG 076 - comparing AZT with a placebo - was halted and published in 1994 when these dramatic results were evident. It has become the standard of care to offer all HIV+ pregnant women AZT therapy in the U.S.

An important unanswered research question is at what point during pregnancy or birth do women transmit HIV to their babies -- and if it is necessary to administer AZT over many months to prevent HIV infection in infants. Because many developing countries cannot afford expensive drug therapies for their citizens, pinpointing the critical period in which to administer AZT to prevent perinatal transmission is important so that the greatest number of women could be offered treatment.

Research Study Design Issues The public health leadership of several WHO member countries collaborated with the NIH and Centers for Disease Control and Prevention (CDC) to design and develop research studies to prevent perinatal HIV transmission in countries with limited health care infrastructure and resources. Each research study included an informed consent document outlining the research question, the randomization to an AZT or placebo group, and a detailed description of potential risks study participants may incur. All study protocols were reviewed and approved by the NIH and CDC Institutional Review Boards (IRBs) and the host countries. The political leadership of each host country were also fully informed of the study methodologies and concurred with their implementation. The first studies proposed by this international collaborative group began in 1993 with funding support from the U.S. (NIH, CDC) and France.

World Health Organization Activity In June 1994, the WHO hosted a meeting of researchers and public health practitioners from the U.S., Europe, and countries in Africa, Asia and the Carribean which have a high incidence of HIV disease. The purpose of the meeting was to examine the results of the NIH ACTG 076 trial in terms of their applicability internationally. The following recommendations were issued from this meeting:

1) Encourage the use of AZT as outlined by the NIH ACTG 076 study in industrialized countries; and

2) Immediate exploration of alternative regimens that could be used to achieve prevention of perinatal HIV prevention in the developing world.

WHO participants established parameters for the conduct of research studies in developing countries. The studies supported by the U.S. and France were consistent with these parameters.

Concerns of Some U.S. Public Interest Groups Dr. Sidney Wolfe of the Public Citizen Health Research Group wrote a long critique of U.S. involvement and support for these international perinatal HIV prevention studies in a letter to Secretary Shalala. The letter was broadly distributed to the media. Key concerns raised were:

- Some research designs include a placebo arm when AZT has proven benefit. Such a research design would never be allowed in the U.S.

- The studies violate major international ethical guidelines, specifically: the World Medical Association's 1975 Declaration of Helsinki; four of the Nuremberg codes for human experimentation; and the International Ethical Guidelines for Biomedical Research Involving Human Subjects designed to address ethical issues in developing countries

- There is no guarantee that women and infants in host countries will benefit from the research knowledge gained

- The lack of appropriate care in host countries does not justify study designs with placebo arms that have no benefit. The standard of care in many countries does not include access to prenatal care, medications, hospital births or intravenous infusions

- Comparison of these studies to the Tuskeegee syphilis study; criticism that IRBs should ensure that risks to subjects are minimized and subjects are not unnecessarily exposed to risk; this is colonialism at its worst

Senator Carol Moseley-Braun (D-IL) has also voiced her concern regarding study designs with a placebo arm when there is a known effective treatment for HIV prevention. She is alarmed that such studies are supported with U.S. funds, and thinks it is inappropriate to continue such funding in face of the apology being offered to the Tuskeegee survivors this Friday.

Department of Health and Human Services The Department of Health and Human Services has conducted a review of the U.S.-funded studies in question and continues to support both the study designs and public health importance of completing them. They are ongoing as of this date. HHS testified to this effect before the House Government Reform and Oversight Committee last week. There was very little discussion of the issue among Representatives present.

In brief, the HHS position maintains:

o The studies address a pressing need in the global control of the spread of HIV, defining interventions that will result in reductions in maternal-infant transmission which can be safely and routinely implemented in the developing world;

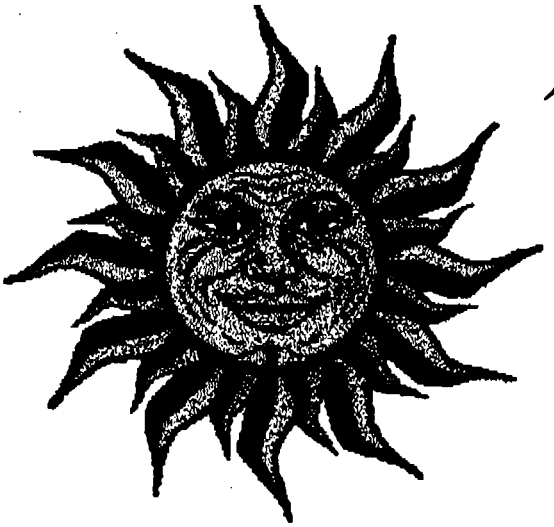
o The studies are based on the assumption that the NIH ACTG 076 regimen is not a feasible therapeutic intervention in developing countries due to lack of medical infrastructure and cost constraints; the research design examines options for treatment which are viable and affordable within the medical care delivery systems of the study countries

o All ongoing studies are in full compliance with U.S. and in-country regulations and laws, have gone through extensive in-country and U.S. ethical review processes and an international ethical review, and all studies have strong in-country support; an independent Data and Safety Monitoring Board continues to provide oversight of research findings at regular intervals

o Broadly accepted ethical principles for international research recognize a role for the local standard of care when testing the effectiveness of a new intervention. In the case of developing host countries, the local standard is minimal to no health care access. Studying new research options of AZT administration at specific times during pregnancy offers a new benefit to individuals who would not otherwise have had it, while defining research knowledge that may allow many individuals to benefit if shorter courses of AZT prove effective for HIV prevention. The placebo arm is equivalent to the local standard of care.

Attached are Q&As and talking points which support the HHS position on this issues.

Jaunch apt —
310 385-0630



RESULTS by DESIGN
(policy and strategy architects)
Michael Iskowitz
Sandy Thurman
Partners
(202)265-1603
(202)265-0672 (fax)

Name Sandy

Fax Number ~~202~~ 0575

Pages cover + 10

Comments

FYI — call me when you are ready to review this stuff ! come up with a plan for del.

thanks — xxo

SEROCONVERSION WITHIN A DEFINED GEOGRAPHIC AREA

PROPOSAL OUTLINE

I. Overview

- o Description of Proposal
- o Rationale for Proposal
- o Why Dedicated Resources and a Focused Project are Necessary
- o Building upon Lessons Learned

II. Background Data

- o Epidemiology
- o Behavioral Intervention Studies

III. Selection Criteria for Demonstration Sites

IV. Implementation Plan

- o DHHS Planning Group
- o Beginning Dialogue with Demonstration Sites

PROPOSAL FOR DEMONSTRATION PROJECT

EVALUATION OF THE EFFECTIVENESS OF INTEGRATING HIV PREVENTION AND TREATMENT SERVICES IN REDUCING HIV SEROCONVERSION RATES WITHIN A DEFINED AREA

I. OVERVIEW

DESCRIPTION OF PROPOSAL

This document proposes a 2 to 3 city demonstration project to evaluate one model for reducing the incidence of new HIV infections within a defined area. Following an initial planning process to begin in January 1997, a commitment to enter a three year demonstration project would be made by the local grantee and the Department. The Department would provide technical assistance and up to $ 3 million per city over the 3 year period.

