

**LOCAL ECONOMIC DEVELOPMENT
SUPPORT PROGRAMME**

KWAZULU NATAL

HIV/AIDS and DEVELOPMENT COMPONENT

**FINAL REPORT
Volume 1 – Main Report**

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral drugs
ASSA	Actuarial Society of Southern Africa
DEDT	Department of Economic Development and Tourism
HAART	Highly Active Antiretroviral Treatment
HBC	Home based care
HIV	Human Immunodeficiency Virus
HIVAN	Centre for HIV/AIDS Networking
HSRC	Human Sciences Research Council
GIS	Geographical Information Systems
KAP	Knowledge, Attitude and Practice (surveys)
KZN	the province of KwaZulu Natal
LED	Local Economic Development
MTCT	Mother to Child Transmission (of HIV)
MRC	Medical Research Council
PAAU	Provincial AIDS Action Unit
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PMU	Permanent Management Unit
PLWHA	People Living with HIV/AIDS
SABCOHA	South African Business Coalition Against HIV/AIDS
SACOB	South African Chamber of Business
STI	Sexually Transmitted Infection
SMME	Small, Medium and Micro Enterprises
TB	Tuberculosis
ToR	Terms of Reference
VCT	Voluntary Counselling and Testing (for HIV)

EXECUTIVE SUMMARY

The aim of the KwaZulu-Natal (KZN) Local Economic Development (LED) Support Programme is to improve the quality of life of communities through promoting and supporting local economic development in KZN. Because of the links between poverty and HIV/AIDS, this programme is addressing one of the key driving forces behind the explosive spread of HIV that is occurring in this province.

However, in the short term, development initiatives do not automatically address issues of HIV/AIDS. Poorly conceived and implemented development projects may even exacerbate the transmission of HIV. Therefore, the overall purpose of this component of the KZN LED project is to develop guidelines and practical “toolkits” that will enable local economic development to occur such that it contributes to combating the HIV/AIDS epidemic by reducing transmission and decreasing the impact.

There is a substantial body of literature on the theory and implementation of workplace HIV/AIDS programmes and this report contains a thorough review of what is considered “best practice” both internationally and locally. This review is contextualised within the conceptual framework of “mainstreaming”. Mainstreaming of HIV/AIDS in the workplace essentially refers to a process whereby an organisation considers at a strategic level all the ways in which they may be impacted upon by the epidemic and how they may impact on the epidemic. The final output of the mainstreaming process is the development and implementation of a comprehensive and appropriate HIV/AIDS strategic plan. The extent and scope of any such plan is tailored to the capacity and competitive advantage of the particular organisation be it local government, an SMME or a large corporate organisation.

This report also presents the latest current estimates and 10 year forecasts of the HIV and AIDS prevalence levels and anticipated mortality levels in the province of KZN. This data is useful for understanding the extent and impact of the epidemic and to determine likely care and treatment requirements during the lifecycle of this LED project. This is followed by a review of the main factors that are driving the spread of HIV in our population. Whilst there is no single factor responsible for the increase in HIV levels it is likely to be due to a combination of cultural practices, a high level of STIs, social disruption (including migrancy) and poverty.

There is no sector of society that has been left untouched by the HIV/AIDS epidemic and there is a discussion in this report (with a longer version as an appendix) as to how the epidemic has impacted upon society, the economy and on households.

This is useful information because it provides insights into the economic and human costs of HIV/AIDS in addition to underpinning the design of interventions.

The “desk top” research components of this project mentioned above provide the context for understanding how to respond to the epidemic. The subsequent section draws on field research conducted specifically for this project and entailed conducting a situational analysis within each of the four learning areas. Senior researchers used existing databases and key informant interviews to determine who the main role players are in each district as regards responses to HIV/AIDS. This was done for the health, business and NGO/CBO service organisation sectors.

A striking result of this research was the huge variation in capacity and impact between and within districts. Typically, within the metropolitan areas there are powerful and effective municipalities and NGOs that are involved in state-of-the-art responses to HIV/AIDS. However, in contrast, there are other municipalities that have no HIV/AIDS programme whatsoever and, particularly in rural areas, an almost complete absence of NGOs/CBOs.

