ACTION ON AIDS IN SOUTHERN AFRICA

Maputo Conference on Health in Transition in Southern Africa
April 1990

Editors:
Zena Stein & Anthony Zwi

Proceedings

of

Maputo Conference

on

Health in Transition in Southern Africa

April 9 - 16, 1990

Published by

Committee for Health in Southern Africa (CHISA)

and

HIV Center for Clinical and Behavioral Studies
New York State Psychiatric Institute and
Columbia University in the City of New York

Order from: CHISA
Box 16
630 West 168th Street
New York, NY 10032

TABLE OF CONTENTS

PREFACE

An International Conference on Health in Southern Africa was held from April 9 - 16, 1990 in Maputo, Mozambique at the gracious invitation of the Minister of Health of Mozambique, the Honorable Leonard Simao. Staff at all levels of the Ministry did much towards the success of the conference. The conference was undertaken on the joint decision of the African National Congress Health Secretariat, the Committee for Health in Southern Africa (CHISA) and the South African National Medical and Dental Association (NAMDA) at CHISA's Third International Workshop in New York in May, 1988. The conference was sponsored and organized jointly by CHISA in New York (which oversaw the international aspects, with assistance in London from the ANC Health Secretariat and the Anti-Apartheid Movement Health Committee), NAMDA in South Africa (which enlisted the participation of virtually all other progressive health related groups in the country) and the Ministry of Health in Maputo. In addition, the WHO Collaborative Center for Community-Based Medical Education at the University of New Mexico contributed largely to the section of the program on education. The HIV/AIDS section of the program reported here was the responsibility of Zena Stein (of CHISA and the HIV Center for Behavioral and Clinical Studies of the New York Psychiatric Institute and Columbia University in New York) and Anthony Zwi, for the ANC Secretariat and the Anti-Apartheid Movement Health Committee in London.

ACKNOWLEDGEMENTS

For assistance with this publication, we wish to thank Kate Bingley and the North East Thames Regional Health Authority, London, United Kingdom and Laura Boylan and the Administrative Core of the HIV Center for Clinical and Behavioral Studies, New York, USA.

On behalf of the organizations and individuals who participated in the Maputo Conference on Health in Transition in Southern Africa, we warmly thank the following donors for their contributions that enabled this conference to take place.

American Foundation for AIDS Research
ARO - Sweden
British Council
CAA - Australia
Committee for Health in Southern Africa
CIDA - Canada
CUAMM - Italy
Canadian Universities Service Organization
Danida
Danish Cooperation Mozambique
HIV Center for Clinical and Behavioral Studies, New York, NIMH P5O-MH43520
IDRC - International Development and Research
Kellogg Foundation
John D. and Catherine T. MacArthur Foundation
Medecins du Monde
Medico International
Network of AIDS Research in Eastern and Southern Africa
OXFAM - Canada
OXFAM - UK
Projecto Sud - Italy
Save the Children - UK
United Nations Childrens Fund
United States Agency for International Development (UNSAID)
World Health Organization

We also thank the following Mozambican business enterprises for their generous support:

COMETAL/MOMETAL, SARL
EE MEDIMOC
TUDOR
Interfranca de Mocambique
PETROMOC, EE
ZUID (Mocambique); LIMITADA
Entreposto Comercial de Mocambique, SARL
Telecomunicacoes de Mocambique
Unidade de Direccao de Aproveitamentos Hidraulicos
ROBIALAC (Tintas Berger), LDA.
HIDROMOC, EE
CONSTRUIL, LDA
MABOR (MOC)
Pescom Internacional
SOGERE - Soc. Geral de Cervejas E Refrigerantes de Moc., SARL
EE FARMAC
PINTEX - Fab. de Tintas do Ultramar, LDA.
DIMAC - Distribuidora de Materiais de Construcao, EE
Complexo Macaneta
Sociedad Austral de Desenvolvimento, SARL
STEIA - Soc. Tecnica de Equip. Industriais e Agricolas, LDA.
Bayer International Service G.m.b.H.
ENACOMO, EE
Gani Comercial, LDA
International Compiters 9MOC.0, LDA.
CETA - Construtora de Obras de Engenharia, EE

DECLARATION ON HEALTH IN SOUTHERN AFRICA, MAPUTO, APRIL 15, 1990

INTRODUCTION

This Maputo Conference - an International Conference on Health in Southern Africa - held between April 9 - 16, 1990, has been a unique and unprecedented event at a moment of historic opportunity for the liberation struggle.

This meeting has had a special and remarkable character for three reasons.

1. It has brought together for the first time health and social welfare workers, antiapartheid activists, organizations representing more than 54,000 health workers from within South Africa, and their counterparts and comrades from the ANC, Mozambique, and all of the Frontline States.

2. It has addressed the urgent challenge in this final and decisive stage of the liberation struggle of formulating specific proposals, strategies, and policies for the structure, organization, financing, and development of health and welfare services for a truly democratic South Africa.

3. Of further political significance, the Maputo Conference has been an expression of the Mozambique government's solidarity with progressive forces in South Africa and a recognition of our shared experience of the tyranny of apartheid, and our mutual abhorrence of the deliberate destabilization of Mozambique, and in particular of the appalling atrocities perpetrated by the apartheid regime. This shared experience - including the deliberate apartheid effort, both within and outside South Africa, to destroy the potential for full development of entire generations - united us as brothers and sisters.

THIS CONFERENCE COMMITS ITSELF TO:

* Transforming the existing health and social services in South Africa into a nonracial, accessible, equitable, cost effective, and democratic national health and welfare system.

* Promoting a new vision of health and welfare services as a tool of national development.

* Devising an appropriate social welfare policy for a future South Africa and placing the development of this policy high on the agenda of the national liberation movement.

* Prioritizing the development of a progressive primary care strategy as the basis for the provision of health and welfare services.

* Emphasizing the importance of making realistic assessments of the resources required to meet national health and welfare needs equitably and researching means for mobilizing such resources.

In line with the above commitments, high priority must be placed on applied health and welfare research and training. Communities, political organizations, and research groupings should be mobilized to achieve this in the shortest possible time.

The conference devoted particular attention to the problems of financing future national health and welfare systems in South Africa and recognizes the need for further research. These debates need to be placed in the context of the specific characteristics of a mixed economy. Discussions around the role of the private health and welfare sector should be extended through health and community organizations, taking cognisance of effective international models.

Adequate primary health care and welfare services will require appropriate personnel. The conference stressed the need for research and training, for the integration of ANC health workers at every level into the health sector, and for understanding the role of traditional healers.

The participants are unanimous in their belief that the training and education of health and welfare workers is most effective and appropriate when it is situated in the community and achieved through problem based learning methods. The problems of accreditation of health professionals trained by different methods and through different institutions both within and outside South Africa has to be addressed with the relevant authorities in order to maximize opportunities for employment of these individuals.

All delegates to the conference benefitted considerably from presentations of experiences in health and welfare services in the Frontline States. Some of these experiences, which have a direct bearing on the reconstruction of South Africa's health and social services, must be more fully explored. Everyone is fully committed to enhancing the quality of life of all the people of the Southern African subcontinent through regional cooperative endeavors, which would be encouraged and established once South Africa has obtained independence, democracy, and freedom.

A number of issues of urgent priority were identified. This conference affirms the need to integrate women into all health and welfare initiatives and points out that every proposal must

specifically examine the consequences for women. The conference takes particular cognisance of the needs of children and families and the damage that has been done to them by apartheid. That damage must be reversed. The worth and dignity of family life must be restored. Childhood must be reclaimed. The conference stresses the importance of the health and welfare of workers, not only on the factory floor and the rural farm, but also in relation to appalling community and environmental conditions which must be massively improved. To address the urgent problem of the return to South Africa of more than 20,000 exiles, the conference endorses the formation of a National Reception Committee through which the ANC, together with other progressive mass based organizations, can work out concrete measures for the rapid and effective integration of returnees into South African social, political, and economic life.

All those present are acutely aware that South Africa and indeed the entire Southern African region is facing a crisis over the HIV epidemic. Urgent action must be initiated immediately, as the State's programs are fundamentally limited and seriously flawed. Community based initiatives are known to be more effective since they pay attention to the broader psychosocial implications of the disease. An alternative progressive campaign with the support of political and other representative organizations has to be set up immediately. An AIDS Task Force with strong political leadership is proposed to take this program forward.

Finally, this Conference expresses our hope, our determination, and our confidence.

Our hope is derived from the fact that all the nations in the region are accomplishing the complete decolonization of the subcontinent of Southern Africa. The independence of Namibia is a recent example. Our determination is to eradicate the last vestiges of racial oppression and colonial exploitation from the entire region. Our confidence stems from our capacity for unity which has been affirmed by the common sense of purpose which has brought together people from many nations, many origins and backgrounds, and many disciplines to address the short- and longer- term tasks of charting the future of a truly democratic South Africa.

ISSUED BY THE CONFERENCE ORGANIZING GROUPS:

The African National Congress; National Education Health and Allied Workers Union, National Medical and Dental Association; Organization for Appropriate Social Services in South Africa; South African Health Workers Congress; Welfare Coordinating Committee; Ministry of Health, Mozambique; Committee for Health in Southern Africa (USA); Representatives from the University of New Mexico; Anti-Apartheid Movement (London).

Other participants were as follows:

The Deans of the medical schools of the universities of: Edouard Mondlane, Mozambique; Ilorin, Nigeria; Newcastle, Australia; Zambia.

Representatives from the Frontline States: Angola, Namibia, Tanzania, Zambia.

Representatives from FRELIMO; the WHO representative, Maputo; other Mozambian participants.

Representatives from internal South African organizations:
Congress of South African Trade Unions - health and safety group; Concerned Social Workers; Critical Health; Health Workers Society; Health Workers Union; Industrial Health Groups; Islamic Medical Association; National Interim Womens Group; National Union of Students; Progressive Primary Health Care Network; Social Workers Forum; South African Black Social Workers Association; South African Council of Churches; South African National Students Congress; United Democratic Front.

AIDS AND HIV IN SOUTHERN AFRICA

Zena Stein

Co-Director,
HIV Center for Clinical and Behavioral Studies
New York State Psychiatric Institute and
Columbia University, New York, NY

One of the features of this Conference is that it brings together those who will take responsibility for health in transition, the experiences of health workers in the frontline states, and those of health workers in Europe and the US. Lessons on what to do and what not to do in the AIDS/HIV field will emerge in our discussions.

It is clear that HIV disease is claiming an ever increasing toll in Africa. Table 1 gives the official figures for notified AIDS, as of July 1, 1990. A total of nearly 65,000 cases of AIDS were reported from Africa to WHO. The countries of Central Africa are currently affected on the largest scale. Seroprevalence is generally higher in urban than in rural areas, and the highest rates of infection are found among women 20 - 24 years of age and men 30 - 34 years of age. The principal mode of transmission is likely to be sexual with a minimal role likely for injection. There is no evidence for transmission by scarification, or exposure to mosquitos.

Those infected with HIV have an increased risk of developing clinical tuberculosis (TB) (with reactivation of dormant lesions), and thus a rapid increase in the magnitude of the TB problem is anticipated. There is some evidence that those infected with HIV have also been reported to be relatively resistant to standard TB treatment and relapse more frequently.

HIV infection spreads along trade routes and in the path of wars and their concomitant geographic and social dislocations. Tourism also spreads the infection. Migration of men and women in the labor force, because it divides families, makes a large contribution to the spread of HIV in many regions of Africa. The spread of infection may be enhanced by the presence of other sexually transmitted diseases, which are spread in turn by the same population movements. The long incubation period of the illness, during which there are often no symptoms at all, prolongs the period over which infection may be transmitted to others. Thus HIV positive individuals will not generally know that they are infected, and infectious, for many years. Limited resources available to already strained health care systems constitute another challenge to addressing the HIV pandemic in Africa in terms of both prevention and care of the ill.

It is clear that there is now, but will not be for long, a "window of opportunity" for preventive action in Southern Africa. The present prevalence rates are low relative to the other countries listed in Table 1. Far from causing complacency, these preepidemic conditions in Southern Africa point to the possibility of timely preventive action.

The future of the epidemic and the extent to which it gains hold in the South African population may be seen more as a political problem than a health problem. Every country and every social group that has grappled with prevention has met with great difficulty, and easy solutions are not to be had. The slogan "practice safe sex" is incomparably more invasive as a health education message than "do not smoke," "use seatbelts," or "cut down alcohol," and success with these three familiar instructions has seldom been rapid or dramatic. Moreover, if "safe sex," means "use condoms," then how will the compilers reproduce? Should we urge instead, "safe sex now, safe parenting later"?

Experience from elsewhere suggests that, if this epidemic is to be forestalled, there will need to be numerous discussions at the grassroots level among people who respect and trust each other. Trust is crucial: between men and women, between speaker and audience, at national, regional and local levels, across disciplines. There will have to be trust across the progressive organizations, too, and between expatriates and nationals.

SOUTH AFRICA: HIV AND THE TRANSITION TO A POST APARTHEID HEALTH CARE FRAMEWORK

Prospects are now bright for the end of apartheid and a discrete shift of political power in South Africa. Corresponding to the discrete shift in political power will be a discrete shift in the State's public health priorities. However, it is not possible immediately to shift the capacity of the South African health system to address the needs of the majority. Limitations are placed by the physical infrastructure, the number and proportion of personnel in the various health professions, the nature of the training of health professionals, and much more. As stressed at the Maputo conference, the structure of existing health services must be transformed, a process that cannot be achieved overnight. The arrival of the HIV virus in South Africa in this extended period of political transition is alarming. At the same time - perversely - it may provide a vehicle for implementing important elements of the transition to a post apartheid health system. The nature of the initiatives needed to combat the epidemic - stressing primary care, education, and community involvement - coincide closely with the important departures needed in the transition to a post apartheid health system. Furthermore, the true emergency nature of these initiatives, at a time when the national government has neither the disposition nor the credibility to implement effective measures, provides a strong rationale for funding from a broad spectrum of sources to groups with a program to combat the HIV virus. The struggle against the HIV/AIDS epidemic should be

consciously adopted as a strategic element in the transformation of the health system to one that serves the needs of a truly democratic South Africa.

TABLE 1

AIDS CASES REPORTED TO WORLD HEALTH ORGANIZATION FROM SOUTHERN AFRICA AS OF JULY 1, 1990

Country	Date of Report	No of Cases	*1988 Case Rate
Uganda	31.12.89	12444	19.6
Zaire	31.01.90	11732	8.7
Malawi	08.01.90	7160	36.0
Tanzania	01.03.90	6251	9.3
Kenya	30.07.89	6004	11.2
Cote d'Ivoire	01.02.90	3647	9.5
Zimbabwe	15.07.90	3134	2.1
Zambia	07.05.90	3000	11.6
Rwanda	30.03.90	2867	3.7
Burundi	31.12.89	2784	19.3
Congo	31.12.89	1940	17.4
Ghana	28.02.90	1252	1.8
Burkina Faso	11.06.90	906	4.4
Central African Republic	31.12.89	662	7.9
South Africa	21.06.90	463	0.3
Ethiopia	11.06.90	411	0.1
Senegal	08.03.90	307	1.6
Namibia	31.03.90	232	2.3
Guinea-Bissau	29.03.90	123	0.0
Mozambique	23.06.90	113	0.1
Angola	31.12.88	104	0.6
Botswana	17.01.90	87	1.7
Cameroon	31.03.89	78	0.3
Nigeria	15.03.90	48	0.0
Swaziland	16.06.88	14	0.9
Lesotho	27.04.90	11	0.2
Mauritius	05.04.90	5	0.1
Madagascar	31.12.89	2	0.0

From: AIDS 4:937-941 (1990).

*Rate: 1988 reported cases/100,000 population

THE MAPUTO CONFERENCE HIV AND AIDS WORKSHOP

Anthony Zwi

**North East Thames Regional Health Authority and
Department of Community Medicine, University College
and Middlesex School of Medicine, London**

This set of papers is the product of a unique conference focusing on health in Southern Africa and held in Maputo, Mozambique, from April 9 to 16, 1990. A major component of the conference dealt with infection with the human immune deficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) in the Southern African region. The papers presented were remarkable in many respects - they represented experience from clinicians, community physicians, epidemiologists, nurses, and other health and community workers. Those participating in the conference came together from a wide variety of countries, both in and outside the region, including Mozambique, Namibia, Uganda, Zimbabwe, Zambia, the Netherlands, the United States, the United Kingdom, and South Africa. The mix of health and political activists provided an unusually focussed context in which to discuss current problems in the region and the need for innovative programs to address them.

The material presented at the conference and reproduced in this volume provided unique insights into current problems affecting the countries of Southern Africa with respect to HIV disease. Many of the structural, social, and political characteristics of the region play some part in facilitating the transmission of HIV disease and retarding the ability of health services to cope with those already infected with HIV, to treat those with clinical disease, and to prevent further transmission within the community.

CONFERENCE PAPERS

In an introductory note, Zena Stein describes the extent of HIV disease in southern Africa and makes a plea for opportunities to be seized now if the epidemic is not to devastate the region. She argues that, aside from the negative impact of HIV, the epidemic may provide an opportunity to drive home the important messages of primary care, education, and community participation.

Ahmed Latif elucidates the clinical presentation of HIV disease in Zimbabwe, drawing on the extensive Zimbabwean experience and focusing attention on issues of diagnosis and treatment. David Serwadda contributes personal insights from the experience of providing care for people with HIV disease in Uganda. These contributions painfully describe the serious consequences of HIV disease for the individuals involved, their communities and

societies, and the health services. They provide a timely warning of the necessity to prevent further transmission of the disease and to take positive steps, at all levels, to prevent the epidemic from reaching similar proportions in South Africa.

Dr. Finckelstein provides some details of HIV disease in newly independent Namibia. It is now apparent that Namibia has a major HIV epidemic on its hands and that the reported incidence rates are amongst the highest in the world. A detailed description of the high level multisectoral structures established to combat the epidemic in Namibia was described at the conference - a notable contrast with the limited response from the South African state at this point in time. Besides the need for clear leadership at national level, a grassroots approach is absolutely crucial, a point driven home by a number of subsequent papers.

Colleagues from the Department of Health in Mozambique present details of the extent of the epidemic in the country and the response of the Ministry of Health. Besides refining the epidemiological information on HIV seroprevalence in Mozambique, studies on knowledge, attitudes, and practices have been carried out and a public information campaign launched. Health education has been characterized by a multisectoral approach with involvement of governmental and nongovernmental organizations. Much positive has been gained by providing an environment in which free discussion about sensitive themes such as sexual behavior and the use of condoms has been possible. Cesar Palha de Sousa provides examples of the approach of the Mozambique Ministry of Health, drawing attention to the concern about the growing extent of the epidemic and the need to train additional personnel, strengthen clinical facilities, and provide laboratory support, as well as the need for operational research to help face the ongoing challenge of HIV infection in Mozambique.

Mariella Baldo and Antonio Jorge Cabral contribute a stimulating account of relationships between the transmission of HIV infection and the existence of low intensity war in Mozambique. They draw attention to the widespread social disruption, civil strife, economic sabotage, destruction of infrastructures, and terrorism of the rural population and argue for the need to view the transmission of HIV infection within a broader social context. They also make an important point: that failure to recognize the context in which HIV transmission occurs creates great difficulties in developing prevention strategies.

The papers from South Africa, too, were enlightening. Anthony Zwi provides a critical look at the epidemiology and public health measures used to control HIV disease in South Africa to date. He draws attention to the pattern of HIV infection in South Africa and the doubling time of 8.5 months. Current estimates of the number of people infected with HIV in South Africa exceed 60,000. The measures taken by the state have so far been inadequate, and he outlines the range of measures that could be taken to address this problem. It is particularly important that representative organizations take the lead in formulating appropriate responses

and to ensure that they are able to draw upon the best available medical, scientific, and social advice.

Two colleagues presented useful advice to those considering the implementation of HIV infection prevention programs. Dan Houston and Gilles de Wildt discuss the issues that need to be considered in planning educational programs; lessons from which the region could benefit and upon which urgent action is required.

Liz Floyd provides a pragmatic approach to the problems faced in placing HIV education on the agenda of progressive organizations. Amongst those identified are the many other priorities facing progressive political organizations at the moment, not least of which is establishing appropriate structures to challenge and contribute to the development of a just and democratic South Africa in the future. Other obstacles include denial that HIV is a problem and the perception that it is somebody else's concern, as well as the neglect by our male dominated societies in providing appropriate opportunities for education around sexuality and health.

Bafana Seripe illustrates in detail the context in which HIV education in South Africa needs to take place. Seripe describes the work of the Workplace Information Group, which assists trade unions and organized communities to respond to health issues. The trade union movement has recognized the importance of HIV and AIDS and begun to address this issue through the development of educational programs and the negotiation with management of appropriate conditions for HIV education, the prevention of HIV transmission, and the care of those affected. In particular, the unions have adopted a strong approach to the cessation of the migrant labor system, a system that disrupts family life and facilitates the spread of sexually transmitted diseases through casual relationships. The unions remain an essential part of any progressive approach to dealing with this epidemic and should be supported by the health community in their endeavors to do so. The contribution from the National Union of Mineworkers forcefully brings home the issues from a trade union perspective.

The ANC Health Department provides insight into how the African National Congress views the problem of HIV infection. The pattern of HIV disease in Southern Africa and its epidemiology in the region are described, with attention being devoted to the need for appropriate educational programs amongst ANC comrades both in and outside the country. The conference benefitted greatly from viewing a video program prepared by the ANC for the education of its comrades - this was felt to be a very useful tool for community education and has been distributed quite widely within the country despite its being prepared with a different audience in mind. Since the conference, the ANC has taken other initiatives to raise the profile of HIV as an important health issue.

The importance of seeing HIV and AIDS within an historical context was clearly made. Both Packard and Epstein, and Vaughan caution us to learn the lessons of history and not get so caught up in current events as to not benefit from previous insights and experiences. Randy Packard and Paul Epstein consider the uneasy relationship between epidemiological and anthropolical research and HIV disease. Megan Vaughan provides useful insights from endemic and epidemic syphilis in Uganda earlier in this century. Both papers draw attention to the way in which women and their sexuality were blamed for the epidemic and how racist connotations of sexuality permeate current debates. Megan Vaughan argues for a new and progressive discourse that allows the discussion of sex related issues, while Packard and Epstein indicate the narrow focus of research on HIV and AIDS to date.

'HIGH RISK SITUATIONS'

In summary, many of the papers and much of the discussion revolved around understanding the social, economic, and political context of HIV disease in Southern Africa. It is all too clear that we need to understand the 'high risk situations' in which so many people in the region live. Not only is it important to identify and change 'high risk behaviors', but we need to elucidate the determinants of such behavior if we are to have any impact on preventing the transmission of HIV. Population movement, migrant labor, lack of education, and poor health services all contribute to the spread of HIV and retard our ability to halt such transmission.

This is not to argue that prevention activity should wait until these social ills are remedied, for that may take a long time and we have no time to waste. But it does imply that preventive strategies and educational programs should acknowledge the link between the social context and risky behavior. Building upon this link may help strengthen health promotion messages and increase the organizational pressure for the demise of health harming 'high risk situations'.

MAPUTO STATEMENT ON HIV AND AIDS

The conference culminated in the adoption of the Maputo statement on HIV and AIDS in Southern Africa. This is reproduced in full in these collected papers. The document sets out the main themes described and discussed at the conference and charts the way forward for all. There is no doubt that action must to be taken urgently.

We hope that the proceedings of the HIV and AIDS component of the Maputo Conference on Health and Welfare in Southern Africa helps provide some of the background material, experiences, and approaches which will ensure, even at this late stage, that the HIV epidemic does not reap the massive toll that is otherwise likely to occur in our region.

CLINICAL ASPECTS OF AIDS IN AFRICA

Professor Ahmed S. Latif

University of Zimbabwe Medical School
Harare, Zimbabwe

ABSTRACT:

In Africa men and women are infected with HIV in an approximately 1:1 ratio. Differences in clinical presentation of HIV infection between Africa and Europe and the United States may be due to the different patterns of prevalence of opportunistic pathogens in the environment. Salient clinical aspects of HIV infection in Africa are discussed. HIV may alter the clinical presentation and response to treatment of a number of sexually transmitted diseases. HIV infection is highly prevalent among those with tuberculosis, and, in our experience, the response to antituberculosis therapy is good. No relationship has been found between HIV infection and parasitic infections, including malaria. Diarrhoeal disease is one of the more common manifestations of HIV infection in both adults and children, and skin rashes of many types are also quite common. While Kaposi's Sarcoma has been familiar in Zimbabwe for decades, in 1983 there was a shift in the pattern of Kaposi's: patients were younger and presented in a more advanced clinical stage. Patients whose Kaposi's is associated with HIV infection respond less well to therapy and often have visceral involvement.

INTRODUCTION

The first cases of AIDS were reported in the US in 1981. In 1983 the human immunodeficiency virus (HIV) was identified as the cause of AIDS, and in 1985 tests became available for the presence of HIV antibody in sera. By the end of November 1989, over 203,000 cases of AIDS had been reported to the World Health Organization. AIDS has become a true pandemic.

TRANSMISSION OF HIV

In the United States surveys indicate that the disease occurs most commonly among homosexual and bisexual men, men and women who have been intravenous drug users or have received blood and blood products, women who have had sexual encounters with infected men, and children born to women with HIV infection. In Africa, where homosexuality and recreational intravenous drug use is apparently rare, the infection is transmitted mainly

through sexual intercourse between men and women and vertically from infected woman to her foetus/neonate. In countries where there is no or insufficient screening of the blood supply there is an additional risk of transmission through the transfusion of blood and blood products obtained from infected persons. In Africa HIV transmission follows the same patterns as other sexually transmitted disease such as syphilis and gonorrhoea.

EPIDEMIOLOGY

The male to female ratio among those infected in most parts of Africa is approximately 1:1. Among adults the disease is most commonly found in those between 20 and 40 years of age. Among children it is most common in those under five. These groupings reflect sexual and vertical transmission respectively. This pattern of HIV distribution strongly suggests that transmission of the virus is not through insect vectors, and seldom through needles used for the purpose of injections or through sharp instruments used for the purpose of traditional scarification.

In studies carried out in various parts of Africa it has been shown that the risk factors associated with the acquisition of HIV include having numerous heterosexual partners, having sexual contact with prostitutes, being a prostitute oneself, and having had sexually transmitted diseases, in particular genital ulcerative disease. In studies carried out to determine the factors associated with transmission of HIV it has been shown that male to female transmission is facilitated by the presence of genital ulcers, and female to male transmission is facilitated by the concomitant acquisition of genital ulcer disease. In one study in Nairobi, Kenya it has been shown that the acquisition of HIV may be facilitated by the presence of an intact foreskin. This study suggested that the uncircumcised state alone was a risk factor for HIV acquisition independent of the acquisition of genital ulcers.

CLINICAL FEATURES OF HIV INFECTION

The clinical features of HIV infection in Africa differ only slightly from those seen in patients in Europe and the Americas. Differences seen may be attributed to the different pattern of prevalence of opportunistic pathogens in the community. Major differences seen are the relative infrequency with which Pneumocystis carinii pneumonia and atypical mycobacteriosis occur in patients in Africa when compared with patients with AIDS in the developed world. However, the spectrum of clinical presentation is very broad and ranges from asymptomatic infection to life threatening opportunistic infections and opportunistic cancers.

HIV INFECTION AND OTHER HEALTH DISORDERS

1. *HIV and Sexually Transmitted Diseases:*

HIV infection may alter the clinical presentation and response to treatment of a number of sexually transmitted diseases. There is evidence that patients with HIV infection who develop pelvic inflammatory disease often present with severe pelvic infection and may accumulate pus in the pelvis and abdomen.

Recent reports indicate that single day courses and short courses of long acting depot penicillin may not be effective in the treatment of syphilis and in addition some patients with clinically and histologically proven syphilis may not develop positive serologic tests for syphilis.

In patients with HIV infection, chancroid may present in an atypical way. Most patients will develop genital ulcers and buboes, but they may not respond to the usual single day and short courses of therapy. Some patients with HIV infection and immunosuppression, when they develop chancroid, develop extensive and persistent genital ulcers but not buboes. This condition we have labelled "non reactive" chancroid, and it is an indicator of poor cellular immunity. Similarly, patients with HIV infection who have genital herpes simplex virus infection develop recurrent persistent and extensive lesions depending on their immune status. The significance of genital ulcerative conditions is chiefly in the fact that morbidity is greatly enhanced and that it is known that genital ulcers facilitate the transmission and acquisition of HIV.

2. *HIV Infection and Tuberculosis*

There has been an increase in the annual incidence of tuberculosis in the age group 20 to 40 years. Studies in various parts of Africa have shown that the prevalence of HIV infection in patients with TB may be as high as 65%. The pattern of clinical presentation of TB in HIV infected patients is also altered depending on cellular immune function. Patients may present with features typical of postprimary TB, but depending on the degree of immune suppression patients will often present with disseminated and atypical features. Extra pulmonary TB is also found more often in patients with HIV infection. Biopsy of tuberculous lesions in patients with cellular immune deficiency may show atypical features such as the absence of granuloma formation and the presence of large numbers of mycobacteria. This condition is called "nonreactive TB".

In our experience, the response to anti-TB therapy in patients with HIV infection is good. However the prevalence of drug reactions, especially to thiacetazone, may be quite high.

We have not seen any complications caused by BCG vaccination in children born to mothers with HIV infection, and, despite BCG being a live virus, the practice of vaccination at birth should not be discouraged.