The demonstration project would target the merging of HIV prevention with all existing service delivery systems. High risk populations within a defined area would be identified, and multiple access points to medical care and support services would be enhanced through a more tightly coordinated continuum of care. Effectively merging targeted HIV prevention messages into all service delivery systems in a community, linked with early intervention services, should result in changes in high risk behavior that will translate into decreasing seroconversion rates for each specific target population. An evaluation component to assess the effectiveness of this intervention is a necessary part of the project.

The demonstration project would also provide an opportunity to pilot a new role for the Public Health Service in providing assistance to localities, focusing on the specific outcome of reduced HIV transmission. As responsibility for defining, prioritizing and directing public health initiatives increasingly devolves to the States, it is timely to take a fresh look at the structures and functions of the federal government with the goal of a more efficient relationship between the various levels of government and the people to be served. At present, multiple federal funding streams at HRSA, CDC, SAMHSA and NIH impact on populations at high risk for HIV infection, with State, city, and categorical grantees. New models of intergovernmental collaboration should be considered to secure a better return on the federal investment, and change the dynamic of the federal role from overseer to partner in achieving common goals. A brief talking paper on the "reinventing government" aspects contained in this proposal are provided at TAB ____.

RATIONALE FOR PROPOSAL

The HIV epidemic has continued to expand in inner city populations, manifested by increases in seroconversion rates among specific populations: injection drug users, adolescents, women, gay men of color and young gay men. This situation has persisted even with significant increases in resources streaming into these same municipalities. Primary reasons

for this are two fold: (1) advances in our understanding of primary prevention interventions have been poorly incorporated into existing service delivery programs, and (2) the target populations at highest risk are often outside of all traditional systems of care.

New advances in census tract analysis and demographically based consumer research has improved our ability to characterize behavior patterns of at risk vulnerable populations, along with the mixing patterns between high risk and lower risk groups, much more specifically within a geographic area. Pilot studies conducted in New York City and Los Angeles have shown that risk profiles can be achieved by specific zip code areas and even specific blocks of residence to guide highly targeted public health interventions.

Much has also been learned about effective prevention strategies among targeted high risk groups such as gay men, women, and injection drug users. Recent epidemiologic studies looking at behavioral interventions in the U.S. and abroad have shown behavior changes with low rates of recidivism. Combining these targeted intervention approaches to high risk populations in a defined area, along with actively merging prevention strategies into primary health care or other service delivery settings offers a unique opportunity to reduce seroconversions and the burden of new HIV cases. A bibliography drawn from a review of the literature supporting this hypothesis is provided at TAB ____.

To reach the greatest number of persons at risk for HIV, it is necessary to reconceptualize HIV prevention as an important and viable activity within all care settings -- including family planning clinics, STD clinics, community health centers, substance abuse intervention and treatment programs, maternal and child health providers, episodic emergency room encounters, social service agencies, and all primary care delivery sites. Affected community-based organizations, high risk communities, the provider health and social service community, health departments and policy makers all need a conceptual framework in which to achieve the merging of prevention efforts with service delivery, and specific knowledge of effective prevention messages for each population. As many individuals at highest risk for HIV infection remain outside delivery system settings, engaging community support and trust for these initiatives is critical to the success of the project.

WHY DEDICATED RESOURCES AND A FOCUSED PROJECT ARE NECESSARY

Most grants administered by HRSA, CDC and SAMHSA include a requirement for coordination and collaboration with a diverse spectrum of service providers. Coordination requirements usually revolve around getting individuals in need into care, needs assessment activities involving resources and gaps in services, and facilitating access to a range of appropriate services. Despite these mandates, many programs remain categorically focused around immediate goals on which they will be judged, and grant dollars are stretched to address the needs of existing clients, much less identify potential clients or implement HIV prevention strategies as a focal activity. In the case of the Ryan White CARE Act Planning Councils, preventing or reducing HIV transmission is currently beyond their charge; the same is true for Title X clinics, substance abuse treatment programs, and community health centers. To successfully bring these providers to a shared table and invested in a vision for HIV prevention that may exceed the scope of their individual agency mission, a range of

monetary and nonmonetary incentives will need to be defined. In addition, public and private sector agencies and community-based organizations, as well as many community voices who are not engaged at any table, need to perceive a clear benefit and stakeholder role in making the effort to overcome turf issues, fatigue, bureaucratic procedures, and discrimination.

Monetary resources should be conceived of primarily as "glue money" intended to enable a coalition of providers and community groups to come together and maximize existing resources, achieving more together than they could have achieved alone. It would also address identified gaps in an integrated service delivery system, in partnership with state and local resources. Of the $3 million proposed to each project site over 3 years, a portion must be set aside to fund an evaluation of the demonstration grant.

Nonmonetary strategies to marshall existing resources and support integration of a common goal include:

visibility - use the presence of the federal government to bring much needed attention to HIV at a time when providers and the public are weary. To be effective, the attention must be focused on the local nature of the epidemic and efforts of community players to address it.

facilitation and coalition development - use the presence of the federal government to bring people together to try new solutions to reduce HIV incidence. Ongoing involvement is needed to keep the process moving, distinguishing it from other "flash in the pan" federal interventions that communities have grown to expect and distrust. Creating a sense of collective accountability among providers and groups within an area is an important goal.

training and technical assistance - the federal government has many resources to offer to help communities reach their goals. For communities to view this positively, T/TA should be driven by assisting communities to identify what would be most helpful to them -- and then being responsive. Examples of federal expertise that can be brought to the table include sharing effective behavioral intervention strategies for targeted groups, ways to weave HIV prevention messages into a host of delivery sites, and surveillance strategies to map out groups at highest risk so that intensive interventions may be targeted and their effect evaluated.

enhanced flexibility in federally funded programs - the federal government should be responsive to a facilitated "bottom-up" identification of actual obstacles to effective performance and to the coordination and maximization of existing resources. As specific barriers are identified, the Department should work in partnership with the state and local government toward a mutually agreed upon solution. (Further discussion at TAB ___). define with specificity

BUILDING UPON LESSONS LEARNED

Two programs, Lessons Without Borders and Healthy Start, have provided valuable experience in designing this urban demonstration project. Lessons Without Borders has worked to bring the lessons learned from international development projects back to a

number of U.S. communities. A key premise of effective foreign assistance is to provide that support to communities which enables them to develop sustainable solutions to their problems, as opposed to imposing a single solution or world view on them. The Lessons Without Borders (LWB) initiative offers two philosophical underpinnings that guide the development of this demonstration project:

(1) **individual and community empowerment** - On the individual level, LWB promotes giving people the practical tools they need to improve their lives. This is nowhere more true than in the context of effective HIV prevention. Service delivery systems should be demand driven and actively involve the communities to be served. While this has been the hallmark of Ryan White and HIV Prevention Planning, it is made increasingly complex as the epidemic diversifies into disenfranchised groups. In addition, this orientation has not as readily characterized other federal programs; as communities seek to integrate HIV programs into a broader social context, this philosophy will need to be reiterated.

(2) **integrated services** - Meeting the needs of people often means taking a range of services to where they are. Those most at risk are generally unable or unwilling to navigate a complex maze of providers and agencies in order to get their needs met. The value of making services readily available at the point an individual accesses any point in the system is the increased opportunity to effectively engage them in a broader range of health and prevention services. In addition to health care and social service locations, HIV prevention efforts should be integrated into other service systems where those at risk may find themselves, such as drug treatment programs, homeless shelters, soup kitchens, and halfway houses.