Key services provided by the DoH such as HIV voluntary counselling and testing, prevention of mother to child transmission of HIV and access to antiretrovirals (ARVs) are increasingly becoming available although coverage, particularly for ARVs, is patchy.

Volume 2 of this report contains details of all the main HIV/AIDS-related service organisations in each of the four districts plus information on selected organisations at regional and national level. This database in Microsoft Access format which makes it easy to use, very flexible and simple to keep updated. It is envisaged that the KZN LED programme staff and potential beneficiaries will be able to consult this database in order to source assistance in developing workplace HIV/AIDS programmes.

The final volume of this report consists of a leadership training manual and workplace HIV/AIDS toolkit. This comprehensive document is both paper based as well as being Excel based. It may be used by fund applicants to determine their vulnerability to the impacts of HIV/AIDS and to subsequently devise appropriate and cost effective responses. The toolkit component can also be used by KZN LED programme staff to monitor and evaluate beneficiary applications and ongoing programmes.

This report concludes with a chapter on how KZN LED programme staff, assisted by consultants, may be able to best ensure that the recommendations of this component of the project are implemented, achieved and monitored. This will ensure that real outcomes are realised rather than letting this document gather dust on a shelf.

1. BACKGROUND AND MOTIVATION FOR THE STUDY

The aim of the KwaZulu-Natal (KZN) Local Economic Development (LED) Support Programme is to improve the quality of life of communities through promoting and supporting local economic development in KZN. Initially, the project will be implemented in four districts in the province and will be undertaken in collaboration with the provincial Department of Economic Development and Tourism (DEDT), local government and a broad range of other stakeholders.

This poverty alleviation project is occurring in the context of a severe HIV/AIDS epidemic. Indeed, South Africa has more people living with HIV than any other country in the world and the province of KZN has the highest HIV prevalence level of all the provinces. The links between poverty and HIV/AIDS are myriad and complex and there is no doubt that poverty eradication is a key long term strategy to bringing the HIV/AIDS epidemic under control.

However, in the short term, development initiatives do not automatically address issues of HIV/AIDS. Poorly conceived and implemented development projects may even exacerbate the transmission of HIV as is discussed later in this report. Therefore, the overall purpose of this component of the KZN LED project is to develop guidelines and practical “toolkits” that will enable local economic development to occur such that it contributes to combating the HIV/AIDS epidemic by reducing transmission and decreasing the impact.

1.1. *The Project Environment*

The KwaZulu-Natal (KZN) Local Economic Development (LED) support programme is a six-year programme designed to support the provincial Department of Economic Development and Tourism (DEDT) and a broad range of other stakeholders to more effectively implement LED that achieves equitable economic growth in the Province.

The core problem to which the programme responds is the major market failures and human and institutional capacity limitations that operate to perpetuate the exclusion of the majority population from the mainstream economy. This exclusion is manifest in rising unemployment, continuing socio-spatial divisions, poverty and vulnerability. The programme will support LED initiatives from provincial and local actors, initially focusing on four district municipalities – uGu, uMgungundlovu, uThungulu and uMkhanyekude.

The overall objective of the programme is to improve the quality of life of the people of KwaZulu Natal. The purpose of the programme is to achieve equitable economic growth starting initially in the selected districts.

To achieve this purpose, the programme has been designed achieve results in four areas:

- *Result Area 1:* Build sustainable partnerships between LED stakeholders in the four 'learning areas';
- *Result Area 2:* Strengthen and cohere the enabling environment for investment and enterprise development, skills development, HIV/Aids and TB mitigation, and developmental local government around projects that promote economic growth and poverty reduction;
- *Result Area 3:* Promote learning, knowledge exchange and replication; and
- *Result Area 4:* Establish effective, adaptable and innovative LED management functions at the 'learning area' and provincial level.

The preparation phase of this programme is drawing to a close, and the various funds that will be used to drive projects activities have been established. This review of HIV/AIDS and TB best practice is the final programme preparation activity, and the outputs from this research will form a key component of the evaluation of applications made to the programme for project funding.