3. *HIV Infection and Parasitic Infections*

No relationship has been found between malaria and HIV infection, nor does HIV infection cause a greater incidence of complications in malaria. We have also not seen any interaction between HIV infection and other parasitic infections. However, there are reports that suggest that latent visceral leishmaniasis may be reactivated and does disseminate in subjects immunosuppressed by HIV. Disseminated strongyloidiasis has not been found commonly in patients with HIV infection in our experience, but this has been reported by other workers. We, however, have seen a small increase in the prevalence of neurocysticercosis in patients with HIV infection presenting with epileptic fits. Schistosomiasis does not seem to have any relationship with HIV infection.

4. *HIV and Neurologic Disease*

HIV is a neurotropic virus, and it has been suggested that invasion of the nervous system occurs early in the course of HIV infection. The transfer of HIV to the nervous tissue is facilitated by the macrophage system in the body. Various different neurologic syndromes occur as a result of HIV itself or as a result of opportunistic infection.

5. *HIV Infection and Diarrhoeal Disease*

In adults as well as children, one of the more common manifestations of HIV infection is diarrhoeal disease. Some patients experience recurring bouts of severe diarrhoea while others have chronic diarrhoea interspersed with acute explosive episodes. Thorough investigation may reveal no pathogenic cause for the diarrhoea, and it has been suggested that the diarrhoea may be caused by HIV itself. The exact pathogenesis is not known, but it is felt that the diarrhoea is probably of the secretory type. Patients often tend to lose body mass, and severe emaciation results. This syndrome of "slim" disease may be associated with other features of immunosuppression.

6. *HIV Infection and Dermatoses*

Any type of skin rash may be associated with HIV infection. The rash may be caused by HIV itself, by other opportunistic and nonopportunistic pathogens, and by other factors. The spectrum of dermatologic findings is very broad and includes mild fungal infections such as tinea versicolor as well as the devastating tumor infiltrations of Kaposi's sarcoma.

7. *HIV Infection and Kaposi's Sarcoma*

The association between immunosuppression and Kaposi's sarcoma has been known for some time. Kaposi's sarcoma occurs in an endemic fashion in many African countries. Endemic disease is known to occur in elderly persons and is thought to be due to age related immunodeficiency. In Zimbabwe, we have had experience with this tumor for decades. In 1983, however, we began to see a different pattern of Kaposi's sarcoma. Kaposi's was showing up in younger patients, presented in a more advanced clinical stage, and progressed more rapidly than the more familiar type. When tests became available for the detection of HIV antibody in 1985, we were able to test all stored sera for the infection.

The first cases of HIV related or epidemic Kaposi's sarcoma occurred in 1983. Subsequently, there has been an exponential increase in the HIV related tumor. Patients with the epidemic form of the tumor tend to respond less well to therapy and often have visceral involvement, especially pulmonary involvement. In such patients the prognosis is poor.

The cause of Kaposi's sarcoma has not as yet been established. A viral pathogen has been suggested, and the cytomegalovirus was implicated at one point. This theory was soon discarded and another herpes virus, the human, been established. However, it does seem that Kaposi's sarcoma is caused by a virus that is sexually transmissible as the tumor occurs more frequently amongst persons who have become infected with HIV sexually rather than through the transfusion of blood or blood products.

CONCLUSION

In conclusion, the pandemic of HIV infection and AIDS is a growing challenge to medical science. Work continues in the search for an effective vaccine and an effective cure. The infection is hitting the most economically productive sector of our communities and is likely to have long term social and economic impact. HIV infection is a sexually transmitted disease and should be preventable. Currently the only weapons we possess to combat further

spread of the epidemic are educating the public in safe sex and ensuring the safety of the blood supply.

SUMÁRIO

As mulheres e os homens africanos estão infectados pelo HIV numa proporção de aproximadamente 1:1. As diferenças na apresentação clínica da infecção por HIV na Africa, na Europa e nos Estados Unidos devem-se, provavelmente, a padrões diferentes de prevalência de patógenos oportunistas no ambiente. Discutem-se os aspectos clínicos importantes da infecção por HIV na Africa. O HIV, poderia alterar a apresentação clínica e a resposta ao tratamento de algumas doenças sexualmente transmissíveis. A infecção por HIV é altamente prevalente entre aqueles com tuberculose, e na nossa experiência, a resposta à terapia anti-tuberculose é satisfatória. Nenhuma relação entre infecção por HIV e infecções parasitárias foi encontrada, incluindo a malária. A doença diarrêica é uma das manifestações mais comuns da infecção por HIV, tanto em adultos como em crianças, e, vários tipos de erupções cutâneas são também frequentes. Apesar do Sarcoma de Kaposi ser conhecido no Zimbabwe há décadas, em 1983 houve uma mudança do padrão do Sarcoma: os pacientes eram mais jovens e apresentavam uma fase clínica mais avançada. Os pacientes cujo Sarcoma está associado com infecção por HIV respondem de forma menos satisfatória a terapia, e frequentemente apresentam comprometimento visceral.

CARE OF THOSE INFECTED: THEORY AND PRACTICES. THE MAGNITUDE OF THE PROBLEMS IN AFRICA

Dr. David Serwadda

Senior Lecturer, Mulhgo Hospital
Makere Medical School, Kampala, Uganda

ABSTRACT:

AIDS presents a major challenge to African countries. The situation is complicated by the long incubation period of HIV disease, lack of access to medicines, and limited diagnostic facilities. In areas of high HIV seroprevalence in Uganda, it has been necessary for hospitals to develop guidelines limiting admissions so as to prevent overwhelming already strained facilities. It is suggested that outpatient clinics and reliance on traditional modes of family care will be critical in managing the AIDS/HIV epidemic. Community and political leaders should work to provide such clinics as well as to provide support and education to families caring for AIDS patients. It is likely that nongovernmental agencies will play an important role in these tasks as well.

PREVALENCE OF HIV INFECTION

It is now estimated by WHO that there are 3.0 million Africans who are infected with the AIDS virus; the true figure may well be higher. About 40,000 AIDS cases so far have been reported from the African continent. Certainly Central and Southern Africa have and will continue to have a major health problem from HIV infection for some time. In Uganda based on a country-wide serosurvey concluded in 1988, we estimate that one million Ugandans are already infected.

FINANCIAL AND HUMAN RESOURCES AVAILABLE FOR HEALTH CARE SYSTEMS

In Africa the Gross Domestic Product (GDP) average is $642 (range $97 - $2,481) with a distribution throughout the continent as shown in Table 1. Many of the countries with high rates of HIV infection are among those with the fewest resources to confront the problem. Africa has a total external debt of $203.9 billion, and there are not enough doctors and other health care personnel to serve the population. Clearly, there is very little money and manpower available for health services.

TABLE 1: GROSS DOMESTIC PRODUCT (GDP) FOR AFRICA

GROSS DOMESTIC PRODUCT

LOW	MEDIUM	HIGH
$51 - 350	$351 - 650	$651 -
Benin	Guinea	Egypt
Burkino Faso*	Morocco	Algeria
Burundi	Ghana	Benin
Central African	Angola	Cameroon
Republic	Botswana	Congo
Cape Verde	Liberia	Tunisia
Chad	Mauritania	Cote d'Ivorie
Comoros	Niger	Djibouti
Gambia	Nigeria	Seychelles
Guinea Bissau	Swaziland	Mauritius
Ethiopia	Zambia	
Kenya		
Lesotho		
Mali		
Malawi		
Madagascar		
Mozambique		
Niger		
Rwanda		
Sierra-Leone		
Somalia		
Tanzania		
Togo		
Uganda		
Zaire		

* Countries underlined have the highest rate of AIDS.

THE CARE OF HIV INFECTED PEOPLE

The care of asymptomatic HIV infected people is crucial. It offers us the opportunity to educate those infected not to spread the infection further. Also, those infected can learn how to take care of themselves in order to prolong their lives and remain as healthy as possible. Prevention and selfcare are usually carried out with the help of counselling services, but certain problems specific to Africa create difficulties.

1) In many countries there is a very large pool of infected people who are unaware of their infection.

2) The concept of counselling is relatively new in Africa. The idea of establishing HIV testing centers is beginning to take shape, but it is hampered by financial and logistical problems. Very few of the present health care services provided counselling before the HIV epidemic. Most counselling services were started by nongovernmental organizations with the help of external funding, and they are not yet widely available (usually they are found only in cities). There is a shortage of funding as well as of skilled personnel to act as trainers. The expansion of counselling programs to rural areas is needed, especially in countries like Uganda and Tanzania where there are high rates of rural seropositivity. Existing services are in danger of being completely overwhelmed with the ever increasing number of infected people. Counselling will not be widely available anywhere in Africa for some time.

THE CARE OF AIDS PATIENTS

There are drugs that have been shown in the US and Europe, to be effective in the treatment of AIDS patients namely, Zidovudine (AZT, Retrovir), and alpha and beta interferon. However, these drugs are still too expensive to be used to any significant extent in Africa. The care of AIDS patients in Africa is mainly aimed at treating opportunistic infections.

1. *Role of the Hospitals*

   The clinical course of HIV infection is highly variable. It is often punctuated by acute attacks of a variable number of infections that necessitate hospitalization for proper management. In areas where HIV prevalence rates are high, i.e. >10%, it has been found useful to develop a policy for admission to hospitals that will prevent the medical wards from being overwhelmed by AIDS cases so that they are unable to cope. Table 2 shows the common criteria for the admission of AIDS patients to Mulago Hospital, Kampala, Uganda.

TABLE 2

COMMON CRITERIA FOR ADMISSION OF AIDS PATIENTS IN MULAGO HOSPITAL MEDICAL WARD

Pulmonary Tuberculosis
Diarrhea with Dehydration
Pneumonia
Meningitis
Pyrexia
Anaemia
Stroke
Neuropathy
Moribund State

Problems in Hospital Care

The diagnosis of opportunistic infections is complicated by limited diagnostic facilities. As a result empirical treatment is often not given. There may not even be medication available to treat common and opportunistic infections, particularly fungal and viral infections. As a result, we must cope with a high mortality for AIDS patients. Table 3 outlines Ugandan strategies to confront this issue.

TABLE 3

SUGGESTIONS FOR COPING WITH HIGH MORTALITY OF AIDS PATIENTS IN HOSPITALS

- Discussions with family and patients regarding the poor prognosis in some patients.
- Early discharge of dying patients to the care of the family where appropriate.
- Regular sessions with hospital staff regarding their own reactions to death and dying.
- More frequent use of counselling and pastoral services for all patients in hospitals.

2. *AIDS Clinics*

A majority of symptomatic HIV infected individuals can easily and conveniently be managed as outpatients in an AIDS clinic. These clinics also enable medical personnel to follow up discharged patients from hospitals. Table 4 lists other objectives of an AIDS clinic.

TABLE 4

OBJECTIVES OF AN AIDS CLINIC

- Early detection and management of opportunistic infections.
- Provide counselling and health education to patient and relatives.
- Learn more about the disease and its natural history.

Setting up an AIDS clinics is often beset with problems. Initially the attendance is poor and the drop out rate is high due to the stigma associated with the disease. This may be discouraging, but with persistence on the part of health personnel the clinic often succeeds.

3. *Family, Home and Community in the Care of AIDS Patients*

In many African cultures, when one member of a family is ill the whole family is involved in his/her care. Death always involves the participation of the community where the patient has been living. Many women will have to continue to take care of ailing family members even while they themselves are infected and ill. Although AIDS is to some extent threatening to undermine these cultural practices, they are very helpful to the care of AIDS patients and need to be exploited.

It is clear that African governments will not be able to cope with the health needs of the ever growing number of AIDS patients. Family members will be called upon to participate in the care of their relatives. Thus it is very important to educate family members about modes of transmission of HIV, the use of palliative drugs for chronic and recurrent problems, and, above all, the nature of the illness.

4. *Community Support*

Community attitudes are very important in the care of HIV infected individuals at home. Community and political leaders play a key role in forming people's attitudes. They can help to foster love and care of AIDS patients by establishing AIDS clinics and counselling services. These services provide support and encouragement to families with an HIV infected member.

5. *Nongovernmental Agencies*

In our experience, these agencies, including churches, are making a significant impact on the provision of AIDS health education and care of AIDS patients. Some of these agencies and churches enjoy long established trust and respect in the community and have been able to secure needed funds to support AIDS victims and their families. Some new organizations have been created specifically to help HIV infected individuals. In Uganda, one of these, known as TASO, includes infected individuals and their families and has been particularly important in modifying stigma, reducing unreasonable fear, and training community and family members in caring for the sick. We can expect nongovernmental organizations to play an increasingly significant role in alleviating the burden of HIV infection in African countries.

SUMÁRIO

A SIDA representa um grande desafio para os países africanos. A situação é exacerbada pelo longo período de incubação da doença, falta de acesso a medicamentos, e limitado número de unidades diagnósticas. Em áreas de alta prevalência do HIV em Uganda, os hospitais são levados a adotar medidas que limitem as admissões como forma de prevenir acúmulo de atividades nas já sobrecarregadas unidades. Sugere-se que ambulatórios clínicos e a crença nos métodos tradicionais de cuidados familiares serão decisivos no lidar com a epidemia de SIDA. Os líderes políticos e comunitários devem trabalhar para prover tais ambulatórios, assim como para dar suporte e educação às famílias que cuidam de pacientes com SIDA. Provavelmente, as instituições não governamentais também terão um papel importante nestas tarefas.

THE SCALE OF HIV INFECTION IN MOZAMBIQUE: ITS RELATION TO PRIMARY HEALTH CARE AND PREVENTION

Cesar Palha De Sousa, M.D.
Antonio Fernandes, M.D.
Jorge Barreto, M.D.
Fernando de La Cruz, M.D., Ph.D.
Antonio Noya, M.D.

AIDS Control Program and National Institute of Health
Ministry of Health, Mozambique

ABSTRACT:

HIV infection is now a major public health concern in Mozambique. Even though Mozambique is not among the countries most affected by the epidemic, seroepidemiologic surveys in 1987-88 found and estimated overall prevalence of 3.5% for the adult population in the ten provincial capital towns. Although previously unidentified in the region, HIV-2 as well as HIV-1 was found in all ten capital towns. The Ministry of Health has sponsored serosurveys in patients suspected to be infected and in "healthy" (blood donor) and "selected" (patients being treated for sexually transmitted disease) population groups. Studies on knowledge, attitudes, and practices (KAP) have been carried out and a public information campaign has been launched. The effort at health education has been multisectorial and has involved both governmental and nongovernmental groups as well as the media. A major achievement of the public education program has been to allow the free discussion among Mozambicans of such sensitive themes as sexual behavior and condom promotion. Promotion of marital fidelity, reduction of sexual partners, and condom use are the messages used to discourage sexual transmission of HIV. To date the education campaign has reached a primarily urban population. In order to help prevent transmission of HIV through the blood supply, blood transfusion centers with HIV screening are being established in each of the provincial capitals. To date, seven of ten such centers provide HIV screening. It is expected that the epidemic will grow in Mozambique. Training of additional personnel, strengthening clinical facilities and laboratory support, and provisions for operational research are all planned to help face the ongoing challenge of HIV infection in Mozambique.

In recent years infection with HIV, the virus which causes AIDS, has become one of the major public health problems affecting Mozambique. AIDS is, to date, invariably fatal. A long incubation period, during which infected individuals without symptoms may pass along the virus, causes great concern to public health authorities. HIV is now given consideration comparable to tropical endemic diseases responsible for high morbidity and mortality rates such as malaria, tuberculosis, and acute diarrheal disease. The principal tactic to combat the spread of HIV is health education focussing on changing sexual behaviors, a highly sensitive area.

Epidemic trends in our country do not differ from those that have occurred in other African countries: since the first AIDS case diagnosed in 1986, reports show cases increasing at a progressive rate. Even though Mozambique is not among the countries most affected by the epidemic, seroepidemiologic surveys in 1987-88 found an estimated overall prevalence of 3.5% for the adult population in the ten provincial capital towns (De La Cruz et al 1988).

The identification of AIDS patients and asymptomatic individuals in Mozambique having purely HIV-2 serological pattern of reactivity (previously not reported in the region) complicates the epidemiological situation (Barreto et al 1988a; Barreto et al 1989a). HIV-2 infected individuals were found in all ten provincial capitals, suggesting a countrywide circulation of HIV-2 (De La Cruz et al 1989).

EPIDEMIOLOGY IN MOZAMBIQUE

Transmission in Mozambique seems to follow WHO "Pattern II" in which heterosexual transmission is primary. Among those showing a higher incidence of HIV infection are STD patients (Bastos dos Santos et al 1988) and people displaced by the war (Palha de Sousa et al 1988). Ominously, a survey among pregnant women found 1% seropositive in Maputo in mid-1988 (Barreto et al 1988b). A pilot study among pulmonary tuberculosis patients revealed a high rate of HIV infection (Barreto et al 1989b). Particularly high rates among TB patients under age 29 are great cause for concern. HIV infection is likely to have a progressively larger impact on the TB control program.

The following data summarize the current knowledge of the epidemiological situation of HIV in Mozambique.

An important part of the context of public health in Mozambique is that there has been a ten year war of destabilization taking place in Mozambique. This has combined with naturally occurring disasters to lead to continuous massive movements of the rural population fleeing tremendous social and economic disruptions. Additionally the national infrastructure has

been severely damaged. National Health facilities have been affected and thus coverage of the population with health services has decreased.

In 1986, before any cases of AIDS were identified in the country, a National Task Force Committee was appointed by the Ministry of Health, and laboratory and epidemiological capabilities were created in the Institute Nacional de Saude (National Institute of Health) to evaluate HIV infection in Mozambique. Three lines of investigation were pursued: patients suspected on clinical grounds were serologically evaluated and "healthy" (blood donors), and "selected" population groups (STD patients) were assessed for the presence of HIV antibodies (Palha de Sousa et al 1987). Studies were conducted on knowledge and attitudes to AIDS and HIV, and a public information campaign was launched (Schwalback et al 1988).

Because these limited studies produced evidence of HIV-1 and HIV-2 infection in Mozambique, a national seroepidemiological survey was carried out in 1987 for the evaluation of the HIV situation in the country's urban population. Targeted seroprevalence studies were also conducted among selected population groups such as STD patients, blood donors, people displaced by the war, and pregnant women.

NATIONAL AIDS CONTROL PROGRAM

Information gathered in these studies enabled us to identify target population groups for the Medium Term National AIDS Control Program (ACP) prepared in 1987/88 (Ministry of Health, 1988). This program was designed to be multisectorial and integrated into the framework of existing primary health care activities. Therefore, resources allocated to fight the HIV epidemic would strengthen National Health System Capabilities in providing services at the corresponding level. In the absence of previous action on STDs, which are recognized as playing an important role in the spread of HIV, a national STD Control Program was simultaneously launched and coordinated with the ACP. In both programs, priority was given to public education.

The Public Education component of these programs involves health workers and trained activists personally contacting community members to deliver health education messages. This approach is especially important because of the obstacles presented by the diversity of languages and high illiteracy rates. Many different organizations and groups have been involved in this effort: the Armed Forces; social organizations such as the Organization of Mozambican Women, the Organization of Mozambican Workers and the Mozambican Teachers Organization; as well as nongovernmental groups such as the Mozambique Red Cross. Moreover, the national AIDS committee has coordinated groups from different religious beliefs and engaged them in promoting education and information about AIDS.

The Health Education component has also included the media. There have been radio broadcasts in Portuguese and local languages and the national printed media are committed to reaching the general population and target groups. Education materials were created based on three knowledge, attitudes, and practice (KAP) surveys carried out in the urban populations in Maputo City (1987), Quelimane (1988), and both rural and urban populations in Manica Province (1989). KAP surveys have shown that knowledge about AIDS increased with the educational level of the population. Surprisingly, the majority of surveyed individuals were not aware that condom use could prevent HIV infection in occasional sex, although AIDS was recognized to be predominantly sexually transmitted. Radio broadcast was referred to as the major source of information about AIDS.

During its first phase of implementation, the Public Education on AIDS and STDs has primarily reached an urban population. Reaching rural and war displaced populations is difficult and calls for targeted approaches. A major achievement of this program has been to allow the free discussion among Mozambicans of such sensitive themes as sexual behavior and condom promotion without raising controversy. Promotion of marital fidelity, reduction of sexual partner and condom use are the messages used to discourage the sexual transmission of HIV. These messages seem to have been well accepted, but a formal evaluation is needed.

Another component of the ACP was to prevent HIV transmission through blood or blood products. Blood Transfusion Centers have been developed in the provincial capital and HIV screening is being established at these centers. At present, seven of ten such centers are screening for HIV. These seven centers collect 90% of all blood used in transfusion. The Immunology Department of the Instituto Nacional de Saude in Maputo has the capacity to process and interpret HIV tests and is organized to provide advice, consultation, and technical supervision to the network of transfusion centers.

The AIDS Epidemiological Surveillance System grew from the first 16 clinically and serologically confirmed AIDS cases reported and was set up to monitor the progress of the epidemic. Seroprevalence surveillance undertaken in the near future will be based on five sentinel sites in STD clinics located in several cities. Additionally, seroprevalence among blood donors and pregnant women will be monitored (National AIDS Control Program, 1989). In order to obtain accuracy of reporting, clinically suspected AIDS cases must be serologically confirmed by the national AIDS Reference Laboratory which serves for case notification.

All these activities have required an intense training effort. Local seminars have been organized and personnel have been trained in all provinces. Health personnel were called upon to play a key role in establishing a link between the health system and the communities. Particular emphasis was placed on refresher courses and delivery of equipment to guarantee

sterile procedures. The long term success of ACP will require a strong commitment to the training of health personnel.

On the eve of the second Phase of the ACP, the scenario for the HIV epidemic in Mozambique in the near future can be forecasted. Epidemic growth is expected to follow current trends. The cumulative number of AIDS cases will rise by hundreds or even thousands. HIV-1 cases will be predominant but HIV-2 will continue to disseminate, spreading to neighboring countries. It can be anticipated that hospitals and sanitary units will be overflowing. Following regional political trends, new areas will come under the National Health Service coverage with resettlement of their populations.

To face this challenge, Mozambique's ACP has joined in the effort to rehabilitate these services and strengthen clinical support capabilities. Training clinical staff, strengthening of clinical facilities and laboratory support, and providing for operational research aiming at recognizing disease patterns and their proper management in Mozambique are all part of this effort. At the same time, approaches involving community engagement for counselling and social support of patients and their families are also being investigated. Public Health Education activities will be directed to selected population groups through specific approaches, while epidemiological surveillance to monitor epidemic progression and operational research to characterize and assess ACP impact will continue on a regular basis. Finally, in order to assure adequate development of the program, activities have been based in the provinces. Emphasis has been placed on reinforcing local capacities and providing provincial organizations with methodologies, supervision, and evaluation which will strengthen primary health care overall.

SUMÁRIO

Atualmente a infecção por HIV é de grande interesse para a saúde pública em Moçambique. Apesar de Moçambique não estar entre os países mais afetados pela epidemia, pesquisas soroepidemiológicas em 1987-88 encontraram e estimaram uma prevalência total de 3,5% na população adulta nas dez capitais de província. Embora não identificados previamente na região, tanto HIV-2 como HIV-1 foram encontrados em todas as dez capitais. O Ministério da Saúde tem patrocinado pesquisas sorológicas em pacientes suspeitos de contaminação e em alguns grupos da população, como "saudáveis" (doadores de sangue) e "selecionados" (pacientes já tratados por doenças sexualmente transmissíveis). Estudos sobre conhecimento, atitudes e práticas tem sido realizadas e uma campanha de informação pública foi lançada recentemente. O trabalho em educação para a saúde tem sido multi-setorial e vem envolvendo grupos governamentais e não- governamentais, bem como a mídia. A grande conquista do programa de educação pública tem sido permitir a livre discussão entre os moçambicanos de temas delicados como comportamento sexual e uso do condom. O estímulo à fidelidade conjugal e à redução de parceiros sexuais, bem como o incentivo ao uso do condom são as mensagens utilizadas para desencorajar a transmissão sexual do HIV. Até agora a campanha educativa atingiu principalmente a população urbana. Para auxiliar a prevenir a transmissão do HIV através de doação de sangue estão sendo instalados centros de transfusão de sangue com testes para o HIV em cada capital de província. No momento, sete destes dez centros oferecem o teste. Espera-se que a epidemia cresça em Moçambique. O treinamento de pessoal suplementar, o fortalecimento das unidades clínicas e do suporte laboratorial, bem como recursos para pesquisa operacional são planejados para ajudar a enfrentar o desafio crescente da infecção por HIV em Moçambique. _9_4

REFERENCES

1. Barreto J, Palha de Sousa C, Djedje M, Parkkali L, Barquet L, De la Cruz F, Nunes E, Neves F and Perdigao P 1989b. HIV infection and Tuberculosis in Mozambique. V International Conference on AIDS, Montreal, Canada.

2. Barreto J, Djedje M, Palha de Sousa C, Cossa A, Yokohama H and De la Cruz F 1988a. HIV2 AIDS cases in Mozambique: Clinical, epidemiological and serological findings. IV International Conference on AIDs, Stockholm, Sweden.

3. Barreto J, Palha de Sousa C, De la Cruz F 1989a. HIV2 in Mozambique. First meeting WHO collaborative group on HIV2. Geneva, February.

4. Barreto J, Araujo T, Bergstrom S, Bugalho A, Bottiger B, De la Cruz F, Liljestrand J, Palha de Sousa C, and Barquet L 1989b. Comparative study on HIV prevalence in pregnant women, Maputo Mozambique, 1982-88. IV International Conference on AIDS, Stockholm, Sweden.

5. Bastos dos Santos R, Folgosa E, Palha de Sousa C, Barreto J, Barquet L, Noya A and De la Cruz F 1988. Prevalence of HIV1 and HIV2 infection in STD patients, Maputo, Mozambique 1987. IV International Conference on AIDS, Stockholm, Sweden.

6. De la Cruz F, Barreto J, Palha de Sousa C, Barquet L, Cabral AJR and Schwalbach J 1989. HIV in Mozambique. A General Overview. V International Conference on AIDS, Montreal, Canada.

7. De la Cruz F, Barreto J, Palha De Sousa C, Barquet L, Noya A, Cabral J and Schwalbach, J 1988. Seroepidemiological study on HIV1 and HIV2 prevalence in general population (15-44 yrs) in Mozambique, 1987. IV International Conference on AIDS, Stockholm, Sweden.

8. Ministry of Health, People's Republic of Mozambique 1988. National programme on AIDS. Three year plan, 1988-1990. Donors Meeting, April.

9. National AIDS Control Programme 1989. Operational program for AIDS Epidemiological Surveillance. Ministry of Health. Mozambique.

10. Palha de Sousa C, Bomba A, Djedje M, De la Cruz F, Barreto J, and Barquet L 1988. War, population movements and HIV spreading in Mozambique. IV International Conference on AIDS, Stockholm, Sweden.

11. Palha de Sousa C, Barreto J, De La Cruz F and Barquet L 1987. HIV situation in Mozambique. IV Meeting of the AUVDT, Harare, Zimbabwe, June.

12. Schwalbach J, Liljestrang J, Barreto J, Karlsson M and Cabral J 1988. AIDS Education Programme in Mozambique. IV International Conference on AIDS, Stockholm, Sweden.

LOW INTENSITY WARS AND SOCIAL DETERMINATION OF THE HIV TRANSMISSION: THE SEARCH FOR A NEW PARADIGM TO GUIDE RESEARCH AND CONTROL OF THE HIV-AIDS PANDEMIC

Mariella Baldo, Ph.D. and Antonio Jorge Cabral

Consultant to WHO, Global Program on AIDS, Geneva
Antonio Jorge R. Cabral, M.D., M.Sc.
Ministry of Health, Maputo, Mozambique

ABSTRACT:

Widespread social disruptions due to low intensity wars (LIW) and economic migrations are key to the spread of HIV in Africa. Low intensity wars are protracted conflicts where open military confrontation alternates with civil strife, economic sabotage, destruction of vital infrastructures, and banditry. Complex interactions of LIW and individuals and social groups create distinct psychosocial syndromes of disempowerment and a preponderance of violent forms of thinking, feeling, and acting. Paradigms that do not take these social realities into account are limited in their ability to guide research and public health measures in the African context. Future work should not be limited by models from the past. Recent theory on the social construction of meaning, drawn from anthropology and linguistics, should inform the investigation of HIV epidemiology and prevention. Research workers and institutions need to work together, pooling their skills and resources.

INTRODUCTION

Low intensity wars (LIW) have been going on in many Third World countries since the late '70s, associated with various forms of civil strife or economic/political coercion. The usual result is social disruption, subsequent reorganization, and a complex web of processes affecting the social life of populations, groups, and individuals.

The influence of armed conflicts on the health status has been widely studied, but mainly addresses problems like specific war related pathologies (such as trauma or posttraumatic stress syndromes), indirect consequences of the difficult access to health facilities (increased infant and maternal mortality rates), or economic effects of social disruption (malnutrition). The HIV-AIDS pandemic is already affecting a number of Southern African countries at the same time as the effects of LIW: Mozambique, Angola, and Zimbabwe. The concern for the association between LIW and HIV transmission, particularly in Southern Africa, derives from

the need to clarify concepts about what a "social disease" is (HIV-AIDS is characterized as such by WHO's Global Program on AIDS) or, better, what the social determinations of the distribution of the disease are. The interest in the topic is not academic: how the association and determinants are perceived between two levels of reality, the social and the biological, will guide efforts not only in research, but also in disease control and particularly in education and communication.