The Healthy Start program, now in its sixth year, has funded and facilitated locally-driven processes to reduce high rates of infant mortality in selected urban areas. The federal government put a priority on this outcome measure, while allowing a great deal of flexibility in designing and implementing programs to achieve it. Many important lessons have been learned that impact on the planning for this demonstration project. Some of these are provided in brief:

- o clear definition of expectations and accountability
- o value of flexibility as no one model fits all cities
- o importance of continued federal involvement and facilitation of local dialogues
- o essential role of consumer involvement to reach the people you want to serve
- o importance of engaging community leaders who have trust and credibility locally
- o the critical role of community-based outreach workers in reaching people not in care
- o importance of technical assistance, training and supervision when using outreach workers from the community or nontraditional providers; mentoring, peer learning opportunities, nurturing leadership
- o technical assistance to small CBOs trying to respond to RFPs for funding
- o recognition of community priorities
- o building in sustainability by linking with stakeholders, building equitable and effective partnerships
- o importance of supporting activities key to success but hard to find reimbursement

for, such as community organizing, training and leadership development
- o advantages of building upon existing entities instead of creating new structures, if they can adapt to engage all key players needed at the table

There are other lessons of experience from targeted community programs such as empowerment zones, enterprise zones, the CDC Prevention Community Planning processes and Ryan White CARE Act Title I Planning Councils. These will be identified and incorporated into subsequent planning sessions for the demonstration project.

II. BACKGROUND DATA

EPIDEMIOLOGY

The public health burden of HIV remains enormous for the nation, as the leading cause of death among Americans between the ages of 25 and 44. The epidemic continues to be characterized by a significant concentration of AIDS cases in urban areas, as well as new patterns of expansion into more rural populations. Over 80% of both cumulative AIDS cases through 1995 (433,628 of 513,486), and AIDS cases diagnosed in 1995 alone (60,912 of 74,180), were reported from metropolitan areas with 500,000 or more population. This ongoing concentration of new cases in urban areas raises hope that a significant decrease in new transmission could be achieved by intensively focusing efforts among populations where HIV rates are high, instead of broader educational messages aimed at the general population. Although AIDS is a late manifestation of HIV disease, AIDS cases are the only nationally standardized measure available to estimate the geographic distribution of HIV disease.

Surveillance data and epidemiologic profiles have clearly defined behavioral risk factors for HIV and characterized/described those populations where HIV transmission is most commonly occurring. Summary statistics (see TAB ___) reflect the rising proportion of new cases among substance abusers, communities of color, women and adolescents. What is not captured in aggregate data is the presence of multiple concurrent epidemics within these numbers. It is now possible to identify specific populations with distinct characteristics in a defined geographic area, which may or may not overlap with each other. Co-factors such as STDs, substance abuse, tuberculosis and poverty often characterize the epidemic among specific groups, increasing the likelihood of HIV transmission throughout that specific population. It is well recognized that the behavioral characteristics of the HIV epidemic among a community of young gay males differs significantly from that of a longterm IDU or minority woman infected through heterosexual transmission. These differences influence which prevention strategies will be effective and what access points individuals enter systems of care through.

The following five principles support the epidemiological rationale for this demonstration project:

1) **HIV enters new groups through a seropositive individual** This fact underscores the

importance of a strong focus on the delivery of appropriate prevention messages to all HIV+ individuals in whatever system of care they are accessing. It is important to engage persons at high risk for seropositivity in a service delivery system where their HIV status can be assessed, and if necessary, treatment linkages made, to reduce further transmission.

2) **HIV transmission continues to be primarily through the high risk behaviors of unsafe sex and sharing of injection needles/syringes.** Targeting effective prevention messages and early intervention strategies/programs at these risky behaviors will reduce the rate of new seroconversions.

3) **the likelihood of HIV transmission is dependent not only on an individual's high risk behavior, but on the mixing patterns of HIV+ persons into broader populations.** It is important to define and understand these dynamics at a local community level in order to effectively target prevention messages to specific risk groups.

4) **HIV transmission also ocurs among individuals who are in "low risk behavior" groupings who are exposed by mixing patterns with seropositive individuals.** This represents the "hidden risk" that is often present for partners affected by heterosexual transmission and subsequent vertical transmission to children. Identifying individuals who are unaware of their risk requires a heightened awareness among all providers who care for them in diverse settings.

5) **multiple studies show that behavior change dramatically reduces or eliminates the risk of infection for a measurable period of time.** Recent studies on behavioral interventions in the U.S. and abroad have demonstrated behavior changes with low rates of recidivism in the target population. The challenge is to bring what we know about interventions for specific populations and apply it to well-defined local epidemics, and follow the impact on the rate of new seroconversions. Different approaches may be required to effectively impact on distinct or or overlapping concurrent local epidemics.

A significant proportion of seropositive individuals remain unaware of their HIV status until the emergence of symptoms. Review of CDC's most recent data from publicly funded HIV couseling and testing sites underscores the need for a community-wide strategy to achieve prevention and early intervention. The percentage of tests positive for HIV in publicly funded programs ranges from a low of 0.1 percent (colleges) to 3.2 percent (drug treatment). By contrast, data from blinded surveillance studies has shown higher rates of seropositivity among high risk groups. Data through 1992 found a median prevalence of 7.8% among IDUs in drug treatment programs; among African American IDUs was higher at 18.4%. Locally based strategies to increase awareness of HIV risk among high risk populations and acceptance of voluntary testing is key to breaking the cycle of HIV transmission. As over 60% of persons reporting a voluntary HIV test in the National Health Intervies Survey were tested in privately funded settings and hospitals, these strategies must encompass the full range of public and private provider sites in any given area.

BEHAVIORAL INTERVENTION STUDIES

(ERIC - Please insert a review of key studies as appropriate)

III. SELECTION CRITERIA FOR DEMONSTRATION SITES

Two major urban areas will be selected as initial pilot sites for this demonstration project. A third site may be added if funding considerations permit. Selection of one site will be based very heavily on severity of need measures, with a second site combining considerations of s everity of need with effectiveness of local infrastructure in order to maximize the opportunity of a successful result. Prerequisites for selection include: population over 500,000, and the presence of a public hospital, Class IV virology laboratory, substance abuse treatment programs including methadone clinics and harm reduction programs, community health center, family planning clinic, STD clinic, entities with substantive HIV prevention expertise with the capacity to delivery technical assistance to community based organizations, and data and statistical analysis capacity. **[[ERIC - DO YOU WANT TO ADD TO THIS ....]]**

SEVERITY OF NEED MEASURES

Uniform statistical data was collected from all cities with a population equal or greater to 500,000, which numbered 27. Cities were ranked 1 through 27 on the individual parameters listed below, then individual rankings were summed up for a cumulative city score. The highest scoring city was selected as one demonstration site. **(ERIC - WHAT ABOUT SUBJECTIVE RATINGS FOR ALCOHOL AND SUBSTANCE ABUSE - ANALYTIC, DESCRIPTIVE-, AND MENTAL HEALTH)**

Socioeconomic and Demographic Characteristics
- o poverty rate
- o percent with less than 12 years education
- o unemployment rate
- o work-disabled, 1990 data

Maternal and Infant Health Indicators - tabulated separately for white mothers and African American mothers
- o low birthweight rate, 1992
- o very low birthweight rate, 1992
- o late of no prenatal care for live births, 1992
- o percent of live births to unmarried women, 1992
- o percent of live births born to mothers under 18 yrs, 1992
- o percent of live births born to mothers with less than 12 years of education, 1992

Notifiable Diseases
- o tuberculosis cases and case rates, 1993, 1994
- o AIDS reported cases and case rates, 1993, 1994
- o rate of HIV infections reported (where available)
- o sexually transmitted diseases

a. chlamydia reported cases and rates, 1993, 1994
b. gonorrhea reported cases and rates, 1993, 1994
c. primary and secondary syphilis reported cases and rates, 1993 and 1994
d. early latent syphilis reported cases and rates, 1993, 1994
e. late and late latent syphilis reported cases, rates, 1993-1994
f. congenital syphilis reported cases and infants under one year of age, 1993 and 1994

what do we need here? Justification of cities

A broader discussion of the severe need measures, and infrastructure issues considered in the selection of the second city, is included at TAB ____, along with a description of the HIV epidemic in each city. A list of all grantees receiving DHHS funds within each city is also included, to show the breadth of programs and providers serving populations at high risk for HIV within each city.