1.2. Aims and Objectives of the HIV/AIDS Project

Overall objectives

The overall objective of this project is to produce a comprehensive report on the HIV/AIDS prevention and management policies and practices in the four learning areas. This includes a review of international and national best practices.

Specific objectives

The specific objectives of the best practice study are:

- Methodology definition
- An overview of international and national best practice
- An investigation into HIV/AIDS and TB prevention and management programmes commonly practised in the four learning areas.
- A critical review of the prevention and management programmes identified with a comprehensive gap analysis
- Identification of new job opportunities to respond to social needs created by the pandemic.
- The development of a menu of service providers in each district who may provide options that can be used by businesses of all scales to prevent, treat or manage HIV/AIDS/TB.
- A clear indication of the costs of implementing the prevention, treatment and management programmes in the work place.

1.3. Methods

In this section we describe the methodology used for the various content areas of the study. Figure 1 below illustrates how the overall process was undertaken and the relationships between the various components of the project.

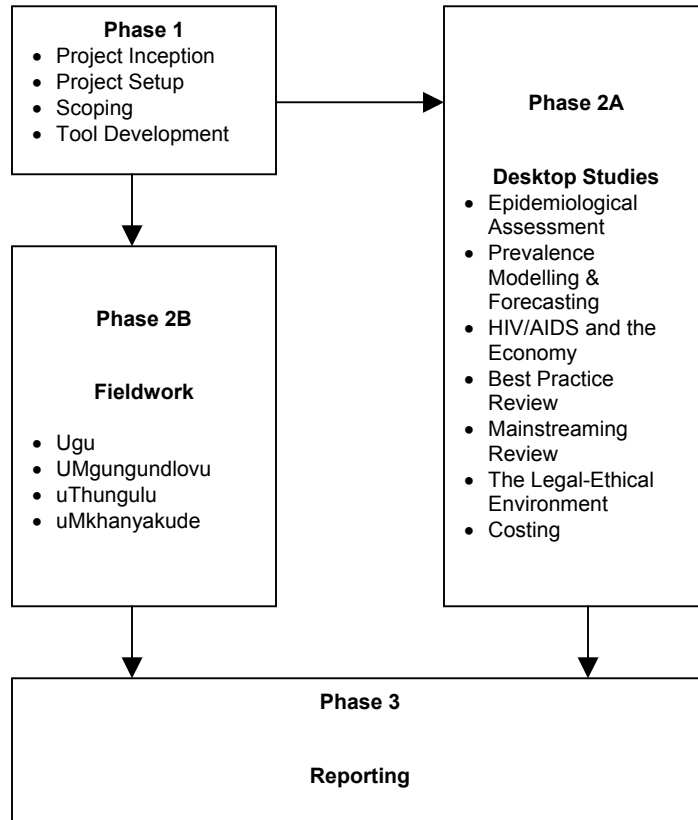


Figure 1: The Overall Process

Phase 1 – Project Preparation

Phase 1 focussed on preparing and mobilising the project team for undertaking the research, identifying sources of information and data, and finalising contractual and administrative arrangements.

Databases existing within the province and nationally with details of individuals and organisations involved in a wide range of HIV/AIDS prevention, mitigation and support activities were identified and consulted. Examples of these databases include HIVAN, DoH and SABHCOA. Information was obtained from these databases, with particular attention being paid to organisations active in the four districts.

As part of the preparation for the project, a team member spent a day in each district undertaking a scoping exercise to determine the capacity of local institutions and to gather information with regard to types of HIV/AIDS programmes being undertaken in the district and who the key role players are. This involved meeting with the LED Programme's area offices, district municipalities and chambers of business/commerce.

The information obtained from the scoping visits, along with other databases was used to identify key informants representative of the following:

- Corporate businesses
- Smaller businesses
- District and local government
- Non-governmental organisations/community based organisations

These organisations will be one of two types:

- Those that operate provincially or nationally; and
- Those that operate regionally or within the district.

Phase 2A – Desktop Studies

These studies took place in parallel with Phase 2A – Fieldwork and provided the context within which the HIV/AIDS epidemic in KwaZulu-Natal may be understood, as well as providing a framework for analysing and understanding the data gathered during the fieldwork component of this project. A more detailed discussion of each component of the desktop study follows.