The dominant explanatory paradigm for HIV transmission and control disseminated throughout the world by the WHO-Global Program on AIDS (WHO-GPA) crystallizes into a few tenets:

i) from standard "risky behaviors", "groups-at-risk" were derived, that were also standardized throughout the world;

ii) the variability of HIV transmission is expressed in four patterns;

iii) information, education, and communication activities assume that all individuals can change their risky sexual behaviors provided that appropriate messages are understood and condoms are made available.

This paper does not intend to present empirical data to prove an hypothesis. The authors wish to suggest a new set of concepts which will generate new hypotheses for research and disease control from the relationships between group/individual behaviors and i) the routes of HIV transmission, ii) the biological cofactors of HIV transmission; and iii) the control messages prepared by the medical corporation.

The Southern African context was chosen for two main reasons:

i) the present, all pervading situation of LIW and other political, social, and economic problems: their social consequences would last well beyond the end of the war of destabilization in Mozambique; and

ii) the HIV pandemic is slowly expanding from Central to Southern Africa, reaching LIW affected countries.

This justifies that new paradigms and lines of research be presented now as cooperation needs to be established among National AIDS Programs in neighboring countries, and research will have to be undertaken by a subregional network of institutions.

WARS OF DESTABILIZATION

Modern wars in developing countries reflect modern foreign policies on intervention. Southern Africa, like so many other hot spots in the world, is the theater of a complex set of contradictions that has pushed its powerful economic pole (South Africa) into an aggressive war of destabilization of the whole region for 15 years. Countries neighboring South Africa were at one and the same time relying on its labor and trade opportunities and experimenting with social systems alternative to apartheid. All have been suffering from different forms of aggression, and some have been severely crippled in their development.

LIW are protracted conflicts where open military confrontation alternates with civil strife, economic sabotage, destruction of vital infrastructures (including the health and education services), plain banditry, and induced painful despair over the country's chances of resistance and survival. LIWs may affect some areas of the country, leaving the rest in an uneasy pretence of normality; entire generations of children may live in such a situation without it even being officially called "war".

The consequences of war for the individuals and the communities have been studied, but, as a psychologist killed in EL Salvador noted,

> *"There is ... an aspect of war that is of great importance ...: its way of defining all that is social. By its very dynamic, a war tends to become the most all encompassing phenomenon of a country's situation, the dominant process to which all other ... processes are subordinated." (Martin-Baro 1989)"*

In Southern Africa, because of the historical links between the countries of the region and their interdependence, the breaking down of the economy in some countries led to massive displacements of population and increased illegal emigration. Because of the relative unbalanced pace of development, some countries saw new phenomena emerging like war induced famine, extended parttime prostitution, internal refugees, and orphaned street children. Among people affected by social destabilization there will be distinctive syndromes of psychological instability. (See Figure 1).

The trauma of war in individuals is a psychosocial trauma: it is directly linked to an historical structural process (war) and the different ways this affects specific social complexes (population groups)[1].

---

[1] Editors' note: See the section on social determination of health and disease, Section 3.1, below.

Cognitive and behavioral changes induced by LIW lead to a progressive impoverishment of important abilities of the human being like the ability to think lucidly and to communicate truthfully, sensitivity to the suffering of others, and loss of hope amounting to dehumanization (Samayoa 1987). More specifically, cognitive and behavioral schemata such as increased selective inattention, evasive skepticism and hatred and desire for revenge have been identified that are both induced by war and critical for AIDS communication geared at encouraging a healthy life style. Important mediating factors are the processes generated by war related fear (Lira, Weinstein and Salamovich 1986), for example a sensation of vulnerability and a sense of impotence or loss of control over one's life.

It is important to stress that most LIW traumas affect people who may never personally witness an armed confrontation, and their effects will last well beyond the end of the destabilization years, particularly in children. The progressive militarization of social life structures the ways of knowing, of communicating, of relating with others even in intimacy, of processing information, and of making sense of the world. The progressive militarization of the mind leads to a growing preponderance of violent forms of thinking, feeling, and acting: in El Salvador, 200 children were asked in 1987 what could be a way to solve the problems of the poor, and several children from higher socioeconomic sectors replied "Kill them all" (Martin-Baro, 1990).

In countries were LIW have been a harsh reality for many years, how will people react to suggested solidarity towards persons with HIV? How will they respond to messages encouraging responsible sexual behavior? What will be made of condoms distributed in refugees camps as a means of protection? And who will be considered at risk?

A NEW MODEL FOR THE SOCIAL DETERMINATION OF HIV TRANSMISSION?

WHO-GPA has defined and standardized at risk behaviors and groups-at-risk. Both categories originated in research done in the USA and Europe where the pandemic was first recognized. WHO has also defined four patterns of HIV transmission around the world that are, in fact, only simplified combinations of these categories (homosexual behaviors, parenteral drug use behaviors, transfusions, and heterosexual transmission) in various proportions. This model enabled a worldwide effort to control the pandemic and a substantial accumulation of knowledge.

However, as time elapses, the reality of HIV transmission rebels against the four pattern framework, as transitions and changes occur within and among the pattern areas. The complexities and variety of manifestations of reality are calling for a new model: not only are transitions being detected among patterns, but also behavioral changes are occurring (or not

occurring) at various rates. How, then, to cope with those complexities, and go deeper in the identification of the local specificities of HIV transmission?

We think that dealing with the social determination of HIV transmission from another angle can have important methodological and practical consequences for epidemiology. Two important tools can be further elucidated and quantified:

i) the infection rate: as it is affected by different forms of social organization that may or may not ease contacts between infectious and susceptible individuals; and

ii) the geographical characterization of the various zones of high and low prevalence: grading and communication between center (high prevalence/high transmission) and periphery (low prevalence/low transmission).

HOW DO WE APPROACH THE CONCEPT OF SOCIAL DETERMINATION OF HEALTH AND DISEASE?

The Relationship of Man with Nature.

The interaction between Man and Nature is mostly social. The variety of events in that interaction can be categorized in various levels of processes, each level being ruled by a set of laws. Processes and laws belonging to the upper levels of the system determine laws, processes, and events of the lower levels. For example, industrialization (an historic structural process) generates urbanization. This leads to demographic changes, alterations in the distribution of age groups, and generic spatial distribution of different groups within the urban area, with variable conditions of salubrity (the social-class-group processes). The latter will define the degree of exposure to specific risks of contracting diseases of the individuals belonging to the various classes or groups (the individual-biological level).

The Specificity of Historical Processes.

Each particular historic structural process, according to time and space, generates specific complexes of social classes and groups - whatever the standard labels we may apply to them.

Within each specific social complex, the different classes or groups develop their own models of work-consumption-reproduction, which include exposure to risk of contracting diseases as well as protection within the health services. Differences in individual exposure to risk mostly depend upon inclusion in these groups. In certain circumstances, social groups can be brought to an extreme situation of survival or marginality. In such cases, the group quickly

builds up its own "culture of survival", reacting creatively to the hardships of circumstances or to the dominant culture-mores of the rest of society. This means that the causal process is not unidirectional from upside-down.

The Chances for Individual Behavior Changes

In sexually transmitted diseases too, as health education research shows, changes in individual behavior depend largely on factors beyond the control of the individual:

i) a risky behavior may be linked to the codes of a group (e.g. high partner exchange rate among certain homosexual communities)

ii) a risky behavior can be the basis of economic survival (e.g. prostitutes).

The response to educational efforts is framed in these constraining factors-processes.

In developing viable application models of social determinants of disease distribution, a common problem is that of defining the appropriate intermediate (social group) level of reality between the historical structural and the individual-biological. Those intermediate levels have to be specific to the disease under study. Furthermore, these intermediate social processes may be difficult to express mathematically and consequently to allow for the use of common statistical tools to confirm a cause-event relationship.

SPECIFICITIES OF HETEROSEXUAL HIV-TRANSMISSION IN LIW-AFFECTED COUNTRIES IN SOUTHERN AFRICA.

It has been argued above that reality is much more complex than the patterns of HIV transmission as defined by WHO-GPA. We can consider LIW affected countries in Southern Africa a case study for the characterization of these specificities within the broad pattern 2 of transmission, which is applied to the whole Subsaharan Africa[2]. We will deal with heterosexual transmission only, the main route of transmission in the area.

What groups do we need to characterize, in order to understand the specific patterns of transmission (as a geographically scattered focus)?

i) the highrisk/high prevalence-and-transmission groups at the center of the various epitopes (geographic foci of HIV infection);

---

[2] In other areas of Pattern 2 Sub-Saharan Africa there will be other combinations of historic-structural processes leading to the formation of different sets of high transmission and bridge groups. The causal framework for each area needs to be studied and clarified.

ii) the 'bridge' groups, that connect the former and the population at large, as well as the various geographically separated sites.

Social processes are linked with geospatial specificities; such as the intense rate of displacement and movement of population caused by both war and the extended network of rail and road transports among the Southern Africa Development Coordinating Conference countries. We are therefore dealing with a very large endemic focus consisting of a large number of interconnected sites. As we will see later, highrisk groups are not fenced off with the stigma of marginalization the same way as in the USA or Europe. This helps to explain the massive, though slow, progress of the epidemic from urban to rural areas and is an important factor for the study of longterm trends in transmission. Having an extended population-at-risk (the periphery of the area involved), the self containment (saturation) of the pandemic will only take place when at least 40% of the population will be infected. This is a protracted tragedy.

LIW AND SOCIAL GROUPS AT RISK

The most important historical structural processes concerning HIV transmission in Southern Africa are the LIW and the disruption of the economy, particularly the rural economy. Various population groups are forced into continuous movements, including displacement flight from the war affected areas, regular armies and groups of bandits, rural populations moving to towns (joining the poverty and marginality circle including prostitution and street children), and rural populations moving near army barracks for trading (promiscuity).

Within the area of this largely scattered endemic focus, various high risk groups appear at the center of our concerns: prostitutes, displaced people, the army and promiscuous persons with STDs. Other groups, also generated by the same social processes, play the role of bridge between the high risk groups and the general population, such as nonprofessional prostitutes (e.g. young school girls in large towns) in urban areas and around rural army barracks, migrant workers, long distance truck drivers, armed forces, and street children. These groups share common characteristics, such as a high number of heterosexual partners, links with the family or circle of friends and relatives, and large geographical diffusion. Additionally, these low socioeconomic groups share biological cofactors for HIV-AIDS, such as a high prevalence of STDs and a high rate of TB infection. The progression from HIV infection to clinical AIDS will thus often be quicker.

CONSEQUENCES FOR HEALTH PROGRAMS

Epidemiological surveillance will have a large variety of groups to monitor. This cannot be done on a routine basis, but needs to be carried out through periodic surveys to monitor time

trends of HIV prevalence. Then, the risks of extension to the general population will be better understood.

Information, education, and communication (IEC) activities and condom services have to take into account this variety of groups. IEC messages and distribution outlets for condoms will have to be designed accordingly, to ensure coverage. Moreover, for difficult-to-reach groups like the displaced, it is absolutely nonsensical to target them for IEC and condoms without providing them with a minimal package of Primary Health Care services to ensure survival.

SOCIAL CONSTRUCTION OF MEANINGS IN AIDS EDUCATION

HIV transmission is highly sensitive to all features of LIW. IEC strategies and activities are profoundly affected by the psychosocial trauma of war, which alters those very abilities that allow the individual to make sense of and translate educational messages into practice.

A common tenet is that 'educational messages should be culture appropriate and relevant'. Only then will individuals 'respond' by changing behavior and adopting safe lifestyles and safer sex. This approach betrays an underlying behavior modification model that equates culture with society's endowment and sees persons as basically reactive individuals.

Culture is not only what makes individuals behave, think, and feel in a particular way, different from their neighbors across the ethnic or group border. Culture is also what people produce every day in their relationship with Nature as a social process. People are active in their continuous work of social construction of reality: we make sense of the ever changing world by assigning meanings primarily linked to the historical structural processes we happen to be part of. As a consequence, the meaning of 'risk', 'protection', 'steady partner', 'control', 'health seeking', etc., is not what scientists and health promoters decide it to be, but rather what people experiencing different historical structural processes construct.

Ways of knowing are also socially constructed (which information we select, from whom, when, and how we connect, process, and enrich it), as are ways of learning (from oral sources? in workshops? by waiting to observe predicted effects? by reading?) and ways of communicating. Often, designing culture appropriate educational materials only means a clumsy imitation of the language supposedly used by our target group; it rarely means adopting their ways of seeing the world, as this can only be done by people who cease to be target group to become protagonists.

The Ottawa Charter for Health Promotion, a valuable document in many aspects, states that health promotion means to "develop personal skills... increase the options available to people to exercise more control over their own health and over their own environments, and to make

choices conducive to health" (Ottawa Charter 1986). The sense of loss of control experienced by people in LIW situations, far from being an exception, is merely more acute than the ordinary sense of impotence experienced by the poor all over the world, and this is what structures the very concept of risk and health for millions of people. If the object is to capture the full range of potentially significant explanatory factors" in AIDS research (Kaplan et al 1990; Kaplan 1989), then the mechanisms by which people construct their own meanings in health and AIDS should be part of the catch and linguistics/anthropology part of the net.

The criticism of a quantitative research methodology in social sciences applied to AIDS research, particularly in developing countries, has been clearly exposed by Ankrah (1989). We would like to add that the choice of such methodologies indicates a positivist posture in a time when it is severely discredited by vanguard thinkers, while still extensively used by practitioners of inquiry.

In a post-positivist era, we do not assume that reality is a sum of the parts, nor that there is a possibility to separate the knower from the known, nor that the aim of the inquiry is to develop a body of knowledge in the form of generalizations that are statements of truth free from both time and context. Nor do we assume that inquiry is value free and can be guaranteed to be so by virtue of the objective methodology employed (Lincoln and Juba 1985).

Indeed,

> *"Conditions in developing countries suggest the need, above all, for new methodological approaches rather than rigid adherence to old ways of acquiring knowledge" (Ankrah 1989).*

ACTION NEEDED

The development of the two paradigms, epidemiology of HIV transmission and social construction of meanings, present the need for the same underlying approach and a body of knowledge about the social processes leading to the formation of groups at higher or lower risk.

This implies a considerable amount of research work to be undertaken by large networks of biomedical and social sciences institutions: a problem in itself, at least, in Southern Africa. These institutions always have very limited resources, do not usually cohabit under the same authority, and rarely undertake genuine collaborative research with a multidisciplinary approach.

Regional research networking in Southern Africa needs to be developed. Various focal points are possible such as the Network of AIDS Researchers in Eastern and Southern Africa (NARESA). Other potential research groups, like the Departments of Community Health of various medical schools and particularly the Centers for African Studies of the Southern Africa Development Coordination Conference Universities should be involved. The latter have much to offer, as they have been engaged in research on many aspects of recent political history of the region and include anthropology and sociology units. A coordinated division of work among these various national institutions could be established with all institutions participating in the network needing support and improved communication among them.

SUMÁRIO

Extensas rupturas sociais resultantes de guerras de baixa intensidade e migrações economicas são peças-chave na propagação do HIV na Africa. Guerras de baixa intensidade são conflitos prolongados, onde o confronto militar aberto se alterna com conflito civil, sabotagem economica, destruição de infra-estruturas vitais e banditismo. Interações complexas entre guerras de baixa intensidade, indivíduos e grupos sociais criam distintas síndromes psico-sociais de perda de poder e preponderância de formas violentas de pensar, sentir e agir. Os paradigmas que não consideram estas realidades sociais estão limitados na sua capacidade de coordenar pesquisas e medidas de saúde pública no contexto africano. O trabalho futuro não pode ser limitado por modelos do passado. Teorias recentes sobre a construção social do significado, originadas da antropologia e linguística, devem auxiliar na investigação da epidemiologia e prevenção do HIV. Pesquisadores e instituições precisam trabalhar juntos, compartilhando suas habilidades e recursos.

REFERENCES

Ankrah EM, 1989: AIDS: Methodological problems in studying its prevention and spread. Social Science and Medicine, 29, 3:265-276.

Breilh J, et al, 1983: Ciudad Y Muerte Infantil - Ceas Ediciones, Quito.

Lincoln YS, and Guba EG, 1985: Naturalistic Inquiry. Sage Publications, Beverly Hills.

Lira E, Weinstein E, and Salamovich S, 1986: El miedo: un enfoque psicosocial. Revista chilena de psicologia, 8:51.

Martin-Baro I, 1989: Political violence and war as causes of psychosocial trauma in El Salvador. International Journal of Mental Health 18:3-20

The Ottawa Charter for Health Promotion. International Conference on Health Promotion, organized by WHO, Health and Welfare Canada, Canadian Public Health Association, Ottawa, Canada, November 1986.

Palloni A, 1989: Models for the spread of HIV to Inform the Design in interventions. Nature of Models, Advantages and shortcomings -- paper prepared for the UN/WHO Workshop on modelling the demographic impact II countries, New York, 13-15 December 1989.

AIDS IN NAMIBIA
A note covering 31/12/1986 - 30/9/1989

Dr. B. Finckenstein

Ministry of Health and Social Services
P/B 13198
Windhoek, Namibia

Namibia became an independent state on March 23, 1990. The Ministry of Health sent a representative to the Maputo Conference to report on the prevalence of AIDS in that country. A description of the steps taken to ascertain the cases during the period of transition in 1989 and the plans in the Ministry that were formulated to control the epidemic were presented.

PREVALENCE AND MORTALITY: SEX AND AGE

As of September 30, 1989 a cumulative total of 152 AIDS cases were reported to the Department of National Health and Welfare, Epidemiology Section. This represents an increase of 21 cases (16%) over the previous month and raises the prevalence rate to 12 cases per 100,000 population (including imported cases) based on a total population estimate of 1.262 million. The recent upsurge in reported cases of AIDS is attributed partly to the increasing awareness of health care personnel about the presence of AIDS in SWA/Namibia.

A cumulative total of 10 AIDS related deaths were reported by September 30, an increase of 1 case (11%) over the previous month. The mortality data received, however, are incomplete.

Nine (6%) of all AIDS cases reported were under the age of 15 years, with the majority of cases (55%, n=83) reported in the 15 - 34 age group.

53% (81) of all AIDS patients were known to be males, while only 39% (59) were known to be females. Up to the age group of 25 - 34 year olds, both sexes seem to be equally affected, while in the age group of 35 - 44 year olds, only 18% (3) are women. No women over 45 years of age have been reported with AIDS.

BREAKDOWN OF CUMULATIVE TOTAL CASES ACCORDING TO REGION OF ORIGIN

In 17 patients (11% of those reported) it is assumed that the disease was acquired outside of SWA/Namibia. In SWA/Namibia more cases were reported from Caprivi than from any other

region. 53% of all reported cases (n=80) were from Caprivi. The next most frequent reported cases were from the Central Region, which reported 30 cases (20% of total reported cases), and Ovamboland with 12 cases (8% of reported cases).

HIV AND AIDS IN SOUTH AFRICA - TOWARDS AN APPROPRIATE PUBLIC HEALTH RESPONSE

Anthony Zwi,[*] MB.BCh, M.Sc., D.O.H., D.T.M. and H. and Debby Bachmayer,[**] B.A.(Soc Wk), MB.BCh., D.C.H.

* **North East Thames Regional Health Authority and Department of Community Medicine, University College and Middlesex School of Medicine, London, England**

** **Kentish Town Health Center, London.**

ABSTRACT:

Ninety-eight cases of AIDS were reported in the Republic of South Africa (RSA) by the end of 1987 and 166 by mid December 1988. By 12th February 1990, 353 cases of AIDS had been reported: 326 in South Africans and 27 in people from elsewhere in Southern Africa and abroad. The South African patients comprised two main groups: white men with the pattern of infection typical of homosexual and bisexual men, and heterosexuals exhibiting the pattern common in much of central and southern Africa. There have been a small number of people with hemophilia affected and only one injecting drug user with AIDS to date. There is evidence of considerable spread of the epidemic into the South African black population - migrant labor, the high prevalence of sexually transmitted diseases, and suspicion of government directed family planning programs have contributed to this. Seropositivity rates in South African blacks are noted to be rising rapidly, and the doubling time is considered to be about 8.5 months. The government and some employers have adopted discriminatory measures to control the disease, including the screening of migrant workers and the repatriation of those found to be seropositive. Public health leadership from the state authorities has been inappropriate. Much greater involvement of homosexual, worker, community, and public health personnel is needed to develop policies of control for HIV infection in South Africa, if the response is to be ethical, nondiscriminatory, sensitive, prevention oriented and effective.

EPIDEMIOLOGY OF AIDS AND HIV INFECTION IN SOUTH AFRICA

The spread of HIV infection and AIDS in South Africa has become a major public health issue over the last few years. As in many other countries, the response to AIDS reveals discriminatory and politically motivated reactions. In the light of this it is important to accurately document and analyze existing data and responses. The political situation in South Africa both fuels the spread of HIV infection and retards its effective control.

Data on HIV infection and AIDS in South Africa may be derived from a number of sources. These include officially collected data, passive surveillance data, and specific HIV seroepidemiological studies.

1. *Official data*

By 12 February 1990, a cumulative total of 353 cases of AIDS had been reported in the Republic of South Africa (RSA) (Advisory Group on AIDS, 1990). Of these, 326 were in South Africans and 27 from elsewhere [Malawi (11), Zambia (8), other African countries (2), countries in Europe, South America and Caribbean (6)]. The progressive increase in these cases in the years 1982 - 1989 is apparent in Figure 1. The doubling time is currently considered to be approximately 8.5 months (Padayachee and Schall, 1990).

A combination of the pattern common to homosexual and bisexual men which has occurred in the USA and much of Western Europe, and that of heterosexual spread which has occurred in much of central and southern Africa has been evident in South Africa. Of the 326 South African cases of AIDS, 231 (71%) were whites, 79 Africans (24%), 13 coloreds (4%), and 3 Indians (1%)[3]. For all races combined, 216 (66%) of all the cases were in men who have sex with men, 72 (22%) in heterosexuals, 15 (5%) in recipients of blood products, 12 (4%) in patients with hemophilia, 10 (3%) in children, and 1 in an injecting drug user. (Advisory Group on AIDS, 1990). The proportion of cases in the African population and amongst heterosexuals is increasing all the time, and the pattern is becoming more and more similar to that in many underdeveloped countries.

The patterns in the white and African communities are different. Figure 2 dramatically illustrates this. 87.4% of cases in whites occurred amongst men who have sex with men. More than three quarters of cases in Africans (62 of 79 cases) have resulted from

[3] In this paper, the term 'black' refers collectively to Africans, coloreds and Indians. As the social, economic and political institutions in South Africa are structured along legally defined racial categories which divide blacks into the above categories, their daily experience and consequent health patterns cannot be described without recourse to such racial terminology. Their use in this paper, however, does not imply their legitimacy.

heterosexual spread, with an additional 10 cases resulting from transmission from mother to child. The remaining seven cases in Africans have occurred in people who have received infected blood products (three cases), people with hemophilia (two cases), and men who have sex with men (two cases). Amongst the Indian population, the three cases have been in men who have sex with men, whereas in coloreds there has been a mixed picture of transmission. The figures in blacks are less likely to be reliable due to misdiagnosis, under reporting and lack of access to the health services generally.

2. *Passive surveillance data*

Data on HIV seropositivity in South Africa are mostly derived from two main sources: laboratories doing routine testing and blood transfusion centers testing donors. 1,857 seropositives had been detected in routine tests by the end of 1988 (Sher 1989).

Of an estimated 710,000 blood donors tested in South Africa up to 20 October 1988, 244 were HIV positive. Of these positive tests, 180 were in blacks (81 males, 99 females) and 56 in whites (55 males, 1 female). These figures are clearly not representative of the general population and are therefore difficult to interpret. Schoub et al (1988) presented data from the blood transfusion service indicating seropositivity rates of 0.01% and 0.001% in white males and females; and 0.05% and 0.06% in African males and females, again highlighting heterosexual patterns of transmission in this community.

3. *Active HIV prevalence studies*

In general, published epidemiological data are poor and contradictory. Seroprevalence rates have been examined in the mineworker population, in homosexual men, in sexually transmitted disease clinic attenders, in prostitutes, and in pregnant women attending antenatal clinics.

Mining is central to the South African economy, and the industry has been built upon it. Migrants are generally young, sexually active men. In 26,528 miners tested on the basis of territory of origin, seropositivity rates of 0.012% and 1.02% were found in South African and non-South African miners respectively (Department of National Health and Population Development, 1987). Amongst miners of Malawian nationality, the seropositivity rate approached 3.8%, while amongst those Malawians with sexually transmitted diseases (STD's), it reached 17.8% (Brink, 1987).

1,200 women "providing companionship" to miners were tested in 1986, and none were seropositive for HIV (Sher, 1989). In another study, Schoub et al (1989) found one seropositive amongst 296 females attending sexually transmitted disease clinics in

Johannesburg. He also reported that 0.5% of 419 male STD clinic attenders were seropositive. Sexually transmitted diseases have been shown to be strongly linked with HIV infection, both as a result of genital ulceration and behaviors associated with HIV transmission.

Prevalence studies in white homosexuals suggest rates of infection from 10 - 15% (Sher 1989). No information to date is available regarding prevalence in black homosexuals.

Shapiro et al (1989) present the most convincing evidence of rapidly increasing rates of HIV seropositivity in black heterosexuals. They screened routine ante-natal blood samples from 104,683 pregnant women resident in the southern Transvaal region from 1 May 1987 - 31 October 1988. Of 84,527 tested, ninety six (0.11%) African women were confirmed to be seropositive, and eight colored women of 6751 (0.12%) tested were seropositive. No seropositives were detected in whites and Indians. The incidence, using ELISA, in African women rose from 1/2294 (0.04%) in May - July 1987 progressively by quarter to 1/292 (0.34%) in August - October 1988. With Western Blot analysis it rose from 1/2753 (0.036%) to 1/461 (0.217%) over the same period. The doubling time was observed to be approximately six months. Based on these data, the authors estimated that incidence among pregnant African women in the southern Transvaal is likely to exceed 1% by the end of 1989 and 6% by the end of 1990.

Recent estimates of seroprevalence have been made by Padayachee and Schall (1990). Using the direct method, they consider that 44,763 - 63,076 Africans were HIV positive in 1989 and that 316,725 - 446,300 would be by the end of 1991. Using the back calculation, slightly higher figures are predicted. Schall et al (1990) argue that the HIV epidemic is the greatest threat to public health in South Africa this century.

WHY ARE RATES LOWER THAN EXPECTED?

Despite rising rates of HIV infection and AIDS, the prevalence of HIV disease in the RSA is still not at levels seen elsewhere in southern and central Africa. There are a number of possible explanations for this.

The epidemic appears to be spreading geographically. South Africa being at the southern tip of Africa has consequently had less exposure to date, despite the mobility of migrant workers from neighboring countries. Unlike many other African countries, routine screening of blood products in the RSA has been taking place for some years, and this has played some part in reducing spread through health services in general. Fewer unsterile injections and procedures are likely to be performed in the RSA due to the availability of more funds for health services than in poorer countries in Africa. However in many rural areas, health service

provision still exists below acceptable levels. Finally, the low rates observed may partly reflect underdiagnosis and underreporting especially from rural and "bantustan"[4] underserved areas.

The fragmentation of health services in the RSA, primarily in order to achieve apartheid political objectives, ensures that health services are poorly coordinated (Zwi, 1982; De Beer, 1984; Price, 1986). Consequently epidemiological and statistical information is often not collected or presented in a comprehensive manner. This may play a part in underestimating the true rates of seropositivity.

WHY ARE INCREASED RATES PREDICTED?

A rapid increase in HIV infection is already evident and a worse scenario is predicted (Padayachee and Schall, 1990). It is only a matter of time before clinical manifestations of HIV disease develop. The majority of the South African population exhibit a disease profile similar to that of any underdeveloped African country despite the availability of national resources to overcome these. The inequitable distribution of resources as a result of apartheid policies has ensured that the diseases of poverty, including sexually transmitted diseases, have high prevalences in the black population. This is exacerbated by poor access to health and educational services.

The migrant labor system annually draws over 2.6 million official migrants (from within and outside South Africa) to work, temporarily, in RSA mines and factories (South African Barometer, 1987a). The number including unofficial migrants is thought to be substantially higher. The disruption of family life facilitates the spread of STD's through casual sex, prostitution, and 'situational' homosexuality. These conditions are likely to increase the risk of spread of HIV infection (Jochelson et al, in press). Although there is debate in academic and union circles about the extent of homosexuality in migrant workers, Nkoli (1989), a gay rights activist, asserts that many miners have sex with one another. Moodie (1988) argues that nonpenetrative sex is the main mode of sexual interaction (Moodie, 1988). More research is clearly needed.

Despite poor epidemiological data on sexually transmitted diseases, there are suggestions that the rates of these infections have increased markedly in recent years (Brink and Clausen, 1987) amongst miners in particular. It is unclear whether this is the result of increased incidence or improved case-finding.

---

[4] The "bantustans" are ethnic areas designated by the Nationalist party as "homelands" for the African majority. This policy is one of the pillars of apartheid. It was envisaged that Africans of different ethnic origins would regard these fragments of land as their "homelands" where they would exercise their political views, thus being deprived of a political say in the rest of the country. The vast majority of the population reject this notion.

Another potential factor which may play a part in raising HIV transmission rates is the large prison population in the RSA, many resulting from minor crimes against apartheid regulatory systems. The average daily prison population is over 114,000 (SA Barometer, 1987b). Prisons present a potential focus for the spread of HIV infection due to sex between men in such conditions. There are no available data available on this in South Africa.