IV. IMPLEMENTATION PLAN

DHHS PLANNING GROUP

A small planning group will be convened to bring expertise in HIV prevention, treatment, behavioral research, substance abuse, and statistical analysis together in January. Preliminary discussions have taken place with CDC, HRSA, OAR/NIMH, and SAMHSA, with a substantial level of interest expressed by these agencies. The role of the planning group is three-fold: 1) to review demographic data of the HIV epidemic in each site in light of the most current research data regarding primary and secondary prevention; 2) review the list of current DHHS grantees within the city at TAB __ and identify how to work with grantee programs within individual agencies to facilitate coordination with the goals of this project; and 3) advise on the necessary components for a thorough evaluation of the demonstration project, including statistical and data analyses necessary to show reductions in new seroconversions. A second group of external advisors with specific expertise in substance abuse treatment, HIV prevention, behavioral research, and STD programs will also be brought together on an ad hoc basis to meet with the DHHS Planning Group.

BEGINNING DIALOGUE WITH DEMONSTRATION SITES

To date, there have been no discussions of this proposed demonstration project with potential cities. The specifics of which specific city/county/state entity is best positioned to take the lead in working with DHHS to implement this project depends on the final choice of 2 cities. In the Healthy Start program, different configurations of grantees included the city health department, county health department, or a lead agency designated by the chief elected official.

The most crucial step to the success of this project will be gaining the support of high risk communities in substantively reducing the burden of HIV that they bear. Community-specific demographics and dynamics will determine the most effective strategies for engaging

individuals in a system of care at whatever point they access services. Many persons at high risk for HIV, or seropositive but unaware of their status, live in communities which have a historic distrust of "systems" -- health care or otherwise. Achieving ownership of, and local leadership for, these prevention goals is essential. To that end, the manner in which this project is rolled out in each community will have a great deal to do with its success or failure.

Read and Critique

Following are some components of the federal role as currently envisioned:

- o assist cities to establish a dialogue across communities and diverse provider groups serving individuals at risk for HIV, with a multiyear federal commitment to the process
- o provide technical assistance as requested to the lead local entity in planning a data analysis capable of defining the characteristics of the HIV epidemiic and its antecedents/co-factors at the neighborhood level
- o provide technical assistance as requested in establishing dialogue with health care and social service providers within each city; support the development of an HIV prevention focus among all providers serving high risk persons; make HHS personnel available to do meetings in institutional or other settings
- o promote the involvement and coordination of DHHS grantees within each city with the effort to integrate HIV prevention and treatment in all settings; at the federal level, develop and sustain a dialogue between those programs serving persons at high risk for HIV to better coordinate HIV prevention into service delivery programs DHHS-wide (Title X, STD, substance abuse prevention and treatment, Ryan White, etc)
- o provide modest resources (no more than $ 2.5 mil per city) to: meet unmet needs which impede better coordination of prevention into service delivery settings; facilitate the training and technical assistance needs of community outreach workers;
- o make available through technical assistance information about successful models and behavioral intervention research applicable to the demographics of at risk populations within the city
  city
- o work in partnership with city/state/county government and public health entities to identify administrative, programmatic or regulatory barriers to coordinating existing programs to meet the stated goals most effectively, and address these when feasible

The above activities would require a significant level of effort in the first year to support the development of a federal/state/city/county partnership and to assist in integrating a prevention-treatment continuum across service delivery settings and community outreach programs. Depending on the specifics of selected cities, DHHS may work more directly with the cities, or through consultants familiar and trusted within the communities, to fulfill the components identified above.

Gloria: Please send copies my fax to Roscoe Moore (OIRH) Sandy Thurman (ONAP) FAX 202-632-1096 ó 254-9835 Thanks,

FAX TRANSMISSION

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Lloyd 10/22

To:	Dr Lloyd Kolbe, CDC	**Date:**	20 October 1997
Fax No.:	091 770 488 3110	**Pages:**	26, including this cover sheet.
From:	Gonda Perez		
Subject:	**LIFE SKILLS PROGRAMMES IN SCHOOLS & POLICY STATEMENT HIV/AIDS IN SCHOOLS**		

COMMENTS:

Please find the attached documentation for your attention.

Kind regards

Gonda Perez
DIRECTOR: HEALTH PROMOTION AND COMMUNICATION

SOUTH AFRICAN LAW COMMISSION

DISCUSSION PAPER 73

Project 85

ASPECTS OF THE LAW RELATING TO AIDS:

HIV/AIDS and Discrimination in Schools

CLOSING DATE FOR COMMENT: 30 September 1997

ISBN: 0-621-27697-9

INTRODUCTION

The South African Law Commission was established by the South African Law Commission Act 1973 Act 19 of 1973).

The members of the Commission are -

The Honourable Mr Chief Justice I Mahomed (Chairperson)
The Honourable Mr Justice P J J Olivier (Vice-Chairperson)
The Honourable Madam Justice Y Mokgoro
Adv J J Gauntlett SC
Mr Mojapelo
Prof R T Nhlapo
Ms Seedat

The members of the Project Committee for this investigation are -

The Honourable Mr Justice E Cameron (Chairperson)
Mr Z Achmat
Dr I J Haasbroek
Ms N Makhalemele
Dr N J Matjila
Dr G J Mtshali
Prof R T Nhlapo (Full-time member of the Commission)
The Honourable Mr Justice P J J Olivier (Vice-Chairperson of the Commission)
Mr J Seftel
Mr A E Strode
Prof W van Wyk

The Secretary is Mr W Henegan. The Commission's offices are on the 8th floor, 228 Visagie Street Pretoria. Correspondence should be addressed to:

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ACKNOWLEDGEMENT

The Commission is indebted to Prof Christa W Van Wyk (member of the project committee) who undertook additional research for this discussion paper.

PREFACE

This discussion paper (which reflects information accumulated up to the end of May 1997), has been prepared to elicit responses from key parties and to serve as a basis for the Commission's deliberations. Following an evaluation of the responses and any final deliberations on the matter the Commission may issue a report on this subject which will be submitted to the Minister of Justice for tabling in Parliament. The views, conclusions and recommendations in this paper are accordingly not to be regarded as the Commission's final views. The paper is published in full so as to provide persons and bodies wishing to comment or to make suggestions relating to the reform of this particular branch of the law with sufficient background information to enable them to place focused submissions before the Commission.

For the convenience of the reader a summary of issues discussed and requests for comment appears on the next page.

The Commission will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents, unless representations are made that it be confidential. Respondents should be aware that the Commission may in any event be required to release information contained in representations under the Constitution of the Republic of South Africa, Act 108 of 1996.