Epidemiological Assessment

In order for an institution to plan for and manage the impacts of HIV/AIDS, they need to have information on the prevalence of HIV in the populations that they are involved with and what factors are driving the spread of the disease.

There are a variety of HIV prevalence and KAP survey databases available including the annual HIV prevalence survey among pregnant women, the 2002 HSRC national community-based survey, the national LoveLife survey and various workplace studies. These data were reviewed and the epidemiological profile of the HIV/AIDS epidemic in KZN were constructed and described.

Modelling and Forecasting HIV Prevalence Levels

The epidemiological assessment provides information on the prevalence of HIV at present, i.e. like a “snapshot” of one moment in time. Whilst this data is useful in understanding the burden of disease and how it is distributed in the population, the data can be greatly enhanced if it is used to “model” the epidemic in the population and then to project or “forecast” the likely HIV and AIDS prevalence levels for the next 10 years.

We used the ASSA2002 model, which has been calibrated to both the antenatal data and the HSRC data, to obtain baseline estimates and projections of HIV and AIDS prevalence. The output for this component of the study is a narrative description accompanied by tables and graphs of baseline and annual projections of HIV and AIDS cases for the next 10 years.

The Economy and HIV/AIDS

This section took the form of a desktop review of international, national and provincial literature. The aim of this section was to provide an overview of the potential impact that HIV/AIDS has on national and local economies in order to provide a framework for understanding the implications of the epidemiology of HIV/AIDS in the four districts, as well as in terms of the results of the modelling and forecasting exercise.

The HIV/AIDS epidemic has multiple impacts throughout the economy, affecting the performance of the macro-economy as well as the ways in which households are able to secure their livelihoods. A wide range of research has been done in South Africa and internationally both by donors concerned with national economic development and strengthening of livelihoods at the household level, and by multi-national corporations concerned at the impact the epidemic will have on their profitability. Many of these studies are available in the public domain and will be used as the basis for this component of the research. Some examples of this type of research include:

- Economic Impact of AIDS in South Africa: A Dark Cloud on the Horizon – ING Barings (2000)
- The Economic Impact of HIV/AIDS on South Africa and its Implications for Governance – CADRE funded by USAID (2000)
- The Economic Consequences of HIV/AIDS in Southern Africa – International Monetary Fund (2002)
- Microfinance and Households Coping with HIV/AIDS in Zimbabwe: An Exploratory Study – Zambuko Trust (2003)
- Economic Impact of HIV/AIDS on Patients and Households in South India – IAEN (2003)
- Economic Impact of HIV/AIDS on Household Food Security in North West Tanzania – IAEN (2003)
- HIV/AIDS and the Private Sector – A Literature Review (2002)
- Addressing the Impact of HIV/AIDS on Ministries of Agriculture: Focus on Eastern and Southern Africa – UNAIDS (2003)

This component of the research involved no primary data collection, but rather focused on drawing together existing research on the impact of HIV/AIDS on the economy and drawing out what the implications of this might be for local economic development in KwaZulu-Natal in light of the particular characteristics of the epidemic in the province.

Best Practice Review

A 'Best Practices Review' is an analysis of responses by companies to HIV/AIDS. The review is based on studies conducted by local researchers together with internationally recognised 'Best Practice' case studies. While large companies dominated these case studies, there are examples of 'Best Practice' among small, medium and micro enterprises.

Mainstreaming Review

Over the last few years, there has been increasing talk within governments, multi- and bilateral organisations, and development organisations of "mainstreaming AIDS" into all sectors, and of "taking a multisectoral approach to AIDS." This has seldom been accompanied by practical guidance on what a 'multisectoral approach' entails, or what an organisation that 'mainstreams AIDS' might look like.

'Mainstreaming' HIV and AIDS involves bringing the issues into all strategic planning, and into day-to-day operations inside the organisation and in its relationships with others. This section defines mainstreaming and discusses the concept in the context of LED in KZN.