The African population is suspicious of family planning services which have been seen as a politically motivated population control strategy (Brown, 1987). This has made it more difficult to promote condom usage and sexual behavior changes. An African social worker recently stated that condom use has long been associated with attempts to weaken blacks politically by keeping their numbers down (Weekly Mail, 15 - 22 December 1988). There are also concerns, as in much of Africa, that Western media coverage implicating Africa as the source of HIV disease has made people in Africa suspicious and doubtful of the true extent of the epidemic. This more general issue is discussed in some detail by Chirimuuta and Chirimuuta (1989) and Sabatier (1988).

An anonymous right wing group recently circulated a pamphlet (see Figure 3) blaming the African National Congress (ANC) for bringing AIDS to South Africa. Such attempts to discredit this popular organization will be counterproductive, resulting in suspicion of other campaigns around HIV and AIDS.

For all the reasons described above, it is inevitable that higher rates of HIV infection and AIDS will be experienced in the RSA in the coming years. The next section of this paper will examine the nature of responses to date, and their effectiveness, especially in promoting measures for preventing the spread of the infection.

RESPONSES TO AIDS IN SOUTH AFRICA

South African organizations and structures have responded to HIV infection in a variety of ways. The most appropriate changes have originated from community groups, nongovernmental organizations, and progressive health professionals reacting to the lack of educational and preventive measures provided by the state.

1. *Government response*

   The government response has been limited and often inappropriate. Legislation allowing for potentially repressive measures has been introduced. The Government Gazette of 30th October 1987 gave notice of the possibility of compulsory medical examination, hospitalization, and treatment 'of any person who in the opinion of a medical officer of health is or could be suffering from a communicable disease...'. AIDS was listed as such

a 'communicable disease'. The regulations empower local government medical officers of health to detain seropositive persons 'until cured'. In addition, this compulsory screening requires neither informed consent nor counselling to be implemented. Regulations of the Admission of Persons to Republic of South Africa Act (Act 59 of 1972) were amended in 1988 to include infection with HIV and AIDS as a reason for potentially prohibiting entry to the country.

Over one million Rands were spent in a high profile national media campaign early in 1988 (The Star, 4 March 1988). This was an attempt to encourage monogamous relationships and discourage promiscuity (Business Day 1988). Aspects of the education campaign have been criticized for being inappropriate. The material directed at Africans used fear tactics and featured a coffin and funeral. The material directed at whites has been criticized for not conveying enough information. It featured graffiti on a wall, supposedly indicating 'promiscuous' relationships. No mention of the type of risky activities associated with HIV transmission was made. No aspect of the campaign was directed at gay men (Pegge et al 1989). Research after the campaign showed that most white people still saw AIDS as a disease from Africa, while most Africans saw it as a disease from the United States of America. The majority of whites saw no reason to change their behavior (Weekly Mail 15 - 22 December, 1988).

O'Farrel and Will (1989) examined the knowledge, attitudes, and behavior of black patients attending a sexually transmitted disease clinic in Durban before and after the government education campaign. They concluded that there had been no increase and possibly a decrease in the general level of information after the campaign. More than half the patients answered the majority of questions incorrectly. There were a greater number of "don't know" responses indicating increased confusion. Condoms were used by fewer than 10% of the respondents.

Information on funding made available by the Department of National Health and Population Development are difficult to obtain. When requested for data, the Department said it was not possible to determine how much was being spent on combatting AIDS, as "thousands of people within the public health community are involved" (Weekly Mail 15-22 December, 1988).

Blood testing for HIV serostatus takes place within some prisons, by some employers (especially in the mining sector), and routinely by the blood transfusion services. Details of the conditions in which such testing takes place are not available, although the National Union of Mineworkers have indicated that informed consent and counselling are grossly inadequate or nonexistent (National Union of Mineworkers 1988).

The conservative Afrikaner cultural and religious beliefs of the ruling party have made it difficult for explicit and open sex education messages to be directed at the gay population group.

> *"Homosexuality is not accepted by the majority of the population and certainly not by the Afrikaans speaking population. To advocate that homosexuals use the condom is therefore very difficult." - (Dr Coen Slabber, Director-General of the Department of Health, 1987).*

There has been a notable failure of the government to involve the gay community directly (Miller 1990). In September 1987, the Director General of the Department of National Health and Population Development stated publicly that the government would do nothing to assist the gay community in the prevention of HIV infection, as this was the community's "own affair" (Pegge et al 1989). This openly contradicts clear guidance from the Global Program on AIDS and the World Health Assembly recognizing that organizations of HIV infected persons and those with AIDS can contribute to the formulation of policies and programs concerning AIDS. It urges member states to include representatives of nongovernmental organizations on national AIDS committees and in other bodies engaged in combatting AIDS (World Health Organization 1989).

Various coercive measures to control the spread of the disease have been proposed, although they have not been pursued to date. These have included mandatory testing of all immigrants, maintenance of a registry of infected individuals, and quarantine of those infected (Schoub 1987). Although compulsory notification of people with AIDS has been advocated, this is currently not the case.

2. *Advisory Group on AIDS*

A national Advisory Group on AIDS was established in 1987. It includes representatives from the medical schools, Department of Health, South African Institute of Medical Research, Blood Transfusion Services, National Institute of Virology, Defence Force Medical Service, and the Anglo American Corporation (Advisory Group on AIDS 1988). Most of the group members are scientists, clinicians, or 'political' and economic figures. There is little public health input. There is no formal contribution from those groups most affected - the gay community (Pegge et al 1989), the African community, and worker organizations. Their participation in the Advisory group has been explicitly rejected.

It sees its main activity as educating the public and health workers through posters, information brochures, lectures, videos, and training. Support is also give to the private sector in developing company policies (Advisory Group on AIDS 1988).

In 1988 the Advisory Group published its 'Strategic Plan for the Containment of AIDS in South Africa'. The strategy included: i) infection and disease surveillance including HIV testing; ii) identification of "at risk" individuals and populations and appropriate intervention strategies; iii) health education and dissemination of information on AIDS to the public and health professionals; iv) health services for people infected with HIV; and v) evaluation of antibody testing methods (Advisory Group on AIDS 1988).

The plan promulgates discriminatory views, highlights "the danger that AIDS may spread in the local population from outside territories," and advocates the restriction of entry of laborers from such areas. This is despite the fact that screening of foreigners has been branded as ineffective and discriminatory throughout the world. To quote Jonathan Mann, the Director of the Global Program on AIDS:

> *"... if HIV infection or suspicion of HIV infection, leads to stigmatization and discrimination (e.g. loss of employment, forced separation from family, loss of education or housing), persons already HIV infected and those who are concerned they may be infected will actively avoid detection and contact with health and social services will be lost. Those needing information, education, counselling or other support measures will be 'driven underground'. The person who fears he or she may be infected would be reluctant to seek assistance out of fear of being reported - with severe personal consequences. The net result would be to seriously jeopardize educational outreach and thereby exacerbate the difficulty of preventing HIV infection" (Mann 1988).*

The plan fails to mention the role of migrant labor, and fragmented health services have impeded the establishment of appropriate control measures.

3. *Response of employers*

Recently the Chamber of Mines, the most powerful employing organization of black miners, made a grant available for the establishment of an AIDS Training and Information Center in Johannesburg. Additional funding has been provided by the Department of

National Health and Population Development as well as by private enterprise to replicate such centers in other cities in South Africa.

The Chamber stated in 1987 that migrant miners with HIV infection would not be repatriated if well, but would be if they became ill and unable to work[5] (Brink and Clausen 1987). Whiteside (1988) characterized the Chamber's basic policy as:

i) screening of all new recruits from areas in which AIDS is prevalent and no employment of known HIV carriers;

ii) continued employment of those persons in employ discovered to be HIV positive provided they were fit for work;

iii) repatriation of miners who developed AIDS and became clinically unfit for work;

iv) testing for HIV of all miners from high risk areas and those suffering from sexually transmitted diseases and exclusion at employment of those positive; and

v) development of an educational program to combat the spread of the disease.

In contrast, the Minister of Health announced that HIV positive workers would be repatriated if they had a long term contract but would not be dismissed if their work contract was to expire shortly. In late 1987, over 1,000 migrant miners were ordered to be repatriated by the government despite the fact that the National Union of Mineworkers condemned the move as discriminatory and uncompassionate. On February 8 1988, Reuters reported from Cape Town that the Minister of Health had said the repatriations had begun. Personnel associated with the Chamber of Mines denied that this was taking place in practice.

It is now apparent that HIV positive mineworkers are not having their employment contracts renewed. This especially affects migrant workers from countries with high HIV seroprevalence. Issues such as the future medical care of HIV positive individuals, compensation for lost income, and the levels of medical care available in their countries of origin should be examined by employers and the state.

The organized gay community has documented a number of cases in which South African Airways (SAA) has screened people for HIV antibodies at preemployment medical

[5] Editors' note: See the statement on AIDS from the National Union of Mineworkers which appears elsewhere in this volume.

examinations and informed them telephonically of their positive serostatus. Those found to be seropositive were not employed (Pegge et al 1989). Other organizations, such as the parastatal Electricity Supply Commission (ESCOM), have also introduced preemployment screening for HIV infection (Pegge et al 1989).

4. *Response of health professionals*

Although some medical practitioners have argued primarily for a "return to morality" as the solution to AIDS (Hendricks 1988), others have focused on the clinical, immunological and virological issues. The social, economic and political factors affecting the spread of HIV infection in South Africa have been largely neglected.

There have, however, been important interventions by some public health workers. IJsselmuiden et al (1988) outlined the need for a range of representative disciplines and groups to develop an appropriate educational strategy for South Africa. They drew attention to some social and political factors impeding effective action against the disease. They argued that in 1988, "without immediate action and if the urgency is ignored, the consequences for South Africa of the HIV epidemic may be too awful to contemplate".

A number of progressive programs have been developed at local and community levels. The Johannesburg City Health Department has been instrumental in developing appropriate policies for the city. An innovative educational play has been developed and is performed widely. However, funding for such programs is limited. At the Alexandra Health Center, which serves over 100,000 people living in the township on the northern border of Johannesburg, people with sexually transmitted diseases are individually counselled and advised about safer sexual behaviors. An educational program directed at all clinic attenders is also under way.

Other professionals have drawn attention to the need to investigate social conditions contributing to increased spread of HIV disease, for example prostitution (Schoub et al 1988).

5. *Responses by community groups*

The gay community has sought to develop a nonracial and nonsexist approach to HIV education and care in the RSA. A network of services and support structures for HIV-positive people has been established and demands for appropriate care have been advocated. The inadequacy of the government response is documented in an ongoing way (Pegge et al 1989).

Larger than life puppets have been used in innovative educational programs by the "Puppets against AIDS" (Weekly Mail, 15 - 22 December 1988). Groups active in the black community such as the "Township AIDS Project" have played an important role in developing appropriate community-based educational and counselling initiatives.

A range of progressive organizations have developed innovative responses to HIV disease. For example the Workplace Information Group (WIG) and the Industrial Health Research Group, provide assistance to the progressive trade union movement on health and safety issues and have produced publications on AIDS directed specifically at workers (WIG 1988). Critical Health has featured a special issue on AIDS (Critical Health, 1988), and health worker organizations such as the National Medical and Dental Association (NAMDA), the South African Health Workers Congress (SAHWCO), and the Progressive Primary Health Care Network (PPHCN) have developed responses to the epidemic. The Congress of South Africa Trade Unions, the National Union of Mineworkers, and the Transport and General Workers Union have embarked on educational programs around HIV infection. Statements by the African National Congress, have played an important part in "legitimizing" the involvement of community groups in addressing the problems caused by HIV disease.

ELEMENTS OF A PUBLIC HEALTH RESPONSE TO AIDS IN SOUTH AFRICA

Much international material on appropriate responses to HIV infection have been presented by the World Health Organization's Global Program on AIDS and other bodies. These include prevention of transmission through changing behavior, protecting the blood supply, health, education and counselling to name a few. This section of the paper will concentrate on those issues requiring attention and which have been inadequately addressed in South Africa.

The part played by the apartheid system in promoting the spread of HIV infection and retarding the ability to tackle it effectively must be recognized. The systematic fragmentation of health services, as a direct result of apartheid policies (see Zwi 1982; De Beer 1984 and Price 1986), must be ended as this hampers effective and coordinated preventive, promotive, and therapeutic services.

The role of the migrant labor system in facilitating the spread of sexually transmitted diseases and placing people at risk of HIV infection must be explicitly acknowledged. An end to this labor system, allowing workers and their families to reside together while providing full employment opportunities for all in Southern Africa, is likely to have a considerable impact on preventing the spread of HIV infection and other sexually transmitted diseases in the RSA. Government and mine policies to screen migrant workers and exclude the seropositive must be ended. Those infected with HIV but asymptomatic should be employed in the same way

as healthy people. Those with symptomatic HIV disease should be seen as suffering from a chronic condition - therapy should be discussed with them, including where and how they wish to be treated[6].

Health education programs need to be nondiscriminatory and must actively oppose "victim blaming". Undemocratic and repressive measures are more likely to be taken against people with little political influence. The potential for such measures must be anticipated and opposed. Educational materials must be explicit while taking account of cultural sensitivities and language differences. In the South African context it is particularly important to gain the involvement of the recognized progressive political, community, and worker organizations.[7]

Conservative religious beliefs within the governing group should not be allowed to limit discussion of safe sexual practices such as the importance of condom usage and other preventive measures. Explicit messages should be conveyed by legitimate community-based groups.

Programs should focus not only on HIV disease but also on other related conditions. Unwanted pregnancies, septic abortions, sexually transmitted diseases, and cancer of the cervix, all major problems in the African community, should also receive attention. While HIV may be less important than many other diseases associated with poverty, it will pose an additional burden through increased susceptibility to infectious diseases, especially tuberculosis, which is already endemic in the RSA.

Women's organizations and youth groups need to be sensitized to the issues around HIV infection and other sexually transmitted diseases. Their involvement will do much to facilitate grassroots understanding of the nature of sexually transmitted diseases and how to combat them. Racist concepts and stereotyping should be directly opposed.

Health services need to be planned to respond to the increasing numbers of people likely to be diagnosed with HIV infection in the coming years. Counselling, testing, and educational services are required. Improvements in sexually transmitted disease and family planning clinics will be necessary. Inpatient, outpatient, and day care services will need development, as will homecare services. Community-based organizations, such as are present within the gay community, should be actively supported.

Adequate funding should be provided for the development of services to prevent the transmission of HIV infection and to care for those who are ill. The development of new

---

[6] Editors' note: See the response articulated by the National Union of Mineworkers elsewhere in this volume.

[7] This point is stressed in the Maputo Statement on HIV and AIDS which is reproduced in this volume.

services should complement primary care services already in place and should not deplete existing structures or resources.

A progressive National AIDS Task Force, mooted at the Fourth International Conference on Health in Southern Africa in Maputo (April 1990), should seize the initiative to coordinate and promote community-based work, challenge the state to make adequate funds available, and ensure that worker and political organizations have the knowledge and information to embark on campaigns around the prevention of HIV disease.

Appropriate public health policies should be articulated forcefully. There is a crucial need for progressive professional, worker, homosexual, and community organizations to be involved in order to oppose repressive and coercive measures that may directly or indirectly be introduced by government and employers. Their role is necessary to develop an appropriate, effective, ethical, and sensitive approach to dealing with HIV infection. Without their active involvement, measures to combat HIV infection in South Africa are doomed to fail.

SUMÁRIO

Noventa e oito casos de SIDA foram notificados na República da Africa do Sul ao fim de 1987 e 166 em meados de dezembro de 1988. Em torno de 12 de fevereiro de 1990, 353 casos de SIDA haviam sido notificados: 326 sul-africanos e 27 pessoas de outros países do sul da Africa e do exterior. Os pacientes sul-africanos compunham dois grupos principais: homens brancos com padrão de infecção típico de homens homossexuais e bissexuais, e heterossexuais apresentando o padrão usual na maioria das regiões central e sul da Africa. Houve um pequeno número de hemofílicos afetados, e apenas um usuário de droga injetável até o presente momento. Há evidências de propagação considerável da epidemia na população negra sul-africana - o trabalho migrante, a alta prevalência de doenças sexualmente transmissíveis, e programas de planejamento familiar dirigidos pelo governo, vêm sendo apontados como fatores que contribuem para este fato. Taxas soropositivas em sul-africanos negros têm crescido rapidamente e espera-se que o número de casos dobre em torno de 8 meses e meio. O governo e alguns empregadores têm adotado medidas discriminatórias para contolar a doença incluindo o teste para o HIV em trabalhadores migrantes e a expatriação daqueles que apresentam soropositividade. A liderança das autoridades de saúde pública do Estado tem sido inapropriada. É necessário um maior envolvimento de homossexuais, trabalhadores, comunidade e pessoal da saúde pública para desenvolver políticas de controle da infecção pelo HIV na Africa do Sul, para que a ação seja ética, não discriminatória, sensível, efetiva, e orientada para a prevenção.

REFERENCES

1. Advisory Group on AIDS: activities during 1987. 1988. South African Medical Journal 73: 319.

2. Advisory Group on AIDS. 1988. Strategic Plan for the containment in South Africa. South African Medical Journal. 73:495-497.

3. Advisory Group on AIDS. 1988. AIDS - The Current Situation in RSA. South African Medical Journal. 74:317.

4. Advisory Group on AIDS. 1990. Update: AIDS in South Africa. 12 February.

5. Brink B A. 1987. The epidemiology of HIV infection in the mining industry. Paper presented at conference on AIDS: Perspectives on the problem and its management, 10 September.

6. Brink B and Clausen L. 1987. The acquired immune deficiency syndrome. Journal of Mine Medical Officers Association 63: 433.

7. Brown BB. 1987. Facing the 'Black Peril': the politics of population control in South Africa. Journal of Southern Africa Studies 13:256-273.

8. Business Day. 1988. Government launches AIDS awareness campaign. 22 January.

9. Chirimuuta R. and Chirimuuta R. 1989. AIDS, Africa and Racism. Free Association Books, London.

10. Critical Health. AIDS in South Africa - Progressive Perspectives. April 1988. Issue No. 22.

11. De Beer C. 1984. The South African Disease: Apartheid Health and Health Services. Johannesburg, SA Research Service.

12. Department of National Health and Population Development. 1987. Epidemiological Comments 14, (2).

13. Government Gazette. 1987. Vol 268. No. 11014:68-80.

14. Hendricks M. 1988. Underestimation of AIDS - there's nothing to be optimistic about. South African Medical Journal, 73: 573-4.

15. IJsselmuiden CB, Steinberg MH, Padayachee GN et al. 1988. AIDS and South Africa - towards a comprehensive strategy. South African Medical Journal 73: 455-460 (Part I); 461-464 (Part II); 465-467 (Pat III).

16. Jochelson K, Mothibeli M and Leger J.-P. 1989. HIV and migrant labor in South Africa. (In press).

17. Mann J. 1988. AIDS - Discrimination and Public Health. Paper presented at the IV International Conference on AIDS, Stockholm, Sweden.

18. Miller S. 1990. Government AIDS effort sorely lacking. Saturday Star, 21 April 1990.

19. Moodie TD. 1988. Migrancy and male sexuality on the South African gold mines. Journal of Southern African Studies 14(2).

20. National Union of Mineworkers. Press release reproduced in Critical Health, Number 22. April 1988, pp 26-28.

21. Nkoli S. 1989. New Internationalist, No. 201. November, page 19.

22. O'Farrell N. and Will R. 1989. Sexual behavior, knowledge, attitudes and awareness of AIDS amongst sexually transmitted disease clinic attenders in Durban following the national campaign. South African Journal of Epidemiology and Infection 4(3): 45-48.

23. Padayachee GN and Schall R. 1990. Short-term predictions of prevalence of human immunodeficiency virus infection among the black population of South Africa. South African Medical Journal, 77:329-333.

24. Pegge J, Isaacs G, Miller S. 1989. Networking: A Prevention and care strategy for the gay minority in South Africa. Unpublished.

25. Price M. 1986. Health Care as an instrument of Apartheid Policy in South Africa. Health Policy and Planning. 1(2): 158-170.

26. Reuters. 1988. South Africa to deport black migrant workers with AIDS virus. 8 February.

27. SA Barometer. 1987, a. 1(10):152.

28. SA Barometer. 1987,b. 1 (2): 29.

29. Sabatier R. 1988. Blaming others. Prejudice, race and worldwide AIDS. Panos Publications Ltd. London.

30. Schall R, Padayachee GN and Yach D. 1990. The case for HIV surveillance in South Africa. South African Medical Journal, 77:324-325.

31. Schoub B. 1987. AIDS in South Africa - a time for action. South African Medical Journal, 71: 677.

32. Schoub B D, Smith A N, Lyons S F et al. 1988. Epidemiological considerations of the present status and future growth of the acquired immunodeficiency syndrome in South Africa. South African Medical Journal. 74:153-157.

33. Shapiro M, Crookes RL, O'Sullivan E. 1989. Screening antenatal blood samples for anti-human immunodeficiency virus antibodies by a large-pool enzyme-linked immunosorbent assay system. South African Medical Journal, 76:245-247.

34. Sher R. 1989. HIV infection in South Africa 1982-1988 - a review. South African Medical Journal. 76:314-318.

35. Slabber C. 1987. Sunday Star. 20 December.

36. Sunday Star, 20 December 1987.

37. Weekly Mail. 1988. The fine line between knowledge and terror. 15-22 December: 10-11.

38. Whiteside A. 1988. Migrant Labor and AIDS in Southern Africa. Paper presented to The Global Impact of AIDS Conference, London.

39. Workplace information Group. 1988. AIDS - is it an issue for workers?

40. World Health Organization. 1989. Nongovernmental organizations and the global strategy for the prevention and control of AIDS.

41. Zwi A. 1982. Piecing together health in the homelands. Second Carnegie Inquiry into Poverty and Development in Southern Africa. Cape Town, University of Cape Town.

Note: An earlier version of this paper was presented at the Global Impact on AIDS Conference, London, March 1988.
This paper will be published in Health Policy and Planning, December 1990.

Acknowledgement:

Karen Jochelson supplied the poster reproduced in Figure 3.

LEGENDS FOR FIGURES

Figure 1

Reported cases of AIDS in South Africa from 1982 to 1989.

Figure 2

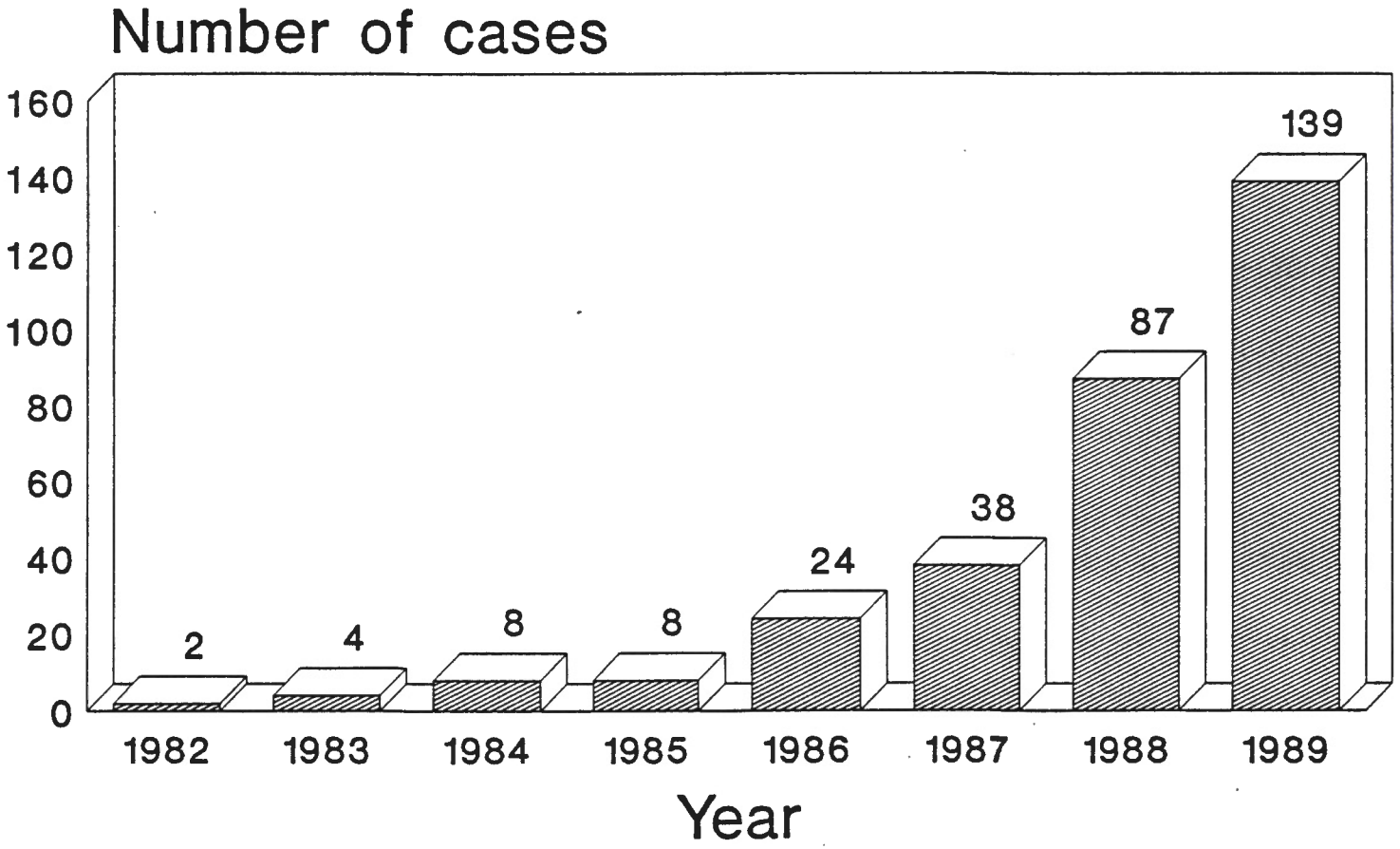
Cases of AIDS in South Africa: routes of transmission in whites (n=231) and Africans (n=79), both sexes combined (cumulative data from 1982 to 12 February 1990.

Figure 3

Rightwing pamphlet circulated in parts of Johannesburg in an attempt to discredit the African National Congress (ANC).

FIGURE 1

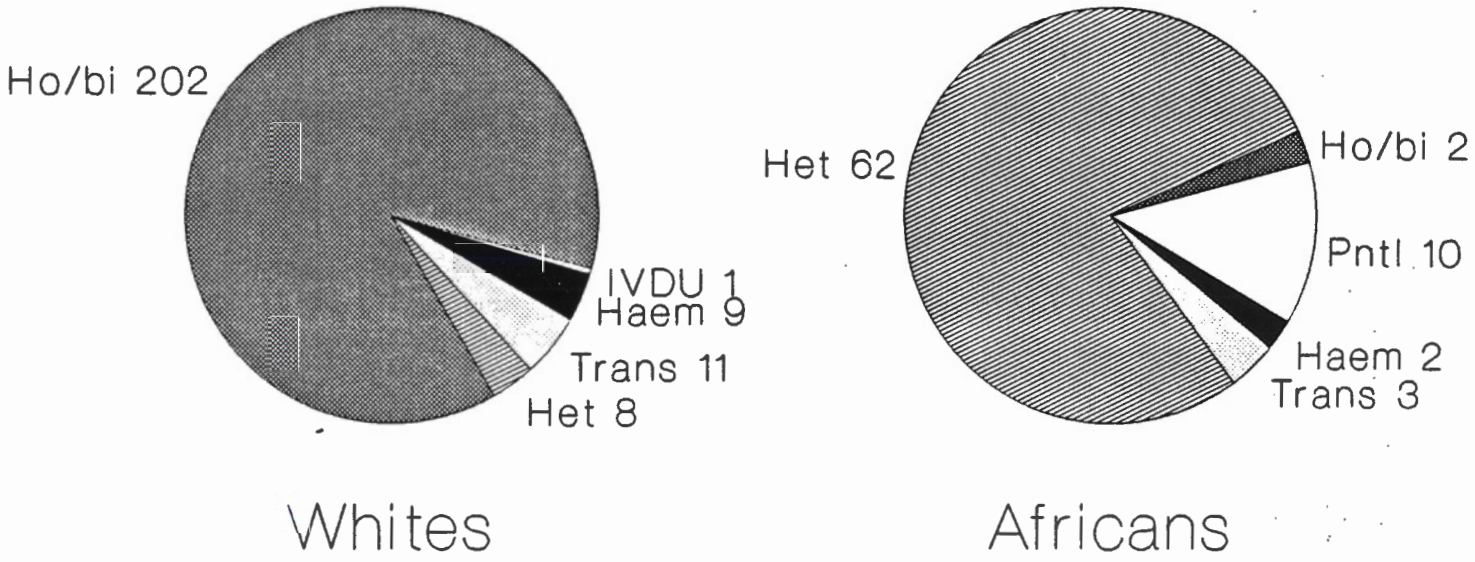
Cases of AIDS in South Africa
1982 - 1989



Note: Excludes non-South Africans
Source: AIDS Advisory Group

FIGURE 2

SA AIDS cases: routes of transmission
(Cumulative from 1982-1989)



Source: Data from AIDS Advisory Group
Excludes non-South Africans

ANTI-AIDS CAMPAIGN

AIDS FROM

1. IF YOU DON'T BELIEVE, ASK MK CADRES.
2. AIDS IS VERY RIFE IN AFRICAN COUNTRIES WHERE THEY ARE TRAINED.
3. NOW THEY ARE IMPORTING AIDS INTO SOUTH AFRICA.
4. J.H.B. IS A CASE IN PIONT.