Respondents are requested to submit written comments, representations or requests to the Commission by 30 September 1997 at the address appearing on the previous page. The Commission will endeavour to assist you with particular difficulties you may have.

The researcher allocated to this project, who may be contacted for further information, is Mrs A D Havenga. The project leader responsible for this project is the Honourable Mr Justice E Cameron.

SUMMARY

The risk of HIV transmission in schools, under normal circumstances, is negligible and there are also no known cases of transmission of HIV in the educational setting.

Nevertheless, HIV/AIDS will undoubtedly affect most schools.

Amongst children, the most important route of HIV transmission by far is vertical (from mother to baby). Although the majority of infants with HIV in South Africa are unlikely to reach school going age, recent studies show that some infected children may remain symptom-free up to the age of seven years and will therefore reach school going age.

Statistics also indicate that adolescents and young adults account for a disproportionate share of the increase in HIV infection in our country.

Learners may be faced with the illness of their parents. Learners may have to take time off to look after young ones at home, care for a sick parent and carry out household tasks. This is not only emotionally draining to the learner but may disrupt the learning process. The education authorities may be faced with a situation where orphans drop out of school because their guardians are unable or unwilling to pay for school requisites. Sickness and death of a learner may also impact on both other learners and educators. In the latter stages of AIDS a sick learner may be absent for almost 80% of school days. There could also be increasing discrimination because of stigma.

The Commission in 1995 in its Working Paper 58 made preliminary recommendations on HIV/AIDS in schools. These were based on the negligible risk of transmission of HIV in the school setting and the principle of non-discrimination enunciated in the 1993 interim Constitution.

11 The Commission specifically concluded that HIV testing should not be a prerequisite for admission to schools or for continued school attendance; that a learner may not be barred from continued school attendance solely on the ground of his or her HIV infection; that confidentiality of AIDS related information should be maintained; that the education authorities should be compelled to provide AIDS information and education as part of the compulsory curriculum to primary and secondary school learners; and that the education authorities should establish a clear and comprehensive national policy regarding the management of learners with HIV in which these principles are embodied.

12 The Commission at the time emphasised the lack of a uniform national policy dealing with the issue of HIV/AIDS in schools.

13 The responses received to these preliminary recommendations were generally supportive. They reflected that a large measure of consensus on the need for, and contents of, a national policy on HIV/AIDS for schools exists.

14 The recent well-publicised crisis caused by the application by Nkosi Johnson, an eight-year-old boy with AIDS, to be admitted to a public school in Johannesburg, the reaction of some members of the public and the apparent lack of a national education policy on this issue, underscore the lesson that the situation has not improved since 1995. This is despite the fact that the South African Schools Act was passed in 1996 which gives effect to both the spirit and letter of the 1996 Constitution by protecting learners from unfair discrimination and by guaranteeing them their rights to basic education and to equal access to public schools.

15 In view of the Commission's initial work on the matter, the project committee has, since the Nkosi Johnson incident, been engaged in informal discussions and liaison with the Department of Education to ascertain whether the Commission could be of assistance in advancing resolution of the matter. The present proposals and policy have been developed in a joint consultative process. They result from input and guidance from the

Department. The Department will again be included in the committee's work when comment on this discussion paper is processed and final recommendations formulated.

The project committee is of the view that recent experience suggests that a precisely directed and clearly targeted policy would create legal certainty and help prevent injustice to learners with HIV. It thus provisionally recommends the adoption of a national policy on HIV/AIDS in schools that will constitute a set of basic principles from which the governing bodies of schools may not deviate. Provision is made for the governing body, in addition, to adopt an HIV/AIDS school level policy to give operational effect to the national policy. The school level policy may reflect the needs, ethos and values of the specific school and community, though it may not deviate from the national policy's basic principles. In the absence of a school level policy the national policy will apply.

The proposed policy - which would apply to public as well as independent schools - includes the following principles:

1.1 Compulsory testing of learners as a prerequisite for admission to any school, or any unfair discriminatory treatment (for instance by refusing continued school attendance solely on the basis of the HIV status of the learner), is not justified.

1.2 However, it is recognised that special measures in respect of learners with HIV may be necessary. These must be medically indicated or in the learner's best interests.

1.3 Learners' rights in respect of privacy are confirmed. Where AIDS related information is disclosed to the educational authorities, the policy provides that, except where statutory or other legal authorisation exists, it may be divulged only with the written consent of the learner (above the age of 14 years) or in other cases with that

of his or her parent or guardian.

(c) The needs of learners with HIV should, as far as is reasonably practicable, be accommodated within the school environment.

(d) All learners have a right to be educated on AIDS, sexuality and healthy lifestyles, in order to protect themselves against HIV infection. The policy recognises the need for consultations with parent communities in order to ensure that sexuality education will accord with the community ethos and values. The policy requires that information be given in an accurate and scientific manner.

(e) Universal precautions should be implemented by all schools to further minimise the negligible risk of transmission of HIV in the educational setting. The policy contains specific provisions on participation in contact sports.

5. The draft policy is attached for comment. The project committee will especially welcome comment on whether the proposed national policy should also apply to school hostels, and if so, whether additional policy measures are necessary.

(viii)

NOTICE NO ... OF 1997

DEPARTMENT OF EDUCATION

PROPOSED NATIONAL POLICY ON HIV/AIDS FOR SCHOOLS

I ....., Minister of Education, hereby give notice in terms of section 3 of the National Education Policy Act, 1996 (Act No. 27 of 1996) that, after consultation with such appropriate consultative bodies as have been established for that purpose in terms of section 11 of that Act or any applicable law, I have determined the national policy to be applied in respect of HIV/AIDS for schools as set out in the Schedule hereto.

SCHEDULE

NATIONAL POLICY ON HIV/AIDS FOR SCHOOLS

There are no known cases of the transmission of HIV in the educational setting. HIV cannot be transmitted through day to day social contact. The virus is transmitted only through blood, semen, vaginal and cervical fluids and breast milk. Although the virus has been identified in other body fluids such as saliva and urine, no scientific evidence exists that these fluids can cause transmission of HIV.

Because of the increase in infection rates, learners with HIV/AIDS will increasingly form

part of the school population. More and more children born with HIV will, with better medical care, reach school going age and attend primary schools. Indications that young people are sexually active, mean that increasing numbers of learners attending secondary schools might be infected. Intravenous drug use may also become an increasingly important source of HIV transmission among learners. Recipients of infected blood transfusions, primarily haemophiliacs, may also be present at schools.

It is impossible to know who is infected and who not. Even if mandatory screening for HIV of all learners were implemented, it would be impossible to know with certainty who were infected and who not, or to effectively exclude infected (or subsequently infected) learners.

Children with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity to receive an education to the maximum of their ability. Their infection as such does not expose others to significant risks within the educational setting. However, if it is ascertained that an infected learner poses a "medically recognised risk" to others owing to secondary infections, appropriate measures may be taken.

The negligible risk of transmission of HIV can be further minimised by following standard infection control procedures and good hygiene practices under all circumstances. In the educational setting this means that all blood, open wounds, breaks in the skin, grazes and infected skin lesions, as well as all body fluids, should be handled in a prescribed manner by a member of staff. Strict adherence to universal precautions under all circumstances is advised as the state may be liable for any damage or loss caused as a result of any act or omission in connection with any educational activity conducted by a public school.