The Legal-Ethical Environment

Legislation relevant to HIV/AIDS in the workplace includes the application of the following acts:

- Labour Relations Act, Act 66 of 1995
- Employment Equity Act, Act 55 of 1998
- Occupational Health and Safety Act, 1993
- Compensation for Occupation Injuries and Diseases Act, Act 130, 1993
- Basic Conditions of Employment Act, 1997
- Medical Schemes Act, Act 131 (1998)

The desktop review of legislation looked at the contents of these acts in greater detail, and discusses their implications for the management of HIV/AIDS in the workplace. A review was also undertaken of how the provisions of these pieces of legislation have been applied in practice.

In addition to legislation, there have been other responses to the epidemic in terms of its legal and ethical dimensions. The Department of Labour has set out a Code of Good Practice on Key Aspects of AIDS and Employment, linked to the Employment Equity and Labour Relations Acts. The University of the Witwatersrand has set up the AIDS Law project at their Centre for Applied Legal Studies, which provides legal support to people and organisations affected by HIV/AIDS.

The legal perspective, however, is not the only perspective that was explored in the desktop review. An investigation of the ethical aspects related to HIV/AIDS was also be undertaken.

Phase 2B - Fieldwork

Appointments with key informants were made based on the information collected during Phase 1 – Project Preparation. Interviews with key informants were undertaken using a basic questionnaire as a guideline (Appendix 1). This questionnaire will covered the description of the programme; how long it has been running; where it has been successful and where it has not (i.e. how effective it has been in reaching its objectives); areas where it needs support; as well as information required for the M&E framework etc.

Interviews for all four districts were set up from the consultant's home office prior to going into field. Each district was visited by the field worker for at least three days, during which time the key informants were interviewed and the results written up.

Arising out of the fieldwork and from conducting internet searches, a “menu” of HIV/AIDS-related service providers was compiled and forms Volume 2 of this report. The database is presented in two forms in Volume 2. This is a Microsoft Access based system which makes it easy to continue updating the database and using it in a variety of ways. For example, once the database was compiled, we were able to automatically email the description of each organisation to the actual organisation for verification of data.

Phase 3 - Reporting

This phase will see the production of the final outputs of the project, and will draw together the desktop reviews and the data collected in field.

2. PREVALENCE AND RISK FACTORS FOR HIV/AIDS IN KWAZULU-NATAL

2.1. The extent of the HIV and TB epidemics in South Africa and KwaZulu-Natal

Whilst there is considerable debate on the actual numbers of people living with HIV/AIDS in South Africa and how it is distributed in the population, there is no doubt that KwaZulu-Natal lies at the very epicentre of the global HIV/AIDS pandemic. Five of the countries that have the highest HIV prevalence in the world are in Southern Africa and South Africa has more PLWHA than any other country. Within South Africa, the province of KwaZulu-Natal is believed to have the highest HIV prevalence levels with an estimated 32% of pregnant women carrying the virus.

Estimates of HIV prevalence in South Africa come from a variety of data sources including the annual antenatal HIV prevalence survey which has been conducted since 1989 and a variety of community-based and workplace-based studies. These data sources have allowed us to track the course of the epidemic over time and in selected populations. However, South Africa, like other African countries, lacks sophisticated surveillance systems that produce “real time” data right down to district and municipality level. So, for example, whilst we know that about one third of pregnant women in KZN are HIV infected, the sample size at district level is too small to allow estimates to be made at that level. The same problem with sample size occurs with community-based surveys that provide stable estimates at national and provincial level but not at district level.

Therefore, for the purposes of this project, we are considering the province of KZN as a whole rather than attempting to make projections and forecasts on a district basis. This is legitimate as data from the province shows that there are not great differences in prevalence based on geographical areas. Indeed, other variables such as race and type of settlement (informal vs. formal) are more important as risk factors (see section 7) than geographical area.

2.2. HIV and AIDS Prevalence Levels

The demographic model of the Actuarial Society of South Africa (ASSA) is the most widely used publicly available model for making estimates of current and future HIV prevalence levels. The latest version of the model, ASSA2002, became available in 2004 and is calibrated to data including the antenatal clinic survey results and deaths from the population register. The most recent year for which these were available at the time of release was 2002, hence the date in the name.