FREEDOM FIGHTERS

HE WHO DIES NATURALLY NEVER CRIES.
HE WHO HAS AIDS CRIES AND DIES.
SOCIALIZE WITH THE ANC FREEDOM FIGHTERS AND CRY AND DIE FROM

AIDS.

Figure 3. Right-wing pamphlet circulated in parts of Johannesburg in an attempt to discredit the African National Congress

promoting measures for preventing the spread of the infection.

Responses to AIDS in South Africa

South African organizations and structures have responded to HIV infection in a variety of ways. Many changes have originated from community groups, non-governmental organizations and progressive health professionals reacting to the lack of educational and preventive measures provided by the state.

Government response

The government response has been limited, and often inappropriate. Legislation allowing for potentially repressive measures has been introduced. The Government Gazette of 30 October 1987 gave notice of the possibility of compulsory medical examination, hospitalization and treatment 'if any person who in the opinion of a medical officer of health is or could be suffering from a communicable disease'. AIDS was listed as such a 'communicable disease'. The regulations empower local government medical officers of health to detain seropositive persons 'until cured'. In addition, this compulsory screening requires neither informed consent nor counselling to be implemented. Regulations of the Admission of Persons to Republic of South Africa Act (Act 59 of 1972) were amended in 1988 to include infection with HIV and AIDS as

ASSESSING EDUCATIONAL STRATEGIES FOR THE PREVENTION OF AIDS. WHICH APPROACH IS EFFECTIVE?

Gilles R de Wildt, M.D., MSc.

P.O. Box 1253, Gaborone, Botswana
Brederodestraat 5, Amsterdam 1054 MP, Netherlands

ABSTRACT:

Evaluating the impact of health education (HE) for the prevention of HIV infection is very difficult to achieve. In order to simplify evaluation, "intermediate variables" can be used as indicators for success of the intervention instead of seroconversion, but methodological problems remain. It is hard to establish which educational strategy works best. It is therefore proposed here to draw lessons from past experiences in HE for the control of sexually transmitted diseases, antismoking and, more recently, for the prevention of HIV transmission. These lessons are: 1) HE should not focus on fear; 2) it is best to address sexuality in an open, straightforward, and factual manner; 3) those individuals who are most at risk are most likely to reject HE that promotes safer behavior; 4) media messages alone will not bring about behavior change, community involvement is necessary. For evaluation, it is proposed that qualitative studies along the lines of "participatory evaluation" be carried out. When the academic resources are available, surveys of knowledge, attitudes, and practices can also play an important role.

HIV AND AIDS IN THE WORLD

By the end of January 1990, 215,144 cases of AIDS had been reported to WHO. Of this number, 142,605 were reported in the Americas (117,781 cases in the USA alone) and 40,519 in Africa (Weekly Epidemiological Record, 1990). The real cumulative number of AIDS cases is much higher, since considerable underreporting occurs. Millions of people are thought to be seropositive but not ill, and the epidemic is spreading fast.

Since there is no effective drug or vaccine available, prevention is currently the only option for control. To this end, national AIDS control programs are being developed. Some elements

are: reduction of transmission through sexual activity by promoting abstinence or safe sex[8], counselling of seropositive women of child bearing age, early diagnosis and treatment of STDs, (genital ulcer disease, especially chancroid, and possibly other STDs are independent risk factors for the acquisition and the passing on of HIV infection [Latif and Katzenstein 1989], screening of donated blood and dissuasion of persons with risky behavior to donate[9], and improved sterilization and disposal techniques in health care. Care for and solidarity with the sick and nondiscrimination towards carriers and patients are essential.

BEHAVIORAL CHANGE

The greatest reduction of transmission can be expected from changes in behavior. The most important interventions are health education and making condoms easily accessible. The questions asked here are:

i) how do we know how and whether health education works, and

ii) which strategies in health education should we pursue?

METHODOLOGICAL CONSIDERATIONS

To discuss these questions the issue of evaluation is important. The evaluation of HE for AIDS prevention requires a complicated study design. The ultimate objective of the intervention is a reduction in seroconversion, which is theoretically the best indicator of success. Surveying seroconversion is not easily done: informed consent is needed for blood samples to be drawn from individuals, (unless an "unlinked" approach is followed") while problems of a statistical nature may also arise. (Very large numbers of people must be tested when there is low seroprevalence). This problem could be avoided by using "intermediate variables." Knowledge, attitudes, and practices could be measured in surveys (KAP surveys). However, selfreported information, especially on behavior, must be viewed with a great degree of caution.

An intervention group exposed to the health education program and a control group (is not exposed to the health education program) must be recruited. Furthermore, for methodological reasons the unit under study must be a community and not an individual, and

---

[8] In most instances it is recommended to have a relationship between two faithful partners, or when this is not possible, to use condoms. Easy accessibility and the promotion of acceptability of condoms are thus essential.

[9] This is in order to minimize the risk of infection within the "window" period when a donor has been infected but is not yet seropositive.

for statistical reasons a number of communities in both the intervention and control group would be needed. Both groups need to be carefully selected so as to ensure comparability.

For ethical reasons it is very difficult, if not unacceptable, to withhold health education from communities. Also, it is very difficult to separate the effect of the intervention (the health education program) from the effect of other sources of health education, such as information from the radio that is not part of the program or the impact of a respected member of the community ostensibly dying from AIDS.

Studies to evaluate the influence of health education will be very difficult to design, expensive to carry out, and may take years to complete. One study that goes a long way towards overcoming these methodological problems is the intervention in Nairobi prostitutes (Ngugi et al 1988). For routine purposes, however, evaluators will have to rely upon other study approaches.

FOUR LESSONS FROM THE PAST

Past experiences with health education for the promotion of healthy behavior demonstrate important lessons. This paper considers whether current programs take such experiences into account. These experiences emerge from health education for the prevention of STDs in the past and present century, antismoking campaigns for the prevention of lung cancer (Baggaley 1986), and recent AIDS prevention campaigns (Baggaley 1986).

The first lesson is that the best course of action when addressing sexuality is a clear, straightforward, and open approach. There is no evidence of any harm caused by this approach. "Beating around the bush" is counterproductive (Lashley and Watson, 1921). Furthermore, attention from the message must not be diverted by too much drama.

The second lesson is that it is counterproductive to focus too much on fear. Campaigns with tombstones, graveyards, and the "grim reaper" as was the case in Australia (Taylor 1988; Morlet at al 1988; Harcourt et al 1988) created an increase of awareness of the danger of AIDS, but tended to scare away many people who are at risk[10].

The third lessons is that those individuals who are most at risk are more likely to reject the message. They would use the slightest pretext to do so, such as inferring a preaching tone in those providing the education or focusing on minor contradictions in messages. This is true for STD prevention, smoking campaigns, and AIDS prevention (Van Mens 1989).

---

10 Editor's note: In South Africa a well publicized campaign showed a coffin being lowered into a grave. Such messages are clearly more frightening than educational and informative.

A fourth lesson is that media campaigns alone are unlikely to bring about safe behavior. Community involvement is necessary. In those instances where prevention campaigns have proven to be successful, the target group was actively involved and was to a great extent in charge of the AIDS prevention program. Examples are groups of gay people in the Netherlands and the USA (where seroconversion is now very low), and, to a lesser degree, prostitutes in Nairobi (Ngugi et al 1988) and activities in Zaire where workshops were held with women who tried to devise strategies to avoid risky behavior (Grundfest et al 1988).

PARTICIPATORY EVALUATION

Since community involvement is essential and resources for evaluation are often limited, an approach can be pursued that makes the best of both. Evaluation along the lines of Marie-Therese Feuerstein's "Participatory Evaluation" (Feuerstein 1986) is advocated. Here, representatives of the community should be involved in the design and the execution of the program. The aim is to identify the available resources within a program and within a community. Are public health nurses, or other persons, available to help carry out evaluations of a qualitative nature? (Mainly using techniques derived from anthropology such as focus group discussions and indepth interviews). In general, such groups will be present and able to assist.

Some programs (but far from all) can rely upon public health experts who can advise on qualitative techniques as well as conduct quantitative surveys. This is facilitated by possession of statistical expertise and microcomputers. KAP surveys are the obvious choices. In order to meet the need for community participation, it is essential that the design of the evaluation is discussed with community representatives beforehand and that results do not take long to come out and are fed back to the community promptly. It is always recommended that quantitative surveys, such as KAP studies, be coupled with qualitative techniques. If quantitative surveys only are carried out, it is possible that essential information is missed: precoded questions often do not allow for information which has not been foreseen by the program designers to be incorporated in the study results.

It is proposed to try and incorporate members of the community as much as possible, not only in qualitative evaluation, but in quantitative surveys as well. For instance, secondary school students could help distribute and explain KAP questionnaires administered to students elsewhere[11] as well as feed results back. They could be trained further to act as resource persons on AIDS control.

---

11 Students should be from a school which is far away in order to ease confidentiality and privacy of the students who are interviewed.

SUMÁRIO

É muito difícil avaliar o impacto de educação para saúde na prevenção da infecção por HIV. Para simplificar a avaliação "variáveis intermediárias" podem ser utilizadas como indicadores de sucesso da intervenção, ao invés de soroconversão, mas os problemas metodológicos permanecem. É difícil estabelecer qual estratégia educativa funcionaria melhor. Portanto, aqui é proposto que se tirem lições de experiências anteriores em educação para saúde no controle de doenças sexualmente transmissíveis, em campanhas anti-fumo e, mais recentemente na prevenção da transmissão por HIV, analisando estas lições nos seguintes aspectos: 1) educação para a saúde não deve focar no medo; 2) é melhor abordar a sexualidade de forma aberta e factual; 3) aqueles indivíduos mais propensos ao risco provavelmente rejeitarão a educação para saúde que promova comportamento mais seguro; 4) somente mensagens da mídia não trarão mudanças de comportamento, pois o envolvimento da comunidade também é necessário. Para a avaliação, propõe-se executar estudos qualitativos na linha de "avaliação participativa." Quando há recursos acadêmicos disponíveis, pesquisas de opinião, atitudes e práticas podem vir a desempenhar um papel fundamental.

REFERENCES

1. Baggaley JP, 1986. Developing a televised health campaign: I Smoking prevention. Media in Education and Development, 19:86-90.

2. Baggaley JP, 1988. Perceived effectiveness of international AIDS campaigns. Health education research, 3:7-18.

3. Feuerstein M-T, 1986. Partners in Evaluation. Evaluating Development and Community Programs with participants. TALC, St Albans, England.1.

4. Grundfest Schoepf B, Engundu W, wa Nkera R et al, 1988. Action Research on AIDS with women in Central Africa. Paper presented at the first International Conference on AIDS Education and Information, Itaxpa, Mexico, October 16, 1988.

5. Harcourt C, Edwards J and Philpot R, 1988. On the Grim Reaper Campaign. Medical Journal of Australia, 149:162-4.

6. Lashley KS and Watson JB, 1921. A Psychological Study of Motion Pictures in Relation to Venereal Disease Campaigns. Social Hygiene, 7:181-219.

7. Latif AS, Katzenstein DA et al, 1989. Genital ulcers and transmission of HIV among couples in Zimbabwe. AIDS, 3:519-523.

8. Morlet A, Gurian JJ, Diefenthaler I and Gold J, 1988. The Impact of the Grim Reaper National AIDS education campaign on the Albion STD (AIDS) Center with AIDS Hotline. Medical Journal of Australia,148:282-6

9. Ngugi EN, Plummer FA, Simonsen JN, 1988. Prevention of transmission of Human Immunodeficiency Virus in Africa: Effectiveness of condom promotion and health education among prostitutes. The Lancet, October 15, pp 887-90.

10. Taylor WTL, 1988. The Grim Reaper: the use of research in policy development and public education. Department of Community Services and Health, Woden, Australia.

11. Van Mens L, 1989. De invloed van de vrij veilig campagne op condoomgebruik bij prostituanten. Maandblad Geestelijke Volksgezondheid, 44:774-85

12. Weekly Epidemiological Record, 1990, 65:29-30, WHO, Geneva.

OBSTACLES TO PREVENTION OF THE HIV EPIDEMIC

Dr. Stan Houston

Division of Infectious Diseases
University of Alberta Hospital
Edmonton, Canada
Formerly lecturer, University of Zimbabwe

ABSTRACT:

The issue of AIDS and HIV infection is likely to have a profound historic impact. The HIV epidemic is compared to the plague in 14th Century Europe. Despite scientific advances since that time and the current understanding of how the virus is transmitted, the author sees several obstacles to prevention of further spread of the disease in Africa. Some important obstacles are the long incubation period of HIV disease, the difficulty in addressing issues related to sexuality, a medieval attitude which perceives of illness as shameful, and the lack of time. The author is nonetheless optimistic that the AIDS epidemic can be prevented in South Africa, where current levels of infection are limited. Attention to the issue of AIDS prevention in the context of the ongoing struggle for liberation in South Africa is urged.

It is an honor to participate in this conference particularly at such an exciting and critical time in the history of South Africa. The subject of my talk is another event of great historical importance which is taking place worldwide at this same time -- the AIDS or HIV epidemic.

THE BLACK DEATH AND HIV DISEASE

Several historians have suggested that health and disease have had a much greater impact on history than we usually give them credit for. Nevertheless, there is only one epidemic in history that is widely recognized as a major historical event -- the Black Death or Bubonic Plague. I think this analogy is worth considering in order to illustrate the concept that a disease or public health issue can be of profound historical importance.

The Black Death arrived in Europe in 1349. It is estimated that it killed some 25 million people -- 20 - 30% of the European population at the time. It was one of the dominant events of that period of history. There were major economic effects from the sudden decline in the labor force and perhaps important long term effects from the improved bargaining position of the workers which resulted. The profound psychological impact of the Plague probably

played a part in shaking people's beliefs in the certainties that had prevailed for a thousand years, contributing to the climate that produced the Renaissance and the Reformation. It seems likely that AIDS will take a greater toll in human life than did the Black Death and perhaps even cause comparable proportional mortality in some communities. I am not able to speculate on the possible long term social and economic consequences, but I assume that they will be substantial.

Another characteristic of Plague that is strikingly similar to HIV is its ability to persist or recur. Recurrent outbreaks of plagues devastated Europe at least into the eighteenth century. Similarly HIV, once established in a community, will result in an ongoing burden of illness, death, and expense. It will be practically impossible to eradicate until such time as a vaccine and/or treatment that is effective, safe, practical, and affordable comes along. That may be a good many years and a great many deaths from now.

Plague had its greatest impact in Europe and the Mediterranean basin. Much of its epidemiology is readily explainable on the basis of prevailing trade routes and the presence of social conditions that favor close contact between rats, fleas, and people. Still there is much we do not understand about the epidemiology of plague: why some communities were particularly hard hit and others, apparently similar, relatively spared. With HIV, it is Africa which is bearing the brunt of the epidemic, at least at this stage. Some of the reasons for the very different pattern of disease in Africa such as the relative infrequency of homosexuality and intravenous drug use, are readily apparent. Prevailing social factors such as war, poverty, rapid urbanization, and particularly, relevant to South Africa, large scale migrant labor probably account for much of the pattern we have observed. Studies in Nairobi, Harare, and elsewhere clearly indicate that other STDs, particularly genital ulcer disease, can dramatically increase the efficiency of sexual transmission of HIV. This may explain to a large degree the rapid spread of HIV in many of the countries of Africa.

We have a great advantage over the people of the Middle Ages. We know the cause of our Plague, we know how it is spread, and we know how to prevent its transmission. In spite of this knowledge, results of efforts to limit the spread of HIV have been tragically disappointing in most affected communities worldwide. There have certainly been successes which encourage us to believe that knowledge and preventive efforts can be fruitful. There are, however, problems and obstacles that we must identify and anticipate if South Africa is to have any chance of protecting itself from AIDS.

PROBLEMS AND OBSTACLES TO OVERCOMING HIV DISEASE

1. *The long incubation period of HIV*

We are now learning that the median time from acquisition of the AIDS virus to the development of AIDS disease is eight to nine years, probably longer in some groups. This is good news for patients I see with early HIV infection, but from an epidemiological point of view the implications are all bad.

First, the long incubation period means that the disease is invisible in the community for a long time. By the time large numbers of people begin presenting with HIV related illness, the disease has been spreading silently for years and is likely to be well established in the community. It is very difficult to get anyone, the public, governments, or even health professionals, to worry about something they can't see.

Secondly, HIV infected individuals, as far as we know, are infectious to others throughout their long incubation. This is unique among fatal human infections. Only a very small proportion of typhoid patients, for example, may become chronic, asymptomatic carriers. But with HIV, every infected adult is capable of infecting others for many years during most of which time he or she is likely to feel perfectly well and be unaware of his or her infection.

2. *Sexual transmission*

Sex, the primary route of HIV transmission, offers unique difficulties to effective prevention. Sex, after all, is popular everywhere. It is a powerfully motivated activity. But even more difficult, I think, is the fact that in every culture, sex is surrounded by taboos. These cultural traditions and social controls cover not only who you can do it with, but how and with whom you may talk about it. This is a problem because you can't fight AIDS without talking about sex any more than you can fight a war without talking about guns. Talking about sex makes health workers uncomfortable, patients uncommunicative, the media nervous, and politicians reluctant for fear of offending someone. In the U.S. for example, where sex is marketed aggressively everywhere you look, President Bush opposed a proposal for a national, anonymous questionnaire sample designed to gather information critical to HIV control.

3. *The medieval attitude.*

Back again in the Middle Ages, conditions such as leprosy and mental illness were considered shameful. This association of disease and shame is inconsistent with

scientific and humanistic attitudes toward disease and patients, but it has been a recurring theme of the AIDS epidemic. When the response to a disease is a feeling of shame, objective assessment and constructive action become impossible on the part of both patients and society. Lack of free and open discussion is inevitable if the patient or the society are ashamed of the condition. If society sees a disease as shameful, it becomes possible to discriminate against its victims. A patient or a country that perceives AIDS to be a shameful condition will misinterpret efforts to recognize and deal with the problem as being discriminatory.

4. *Lack of time*

AIDS is a public health emergency. This is so for several reasons:

a) Its potential for rapid spread. HIV seroprevalence in Thai drug abusers went from less than 1% to 40% in seven months. I am told that the doubling time for HIV seroprevalence in Johannesburg is 8 1/2 months.

b) Effective action must be taken before the disease becomes established in the community.

c) Because of the exponential pattern of growth which has characterized AIDS, every delay in controlling the spread of HIV will mean that we face a bigger problem - more death, more infectious "carriers", and greater expense -- next month or next year when we do get around to responding effectively.

d) At present our primary weapons in the fight against AIDS are information, education, and motivation of people to modify highrisk behavior. We will not change knowledge, beliefs, and practices, certainly not those related to sex, overnight. Even if we could devise the optimal AIDS Control Program, there would be a lag phase before we began to get results. So we must start now.

CAN THE HIV EPIDEMIC BE STOPPED?

With all these obstacles and probably many more, with examples of failures even in societies with much more material resources, is it realistic to think we can prevent the AIDS epidemic in South Africa? Of course I believe the answer is yes or I wouldn't be here. But in any case, it is a question we can't afford the luxury of debating. Our only alternative is an all out effort.

In South Africa we have a unique opportunity. We know enough, early enough, and have, at least potentially, sufficient resources to respond effectively. But there is no doubt that the

time to respond is now. In fact, yesterday would have been better. The relatively low HIV seroprevalence figures from South Africa should not be a source of reassurance or complacency but rather should encourage us to redouble our efforts with hopes of success.

Everything that we know of South Africa, the biology of the AIDS virus, and the risk factors for spread suggests the potential for an epidemic at least as severe as those of other countries in Africa.

WHO CAN PREVENT AIDS IN SOUTH AFRICA?

In more normal circumstances the leading role in AIDS prevention would be taken by government. In the current South African context, a program mounted by government to advise the black community on their sexual behavior would be an obvious nonstarter. Their credibility would be zero or worse. Such information, such a program, can only be effective if it comes from people or organizations that have the trust of the majority of South Africans, i.e., the progressive and liberation movements. In other words, only you can prevent AIDS.

Finally, I would like to reply in advance to an argument which might reasonably be advanced by members of the liberation movements who may not be fully aware of the implications of the AIDS epidemic. The argument is this: At this critical moment in South African history the people and the liberation movements need to concentrate every bit of their strength and effort on the struggle: a health issue is peripheral and can wait.

First, I believe you can't afford not to concentrate on the issue of AIDS urgently. Inheriting a country ravaged by AIDS would be a poor victory.

Secondly, I don't believe that an effective response to AIDS would detract from the political struggle. An effective response against AIDS will require mobilization at all levels of society. It will necessitate the participation of political leaders, the media, churches, labor and women's organizations, the schools, the private sector, the advertising industry, psychologists, and sociologists, among others. It will demand the motivation and organization of millions of individuals. And I emphasize that in responding to this disease, the leading role can only be taken by the progressive forces that have the trust of the people.

If you are able to achieve the goal of stopping the AIDS epidemic, you will not only have prevented an immense toll of death and disease and a chronic burden on the new nation and its health system. You will also have the distinction of having accomplished something for your people that no one has been able to do before, at least on a national scale. Incidentally, you will have harnessed the power of the people of South Africa in a way that I believe could only be synergistic with, not detract from, the political struggle.

SUMÁRIO

A questão da SIDA e da infecção por HIV traz provavelmente um impacto histórico profundo. A epidemia de HIV é comparada à praga na Europa do século XIV. Apesar dos avanços científicos desde aquela data e o conhecimento atual de como o vírus é transmitido, o autor vê vários obstáculos na prevenção da propagação da doença na Africa. Alguns obstáculos importantes são, o longo período de incubação da doença, a dificuldade em abordar assuntos relacionados à sexualidade, uma atitude medieval que percebe a doença como algo vergonhoso e falta de tempo. Apesar de tudo, o autor é otimista quanto à prevenção da epidemia de SIDA na Africa do Sul, onde os níveis atuais da infecção estão limitados. Enfatiza-se a questão da prevenção da SIDA no contexto da luta atual pela libertação na Africa do Sul.

HIV AND AIDS IN SOUTH AFRICA TODAY

Liz Floyd

Johannesburg, South Africa

ABSTRACT:

This paper analyses the response of HIV and AIDS from the perspective of progressive community, worker, and health organizations. It suggests why HIV disease may not seem real to grassroots organizations. It examines which features of South African life promote the spread of HIV infection including dislocated families, rapid social change, and the basic fight for survival. The responses to the epidemic by the health services, community-based organizations, and the political health groups are described. The paper challenges those active in the field to establish appropriate strategies and mechanisms to achieve some impact on HIV disease in South Africa. The paper puts forward suggestions on methods for working on AIDS in both the health sector and the progressive movement. It aims to stimulate discussion on how to organize around AIDS. It questions whether we will be equipped to return to our organizations to initiate work on AIDS. It asks how one links the input and discussion at meetings like this conference to organization and action in South Africa.

INTRODUCTION

My base for working on HIV and AIDS is the progressive trade unions and community organizations and township health services in the Transvaal. I will not attempt to describe the equivalent processes in the gay community whose HIV epidemic started many years back and has already progressed to an AIDS epidemic of tragic proportions. However the experience of the gay community is invaluable to us, and we need to analyze more actively how we integrate with and support that community in responding to HIV and AIDS.

The experience of people in the Southern Transvaal is suggested in Table 1

Table 1

1987
AIDS is considered a "gay disease".
Sensationalized in the media.

1988
AIDS is a "black disease".
Racist government campaign eliciting fear and anger.
A bad year!

1989
AIDS is also our disease.
Substantial progress! (just when we wanted to give up)

1990
HIV is here - We should do something about it
A dramatic increase in political activity:
-"it is difficult for us to make it a priority"
OR
-"we have got more important things to do" (youth)

1991
Prevention:
Increasing deaths of babies from AIDS will increase
community consciousness of AIDS and therefore HIV.

THE HIV EPIDEMIC - WHY DOES IT NOT FEEL VERY REAL?

One of the big problems in working on the HIV epidemic is the lack of reality about it. Some of the factors that account for this are listed below:

1. *The nature of the disease.*

   Many years separate the conditions under which a person becomes infected from serious disease. There are very few symptoms at the time of the infection, and the person is usually unaware of becoming infected. This is different from other diseases (sexually transmitted diseases among them) where people frequently experience severe symptoms soon after they become infected.

2. *Limited personal experience of people with HIV disease.*

   The people we are trying to persuade to take precautions don't know people who have AIDS or who are HIV positive. The identity of HIV positive people is kept secret for fear of discrimination. For example, within a clinic, the staff do not normally know who is HIV positive. We are politically isolated from southern and central African countries with serious epidemics, so their experiences do not inform us.

   We need to i) develop nondiscriminatory and nonstigmatizing attitudes to people with HIV disease and ii) establish more contact with people from neighboring countries.

3. *People naturally fear AIDS*

   Defense and denial are natural responses. Defenses are dramatically increased when people perceive that they are attacked politically for something as private as their sexual relationships. In South Africa racism often permeates work on HIV and AIDS.

   We need to develop i) political work that analyses and exposes the links between racism and AIDS; and ii) thorough work in our own programs to counter racism.

4. *Our society is conservative when it comes to talking about sexuality and sex*

   Mothers do not really talk to their daughters about sex. There is no sex education in black schools. Teenagers who are sexually active have limited knowledge and communicate little about sex. If we are not acknowledging sexuality and unable to talk about it, how do we talk about AIDS?

We need to i) develop sex education at home and at school; and ii) ensure that sex education addresses sexuality in a positive way.

5. *There is disinformation on AIDS*

People do not know what to believe and are distrustful of much of what they hear about AIDS. For example, there is a surgeon at Baragwanath hospital who tells staff that one third of the patients are HIV positive. This is clearly incorrect.

We need i) accurate information from credible sources e.g. the political health organizations; and ii) programs to actively identify and expose disinformation.

ACHIEVING A SENSE OF REALITY

It is important to be aware of the anxieties that may be raised by education. An example concerns women who may face the following sorts of problems:

i) They may have teenage children who are sexually active in an environment where there is no sex education and people are ignorant about AIDS.

ii) They may be single and, in looking for a partner, they will be exposed to AIDS. A suggestion to use a condom may mean the end of the relationship. Some women may choose to avoid sexual relationships for fear of AIDS.

iii) They may have husbands or boyfriends who have other partners. Many women reach a compromise on the issue where they accept other partners provided they do not disrupt the family. That compromise is no longer possible where she risks HIV infection.

LIFE UNDER APARTHEID AND THE SPREAD OF HIV

It is well known that the system of apartheid sets up social conditions that maximize the spread of HIV in South Africa. This understanding is an important motivating factor for many progressives who work on HIV and AIDS. Our experience of state health services on AIDS and other diseases tells us that we cannot rely on those services to make a meaningful impact on the epidemic. The result is a strong and overwhelming sense of responsibility amongst progressive health workers to take on the AIDS epidemic.

Most organizations have responded in some way. There is a sense that an enormous amount of work needs to be done on prevention of HIV infection independently of state

structures. However there are limits to what the progressive organizations can do on their own, and we have to explore ways of influencing the state to finance or contribute to appropriate education and services such as the provision of free condoms.

The progressive organizations differ from state health services (the traditional medical sector) in their interpretation of the epidemic and the solutions to it. The traditional medical sector says that the only way to stop HIV is education and condoms. The progressive sector says you have to eradicate the conditions that promote the spread of HIV. In addition people need to know how to protect themselves.

I mention below four social conditions that promote the spread of HIV.

1. *The family is under attack*

   Many men are migrant laborers living in hostels, travelling for work, or stationed at work sites such as construction sites, where there is no family accommodation. They are required to live in single sex hostels without their wives. As a result relationships are put under stress, and some marriages do not survive. It is natural for men in migrant labor to look for relationships that provide some of the comforts of home, and some women accept compromises, with their partners having a wife at home and a girlfriend at work. Many men remain faithful to their wives despite the conditions.

   Where a marriage fails, what becomes of the wife? She often starts by searching for the husband. She may find herself in town faced with a failed marriage and an income from the father of the children on which she cannot survive. If she finds formal employment, the wages are so low that she will have to supplement it. Often she cannot find any formal employment. Women in these situations may end up in a variety of relationships through the need for accommodation and income. A few will formally become prostitutes. Many will have boyfriends who supplement their income or provide accommodation. Within these relationships, a woman will have little power to negotiate over sex, such as objecting to her partner having other partners or getting her partner to use a condom. If she is aware of HIV and insists on measures to protect herself, she risks losing accommodation and an income that may mean food for her children. She is also at risk of HIV without indulging in high risk sex herself, through her partner's activities.

   Children in these families are also at risk. Where a marriage fails, children will rely on their mother providing an income and care from the extended family. Where the extended family cannot care for them, some children may need to earn money to

support the family - young girls may engage in casual sex for the income it generates. Young boys can also be sexually exploited in return for money.

2. *South Africa is a rapidly changing society*

In the present period young people have very different lifestyles from their parents. Traditional cultural frameworks for educating young people about sex, setting moral standards, and limiting sexual activity amongst teenagers hardly exist. An alternative cultural framework has not developed to cater for the present period where young people are sexually active. They are sexually active while being ignorant about sex, sexuality, and sexually transmitted diseases.

The same young people bear the brunt of many of the hardships of this apartheid society - unemployment, the failure of the education system, political repression, and harassment. The result is that they have very little space within which they can develop their own framework for sex and relationships. It is unrealistic to suggest that young people either abstain from sex or stick to one partner. We already know that our youth are most affected by the HIV epidemic and will continue to be.