Good hygiene practices also include that learners with illnesses such as measles, whooping cough and mumps should be kept from school to protect all other learners, and especially those whose immune systems may be impaired by HIV.

Learners should receive education about HIV/AIDS in the context of life skills education. HIV/AIDS education should not be presented as an isolated learning content. The purpose of education about HIV/AIDS is to prevent HIV infection and to allay excessive fears of the epidemic. Education should ensure that learners acquire the age-appropriate knowledge and skills they will need to adopt and maintain behaviour that will minimise the risk of infection. Education will include information on the sexual transmission of HIV and the dangers of drug abuse, which will be offered in a scientific manner. In the elementary classes, education about HIV/AIDS should be provided by the regular educator, while in secondary grades the guidance counsellor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educator selected to offer this education should be specifically trained, should feel at ease with the content and should be a role-model with whom learners easily identify.

In accordance with the constitutional guarantees of the right to a basic and further education, the right not to be unfairly discriminated against, the right to freedom of access to information, the right to freedom of conscience and the right to privacy, the following policy shall constitute national policy.

Definitions

1 In this policy any word or expression to which a meaning has been assigned in the South African Schools Act, 1996 (Act No. 84 of 1996), shall have that meaning.

Admission and testing

2 (1) No learner will be denied admission or continued attendance at school on account of his or her HIV status or perceived HIV status.

(2) The testing of learners for HIV as a prerequisite for admission or continued attendance

to be prohibited.

Unfair discrimination

(1) No learner with HIV may be unfairly discriminated against.

(2) Any special measures in respect of learners with HIV must be medically indicated or in the learner's best interests.

Disclosure

(1) A child is entitled to the same rights in respect of the protection of his or her privacy as an adult and such rights are limited to the same extent.

(2) Although disclosure to the school principal is probably not legally enforceable (in view of the fact that the Regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions, 1987 have never been applied and will probably shortly be replaced by new Regulations), it may generally be in the best interests of the learner with HIV (for example that special needs may be met) if the principal or other care giver is informed of his or her condition either by his or her parents or guardians or by the learner him- or herself (if the learner is above the age of 14 years).

(3) The principal or other person to whom this information was divulged, may not inform anyone else of the condition of the learner with HIV except with the informed written consent of the learner (above the age of 14 years), or his or her parent(s) or guardian. Disclosure otherwise is justified only if statutory or other legal authorisation exists therefor.

(4) Schools must inform all parents of the incidence of infectious diseases (meaning common childhood diseases) in the school, and of all inoculation programmes that are implemented at the school.

Attendance

(1) The needs of learners with HIV or learners affected by HIV shall as far as is reasonably practicable be accommodated within the school environment.

(2) Learners with HIV are expected to attend classes in accordance with statutory requirements for as long as they are able to function effectively. They have to supply written reasons for any absence.

(3) Academic work should be made available for personal study at home, and parents should be allowed to educate learners with HIV when they become incapacitated through illness, or if they pose a medically recognised health risk to others (for instance if such a learner has a serious secondary infection which cannot be treated and could be transmitted to other persons in the course of day to day contact).

(4) Learners with HIV who develop HIV related behavioural problems or are subject to neurological damage could, if necessary, be accommodated within alternative structures in the same institution.

Education on HIV/AIDS

6 (1) A continuing HIV/AIDS education programme will be implemented at all schools for all learners, educators and other members of staff. Parents and guardians will be informed about all HIV/AIDS education, the learning content and methodology to be used. They should be invited to participate and should be made aware of their role as sexuality educators at home. Other major role-players in the community (for example religious and traditional leaders) should be acknowledged and informed about the HIV/AIDS education offered in schools.

(2) Age-appropriate education on HIV/AIDS will form a part of the curriculum and will be integrated in the life skills education programme for primary and secondary school learners. The education programme will be aimed at giving information on the reality of HIV, AIDS and STD

sexually transmitted diseases) in South Africa and at developing the life skills necessary for the prevention of STD, HIV infection and teenage pregnancy. The information will be given in an accurate and scientific manner.

(h) Learners will be encouraged to make use of health care and counselling facilities including reproductive health care.

(i) A culture of non-discrimination towards people with HIV will be cultivated. Learners will be taught how to behave towards and live with a person with HIV. Social norms against drugs, sexual abuse and violence will be promoted.

Universal precautions

(j) All schools will implement universal precautions to minimise the risk of transmission of all blood-borne pathogens, including HIV, in the educational setting (in the case of HIV, this risk is negligible). All blood, open wounds, breaks in the skin, grazes and infected skin lesions, as well as all body fluids, should be treated as potentially infectious.

(k) All schools will have available at least two first aid kits each of which contains two large and two medium pairs of disposable latex gloves, two large and two medium pairs of rubber household gloves for handling blood-soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate), absorbent material, waterproof dressings, disinfectant (such as hypochlorite), scissors, cotton wool, gauze tape, tissues, containers of water, and a cardio-pulmonary resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids. In addition, each educator should preferably have a pair of rubber household gloves in his or her classroom.

(l) The contents of the first aid kits will be regularly checked and used items should be replaced immediately.

(4) The kits will be stored in one or more selected (class) rooms in the school.

(5) All bleeding wounds should be treated and cleaned while wearing latex gloves, and should be covered well with a dressing or plaster. However, emergency treatment should not be delayed because gloves are not available. Bleeding can be managed by compression with material that will absorb the blood, for example, a towel. People who have skin lesions should not attempt to give first aid when no latex gloves are available.

(6) If blood has contaminated a surface, that surface should be cleaned with a fresh clean bleach solution and the person responsible for this should wear latex gloves. Other body fluids (such as urine, vomit or diarrhoea) should be cleaned up in similar fashion.

(7) Blood-contaminated material should be sealed in a plastic bag and incinerated or sent to a disposal firm.

(8) Skin exposed accidentally to blood should be cleaned promptly with water and disinfectant.

(9) All personnel should be trained on the correct procedure to be followed and on the appropriate use of the various devices contained in the first aid kit. Learners, especially in primary school, should not handle emergencies such as the nosebleeds of friends, on their own.

(10) If there is a biting or scratching incident where the skin is broken, the wound should be squeezed gently to make it bleed, and should then be washed thoroughly with warm water and disinfectant, and covered with a waterproof plaster. The injured person should be given an anti-tetanus injection.

(11) (a) No learner should participate in contact sport, such as rugby or boxing, with an open wound or infected skin lesion.

(b) If bleeding occurs during such a contact sport, the player should be taken off the

field and should be appropriately treated.

(c) Bleeding should be controlled, wounds or lesions should be cleaned with warm water and disinfectant, an antiseptic applied and the wound covered with a non-porous dressing. Only then may the player resume playing and only for as long as the dressing remains effective.

(d) All change rooms or locker rooms should have a fully equipped first aid kit.

School level policies

(1) Governing bodies of schools may adopt an HIV/AIDS policy to give operational effect to the national policy. Such school level policy will reflect the needs, ethos and values of the school and the community. The national policy constitutes a set of basic principles from which the governing bodies of schools may not deviate. In the absence of a school level policy the national policy applies.

(2) It is strongly recommended that each school should establish its own Health Advisory Committee as a committee of the governing body. This committee will consist of members of the academic and administrative staff, representatives of the parents and guardians and a medical doctor or a public health officer.

(3) This committee should be set up and chaired by the principal. The committee should modify and/or approve the school's policy on HIV/AIDS and review it from time to time, especially if new scientific knowledge about HIV becomes available. This committee should advise the governing body on health care matters in the HIV/AIDS field.

Where policy may be obtained

4. This policy may be obtained from The Director-General, Department of Education, Private Bag X895, Pretoria, 0001.

NATIONAL HIV/AIDS AND STD REVIEW

LIFE SKILLS AND SCHOOL BASED PROGRAMMES

INTRODUCTION:

HIV/AIDS and related life skills education in all schools was identified by The National AIDS Plan as one of the priority areas for policy development and implementation. It was believed that this was very important given the nature of South African society - with a high proportion of young people - as well as the pattern of the epidemic.

Subsequent surveys have shown this assumption to have been a correct one, with the highest increasing rate of infections in young people under the age of 25 - particularly in young women. In addition it is well known that

> "Adolescence is a period of profound physical, mental and emotional change
> Young people often experiment with behaviour that increases the probability of HIV infection: unprotected sexual intercourse, the use of alcohol and other drugs that impair judgement and the sharing of needles to inject drugs

(Drawing the National AIDS Response Appendix C4)

However, one of the debates at the time of the drawing up of the National Plan was where the AIDS programme should be located. Although it was subsequently lodged with health, there was clear support for the school based response to be a joint one between at least the departments of Education, Welfare and Health.

There was not a tradition of these Departments collaborating and working together on joint projects. Nevertheless, when the newly appointed Director drew up the five key strategies it was clear that in order for the plan to be realised, the Education Department would have to be involved.

The HIV/AIDS and STD Directorate initiated contact with the Department of Education. While the response was from the beginning favourable there were a few aspects which potentially made collaboration difficult.

- The Education Department had no dedicated budget for HIV/AIDS education
- The Education Department has established structures through which such a programme as HIV/AIDS and life skills could be introduced and this meant some delay in acceptance and agreement as to how best the process could go forward.
- The Department of Health wished to have two teachers trained per school, the Department of Education was more accustomed to working through the guidance and career guidance programmes.
- The syllabus and content of the programme and whether it would be an inter or extra curriculum programme was also a subject for debate and possible contention.

However, a productive collaborative working relationship was established. This inter-departmental initiative crystallised into the calling of a national consultative forum on Life skills and HIV/AIDS education, which was held in Midrand on 29th November 1995.

During this meeting consensus was reached on the minimum requirements with regard to

- *approach and methodology
- *contents
- *educational resources
- *educator/teacher training.

It was also decided to establish a national project committee, and to appoint a task team both of which would serve to facilitate and enhance programme development and implementation.

This decision was approved by the Heads of Education Departments Committee (HEDCOM) and the Department of Health.

The National Project Committee was mandated to oversee and guide the development of

- * a contextually accountable programme to effectively address life skills and HIV/AIDS education within the school curriculum and
- * a strategic implementation plan, with a view to the development and approval of the programme as policy

In order to achieve this the committee would work very closely with the national task team which would be appointed on a full time basis and be accountable to both the Departments of Education and Health. This task team was to be housed within the Education Department.

In order to ensure as widespread support as possible for the HIV/AIDS and life skills programme the composition of the National Project Committee was very wide. It is composed of the following

14 Representatives from the National and the Provincial Departments of Education
14 Representatives from the National and Provincial Departments of Health
Two Teacher educator representatives
One from the Committee of University Principals
Two from the Department of Welfare and Population Development
Seven from National NGOs and
Four from student/teacher organisations

The committee took responsibility for:

- *the training of educators/teachers
- *the development of educational resources and support materials
- * the co ordination, support and expansion of provincial programmes
- *finalisation of the core curriculum
- * the development of policy

*monitoring and evaluation
*lobbying and advocacy
* liaison with organisations dealing with out of school youth

Early in April 1996, the DGs of Health and Education issued a joint statement in which they agreed i.a. that

1. The project is, in the first instance, the responsibility of the Department of Education
2. The project will be directed by the Department of Education taking into account the needs and aims the Department of Health in addressing the HIV/AIDS pandemic
3. As far as possible all decisions regarding the project will be taken in the spirit of collaboration and mutual support

The Department of Health was able to provide a fairly substantial budget for the life skills programme, in the main from donor funding, and the Department of Education took responsibility for re-allocating from other sources into this project.

THE TASK TEAM AND THE TENDER FOR TEACHER TRAINING

The National Project Committee first met in 1996. This was the first time that representatives from the National and Provincial Departments of Health and Education as well a National NGOs and student groups had met. At the initial meetings the composition of the task team, the training of teachers and the available media options were discussed. The question of how funds would be allocated to the provinces was also an issue as well as the controls governing the use of donor funding. Dr K Swart is the person from the Department of Education responsible for this project, and Ms Rentia Agenbach from the Department of Health, HIV/AIDS and STD Directorate. (She has replaced the initator of this project Ms E Swarts whio is currently living in America)

The National Committee formed three sub committees from its members. These were:

1. The sub committee on teacher training
2. The sub committee on curriculum development
3. The sub committee on media and advocacy

The role of these sub committees were to asses how best to ensure that as many teachers as possible would be trained, the evaluate existing school based materials and to ensure that the national and local politicians and bureaucrats were informed and supportive.

Letters were sent out to all the Provincial MECs of Education and Health requesting their support and informing them of the progress being made.

INITIAL PROBLEMS:

The main problem has been around funding. The progress of the National Committee and the appointment of the task team were seriously delayed in the post Sarafina delays and confusions about how to access the money. In addition, the advice and information from the EU seemed to

very [illegible] meeting. This was a potential source of irritation to the Department of Education and of embarrassment to the Department of Health. The tendering process both for the appointment of the task team and for the training of teachers took an extraordinary long time.

In addition there was tension between the provinces which felt that they were already doing fairly extensive HIV and AIDS education in schools, and who wished to proceed in the ways they had established rather than buy into a National Project. There was also heated argument about the allocation of monies. The Department of Health had allocated appr. R35 000 to each province to kick start an HIV and AIDS school based programme, and there was dissatisfaction that the amount was uniform per province rather than allocated on student numbers.

Some Health Department representatives as well as many of the NGOs believed that the Department of Education was not the correct agent to carry the responsibility. There was some hesitancy to the idea of teachers doing the educating in the schools, as there exists a fair degree of intolerance from non teachers about the abilities and capacities of teachers. However, the Department of Education is the only agent with the ongoing capacity to see the process through, as well as being the agent responsible to see that all students receive ongoing education. The Department of Education gave its assurance that the already existing collaborations between itself and NGOs would continue and that new alliances could forged.

The slowness of the process was another source of tension. This was in part due to the problems with funding, but also due to the need to get comparable provincial structures up and running before the programme could be started. In all provinces HIV/AIDS and life skills committees were formed which in the main mirrored the composition of the National Committee with local representatives.

THE APPOINTMENT OF THE TEACHER TRAINING AGENT AND THE TASK TEAM

As these were open to tender procedures, these appointment did take far longer than anticipated. The tender for teacher trainers had to be re advertised given the poor response that was initially received. There was a great deal of interest in the task team positions.

The three sub committees appointed smaller committees to evaluate the tenders and to make the recommendations to the tender board. The executive committee of the National Committee was represented in the process, but the decision was taken by the provincial representatives.

The major problem with the teacher training was the allocation of funds. There was initially an allocation of approx. R4 million available for the whole country. As this was clearly inadequate it was decided that those provinces which felt that they were already engaged in teacher training would receive separate allocation of approx. R1 million each and that those provinces which were unable to do the training would have an agency appointed to train on their behalf from the existing funds.