3. *Many are fighting for survival*

Many people in our society are struggling for survival and face social deprivation such as the lack of housing, education, employment, and recreation facilities. Others, such as refugees and those relocated, may feel displaced. They have few outlets for their frustrations or needs for relaxation. These factors affect the conditions under which people have sex and how people deal with sexual relationships.

As in many other countries, HIV in South Africa is mainly a disease of the cities. However the conditions exist in rural areas that will promote the spread of the epidemic, and some rural areas are already affected.

4. *The Political Context*

The political situation has also affected the way that people can respond to the HIV epidemic:

i) The State has shown itself to be incompetent in dealing with the epidemic. Many examples can be cited:

- the "coffin campaign"[12]
- repressive legislation: people who are HIV positive can be deported
- there is no free condom supply for the prevention of HIV
- there are no gay, black or female members of the Advisory Group on AIDS
- no clear and consistent epidemiological picture of the spread of the HIV epidemic
- the health services have fallen apart and are unable to respond to new demands for funds and staff on a significant scale.

ii) Organizations that represent people and could take on the responsibility of steering campaigns against HIV have been harassed and smashed during the State of Emergency. Now that organizations are reestablishing themselves, they face enormous organizational challenges which leave few resources available for organization around HIV. For example, although Alexandra Clinic has a program on STDs and HIV and while the clinic has good community links, the structures for work in the community were harassed to such an extent that it has not been possible to develop a community program. Now that community organizations are functioning again the clinic can develop a community program.

iii) Progressive health organizations are consumed by activities involved in both defending people against the aggression of the State and dismantling apartheid. Activities such as caring for detainees, exprisoners and returnees, providing care for people injured, or the hospital desegregation campaign have taken up the time of much of the available personnel. More recently there is a need to work towards the reconstruction of health services in the future. These programs compete with organizational resources that are needed to develop large scale AIDS campaigns.

---

12 Editors' note: This is a reference to the Department of National Health and Population Development campaign which illustrates a coffin being lowered into a grave. De Wildt and Zwi in this volume criticize the inappropriateness of promoting fear in educational programs.

RESPONSES TO THE HIV EPIDEMIC IN THE HEALTH SECTOR

This section attempts to analyze briefly the way in which health workers have responded to the epidemic of HIV and AIDS. Specialist health workers such as laboratory and research workers, epidemiologists, community health personnel, and hospital clinicians were the first to become involved. Health workers from alternative structures were often the first to initiate patient based programs. The state primary care services have been the last to get involved, but in the long term they are the most important services to provide for the AIDS epidemic in the community on a large scale.

1. *Response of Soweto Health Services*

   At Baragwanath Hospital, researchers screened patients for HIV without pretest counselling or informed consent. Thereafter people infected with HIV needed to be cared for. Minimal services were provided for them, such as inpatient AIDS education and counselling or outpatient care (which was not sustained properly).

   Hospital workers have often tended to retain patients for follow-up, possibly for research reasons. Workers in primary health care (PHC) will have to initiate their own appropriate PHC based service and develop links with the hospital services. PHC workers are often more sensitive, hence slower to initiate testing. There is therefore not such an urgent need felt to start services for people who are HIV positive.

   Some work has been done to prepare staff for the HIV epidemic, but there are still some problematic responses to people with HIV based on fear. Nurses have not developed advanced educational methods appropriate for AIDS education.

   The nature of the clinic structure means that it will take time to develop and implement a primary care program. However once established it will reach a very large number of people.

   The preventive services in Soweto have only recently started a program on HIV/AIDS, although the central Johannesburg preventive service has probably the most developed program in the country.

   A number of comments can be made:

   i) Work on HIV in Soweto demonstrates once again the disastrous effect of the fragmented apartheid health system. At least, Soweto has an integrated health

service on which coordinated services for people with HIV could be built. Many areas are not fortunate.

ii) Screening of black people for HIV without pretest counselling and informed consent appears to be standard practice for researchers in this country. The screening of blood for transfusion falls into a different category and is obviously essential.

iii) Services for people who are HIV positive are often developed as a result of research that identifies infected people. This was part of the reason why specialist AIDS centers were set up by the South African Institute of Medical Research.

iv) Awareness starts amongst specialized health workers who are the first to work on the problem of HIV. Researchers and community health workers then get involved. Primary care workers are the last to set up a patient based program.

v) Alternative services may get involved at an earlier stage because they have a more flexible structure. They are likely to draw on experienced specialists to develop a patient based program. In this way they pioneer the health worker approach to HIV and AIDS. However they are unlikely to service large communities in the long term.

vi) Throughout the health services there are people thinking about HIV and AIDS. They need training and support to develop appropriate programs. AIDS programs compete with other services for funds, staff, training, and resources at a time when health services are collapsing.

vii) Hospice and the Township AIDS Project plan to provide patient based services for people with AIDS in Soweto. Will they be allowed to link with existing services?

viii) The health services appear to have done no community-based education on HIV and AIDS. Patients receive only limited education when they attend the clinics.

2. *Responses by community-based organizations*

A variety of community-based organizations have responded to the problem of HIV and AIDS. They have generally been started by concerned and aware individuals, associated with health workers servicing the organization and as a result of a variety of influences such as members who are HIV positive, members who are concerned about HIV, or outside influences such as discrimination.

The process with which organizations have come to grips with AIDS follows a typical pattern. The organization develops an analysis of HIV/AIDS as it affects that organization in terms of its major functions - this is essentially a sociopolitical analysis. Health workers contribute information on "AIDS content". They may or may not be involved in the full process. Once the organization has developed a position on HIV and AIDS it has to address a program to implement what it sees as being an appropriate intervention for its members. This usually includes work on the causes of AIDS or specific education orientated to the prevention of the spread of HIV. AIDS education is then integrated into existing education and health programs such as those concerned with women's reproductive health, fertility, cancer of the cervix and sexually transmitted diseases.

3. *National Union of Mineworkers*

It is useful to look at the example of the National Union of Mineworkers[13]. The impetus for working on AIDS did not come from the membership but from the leadership who became aware of the problem and worked on it. Outside influences on the union around HIV were largely negative such as the management program on testing and education and the keen interest of the media and researchers. This made it more difficult for the leadership to find a constructive way of responding.

The union had to integrate the problem of HIV and AIDS into the general union program. This integration and political analysis was done within the union by nonhealth workers and without the need for help from health workers. (Health workers in fact learned from the NUM process). The union developed an organizational position at its national health and safety conference. From there officials and union office bearers have to develop an AIDS education program. However, other priorities compete with these tasks, and the union finds it difficult to identify the resources necessary.

Youth organizations tend to say that they are directly involved in a political struggle that demands all their energy. If there are subgroups that can take up the issue of HIV

13 Editors' note: See article by Bafana Seripe in this volume, as well as the statement on AIDS from the National Union of Mineworkers.

disease, it is likely to be people addressing health and welfare - women or youth from more stable communities that are not simply fighting for survival and basic issues like housing, jobs, and education.

This interpretation, however, reflects a perception that health is a separate agenda that will be addressed if there is time and there are not more pressing issues. Experience shows that if health is a separate agenda and AIDS is just one item on that agenda, then organizations are unlikely to get a round to doing anything active on AIDS. The present political climate of building the future lends itself to addressing concrete problems such as jobs, housing, education, lifestyle, and recreation. If AIDS education is built onto these programs, it will involve adding an AIDS dimension to existing discussions.

If we aim to set up separate structures and education for HIV and AIDS, it is likely to remain a very small program reaching small numbers of people who are probably not those who need it most. The Workplace Information Group method developed for AIDS education reflects this approach[14]. As health workers, we need to guard against our natural tendency of giving both health and ourselves a separate and special role. We risk mystifying health to the point that it is out of the reach and control of people and where, for example, AIDS education would require a trained health worker to carry it out. The challenge is for health workers to understand how organizations work and to learn organizational skills to integrate health work into the major ongoing activities of organizations.

ACHIEVEMENTS AND LIMITATIONS OF COMMUNITY-BASED ORGANIZATIONS

The role of the community-based organizations can be summarized as i) identifying AIDS as a problem; ii) analyzing the problem of AIDS and interpreting it politically; iii) integrating the fight against AIDS into broader political programs; iv) committing itself publicly to fighting against AIDS; and v) communicating its concern both to members and nonmembers.

This is the challenge of the immediate period. As already described, good progress has been made by unions but minimal progress by youth organizations. Many other organizations such as the churches are part of the way through the process.

Much has been done in the face of severe difficulties, but it remains distressing that this activity is not enough to make a significant difference to the spread of the HIV epidemic, which is already spreading silently in our communities. Much more is needed.

---

14 Editors' note: See article by Bafana Seripe for more discussion of this. The workplace Information Group is based in Johannesburg and services community organizations and trade unions concerned with health issues. (Workplace Information Group, PO Box 5244, Johannesburg 2000).

At this stage what is required is the practical implementation of large scale programs for the prevention of HIV starting in 1990. This requires a scale and speed of organization around health which we have previously neither attempted nor achieved. Most health work in the progressive sector follows upon organizational progress rather than leads it. The HIV epidemic throws us into a rather unfamiliar world where we have to use a variety of resources to reach very large numbers of people in a short space of time. It is not realistic to expect the communitybased organizations to take the major responsibility for implementing AIDS prevention programs. Large scale implementation will rely heavily on additional resources such as health organizations of various kinds.

What then is the role of the health organizations and specifically the progressive health organizations?

THE ROLE OF THE POLITICAL HEALTH ORGANIZATIONS

Health workers obviously have a key role in work on HIV and AIDS. There are a number of obvious areas of activity: i) persistently raising the issue in various settings; ii) assisting organizations to address the problem of AIDS and to integrate it into their existing programs; iii) implementing preventive programs within both the state sector and the progressive sector; and iv) providing services for people with HIV and AIDS.

All the progressive health organizations have addressed the problem of HIV and AIDS in some way. Most have plans for implementing practical programs in 1990. Many of these plans recognize the need to employ fulltime workers to sustain programs on a significant scale.

It is not the role of this paper to summarize or comment on those programs. They should be discussed by the organizations themselves in whatever forum is organizationally appropriate for them. However, the following comments aim to stimulate discussion around the role of those organizations and how they work with other health organizations involved with HIV and AIDS.

Firstly, the answers to HIV and AIDS lie in the community and not within the walls of a health institution. This reality confronts health workers with the challenge of integrating health problems into a community setting. Many of us are not trained or experienced in this type of work. Some people within the ranks of the progressive health organizations can develop the skills to assist the community-based organizations to develop programs on AIDS. If the approach is unsophisticated, it may well alienate those one is trying to persuade. A major challenge of AIDS work is that it requires a sophisticated approach. Where we are successful

we will have learned methods of mobilizing people around health that will inform our work in other areas of health.

We should avoid setting up AIDS as a separate issue and should aim to integrate it into existing organizational structures within both our own and community-based organizations. In primary care we need to integrate the care of people who are HIV positive or who have AIDS with other services.

A number of examples spring to mind:

i) We experience problems when AIDS work is allocated to a small working group within our own organizations. In such circumstances HIV and AIDS do not get full organizational support from the main structures of the organization.

ii) HIV education work can be integrated with the whole area of sexuality, sex education, fertility and fertility control, and sexually transmitted diseases. While these are not a well developed aspect of our struggle, they deserve attention in this period of building a future society.

There are different kinds of organizations involved with AIDS in the health sector. It may be useful to analyze their roles, strengths, and weaknesses in order to understand how organizations can complement each other. The undesirable alternative is that organizations compete with each other in areas where they, in fact, have different roles and resources, and where debate or cooperation are indicated.

At present we have three main types of organization: i) health based organizations such as AIDS units/specialized AIDS organizations, AIDS Center at Johannesburg, City Health Department, and State health services providing services on AIDS; ii) community linked organizations with services on AIDS such as Workplace Information Group and Township AIDS Project; and iii) the political health organizations such as the South African Health Workers Congress (SAHWCO), South Africa Black Social Workers Association (SABSWA), National Education, Health and Allied Workers Union (NEHAWU), and the National Medical and Dental Association (NAMDA).

The health organizations have the most limited resources. This may change if funds are raised to employ fulltime staff. However these organizations have special roles such as i) working with community based organizations; ii) campaigning on AIDS in their own right both amongst membership and in a public political way; and iii) working through members who work within state and private services where they are involved in developing services and policies and doing appropriate research.

The health based organizations tend to have the biggest resources, for example, the AIDS Center in Johannesburg has 12 fulltime employees. They also tend to be narrow in their analysis of HIV and AIDS and more distant from the realities of the community. However they will be the services that provide large scale care to people with HIV in the long term. In practice they provide resources for the political and community linked organizations such as training in counselling.

The community linked organizations with services on AIDS have a very special role. They are fulltime in the field and at present the most effective implementation of organizationally appropriate programs.

THE ROLE OF THIS CONFERENCE

This conference throws up a number of questions for us.

1. *What can this conference achieve?*

   People attending the conference may have high expectations of what the conference can achieve for the development of work on AIDS within South Africa. However, a serious limitation that we should note is that most of the people in the progressive sector who are involved in AIDS work in practice were not able to attend the conference. Many of their organizations are not formally represented here, nor were they in the organizational process that preceded the conference. We should therefore carefully work out what this conference can achieve and what it should not set out to achieve. Several people within the country have identified the need for an internal workshop involving all the people involved in AIDS work in the progressive sector. This needs to be explored further.

2. *What kind of structure do we need for AIDS work?*

   AIDS work within our organizations and between our organizations has not been well structured. For example, there was no obvious structure for consultations for this conference. There is also therefore no clear structure for organizing an internal conference. What do we do about the lack of structure for AIDS work within the country?

   Many of us have put effort into the Progressive Primary Health Care (PPHC) AIDS Forum as a structure to maximize unity in work on AIDS. Does the PPHC provide the kind of structure we need? Unity and constructive cooperation are critical to an effective impact on the HIV epidemic. What is our commitment to unity and how does it work in practice?

At present we do not have organizational conflicts on AIDS. But we do have individuals, both within and outside the progressive movement, who are developing careers on AIDS that affect the progressive sector. If so, how do we avoid this?

We do clearly need a structure that will ensure that momentum is maintained and progress evaluated.

3. *The ANC and AIDS*

Many organizations within South Africa have said that they would like to know what the ANC is doing about AIDS and what its public commitment on AIDS is[15]. A variety of organizations see that the ANC has an important political role to play addressing the HIV epidemic and acknowledging the important role of the progressive movement and HIV and AIDS.

Different organizations have very different practical understandings of what this means for the ANC. Some would expect ANC leadership to make a public statement on AIDS without understanding that such a statement would need to reflect an organizational process such as took place within the National Union of Mineworkers. If we all want to talk to the ANC about AIDS, how do we go about it? We do not have a national structure. Is it up to individuals?

We hope this conference will generate debate on some of the solutions to these problems.

---

15 Editors' note: See the article in this volume which indicates the concerns of the ANC. At the Maputo Conference, an executive member of the ANC indicated that the Maputo Conference had helped indicate the seriousness of the situation and that the organization would take a greater role in developing strategies for the control of the disease. The Maputo statement on HIV and AIDS in Southern Africa echoes the conference participants' belief in the important role of the ANC.

SUMÁRIO

Este artigo analisa a reação ao HIV e à SIDA pela perspectiva das organizações progressistas da comunidade, de trabalhadores e de saúde. Sugere porque a doença não parece ser real para organizações de base da sociedade. Examina quais os aspectos da vida sul-africana que promovem a propagação da infecção como por exemplo: famílias que migram, rápidas mudanças sociais e a luta básica pela sobrevivência. São descritas ações contra a epidemia desenvolvidas pelos serviços de saúde, organizações de base da comunidade e por grupos políticos de saúde. O artigo conclama aqueles envolvidos no campo para estabelecer estratégias e mecanismos apropriados que alcancem algum impacto sobre a doença na Africa do Sul. O artigo sugere métodos para trabalhar com SIDA no setor saúde e no movimento progressista. Este artigo tem como objetivo estimular a discussão sobre como se organizar em torno da questão da SIDA. Questiona se nós estaríamos preparados para retornar às nossas organizações para iniciar um trabalho com SIDA. Indaga como vincular as informações e discussões em encontros, como por exemplo este congresso, com a organização e a ação na Africa do Sul.

AIDS: ISSUES AND POLICIES FOR WORKERS AND UNIONS

Bafana Seripe

Workplace Information Group
P.O. Box 5244, Johannesburg, South Africa 2000

ABSTRACT:

AIDS in South Africa cannot be divorced from the sociopolitical and economic context in which it arises. The migrant labor system establishes conditions which facilitate the transmission of HIV infection. The trade union movement has responded to the discriminatory stance adopted by employers and the state. The unions have argued for an end to the migrant labor system, time off for HIV and AIDS education, doing away with discriminatory practices and job security, and care for those affected. Progressive health and safety service organizations have a major role to play in assisting the unions to educate their membership and to formulate their demands.

INTRODUCTION

AIDS was first identified in South Africa in 1982. Since then there has been a slow process of making people conscious of the potential human loss and suffering of an AIDS epidemic in South Africa.

In many parts of the world the government has been able to take an important role in AIDS education. In South Africa we cannot rely on the government to educate the people. It has been recognized for some time that the progressive movement will have to take much of the responsibility for AIDS awareness and education. The progressive trade union movement will play an important part in this process. We as health and safety service organizations (HSSOs) are involved in this process with the unions.

HSSOs operate in four regions of South Africa. Our broad aim is to assist unions to develop organization around health and safety and to improve hazardous and unsafe conditions in the workplace. Our work includes training and education workshops, factory inspections, industrial hygiene monitoring, and the provision of technical and medical assistance with occupational health problems. Our approach to health and safety is not a narrow hazard related approach but is rather one of "health of workers" which encompasses broader health issues like access to health services and AIDS. This approach recognizes that work related health issues cannot be separated from broader health issues.

CONTEXTUALIZING AIDS

AIDS in South Africa cannot be seen in isolation from the socioeconomic and political conditions of people's lives. AIDS as a sexually transmitted disease needs to be seen in the context of the realities of people's lives, realities imposed by the oppression of apartheid and the exploitation of the working classes under capitalism.

Experience in some other parts of the world has shown that those who suffered most from HIV infection and AIDS are often marginalized in society. In South Africa the majority of people are denied access to political power, adequate education, living conditions, health care, jobs, a living wage, and many other things that impact on the health of people. It is these people who will bear the brunt of the suffering in an AIDS epidemic.

In the workplace, the health and safety of workers is one of many areas of conflict to be fought and won by the workers. AIDS has become part of the process. Unions need to take the initiative to develop and confront bosses with progressive strategies to deal with AIDS in the workplace. They need to combat the strategies of dismissal, victimization, repatriation, and discrimination, which have faced the labor movement elsewhere and which are already evident in the South African workplace.

Discussing "AIDS in the workplace" raises two important areas of activity for workers and unions:

i) education of workers to raise their consciousness about AIDS and to inform them so that they can make important and informed choices about their sexuality.

ii) development of policy for negotiations around issues of dismissals, repatriation, pre and post employment testing, screening, inadequate medical care, and the migrant labor system.

MIGRANT LABOR AND AIDS

Denied access to land and jobs, many people are forced to leave their homes and families to seek work. The migrant labor system has long provided the workplaces of South Africa with cheap labor. This forced separation of families causes men and women to be separated for long periods of time. Men and women who are away from home for long periods may seek companionship and comfort in new relationships.

In the rural areas, women left behind may also take lovers for comfort, companionship, and financial help. Women also migrate to seek waged employment. Many women, denied access to a meaningful place in the economy, may need to sell sex to survive.

The more sexual partners a person has, the greater the risk of contracting a sexually transmitted disease like AIDS. It is clear, however, that merely addressing people's sexuality will not solve the problem. We also have to challenge the socioeconomic and political conditions of people's lives.

HOW EMPLOYERS AND THE STATE HAVE RESPONDED

AIDS is an issue for employers. They identify the AIDS problem for themselves in the context of investment of resources and short term gains. In addition they fear investment in "benefits" like medical cover or death benefits, which will involve them in pay outs after short terms of service. The main concern of employers is to protect their interests. This can be done by:

- pre employment screening of applicants for HIV
- not employing HIV positive persons or persons with AIDS
- periodic testing of the workforce (despite the fact that this is unethical and illegal without the informed consent of workers, there are reports of this being done without consent)
- dismissal of HIV positive workers (this constitutes unfair labor practice but is a difficult issue to contest).
- dismissal of workers with AIDS (the law says that workers cannot be dismissed unless they are unable to carry out their work - this is an area of struggle still to be contested - at what point is a worker unfit for work and who decides this?)

Management and fellow workers may respond negatively to working with someone who is HIV positive. There is no health basis for victimizing or firing a worker who is HIV positive or has AIDS. AIDS cannot spread from one person to another through casual contact such as occurs in the course of a normal day's work. The fact that such discrimination does take place is usually a reflection of people's lack of information and uninformed fears about the disease. Often management and the other workers do not know what HIV infection is. They think they can get AIDS through casual contact with someone infected with HIV. Management and workers need to know more about AIDS so they do not victimize people who are HIV positive or have AIDS.

Some work situations do put people at potential, but low, risk i.e. health workers, firstaiders, and workers exposed to blood in accident situations. Protocols for safe work practices need to developed. Adoption and adherence to these will reduce the risk and allow for people to proceed with the work more confidently.

This paper will now briefly examine at the Chamber of Mines response to AIDS as a practical example of some of the issues discussed. This example also shows how the relationship between capital and the state has worked against the interests of workers.

THE CHAMBER OF MINES, THE STATE AND AIDS IN THE MINING INDUSTRY

AIDS in the mining industry was first brought to attention in 1987, after the Chamber of Mines screening results were made known. This screening was done without consultation with the National Union of Mineworkers (NUM), without consent, and without informing the workers. In spite of this, the screening was not done anonymously.

The results of this screening had a number of repercussions. Certain areas of origin of migrants, such as Malawi, were identified as high risk areas.

In October 1987, the government implemented two sets of regulations. These are regulations (Government Gazette no. 11014, no. r2438, 30/10/1987) amending the Health Act (Act 63 of 1977) and (Government Gazette no. 11014, no. 2439, 30/10/87) affecting the Admissions of Persons to the Republic Regulation Act (Act 59 of 1972).

The effect of this was:

i) HIV and AIDS were defined as communicable diseases: this means that health authorities can conduct compulsory testing if they have a "reasonable suspicion" that someone has a communicable disease.

ii) People coming into the country to seek work can be tested for HIV: if the worker is HIV positive or has AIDS he or she will not be allowed to enter the country.

iii) The Minister of Home Affairs can declare "foreigners" with certain diseases, including AIDS and HIV, to be prohibited persons: this means they cannot enter or remain in South Africa.

iv) The new regulations now make it a crime not to inform the State Health Department about HIV carriers. Even if employers like the Chamber of Mines say that screening

information is confidential, the government can by law obtain access to the names of HIV carriers and carriers can then be deported.

The implications of this are obvious. People from areas identified as high risk areas may no longer be considered for jobs in South Africa, particularly in the mining industry. Employers like the mining industry can practice passive repatriation, i.e. they may not immediately dismiss a HIV positive worker, but that person will simply not have his or her contract renewed.

Within South Africa, the government defines the large majority of South Africans as belonging to one or other of the bantustans. These areas are poor, lacking the services and infrastructure to deal with an AIDS epidemic. Historically, sick workers have been dismissed to the bantustans which have often been used as dumping grounds for welfare and health problems, for example, people with tuberculosis or asbestos related disease. Any attempt to perpetuate this policy with respect to AIDS will need to be challenged.

When workers with HIV or AIDS are repatriated or sent back to the "homelands", they take the infection with them. HIV can then spread to their families and other people in the places where they live. Often the people are poor and there are no clinics or doctors, so they cannot get proper care. By sending people home, the government is helping AIDS to spread. This kind of action is also going to force the disease underground: people will avoid testing even when they are concerned, and they will likely avoid seeking treatment for other sexually transmitted diseases if they know that they are at risk of losing their only source of income, their jobs.

The implications of the new regulations were obvious for mine workers. The union resisted. The Chamber then adopted the following policy:

i) The mining industry will not discharge people who are HIV positive if they are fit to work.

ii) The industry can, however, refuse to renew contracts of infected people when they seek reemployment.

iii) It will counsel people about the effects of AIDS and how to avoid spreading AIDS - the Chamber has no education program for workers who do not have AIDS.

iv) If a mine worker develops AIDS and becomes too ill to work, he will be repatriated on medical grounds.

v) Known HIV carriers will not be employed; all recruits from areas where AIDS occurs frequently will be screened before being considered for jobs.

vi) All workers with sexually transmitted diseases will be screened at mine clinics.

For some time the National Union of Mine workers has been negotiating with the Chamber of Mines over the AIDS issue[16]. This process is confidential. The issues which affect the NUM also affect other unions. What are some of these principles?

HOW HAVE THE UNIONS RESPONDED TO AIDS?

A number of unions are taking up the issue of AIDS. This response may be motivated by several factors:

i) Union membership might be directly affected by socioeconomic conditions that put them at risk of HIV infection, such as migrant labor and hostel living.

ii) The larger unions may have the resources to set up health and safety committees and take up AIDS.

iii) There is a need to respond to management initiatives around testing, screening, victimization and dismissal of HIV positive workers etc.

The union approach to AIDS is to protect their members from discrimination, to educate membership about AIDS, to identify and challenge the socioeconomic conditions which put their members at risk, and to develop policy for addressing these issues. These include:

i) Challenging the migrant labor system, hostel living, housing shortages, and economic exploitation. It is not the sexuality of workers that needs to be challenged, but the conditions which determine people's lifestyles.

ii) Negotiating time off for workers for AIDS education: unions recognize the urgency of bringing the AIDS message to their members. They are developing, together with service organizations, a progressive approach that contextualizes people's sexuality within the realities of their lives.

16 Editors' note: See the National Union of Mineworkers statement on AIDS which is reproduced in this volume.

iii) Challenging discriminatory labor practices: this includes unethical and unnecessary testing and screening practices, exclusion of HIV positive people from employment and/or medical cover, dismissal of HIV positive people, and repatriation. The unions want to negotiate for job security for HIV positive workers and benefits, compassionate treatment, and protection for workers incapacitated by AIDS. Ethically, the testing of workers must be done with their informed consent and pre- and post- test counselling. Unions recognize the validity of epidemiological screening, but believe that this must done anonymously with the informed consent of workers and needs to be negotiated with unions to avoid the information being used against workers, as was the outcome of the Chamber of Mines screening was in 1987.

In 1989 many unions made important progress around AIDS and AIDS education, with unions assuming an increasingly leading role. A number of resolutions around AIDS were taken by COSATU and its affiliates, e.g., the COSATU resolutions, COSATU women's group resolutions, and resolutions at the negotiations. The NUMSA study group decided to make AIDS a priority in 1990, and the education work undertaken by unions like TG&WU and NUM are all indications of the progress made.

WHAT THE HSSOs ARE DOING

Our role has been to assist unions with AIDS education and to develop an approach to AIDS issues. This has been done by:

i) Providing information that would be accessible to union members - this includes two booklets written by the Workplace Information Group (WIG) and the Industrial Health Research Group (IHRG).

ii) Running workshops for workers to help them develop a progressive approach to dealing with AIDS, as well as planning how to spread these ideas to fellow workers.

iii) Having ongoing discussions with unions to identify their needs and respond accordingly.

iv) Collecting resources locally and internationally as a service to unions.

AIDS EDUCATION WITH UNIONS

The Workplace Information Group in the Transvaal has done a number of education workshops with unions in the region. This has been an interesting process of developing

appropriate AIDS education for responding to the needs of unions. WIG approaches AIDS education within the context of the socioeconomic and political experience of workers. The program tries to create a balance between people's sexuality and the conditions which determine and impact on people's lifestyles. WIG avoids a lecturing approach to teaching and instead uses workshopping skills to draw on workers' own experiences and knowledge of AIDS and "fills in the gaps" revealed. A lot of time is spent getting workers to identify their own worries, questions and needs. A lot of time is put into "breaking the ice" and doing a role play that draws in the audience. The WIG educators themselves talk freely about sex and sexuality and usually introduce condoms early on the program - blowing them up and playing with them like balloons, getting people to laugh about them.

The audiences have been adult male workers, mainly shop stewards. The educators are "the WIG AIDS Group," which is made up of a black male and black and white women. So far this has not impeded the communication process. We have not, however, run mixed workshops for any union, so cannot comment on this.

Our experience has been that people:

- contribute a lot to the discussions.
- often ask interesting and pertinent questions.
- often talk freely about their relationships and sex - their worries and concerns.
- talk about condoms and argue about what is good and bad about them.
- do come out of the workshop with changed perceptions about AIDS, e.g., accept that AIDS exists and needs to be taken seriously.
- leave the workshop with goals for how to take up the issue: this always includes ways of impacting on their socioeconomic conditions, e.g., long distance truck drivers will want to negotiate for shorter absences away from their families.

CONCLUSION

There is still a lot of work to be done around the issue of AIDS in the workplace and in the community in general. The unions will have to consolidate their work in the area and provide more education to members. The role being played by service organizations has been important, and we plan to consult with the unions in the ongoing work around AIDS.

SUMÁRIO

A SIDA na Africa do Sul não pode ser separada do contexto socio-político e economico no qual se insere. O sistema de trabalho migratório estabelece condições que facilitam a transmissão da infecção pelo HIV. O movimento sindical tem respondido à atitude discriminatória adotada pelos empregadores e pelo Estado. Os sindicatos têm reivindicado o fim para o sistema de trabalho migratório, tempo livre para educação sobre SIDA, fim das práticas discriminatórias, estabilidade no trabalho e garantia de atendimento médico para trabalhadores afetados. Organizações progressistas dos serviços de saúde e segurança têm um papel a desempenhar auxiliando os sindicatos a educar seus filiados e a formular suas demandas.