The final decision was as follows:

The provinces which elected to do their own teacher training were:

- North West Province
- KwaZulu Natal

3 Western Cape
4 Gauteng

In these provinces the provincial committees were required to submit a budget and a work plan, on receipt of which the monies would be transferred to the provinces for the teacher training to commence.

The provinces in which an agency was awarded a tender for training are:

1 N Cape
2 E Cape
3 Mpumalanga
4 Northern Province
5 Free State

The PPASA was awarded the tender for teacher training in these provinces, with the brief to train [illegible] teachers per school as decided in conjunction with the provincial committees.

The task team was appointed early in 1997, fully eight months later than planned. There were many applications for the position, and four people were appointed:

Ms [illegible] gome	Co ordinator
Ms [illegible] ick	
Ms [illegible] athios	
Dr [illegible] w	

Once they were appointed, the task team took over the responsibilities for

1 Overseeing and ensuring that the teacher training proceeds according to schedule and to provincial expectations and needs

2 Evaluating existing school based programmes and distributing a comprehensive collection of such programmes to the provinces

3 Evaluating existing available media and ensuring that provinces receive adequate support media as requested

4 Ongoing evaluation

5 Other administrative and logistical tasks relating to such a project.

Very soon after they were appointed, the task team, together with members of the Executive Committee of the National Project Committee, undertook extensive visits to all the provinces. These visits were intended to ensure that the provincial committees were in place and operational, that the provincial committees were informed as to the availability of funding, that the PPASA was able to present their plan of action as well as to have meetings with the provincial DGs of Education to ensure their support. In addition each task team member took special responsibility for particular provinces.

The provincial visits worked very well, and have ensured that the liaison between the task team and the provinces as well as the liaison between the task team and the three sub committees of the National Project Committee goes smoothly.

FUTURE OF THE NATIONAL PROJECT COMMITTEE

As the work in the Provinces gets underway, and as the work of the three sub committees is strengthened, the role and function of the National Committee will change. Already the number of meetings of this committee has been cut back to two per year and it may well be the case that one meeting per year will be sufficient.

CURRENT PROGRESS

Of the four provinces which elected to do their own training the position very briefly is as follows: (It is anticipated that full accounts of these projects will be given in the provincial reports)

THE PROVINCE

This was one of the first provinces to launch its training project. Although there have been logistical problems the training is proceeding.

[illegible]

In this province there were a number of role players already active in HIV/AIDS and life skills education as well as involvement from the Province. There have been some serious problems in forming a united and cohesive response and in forming a committee and developing a work plan which was fully inclusive of and accepted by all role players. The payment of money to an agent in the province caused some tension and anxiety, but after a revisit from the co ordinator of the task team, it appears as if the process will get moving and proceed according to the action plan and budget submitted.

NORTHERN CAPE

In this province, the life skills programme and HIV/AIDS work in schools had been done, in the main by NGOs. The Department of Education did have a modest programme, with supporting materials. The provincial committee has struggled to get consensus between the needs and perspectives of the NGOs and the sense from the Department of Education of what it has the capacity to deliver. The decision has been taken to train in the first instance school psychologists and plan for cascade training to the teachers into the schools. The action plan and budget were submitted very late, and this together with delays from the Department of Health in paying the money to the province led to cancellations and postponements of training and of some irritation in the province towards the national departments. The relationship between the NGOs and the province remains tense and largely suspicious - a member of the task team will travel to Cape Town to hold a follow up meeting.

not Kwazu - but ... support staff !!

GAUTENG

After initial problems in getting a full collaboration between the Departments of Health and Education, work in this province is proceeding very smoothly, with the training of teachers starting as early as April. The training is being done by the joint departments as well as by a consortium of NGOs.

In the three provinces where the NPPASA was appointed to deliver the training, the training is in the main proceeding as planned. The initial stages were as follows:

Trainers in each province had to be appointed and trained. Once this training was completed, the training of two teachers per school would begin.

It is assumed that a full report of this training will be presented in the provincial reports.

SUPPORT MEDIA

A separate allocation of money was made available for support media - this was to ensure that all provinces had access to media and support materials before the training commenced so that there would be materials in the schools immediately the teachers were trained. Provinces were asked to identify existing media which they liked or felt was appropriate for their province and the task teams responsibility was to ensure that these were duplicated and distributed. It was envisaged that in some cases more than one province would request the same media which would reduce the costs of printing and enable the funds to go further. Provinces could also submit media which they had developed for reproduction.

VIDEOS

Following the establishment of the National Project Committee and the appointment of the task team tenders were called for the production of six videos to be produced for use in school from Grade 1 - 12. This tender was awarded and the production of these videos is currently underway. Although the decision was taken to initiate the schools programme in high schools, to was believed to be important that materials are developed for all levels. The task team has taken on board the production company together with the sub committee for curriculum development and a good working partnership has been established and the videos are scheduled for completion by the end of 1997. It is planned to have exciting companion media to support the videos and their use in schools.

* what about pre-testing of material in Sotho and Zulu

such as what? methodology?

PRIMARY SCHOOLS

An area of great concern to the Department of Education and the National Project Committee is the development of programmes for primary schools. In some provinces there has been a start in primary schools from the current budget. This has happened where the old std 6 is located in primary schools. The task team has begun research on the development of a primary school curriculum as well as on the development of materials. There is as yet, little indication from either

the department of Health or Education as to how much money will be available. In addition, the Provincial teams are trying to ensure that the provincial legislatures make money available for HIV/AIDS and life skills education out of their budgets and that HIV/AIDS education is fully incorporated into curriculum 2005.

EVALUATION

The task team has the responsibility for ensuring that ongoing evaluation of all programmes in all provinces takes place.

TEACHER TRAINING

It is essential for the ongoing success of the programme, that all teachers receive some training in HIV/AIDS and related life skills issues. There is no doubt that teachers will be seriously affected by the epidemic, both in terms of how HIV/AIDS is affecting the quality of life of the pupils they are teaching as well as through their own infections and death.

A 30hrs curriculum for teacher training in colleges and universities has been developed by Pippa Crewe, and has been used by her in teacher training programmes she has taught at the Johannesburg College of Education and the University of the Witwatersrand. In addition, a couple of workshops where this core curriculum has been discussed have been held (KZN/EC). This curriculum has been distributed to colleges and universities as well as to the CUP for consideration as part of a compulsory component of teacher training.

If it is possible to ensure that all teachers receive this basic training as a component during their years of study, the need for the kind of intensive school based training that is currently underway will be significantly eased in the direction of in service training. The sub committee on teacher training is currently investigating this possibility.

CONCLUSION

Despite the very slow progress which has been made, despite the frustrations over funding and the release of money, it is fair to say that the life skills programmes are up and running and are generally on track. The task team are heavily involved and working under extreme pressure and the teacher training is proceeding mainly according to schedule.

There will not be uniformity of delivery in all provinces due to capacity, logistics and to the problem of ensuring the on going co operation between the department of health and education and NGOs. In most cases the department of education have been very supportive and have ensured that in one way or another teachers are released or training and are supported in their training.

The experience has been invaluable in demonstrating that it is possible for state departments to work together at all levels and it should offer guidelines for other interdepartmental collaboration.

Other departments which will become more fully involved during the course of the year and the programme are those of Welfare and Arts, Science, Culture and Technology.

MARY T. REEVE
on behalf of the National Project Committee