NATIONAL UNION OF MINEWORKERS - STATEMENT ON AIDS

National Union of Mineworkers

Johannesburg, South Africa

The National Union of Mineworkers approaches the negotiations in an AIDS policy for the mining industry with the realization that the implications are momentous. The results are likely to affect the quality of life of millions of people, not only mineworkers and their families. Employers in other industries are likely to take their cue from these deliberations, and some of the principles regarding major public health issues will have been established through them.

The NUM proposal involves eight principles and is guided by the recommendations of the World Health Organization and the International Labor Organization, the "London Declaration on AIDS Prevention of the 28 January 1988," and the Global Program on AIDS "Statement from the Consultation on AIDS and the Workplace" (Geneva 27 - 29 June 1988) as well as the Panos Institutes AIDS Unit's publication "Blaming Others. Prejudice, race and worldwide AIDS" (1988).

The principles read as follows[17]:

1. *No discrimination on the basis of HIV infection*

   An AIDS prevention program should be directed to the protection of the human rights of HIV infected persons. The Chamber's document of 4 August 1989 refers to "...the need to treat those with HIV infection or AIDS with due compassion and with full regard for the dignity of rights of the individual". We believe that this principle should be implemented.

   1.1 Safeguards for individual workers: No worker who is HIV positive should suffer any adverse consequence. Dismissal on the basis merely of HIV infection is not defensible policy.

---

17 Editors' note: This document forms part of the response to the Chamber of Mines proposed policy on AIDS. It formed part of a letter to the Chamber by the General Secretary of the NUM, Cyril Ramaphosa, on 28 January 1990 and is reproduced here for information.

1.2 Safeguards for workers from specific recruitment areas: The prevalence of HIV infection in specified geographic areas should not affect the employment opportunities of workers from those areas. While the NUM recognizes that information about geographic prevalence may be important in planning and assessing the efficacy of AIDS education campaigns, regional employment discrimination is irrational and does not constitute an effective response to the disease.

2. *No patient specific testing*

No individual worker should be required to undergo an HIV antibody test at the request of or upon the initiative of mine management. Where testing is made available to workers, as for instance at sexually transmitted disease (STD) clinics, testing should not occur unless counselling about its significance and its consequences is offered by adequately trained counsellors. Furthermore, test results should not be disclosed to those who have consented to tests without full counselling.

3. *Epidemiological testing*

HIV screening for epidemiological purposes may be justified if the objectives of the screening program are clearly defined. These objectives would, however, have to be accepted by the NUM and be subject to objective evaluation and independent scrutiny. Such screening should, furthermore, be subject to an absolute guarantee of anonymity and confidentiality. There should, moreover, be a guarantee that the results of epidemiological studies will not be used as a basis for irrational and discriminatory employment policies. The report of the meeting on criteria for HIV screening programs, WHO/ SPA/ GLO/87.2, Geneva 20 - 21 May 1987 should constitute the principles underlying any screening intervention for HIV.

4. *Lifestyle changes*

It should be accepted that living conditions may generate circumstances that lead to exposure to HIV infection. In practice this means an obligation to provide decent living conditions in employment. The mine hostel and compound systems are inimical to an effective AIDS containment campaign. There should be a firm commitment, on an appropriate time scale, to the provision of family housing facilities for visiting wives and other members and humane hostel management.

5. *Information, education and counselling through negotiation and consultation*

All mineworkers should have access to information about AIDS. The development of educational material and the training of counsellors should be undertaken jointly between workers and management. Provision should be made for peer counselling. No intervention in the context of AIDS - whether research, counselling, education or information - should be made without appropriate and extensive negotiation and consultation.

6. *Protection after incapacity*

The average time between the development of full blown AIDS and death is between 18 months and two years. Abandoning a worker who may have rendered years of service under these circumstances is inhumane. Incapacity benefits involving medical care and security of income should be provided.

7. *Public responsibility*

The mining industry is in a unique position. It is the major employer of the country's (and Southern Africa's) economy. It is also a large employer which has shaped the labor market to meet its needs. There should be a commitment on its part in regard to the AIDS crisis to the creation of appropriate lifestyles, to the protection of HIV infected persons from discrimination, to the creation of appropriate treatment centers, and to the implementation of effective and duly negotiated measures to assist the containment of the disease.

8. *Independent evaluation*

The NUM recognizes that most interventions required in the context of AIDS are probably unique. But the urgency of the AIDS problem will not tolerate further untimely and inappropriate interventions. It is therefore crucial that all interventions aimed at containing the spread of the epidemic and providing care and counselling for those infected and affected is independently evaluated.

STRATEGIES FOR THE CONTROL OF AIDS IN THE AFRICAN NATIONAL CONGRESS

ANC Department of Health

Lusaka, Zambia

ABSTRACT:

The factors influencing transmission are described. General strategies for the control of the infection are discussed. There is no doubt that the major intervention required is education and information, aimed at inducing behavior change so as to make sex safer. The African National Congress has a major part to play in the education of its comrades, as well as in stimulating appropriate educational and health service interventions in South Africa.

AIDS and HIV infection are a global problem and are endemic in much of central, eastern, and southern Africa. In some areas 15% or more of young men and women of reproductive age are infected with HIV. Approximately one quarter to a third of children born to HIV infected mothers will acquire HIV infection; in the most severely affected areas, therefore, a substantial proportion of the next generation will be infected from birth. Currently, it appears probable that most HIV infected persons will eventually develop AIDS.

In Africa this epidemic is predominantly a heterosexual epidemic.

WHAT ARE THE TRANSMISSION DYNAMICS OF STDS AND AIDS?

For any communicable disease to continue to exist or spread in a population one infected individuals must infect others. For diseases transmitted by sexual intercourse, spread occurs rapidly when infected individuals have sexual partners. These individuals are at high risk of acquiring and transmitting a sexually transmitted disease (STD) and are, in essence, a reservoir of STDs. Given the central role of these high frequency transmitter groups in the epidemiology of STDs, these groups also have a major role in the control of STDs.

There are a variety of groups whose members may be at high risk of infection. These include sex workers (prostitutes), soldiers, policemen, truck drivers (long distance), STD clinic patients, young people, students, barmaids, and people attending conferences away from home). This paper uses Francis Plummer and Elizabeth Ngugi's paper in exploring strategies for the control of AIDS.

GENERAL STRATEGIES FOR CONTROL OF INFECTION

Three general approaches to control of HIV infection are theoretically possible: the prevention of infection (primary prevention), the detection of infection prior to the development of disease (secondary prevention), and the treatment of disease and complications once developed (tertiary prevention).

Available therapy for AIDS and HIV infection are not curative, and thus control through secondary or tertiary prevention is not possible at present. Treatment of AIDS with azidothymidine (AZT) in itself is unlikely to have an important effect on the control of HIV. It seems unlikely that a curative therapy will be available in the near future. Barring the discovery of simple short-course, inexpensive therapy for HIV, drug therapy for AIDS or HIV infection will most probably have a limited impact in Africa.

The ideal form of primary prevention (the simplest, most effective, least expensive) would be a vaccine to provide specific protection against infection. However it seems unlikely that a vaccine will be available within the next few years. We cannot wait while hundreds of thousands of new HIV infections occur before acting to prevent the spread of HIV.

Other strategies for primary prevention depend on the known fact that HIV is predominantly a sexually transmitted disease. The overwhelming majority of HIV infections in adults in Africa are acquired through sexual intercourse with an infected heterosexual partner. Although blood transfusions are clearly responsible for a proportion of HIV infection and other parenteral exposures such as injections may also play a role, control of these routes of infection would have a limited effect on the epidemic. Sexual transmission is also the route of transmission that establishes and enlarges the reservoir of HIV virus for perinatal and parenteral transmission. If we are to control this infection with currently available tools, control of heterosexual spread must be the first goal.

PRIMARY PREVENTION OF SEXUAL TRANSMISSION OF HIV

Logically there are several intervention points which may be used for interrupting sexual transmission of HIV. These are decreasing or eradicating the reservoir, of infected persons, reducing the frequency of exposure of susceptibles, and decreasing the likelihood of infection of exposed susceptibles.

The reservoir of HIV infection consists of HIV infected men and women who are sexually active. Men and women engaged in the purchase and sale of sex (prostitutes and their clients) are one component of the reservoir in many African urban areas. Men and women who acquire sexually transmitted diseases are another, overlapping component. As with

other sexually transmitted diseases, these men and women are the reservoir for dissemination of HIV to less sexually active segments of the population.

Reducing the size of the reservoir can be attempted in many ways. In addressing the cycle of prostitution, the best and most permanent solution would be to reduce the supply of prostitutes by providing other economic alternatives for women and to alter the demand for sex among men through reunification of families and health education. These are long term solutions which we must work towards, but they are of limited immediate benefit. Legal proscription of prostitution has been attempted in many countries and is almost universally a failure. Stricter enforcement of existing laws or new harsher laws is certain to drive the people involved further underground, making other control efforts more difficult or impossible. Education about HIV and other diseases aimed at altering behavior (cessation of prostitution and use of condoms) and improving health services to those affected are the most humane and practical.

Men and women attend STD clinics that are crowded and have long waiting periods. This situation presents an unparalleled opportunity to reach large groups of HIV infected and HIV at risk individuals very efficiently. Posters, lectures, demonstrations, continuously running audiovisual programs, and individual counselling for selected individuals such as those with repeated infections are all potential tools for modifying sexual behavior. Education about and distribution of condoms can also be incorporated into such programs.

HIV testing could be incorporated into each of the approaches described above. However this would enormously increase the complexity and expense of the programs. The added benefit is uncertain because a behavioral change is sought in both those infected and those uninfected. The effect of HIV status on subsequent sexual behavior is also uncertain.

STRATEGIES FOR REDUCING EXPOSURE OF SUSCEPTIBLES

As HIV infection becomes more widespread, individual members of the reservoir will become less distinguishable. This is already true in some African settings. For this reason, activities aimed at the general population must form part of the control strategy. Control activities must also be directed at all sexually active individuals and presexual adolescents. Although no data related to sexual behavior are available, it seems likely that effecting a permanent behavior change is more difficult than preventing the development of a behavior. Perhaps relatively greater efforts should be put into programs directed at adolescents before they are sexually active. Such programs on HIV and other STDs should be presented in schools with sex education, contraceptive education, and health education. This type of curriculum will often be extremely sensitive and meet with resistance. However, this must not impede

implementation. Educating those who react negatively to these programs is part of the task of HIV control.

Every opportunity to educate should be taken. HIV education should be incorporated into appropriate existing health education programs based in family planning services, maternal and child health programs, and the workplace. Separate HIV education programs utilizing mass media (posters, newspapers, radio, television) are very effective means of reaching large numbers of people. Innovative approaches such as mobile educational teams with audiovisual equipment can be developed to reach remote areas or other special populations. In these programs, the messages should include current factual information about the infection and disease, routes of transmission, and risks of indiscriminate sex.

REDUCING THE RISK OF HIV ACQUISITION IN EXPOSED SUSCEPTIBLES

No control program based on modification of sexual behavior will approach full prevention. Everlasting mutual monogamy of the entire populations is not achievable. Once established in a population, HIV will continue to spread despite control programs, albeit at a much lower rate. Even with a few sexual partners, the risk of HIV is substantial given the high prevalence levels reported from several African cities. Strategies to reduce the risk of transmission must therefore complement behavioral programs. Several potentially effective strategies can be devised based on an emerging understanding of heterosexual transmission.

The best method currently available is the use of the condom by the male partner. Education is the first step in promoting condom use. The level of education can be very simple and need not involve efforts directed at individuals, such as one-to-one counselling.

The second and probably most important step is making condoms freely available. Experience in Nairobi with prostitutes showed relatively little change in patterns of condom use as a result of education, but once condoms were made freely available the use of condoms increased rapidly. Both an increased insistence on condoms by prostitutes and an increased demand for condoms by their clients are responsible for this marked change.

Other sexually transmitted diseases seem to play a key role in facilitating the transmission of HIV. In one study of prostitutes, it was found that women who experienced genital ulcer disease and women who acquired cervical chlamydia trachomatous infection were more likely to acquire HIV infection. These infections may act to increase susceptibility of the female genital tract to HIV, either by producing breaks in the integrity of the epithelium or by increasing the number of HIV susceptible target cells (activated T4 lymphocytes) in the genital tract. One study of female-male transmission suggests that among men with sexual exposure to an infected prostitute, men who acquire genital ulcers are three to five times more likely

also to acquire HIV infection than are men who acquire gonococcal or nongonococcal urethritis. These data could indicate that increased shedding of HIV occurs in women with genital ulceration.

Given a possible role for conventional STDs in increasing susceptibility of women to HIV and increasing the infectivity of HIV infected women, control of conventional STDs may be an additional strategy for reducing transmission of HIV. For instance, control of chancroid and syphilis in a prostitute population might substantially reduce both the risk of acquisition of HIV among the prostitutes and decrease transmission of HIV by infected prostitutes. Although the efficacy of such a program has not been tested, it seems a reasonable assumption that this would have an important effect on reducing transmission of HIV.

Control of chancroid and syphilis can be achieved through case detection and treatment combined with health education and promotion of condom use. Both diseases can be readily diagnosed clinically or with simple serological tests, can be cured with single dose antimicrobial therapy, and are highly associated with prostitutes and their clients. Innovative approaches to implementation of such control programs will be necessary. Again, organization of prostitutes along primary health care lines with community health workers and participation in the project by prostitutes is one successful model.

CONTROL OF PERINATAL TRANSMISSION

The relative importance of perinatal transmission to the HIV epidemic in epidemiological and public health terms is smaller than that of heterosexual transmission. Currently available evidence suggests that most HIV infected children will develop AIDS and die at an early age. Thus most newborns with HIV infection will not survive for a sufficient time to become part of the reservoir for transmission. Although the death of a child is a great tragedy, the importance to the further spread of the epidemic, as well as the impact on society and the economy, is small when compared to the death of an adult.

The major tool in reducing perinatal infection must be reducing HIV infection in women through control of heterosexual transmission. In addition, known HIV infected women should be counselled about the risks to the newborn, so that they may if they wish, avoid pregnancy. If sufficient resources are available, screening programs in family planning clinics and antenatal clinics to detect asymptomatic HIV infected women combined with counselling could be attempted. Where termination of pregnancy is an option, screening programs to detect pregnant women with HIV infection is an additional potential strategy.

Although the relative importance of HIV transmission through breastfeeding is unknown, it seems that some transmission may occur via this route. In Africa, it is not feasible to advise

HIV infected mothers against breastfeeding as there are no safe inexpensive alternatives for infant nutrition. However, in areas of high HIV prevalence, practices such as sharing of breast milk pools should be managed like a transfusion/blood products service with screening of donors and heat treatment of pooled breast milk (although studies are not available, a protocol similar to that used in preparing Factor VIII concentrate would perhaps be adequate). In Africa, intravenous drug abuse is not a widespread problem. However, the reuse of inadequately sterilized needles and other equipment in medical settings and by "street doctors" or traditional healers is widespread and undoubtedly contributes to the spread of HIV. The size of this contribution is uncertain. In formal medical care settings, switching to oral therapy and provision of disposable injection equipment is a simple but costly solution. Reeducation of health workers and provision of adequate facilities for sterilization is the most practical strategy for much of Africa. Tackling the problem of the use of inadequately sterilized needles by unlicensed practitioners will be more difficult. Because they are often illegal, approaches to educating them may be extremely difficult. Perhaps the most effective strategy would be to educate customers about the risk of this type of injection.

On the surface, prevention of transmission of HIV by blood transfusion seems straightforward. Strict medical indications for blood transfusions must be observed. Combined with donor deferral (perhaps based on history of STDs or number of sexual partners), screening of donated blood should be simultaneously implemented. However, inadequate or nonexistent transfusion services, lack of trained personnel or equipment, logistical problems, and financial constraints complicate these programs. Considerable support for ongoing management will be necessary. A large input of external resources will be required before the blood supply is safe.

THE ANC RESPONSE

The African National Congress cannot escape the epidemic since many of its exile communities are in countries with established epidemics. South Africa is just at an early stage of the epidemic so it is critical that a national campaign should take root now if we are to avoid the catastrophic epidemic that other African countries are experiencing, the magnitude of which is only beginning to be understood.
Some people could argue that it is not necessary for the ANC to spend resources on an AIDS campaign because the host countries have national intervention programs from which we should benefit. However there are very compelling reasons why the ANC has to make a start on AIDS control.

The ANC communities are unique in a number of ways. There are language and cultural differences between ANC people and host countries that limit the benefit from local education and intervention strategies. ANC people are highly mobile, and, depending on deployment,

families are frequently unable to live together. This poses a problem for the one partner strategy. The communities are also very closeknit, and there is a great deal of mixing in terms of relationships that creates a potential for high rates of transmission even though the reservoir may be small.

The ANC therefore has a duty to develop a strong campaign for the control of HIV infection. There is also the important aspect of providing support and counselling for those who are HIV positive or ill from HIV disease without ostracizing, stigmatizing, intimidating, and discriminating against those affected.

When parents become ill, there will have to be some provision for the children, both emotionally and materially. The ANC Department of Health has an ongoing program to strengthen primary health care activities and to increase the ANC community's understanding of the prevention of STDs including HIV and AIDS. The program is divided into two components: a) education and information and b) strengthening of laboratory resources. This program is spread through all the regions that have ANC communities. Since May of last year, many workshops have taken place at both national and regional levels. Health education is also being given to community members through talks, videos, posters, and leaflets.

The AIDS campaign has to be undertaken not only by the Health Department, but also by a multidisciplinary team if it is to succeed. The ANC needs to incorporate an AIDS campaign in its national mobilization program inside and outside South Africa. As a liberation movement it has the credibility that is crucial in any intervention program in South Africa if it is to be accepted by the people. Unfortunately, the South African regime has used AIDS for its own propaganda, and people are not going to take any other campaign seriously unless the ANC is involved[18].

Some aspects of the struggle can be used as entry points eg. the migrant labor system. An AIDS campaign among migrant workers, for example, would have to be linked with the struggle of those workers for the right to live with their families and their consequent right to proper housing. It can also be used in relation to the demand for rural development, so that men can find employment near their homes and families.

---

18 Editors' note: The conference adopted the Maputo Statement on HIV and AIDS which explicitly acknowledges this important point.

The Trade Union movement and some other organizations have started on an AIDS campaign[19], but this needs to be expanded nationally, while at the same time focusing on those at particularly high risk in terms of infection and transmission, such as prostitutes and soldiers. It is also important to put HIV education into the schools, as previously noted, in order to reach the younger generations before they establish high risk behavior patterns.

Early intervention and prevention is necessary: once a large number of people are ill, their care both in hospital and in the community becomes very costly and may pose problems to the development of a national health system.

AIDS will affect mainly the economically active population and a serious epidemic will have grave economic consequences. Many children will be born infected with HIV if large numbers of women are HIV positive. In addition, large numbers of children will be orphaned, resulting in serious social problems for the state, the community, and the children themselves. In countries like Uganda and Tanzania there are tens of thousands of orphaned children as a result of AIDS and governments are finding it impossible to cope. We are fortunate in that the epidemic is reaching Southern Africa last, so that we are able to learn from the experiences of these other countries.

CONCLUSION

The magnitude of the epidemic in Africa is only now beginning to be understood. Progressive groups in South Africa, and particularly the ANC, have to take a lead in the campaign in order to prevent a catastrophic HIV epidemic. While research is racing against time in an effort to develop a cure or vaccine, it is clear that both of these are still years away. Control of HIV infection is still primarily through education, change in sexual behavior, promotion of condom use and distribution of condoms; and control of other STDs. It is up to all of us to make an effort to minimize the effects of the epidemic by being part of the campaign.

---

19 Editors' note: See contribution by Bafana Seripe and the statement by the National Union of Mineworkers in this volume.

SUMÁRIO

São descritos os fatores que influenciam a transmissão. Discutem-se as estratégias gerais para o controle da infecção. Não há dúvidas de que a melhor forma de se intervir é através da educação e da informação, confiando-se na mudança de comportamento que levem a práticas sexuais mais seguras. O Congresso Nacional Africano tem um papel fundamental a desempenhar na educação de seus membros, como também em estimular intervenções apropiadas nos serviços de saúde e educação na Africa do Sul.

SYPHILIS, AIDS, AND THE REPRESENTATION OF SEXUALITY: THE HISTORICAL LEGACY

Megan Vaughan

Nuffield College
Oxford

ABSTRACT:

The outbreak of an apparently alarming epidemic of syphilis in Uganda was debated in the British medical press in 1908. It was argued that the epidemic resulted from the uncontrolled sexuality of African women. It was only subsequently learned that much of the epidemic had been misdiagnosed and was, at least in part, a form of nonsexually transmitted syphilis. Nevertheless it had allowed the construction of language and ideas that contained themes that had racist connotations of African sexuality as well as blaming women. Social scientists and health activists must challenge these notions of sexuality and need to develop a more positive language in which issues around sexual relations are discussed.

INTRODUCTION

A debate unfolded on the pages of the Lancet and the British Medical Journal in 1908[20]. Some of its significance, I think, is self-evident. The debate concerned the causes of an apparently alarming epidemic of syphilis that had broken out in the Uganda Protectorate. In both journals, the debate began with an account of a paper recently presented by Colonel Lambkin, an officer of the Royal Army Medical Corps, entitled "An Outbreak of Syphilis on Virgin Soil." Lambkin, addressing an audience of British medical practitioners, described a situation in which syphilis was so widespread that an estimated eighty percent of the population of Baganda was infected, and in which a resulting infant mortality rate of fifty to sixty percent threatened the very survival of what he described as the Baganda 'race'. The causes of this outbreak, according to Lambkin, were three: the introduction of Christianity, the abolition of previously severe punishments for sexual offenses, and opening up of the country to traders from the East. In his analysis, Lambkin laid great stress on the notion of Uganda as a 'virgin soil' for the disease, which had spread in a devastating way amongst people whose vulnerability had been created by the disintegration of their traditional social and

20 For a longer account of the history of the Uganda syphilis epidemic, see Vaughan (1991).

political system. In particular, he laid stress on the effects of this in increasing the 'freedom' of Bugandan women. The Lancet took this point up in an editorial:

> *"The freedom enjoyed by women in civilized countries has gradually been won by them as one of the results of centuries of civilization, during which they have been educated...Women whose female ancestors had been kept under surveillance were not fit to be treated in a similar manner. They were, in effect, merely female animals with strong passions, to whom unrestricted opportunities for gratifying these passions were suddenly afforded".*

FEMALE SEXUALITY

Before too long a general consensus had developed between missionaries, British officials, and the Baganda male hierarchy that 'female passions' lay at the heart of the problem. Lambkin was placed in charge of a Commission to investigate the problem of syphilis in Uganda, to which a large number of chiefs and headmen gave evidence. They all insisted that in traditional Baganda, women had been placed firmly under the control of men. As the Prime Minister, Sir Apolo Kagwa, put it:

> *"The probable immediate cause of the outbreak is the emancipation of Baganda women from the surveillance to which they have been hitherto subjected".*

Lambkin diagnosed social disintegration and prescribed a bolstering of chiefly authority. The Baganda chiefs, not surprisingly, welcomed this idea wholeheartedly. They provided tribute labor for the building of Mulago hospital (which was originally solely for the treatment of venereal diseases), they passed legislation to ensure the compulsory attendance of victims of the disease at clinics, and they were enthusiastic over the compulsory examination of women. At one meeting they even suggested that every Muganda should be compelled to carry a certificate of examination issued by the medical department.

MORAL PANIC

The early years of the twentieth century in Baganda, then, saw a full-scale moral panic. For the British the problem of syphilis epitomized the dangers and difficulties of colonial rule and brought to the surface their own peculiar psychological vulnerabilities. Though medical solutions were sought and applied to the problem, the real danger as they saw it lay in an uncontrolled African sexuality and particularly in an uncontrolled African female sexuality.

This they saw as bringing sterility, depopulation, degeneration, and eventually 'racial extinction'. This colonial discourse on African sexuality was a powerful and enduring one, and I will try and draw out some of the implications of its legacy later in the paper.

But first, let us return to Uganda. The sense of 'epidemic' lasted from the beginning of the century to the mid 1920s when, although syphilis was still regarded as a serious medical problem, some doubts began to be expressed over the extent of the problem. There was clear evidence now for a large amount of misdiagnosis. A lot of what had previously been confidently diagnosed as syphilis was now recognized as yaws. When correctly specified, the two diseases showed very marked geographical specificity in incidence. Syphilis was common amongst the Baganda and yaws extremely rare. Yaws was common in Northern and Eastern provinces whilst syphilis was very uncommon there. Doctors remarked on the rarity of tertiary syphilis in Uganda and the rapid response of patients to mercurial treatments.

Meanwhile, the whole debate over the relationship between syphilis, yaws, and a nonvenereally transmitted syphilis called bejel, prevalent in Middle East, was underway in the medical journals.

It was not until 1956, however, that Davies (Davies 1956) was able to suggest that the entire history of syphilis in Uganda had been misinterpreted. Not only had the confusion with yaws existed all along but, he argued, the disease which Lambkin had found so widespread amongst the Bagandans at the beginning of the century was an endemic, nonvenereally transmitted form of syphilis, with an increasing admixture of sexually transmitted syphilis. With treatment, changes in the environment, and increased use of clothing, endemic syphilis, a relatively easily treated disease, declined rapidly to be replaced by the more severe, intractable and resistant sexually transmitted syphilis. The endemic disease also left behind it, however, an unusually high positive serological rate for many populations, which was a puzzle to subsequent investigators.

It is, of course, very difficult to come to any firm conclusions regarding the epidemiology of syphilis in Uganda at the beginning of the century, but at the very least one can say that the 'epidemic' witnessed by Lambkin and others was one with a complex causation. Some of the syphilis treated by these early doctors was undoubtedly of the nonsexually transmitted kind. The very popularity of treatment by injection for both syphilis and yaws contributed to the spread of sexually transmitted syphilis, which, by the 1930s, was the more common of the two variants of the disease.

There are some obvious lessons of this story. Firstly, and most obviously, although syphilis was an increasing problem in early colonial Uganda, it was not the epidemic that Lambkin

thought would wipe out the Baganda people, and neither was it attributable to what these doctors, administrators, and chiefs saw as promiscuity and degeneracy.

Secondly, the construction of the problem of syphilis as a problem of sexuality brought forth an immensely powerful language of moral panic and control that was clearly to the advantage of the colonial rulers and of some sections of the colonized people. The declaration of an epidemic, as we all know, can serve many functions. I have only had time to outline the history of the early colonial epidemic in Uganda, but this was not the only declaration of an epidemic of sexually transmitted disease to occur in colonial East and Central Africa. There were many others - most notably in the interwar period and again during the Second World War.

REPRESENTATIONS OF AFRICAN SEXUALITY

I am not arguing that a serious problem did not by then exist - it clearly did - but rather that a powerful medical discourse on African sexuality was produced through discussions of syphilis (and gonorrhoea) and was more generally applied. Nothing would be served by outlining this discourse here, but it has proved to be a powerful and enduring one. The fact that it has also been a 'medicalized' discourse has made it more powerful still, both in directly contributing to the control of its subjects and in contributing to the enduring racism of European and North American thought on 'the African' (Gilman 1987).

Its influence has nowhere been more powerfully felt than in the more recent literature on AIDS in Africa. As Chirimuuta and Chirimuuta have conclusively shown (Chirimuuta and Chirimuuta 1988), much of the western medical and journalistic literature on AIDS in Africa is shot through with quite explicitly racist assumptions about and obsessions with African sexuality. One of the most striking aspects of the power of this discourse has been its ability to silence. Progressive researchers on AIDS in Africa have quite correctly chosen to concentrate on a number of facts about the disease rather than to discuss the issue of the construction of sexuality. Firstly, AIDS it is not in any sense an 'African' problem, and in many parts of Africa such cases as have been recorded can be traced to western 'sex tourists' and other white visitors. Secondly, where it does exist as a medical problem in certain parts of Africa, it has to be understood within the context of the political economy (Packard, 1989). Where AIDS has spread in African communities, it has been greatly assisted by the collapse of health services, by the pre-existing low levels of resistance, and, most importantly, by the patterns of economic survival and social relations produced by colonialism.

I have no disagreement with this analysis. As Randall Packard has pointed out, it is essential that, when social scientists are involved in medical research programs on AIDS, they avoid perpetuating the very myths about sexuality that I have outlined, and turn instead to a proper

contextualization of the political economy of the disease. However, by turning away from a discussion of sexuality, it leaves this 'space' wide open to those who wish to appropriate it. In Africa, as in other parts of the world, those who are most willing to occupy this space and do so usually come from a particular kind of moral perspective that involves the restating and the internalization of the colonial discourse on sexuality. In northern Zambia, where some communities are very worried indeed about the spread of HIV, the Catholic Church is providing the dominant language in which the issue is discussed. AIDS, the church emphasizes, is a moral not a medical problem - people get sick because they are immoral. There is no doubt that this language is an effective and powerful one, and that certain sections of a very vulnerable population find in it a reassurance. It is, however, a language that once again characterizes an 'African sexuality' in very negative terms.

AN APPROPRIATE CONTEXT FOR DISCUSSION OF SEXUALITY

There is little doubt that, whilst more progressive research might continue to emphasize that the problem of AIDS is not solely a problem of sexuality, other influential voices will continue to restate versions of the colonial discourse and exploit AIDS for other purposes. For this reason it may be important for social scientists and health activists not to remain silent on the issue of sexuality but to begin to provide a more positive language in which issues around sexual relations might be discussed[21]. It is likely, I think, that a retreat into a highly technical medical language will not fill this gap.

Black cultural activists in Britain have faced very similar problems not only in resisting dominant representations of 'black sexuality', but also in creating representations of sexuality. Preethi Manuel argues, for instance, that in addition to the dominant association of black female sexuality with prostitution and degeneration, there is, on the other hand, also a complete silencing of black sexuality in neocolonial imaging of the other (Reeves and Hammond 1989). And as Sunil Gupta puts it in the same volume:

> *"There are two almost contradictory but parallel themes. One is that because Black people are less than white people - they don't have a life other than that what white people construct for them. They are seen as either having no sexuality or as having too much sexuality..."*

21 For the politics of representation and the AIDS epidemic in North America and Europe see Crimp ed (1988) and Fee and Fox eds (1988).

Something very similar occurred in mid-nineteenth century Britain during the moral panic over sexually transmitted diseases (Poovey 1990; Mort 1988). Women, and especially 'prostitutes' were scapegoated in the moral panic precisely because the social conditions of industrialization and the economic relations involved in the commercialization of sex were intrinsic parts of the capitalist system that could not be addressed. Female sexuality was seen as dark, dangerous, disease-ridden, and in need of direct control. The liberal and feminist response to this was largely to deny women any sexuality whatsoever. Woman, in the liberal discourse, was asexual, above and beyond desire. Hence the Victorian dual characterization of women as either angel or prostitute, which has had such a lasting influence on European and North American images of women. Constructing an alternative positive and active image of the sexuality of women against this history is therefore an uphill task.

It is, of course, not my position to suggest how a new discourse on sexuality or sexualities might be developed by communities in Africa that are struggling to resist dominant and oppressive representations of themselves. All I can say is that one learns from history that medical research into sexually transmitted disease, whilst it might sometimes claim no moral position, will, in practice, continue to produce powerful statements about sexual relations and indeed, premise many of its models on assumptions about the nature of sexual relations.

SUMÁRIO

Em 1908 debateu-se na imprensa médica britânica o desencadeamento de uma epidemia aparentemente alarmante de sífilis em Uganda. Argumentou-se que a epidemia resultava de uma sexualidade descontrolada das mulheres africanas. Somente mais tarde percebeu-se que grande número de casos desta epidemia havia sido diagnosticado incorretamente, e eram, pelo menos em parte, uma forma de sífilis não sexualmente transmissível. No entanto, isto resultou na construção de linguagens e idéias que continham temas com conotações racistas da sexualidade africana bem como responsabilizando as mulheres. Os cientistas sociais e os militantes do setor saúde devem confrontar estas noções de sexualidade desenvolvendo uma linguagem mais positiva onde assuntos sobre relações sexuais sejam abordados.

REFERENCES

Chirimuuta RC and Chirimuuta RJ, 1987. AIDS, Africa and racism. Burton-on-Trent.

Crimp D (Ed) 1988. AIDS: Cultural analysis, cultural activism. Massachusetts, M.I.T.

Davies JNP, 1956. A History of Syphilis in Uganda. Bulletin of the World Health Organization, 15:1041-1055.

Fee E and Fox DM (Eds),1988. AIDS: The burdens of history. Los Angeles, University of California Press.

Gilman S, 1985. Difference and pathology: stereotypes of sexuality, race and madness. Ithaca, Cornell University Press.

Mort F, 1987. Dangerous sexualities: medico-moral politics in England since 1830. London, Routledge.

Packard R, 1989. Epidemiologists, social scientists, and the structure of medical research on AIDS in Africa. Working Paper in African Studies, No 137 (African Studies Center, Boston University).

Poovey M, 1990. Speaking of the Body: Mid-Victorian Constructions of Female Desire, in Jocobus M, Keller EF and Shuttleworth S (Eds). Body/politics: women and the discourses of science. London, Routledge.

Reeves M and Hammond J, 1989. Looking beyond the frame: racism, representation and resistance. London.

Vaughan M, 1991. 'Syphilis in Colonial East and Central Africa: the Social Construction of an Epidemic', forthcoming in Terence Ranger and Paul Slack (Eds). Epidemics and ideas, Cambridge.

EPIDEMIOLOGISTS, SOCIAL SCIENTISTS, AND THE STRUCTURE OF MEDICAL RESEARCH ON AIDS IN AFRICA

Randall M. Packard, PhD. and Paul Epstein, MD, MPH.

ABSTRACT:

The history of medical research on AIDS in Africa closely resembles earlier attempts by Western trained medical researchers to understand the epidemiology of other diseases that exhibited epidemiological patterns particular to Africa. Key parallels between these efforts and current efforts on AIDS include a limited initial knowledge of disease aetiology and ignorance of the various social contexts in which these diseases occurred in Africa. Explanations and preventive measures offered by European medical authorities reflected widely held, and generally negative, perceptions of Africans and focussed on education and behavior modification over social and economic reforms. Suggestions for future directions in AIDS research as well as more fruitful cooperation between social scientists and medical researchers are made.

INTRODUCTION

The history of western medical research on AIDS in Africa closely resembles earlier attempts by western trained medical researchers to understand the epidemiology of diseases such as tuberculosis and syphilis, which were known in the west but which appeared to exhibit different epidemiological patterns in Africa. Like research into TB and syphilis, early inquiries into AIDS in Africa were primarily concerned with explaining why African experience with the disease differed from western experience. In all three cases, efforts to answer this question were handicapped by the limited state of western knowledge concerning the aetiology of these diseases and by a similar lack of knowledge about the African societies and cultures within which these diseases occurred. This combination of ignorance encouraged the early formulation of medical explanations for the peculiarities of African disease experience that were based less on empirical data than on cultural assumptions and medical guesswork.

This paper compares the development of AIDS research in Africa with the history of earlier efforts by western medical professionals to understand the epidemiology of TB and syphilis. Early discussions about the susceptibility of blacks to TB centered on the problem of explaining why it was that Africans suffered both higher rates of morbidity and mortality from TB than Europeans. At the time little was known about the nature of host resistance to the

disease or about the role of possible cofactors in both the transmission of infection or in the progression of infection to active disease. In the absence of accepted theories or extensive knowledge about Africa, the explanations of European medical authorities came to reflect wider perceptions about Africans that were current in European colonial society.

Central to these perceptions was the image of the 'primitive native' making a difficult adjustment to conditions of a 'civilized' industrial world. This image was embedded in European discussions of African morality, political participation, and labor skills and colored early explanations of TB in Africa. Accordingly, Africans were viewed as being more susceptible to TB because they had not adjusted to the conditions of a 'civilized industrial society'. The central image in this discussion was the 'dressed native'.

> *"European clothing which is coming more and more into general use has not been an unmixed blessing... it has not proved ... conducive to the promotion of health. The use of cotton shirts by men and the habit of allowing wet clothing to dry on the person have been particularly harmful... and a marked increase in consumption, pleurisy, inflammation of the lungs and rheumatism have resulted. European clothes, too, require much more frequent cleansing than their ancestral garb, a fact which, unfortunately, is not sufficiently realized by the Natives who have partially adopted our style of dress."*

This construction of African health, by focusing attention on the Africans' maladjustment to 'civilization', placed responsibility for the adverse environmental conditions under which Africans lived squarely on the shoulders of the Africans themselves. In doing so, it deflected attention away from the low wages and inadequate housing policies of employers and government officials. More importantly, it shaped the development of TB control measures, which came to focus naturally on education rather than social and economic reform.

SYPHILIS AND AFRICAN SEXUALITY

The epidemiology of syphilis, like that of tuberculosis, was not well understood by western medical researchers during the first decades of this century. Specifically, the epidemiological and pathological differences between yaws, venereal syphilis, and endemic or nonvenereal syphilis had yet to be sorted out. This led to considerable confusion among early medical personnel working in Africa. As with TB, early theories about syphilis in Africa came to focus on behavioral theories that were infused with racial stereotypes.

Early medical researchers in East Africa concluded that between 50 and 90 per cent of the African population in parts of Kenya and Uganda were infected with venereal syphilis. Col. F.J. Lambkin, a leading British expert on syphilis, concluded that the major cause of the epidemic was a breakdown of various Ganda social institutions. In this respect he echoed early medical opinions about the spread of TB, as well as later theories about AIDS. Specifically, Lambkin argued that Christianity had broken down customs that restricted the social movement of women.

On the basis of subsequent studies and a careful reexamination of the medical evidence, historian Marc Dawson (1983) suggests that there was not an epidemic of venereal syphilis, but nonvenereal or endemic syphilis, which is caused by the infection with the same spirochete (*Treponema pallidum*) that causes venereal syphilis. Endemic syphilis, however spreads through bodily contact in warm climates and in the absence of adequate sanitation. Dawson suggests that while syphilis was clearly being spread sexually into various parts of East Africa as a result of the development of migrant labor, commercial centers, military movements, and a growing population of African prostitutes, its subsequent spread among large numbers of men, women, and children in rural and urban areas was via bodily contact.

Early medical observers constructed the medical evidence they were observing to fit preexisting assumptions about African sexuality and disease. As Sander Gilman notes, the association of Africans with sexuality and the tendency to link African sexuality with disease has a long history in western thought. Following the behavioral explanation of syphilis, authorities advocated public health policies which centered largely on the development of measures, often draconian in nature, to control the behavior of prostitutes. At the same time, problems associated with living conditions and sanitation, which were in fact centrally important to the spread of endemic syphilis, were ignored.

AIDS AND THE "SEXUAL LIFE OF THE NATIVES"

Early discussions of AIDS in Africa developed in a similar intellectual environment to that in which early inquiries into TB and syphilis were conducted. When medical researchers first began studying AIDS in Africa, they quickly realized that the epidemiology of the disease was different from that in the USA and Europe. While the ratio of male to female cases was 13:1 in the industrialized countries, the ratio in Africa was nearly 1:1. This fact, combined with an apparent absence of known risk groups in the form of either IV drug users or homosexuals, led early researchers to conclude that the AIDS transmission in Africa was different from that in the west. This led researchers to ask what it was about Africa and Africans which accounted for its peculiar pattern of transmission.

A lack of social and medical knowledge combined with the suspicion that the key to understanding AIDS in the west might lie in Africa, contributed to a great deal of speculation about the epidemiology of AIDS in Africa and encouraged researchers to construct hypotheses often were based on extremely limited data. It is, therefore, not surprising that stereotypic images of Africa and Africans entered into the discourse on the epidemiology of AIDS in Africa.

A number of influential western AIDS researchers concluded early on that the apparent equal sex ratio of AIDS cases in Africa was most easily explained by a pattern of heterosexual transmission, a phenomenon which was at the time relatively rare in the USA and Europe. This conclusion was supported by early prevalence studies which seemed to indicate that both cases of AIDS and HIV seropositivity were most frequent among sexually active adults. This raised the problem of why HIV was occurring through heterosexual transmission in Africa and not to any great degree in Europe or the United States.

This question quickly led to two theories. The first argued that AIDS had existed in Africa for a longer period of time than in the West and that it had therefore reached a different stage in its epidemiological history. This theory, combined with the virological research of Essex (Kanki et al 1985), Gallo (1987), and others on Simian T-lymphocyte Retrovirus III in African green monkeys, led to arguments that AIDS originated in Africa. This hypothesis has been hotly debated on scientific grounds. More importantly it ignited a political firestorm among African political leaders who saw the theory as imperialist scapegoating. Currently the medical research community appears to have put aside the question of African origins as well as investigations into the possibility that HTLV-III may have achieved a different epidemiological stage in Africa (Nzilambi et al 1986 is an exception to this).

The second theory put forth to explain the heterosexual transmission of HIV in Africa focused on African sexual behavior. In brief, it was argued as early as 1985 that the heterosexual transmission of HIV in Africa was the result of higher levels of sexual promiscuity among Africans, or, in the current language of social science research on AIDS, 'polypartner sexual activities'. While the association of AIDS in Africa with sexual promiscuity was challenged by both African observers and others with broad knowledge of African societies and cultures, it has nonetheless persisted and, like earlier stereotypes concerning susceptibility of blacks to TB and syphilis, became the central focus of medical inquiries into the problem of AIDS. In a similar vein, it has been suggested that other cultural practices such as scarification, the therapeutic use of razors, and female circumcision might also play a role in the spread of HIV.

THE ROLE OF ANTHROPOLOGISTS

Having constructed AIDS as a behavioral problem resulting from particular culturally sanctioned practices, AIDS researchers turned to anthropologists for information on these practices. One might well have expected that the early incorporation of social scientists with extensive African experience into epidemiological discussions on AIDS would have challenged the sexual stereotypes developed by medical researchers. This did not, however, occur to any great degree. While a number of anthropologists decried the wide spread attribution of sexual promiscuity to Africans, the activities of those social scientists who were most closely linked to the AIDS inquiry in some ways reinforced this stereotype.

We suspect that the main reason why anthropologists failed to challenge the dominant paradigm in AIDS research stemmed from the conditions under which social scientists were brought into the AIDS inquiry. The question became not 'what is the social context within which HIV transmission occurs in Africa?', but rather, 'what are the patterns of behavior which are placing Africans at risk of infection?'. While the first construction would have allowed for open ended discussion of a wide range of social, political, and economic conditions that may be affecting health levels in Africa, the latter formulation quickly narrowed discussion to an enquiry into the 'customs of the natives'. Anthropologists found themselves being asked to dig through the ethnographic record on African cultures in order to identify possible patterns of behavior that might facilitate HIV transmission.

Remarkably, some anthropologists cautioned us not to make generalizations about African sexual behavior and suggested that the problem was not generalized sexual promiscuity but 'urbanization'. Urban promiscuity was seen as the product of the loss of 'traditional restraints'. The image of the 'detribalized' African, an image that was fairly well excised from social science discussions in the 1970s, was being resurrected to explain the frequency of heterosexual transmission of HIV in Africans in the 1980s. Given the behavioral thrust of the explanation, the recommended response was finding ways to modify urban sexual behavior. None of this is to deny that AIDS is transmitted heterosexually or that multiple sexual partners may in fact be a common pattern within the rapidly growing urban centers of Africa. However, explanations which viewed this pattern as a product of declining social constraints ignore the context within which urbanization is occurring in Africa. At the same time, by focusing attention on sexual promiscuity and other cultural behaviors, these explanations have deflected attention from other cofactors which may be as important for the heterosexual transmission of AIDS in Africa as frequency of sexual contacts.

There is every reason to believe that whatever cultural attitudes shape African sexuality, the tendency to have multiple sexual partners has been encouraged by the separation of

households resulting from labor migration[22]. The pattern of multiple sexual partners has undoubtedly also resulted from the political disruption of family life generated by warfare in places like Mozambique, Angola, Burundi, and Uganda[23]. Not only are families torn apart by these experiences, but the rape of rural women by marauding guerrilla armies must represent a particularly brutal form of 'sexual polypartnerism' that has little to do with cultural norms. These particular factors in social life are, in turn, the result of specific historical patterns of development.

It is also important to remember that particular patterns of development have created high demands for family labor. As long as this demand continues, then unprotected sexual activity is going to occur with considerable frequency. For sexual activity involves not only pleasure, but social reproduction. If efforts to control the spread of HIV infection do not include policies that deal with the underlying causes of both family separation and the high demand for family labor, we may be fighting an uphill battle in trying to reduce the heterosexual transmission of AIDS in Africa through behavioral modification and condom use alone.

CONCLUSION

The early contributions of social scientists to our understanding of the epidemiology of AIDS in Africa contributed to a narrowing of research and to the development of a medical model centered on the problem of African sexuality. This paradigm has prevented researchers from exploring factors which may be of equal or greater importance in the transmission and progression of AIDS, but which are not suggested by the paradigm. There are two particular areas we consider to be understudied: the role of high levels of background infection and malnutrition, and unsterilized needle use in the transmission and progression of HIV.

The point in all of this is that in Africa, assumptions about the importance of sexual promiscuity in the transmission of HIV were initially based on limited, and in some cases, methodologically questionable data. These assumptions, nonetheless, served to shape both the questions that AIDS researchers asked and the way in which they interpreted data. This narrowing of research in turn discouraged serious consideration of the role of alternative avenues of transmission, such as injections, or of the role of possible cofactors, such as high

---

22 Editor's note: See contributions by Bafana Seripe, Zwi and Bachmeyer and the National Union of Mineworkers in this volume. All devote some attention to the importance of migratory labor in establishing conditions which facilitate the spread of HIV infection.

23 Editor's note: See the article by Baldo and Cabral who argue that the low-intensity warfare has a significant impact on the spread of HIV infection and also makes control measures more fragile and less likely to succeed.

background levels of infection and malnutrition as well as the associated problems of poverty and maldevelopment that may be as important in the heterosexual transmission of HIV as the frequency of sexual contacts.

We are in fact much further from understanding the epidemiology of AIDS in Africa than some medical researchers, development officers, and social scientists would have us believe. It is clear that heterosexual transmission of HIV occurs in Africa, but it has not been clearly demonstrated how or why it occurs. AIDS, like Burkitt's lymphoma, may yet prove to have a complex aetiology involving a combination of political and economic forces associated with underdevelopment in Africa, which have brought together particularly susceptible populations, subject to high background levels of viral, parasitic, and bacterial infections, within a social setting marked by high levels of familial separation and multiple sexual partners, which has contributed to the spread of other STDs, that in turn have created a high risk of exposure to HIV via genital ulcers and/or infected needles.

It is critical that the medical research community and the social science community working with it develop research agendas that will illuminate these complex interactions, rather than obscure them through a precipitous move to find quick answers that can be easily translated into AIDS containment programs. The early history of western research on TB and syphilis should serve as a warning that if we continue to move along the latter road, we run the risk of developing solutions which may have a limited impact at the same time that our understanding of the wider epidemiology of AIDS may be diminished. Before we spend millions on the type of behavior modification model of intervention now being developed, we must have a higher degree of certainty about how HIV is being transmitted and what the real risk factors are, as well as knowledge of the social and economic context within which risk behaviors are set. If a primary risk factor is being poor and unemployed, then our proposed interventions must address the causes of this condition.

Any attempt to initiate a more comprehensive approach to AIDS research in Africa requires that medical researchers and social scientists work together more productively than in the past.

SUMÁRIO

Epidemias de doenças no mundo coincidem frequentemente com períodos de grandes mudanças e transformações históricas. Este artigo examina três períodos: do Império Romano ao Feudalismo, do Feudalismo ao Capitalismo, e os últimos vinte e cinco anos do século XX. AS epidemias de praga ocorreram no primeiro período citado; as de tuberculose, cólera e febre tifóide no período intermediário; e a de HIV ocorre atualmente. É necessário observar os eventos sociais, políticos e economicos de cada período para compreender a origem das epidemias atuais.

"As epidemias correspondem a grandes sinais de alerta que avisam ao verdadeiro estadista que um distúrbio está ocorrendo no evoluir do seu povo, e que mesmo uma política de apatia não pode ignorar."
Rudolph Virchow, M.D.

REFERENCES

Brokensha D. et al 1987. Social Factors in the Transmission of AIDS. Report prepared for the Directorate for Health, Bureau for Science and Technology, Agency for International Development.

Dawson M. SocioEconomic and Epidemiological Change in Kenya: 1880-1925 PhD. Thesis. University of Wisconsin-Madison, 211-218.

Gallo R.C. 1987. The AIDS Virus, Scientific American, January, pp. 39-48.

Gilman S. 1985. Difference and Pathology: Stereo Types of Sexuality, Race and Madness; Ithaca, Cornell University Press, I985.

Gilman S. 1988. Disease and Representation: Images of Illness from Madness to AIDS. Ithaca, Cornell University Press.

Hardy D.B. 1987. Cultural Practices contributing to the transmission of human immunodeficiency virus in Africa. Reviews of Infectious Disease, 9, 1112.

Kanki P.J., Avroy J. and Essex M. 1985. Isolation of T-lymphotropic retrovirus related to HTLVIII/LAV from wild African green monkeys. Science, 230, 95I-954.

Nzilambi N. et al 1986. The prevalence of infection with immunodeficiency virus over a 10-year period in rural Zaire, New England Journal of Medicine 315, 707-709.

South African Native Comm. Report, 1903-05

MAPUTO STATEMENT ON HIV AND AIDS IN SOUTHERN AFRICA

INTRODUCTION

This statement was prepared and agreed to by delegates at the Fourth International Conference on Health in Southern Africa in Maputo, Mozambique in April 1990. This important event brought together a wide range of progressive organizations inside and outside South Africa, including the African National Congress, the United Democratic Front, and health and welfare workers from a wide variety of organizations. The conference benefitted from the contributions of activists and grassroots members of community, political, and progressive health organizations. In addition, people working in the Frontline States, elsewhere in Africa, in the United Kingdom, and in United States contributed valuable insights and experiences.

The conference acknowledged research that shows that human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) is an established epidemic in South Africa and throughout southern Africa.

The magnitude of the epidemic is increasing rapidly within the southern African region. Recent research has shown that nearly 60,000 people are thought to be infected in South Africa alone. The number of people affected by this disease is expected to double every eight and a half months.

Delegates at the conference agreed that if no significant intervention is made within the next few months, there would be little chance of avoiding its disastrous consequences.

It was noted that the South African state response had been totally inadequate. Lessons drawn from throughout the world have emphasized the crucial role representative organizations have to play in combatting this disease. These community-based organizations need to develop an appropriate strategy which will reach the mass of the people.

The conference therefore made the following recommendations as policy guidelines for developing programs around AIDS and HIV infection.

AN HIV CAMPAIGN MUST HAVE THE FOLLOWING FEATURES

It must be nonstigmatizing and avoid stereotyping individuals and groups.

It must be founded upon community-based action.

It must involve political and other leadership must be involved.

It must identify and address the social and political factors relating to the spread of the disease.

THE POLITICAL PROFILE OF HIV AND AIDS MUST BE RAISED

HIV/AIDS is a social disease and should not be approached in a narrow biomedical fashion. Economic, political, and social factors are major determinants of the rate of development and extent of this epidemic.

Features of life in South Africa and southern Africa facilitate its spread. Poverty, migrant labor, population relocation, homelessness, forced removals, unemployment, lack of education, and poor housing play major parts in the development of this epidemic.

The health care system is fragmented and discriminatory. Little emphasis is placed on prevention and health promotion. Communities do not participate in promoting their health and health services.

The HIV campaign waged by the state has been grossly inadequate. Communities have not been involved, nor have representative organizations been consulted. Too little funds have been allocated to HIV prevention and the care of people with HIV disease. The media and education campaigns have promoted fear, stigmatization and discrimination.

POLITICAL ORGANIZATIONS MUST PLAY A LEADING ROLE

Any attempt to deal with the HIV epidemic must be situated within the broader struggle for sociopolitical change. This will provide a context for preventive work amongst the broad group of people most affected by HIV infection.

Progressive organizations should inform their membership of the magnitude and importance of HIV infection. They should examine, analyze, and respond to HIV with the support of their membership.

We can start by involving senior progressive political leadership within and outside South Africa. The African National Congress has a major role to play in this regard. The involvement of political leaders will help overcome suspicion and mistrust created by the South African state. A high public profile will raise awareness and stimulate appropriate action.

We need to involve worker, youth, women's, gay, religious, political, and other community-based organizations at all levels of work on HIV infection and AIDS. We should assist these organizations to recognize the importance of this epidemic. Wherever possible, committees to develop a response to the epidemic and related problems should be formed within organizations and communities.

CHANGE IN PERSONAL POLITICS IS REQUIRED

The HIV epidemic has revealed inadequacies in how we relate to one another.

Sexism, victim blaming, and racial stereotyping decrease our ability to deal effectively with HIV infection at a grassroots level. Discrimination against prostitutes, members of the gay community, injecting drug users, and other marginalized groups should be overcome. Programs to rectify these discriminatory forms of behavior should be initiated as part of the response to HIV disease.

The rights of people with HIV disease, as with any other health condition, must be firmly recognized.

DEMANDS ON THE SOUTH AFRICAN STATE

The South African state has not displayed any genuine commitment to dealing with the problem facing the population. We need to develop a set of demands directed at the state so that it does not neglect its responsibilities. These will include:

a) Undertaking a serious preventive program for HIV infection in the country. Adequate resources must be provided. Free condoms should be supplied throughout the country.

b) Commitment itself to providing comprehensive preventive, promotive, counselling, support, hospital, and community-based services in consultation with progressive and community-based organizations.

c) Making available material and other infrastructural resources to community-based organizations involved in HIV campaign work.

d) Abolishing discriminatory, repressive, and restrictive legislation such as that discriminating against gays, commercial sex workers, and foreign migrant workers.

Funds for progressive activities around HIV infection should be demanded from the state. This should, however, only take place following consultation with a range of progressive organizations and should be articulated through a representative body. Funds should be fully under the control of the progressive movement in such circumstances. In addition, other funds should be sought to maintain a wide funding base. State resources provided must be adequate for the task ahead. The state should not be allowed to seize the initiative and claim credibility.

The progressive movement should be at the forefront of developing appropriate strategies and should demand the resources to achieve this. State resources are ours and should be used as such. The best technical, scientific and social advice should be drawn upon in developing our response.

DEVELOPING A COMMUNITY-BASED APPROACH

A multisectoral community-based approach is needed to effectively tackle HIV infection. Communities must have control over activities and resources. Representative structures must ensure accountability.

We must acknowledge the importance of working with the unorganized and identify ways of facilitating their involvement and representation.

Broad programs need to be translated into local level activity. Safer sexual practices and behavior change must be encouraged. Condoms must be made widely available and local educational materials and mechanisms developed.

WORKERS MUST BE PROTECTED

We acknowledge the work undertaken by the trade unions in identifying and tackling the work related problems associated with HIV infection. These include such issues as discrimination, testing without consent, denying medical and other benefits, and the lack of facilities for conducting appropriate worker controlled educational programs around HIV infection in the workplace.

We need to provide whatever assistance is required by the trade union movement in campaigning for employers and by the state to fulfil their social responsibility to workers and the community at large.

HEALTH WORKERS

Health workers have a responsibility to care for people with HIV disease in a caring and nondiscriminatory way.

Adequate protection against the risk of HIV and other infections should be provided at all worksites.

APPROPRIATE STRUCTURES SHOULD BE FORMED

An AIDS Task Force should be established. This must coordinate and promote HIV and AIDS work nationally in the progressive movement. It should develop a program for preventing this infection from spreading and ensure that appropriate services are put in place to provide care. It must demand resources from the state to achieve these goals. It will need to build on existing organizations and involve all AIDS interest groups. A democratic structure, including representatives of the progressive movement, must be formed.

An interim committee set up at the conference has undertaken the following urgent program of action:

a) To set up a mid-1990 national conference on HIV and AIDS at which the national AIDS Task Force will be elected.

b) To distribute this statement and consult with organizations about the development of an appropriate response to HIV and AIDS and the formation of a representative structure to take this forward.

c) To draw in progressive political and community-based leadership in order to gain their support and involvement in urgent action to prevent the further spread of HIV infection.

EVALUATION

The state program needs to be examined and monitored in an ongoing way. We should reveal the weaknesses of such a campaign and articulate demands and alternative structures that will more directly address the prevention of this epidemic. Our programs need to be carefully and scientifically evaluated at regular intervals and modified accordingly.

CONCLUSION

South Africa and the whole southern African region is facing a crisis over the HIV epidemic. Urgent action must be initiated immediately. The state program is fundamentally limited and flawed. An alternative progressive campaign with the support of political and other representative organizations must be set up immediately.

An AIDS Task Force is proposed to take this urgent program forward. Realistic objectives must be set based on grassroots participation. The sociopolitical context of this disease must be acknowledged in all programs. Safer sex must be promoted to protect the health of the community.

Maputo, April 1990

CONFERENCE RESOLUTIONS

This conference

NOTING

i) The high priority given to addressing the issue of HIV and AIDS at the conference;

ii) The magnitude of the HIV and AIDS epidemic in southern Africa;

iii) The urgency of applying effective and rapid preventive measures to diminish further spread of this infection;

iv) The Maputo Statement on HIV and AIDS drawn up at the Conference;

RECOGNIZING

i) The role that sociopolitical factors, and apartheid specifically, play in facilitating the spread of HIV infection and retarding the control of this epidemic;

ii) That HIV is not only a medical but a social disease;

iii) That the spread of HIV infection is a regional problem;

iv) That all effective measures, especially community-based programs, should be taken to control the epidemic;

v) The failure of the state to mount an adequate and appropriate response;

vi) The necessity for the involvement of the progressive movement in combatting this disease (with the assistance of regional and international colleagues);

RESOLVES TO

i) Encourage all community-based organizations to develop programs around HIV and AIDS;

ii) To adopt the Maputo Statement on HIV and AIDS as a starting point for taking this urgent matter forward;

iii) Establish an interim committee that will urgently work with the assistance of the Progressive Primary Health Care Network to establish a national conference on HIV and AIDS within four months at which a credible and representative National AIDS Task Force will be elected with strong leadership from the African National Congress;

iv) The purpose of the Task Force will be to:

- coordinate and promote HIV and AIDS work nationally and in the Progressive movement;

- develop a realistic and comprehensive national program for HIV and AIDS control on South Africa;

- make demands on the state for funds, facilities, personnel, and technical resources to be made available and controlled by community-based organizations;

- encourage and assist in the building of a social movement aimed at containing the spread of the epidemic;

- take any other measures deemed appropriate to hasten the control of the HIV epidemic in South Africa and the southern Africa region generally.