The latest estimates from ASSA2002 model predicts that about five million people in SA were infected with HIV in mid-2004. This is about 30% lower than estimates produced by an earlier version of the model and is due mainly to new data obtained from the Mandela/HSRC 2002 community-based survey. In addition, the lower estimates are as a result of incorporating the impacts of interventions such as increasing use of condoms and improved treatment of sexually transmitted diseases (STDs)) as well as newer interventions such as programmes to prevent mother-to-child-transmission of HIV and the roll out of ARV's.

The recent tendency to lower estimates of HIV prevalence is not unique to ASSA as other organizations, such as UNAIDS, have done likewise. A comparison of the estimates made by a variety of organizations is given in Figure 2. Note that whilst the overall HIV prevalence levels may have been marginally overestimated, South Africa is still in the grip of a devastating epidemic, the worst effects of which are still to come.

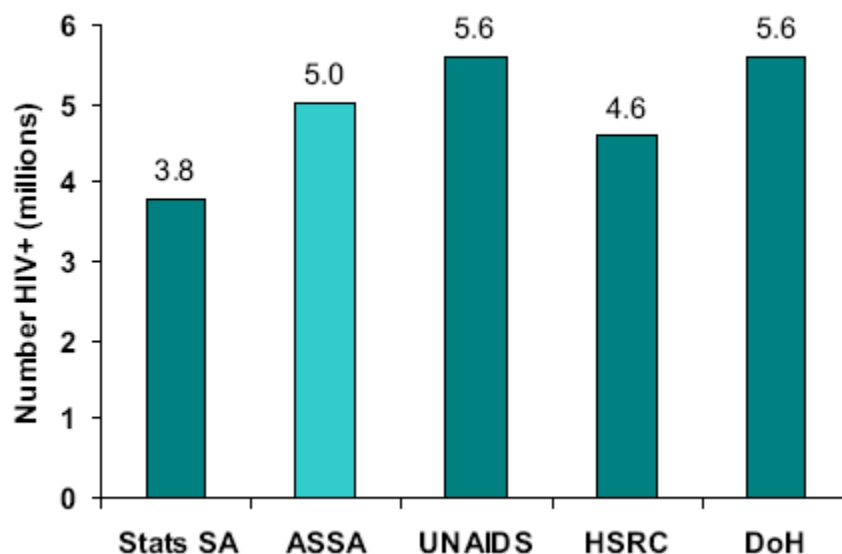


Figure 2: A comparison of the total number of people living with HIV in South Africa in 2005 according to different statistical institutions

2.3. *How is HIV distributed within the population?*

Whilst national or provincial estimates of the prevalence of HIV are useful for planning purposes, these global figures give no indication of whether HIV is spread evenly in the community or whether certain categories of the population are more or less at risk. Below we discuss some of the associations between socio-demographic variables and HIV.

- **HIV prevalence by race:** Data from the NM/HSRC survey has dispelled the myth that HIV/AIDS is a “black disease” with the finding that 6.2% of the white population is HIV infected. This level of infection is indicative of a generalized epidemic and cannot be accounted for by being isolated to sub-sections of the community such as homosexuals or injecting drug users. It is interesting to note that no equivalent HIV infection level has been measured in any other predominantly white community anywhere else on the globe and contrasts with prevalence levels in North America, Europe and Australasia where it is consistently below 1% in the general community (UNAIDS, 2002). The HIV prevalence among Blacks in South Africa was 18.3%.
- **HIV prevalence by socio-economic factors:** Poverty makes individuals more vulnerable to HIV infection for a variety of reasons including restricting access to information and limiting capacity to negotiate safer sexual practices. However, HIV infection is by no means confined to the poorer sectors of society and wealthier people have their own risk factors such as access to disposable income and frequency of travel. The NM/HSRC study showed that, among Black Africans in South Africa, the chance of being infected with HIV was similar across socio-economic strata as measured by self-reported income level. Studies in businesses have shown a slightly different picture in that the prevalence of HIV tends to decrease in the managerial and higher job bands regardless of race.

As with many studies across Africa and in South Africa, the NM/HSRC study showed that there was no association between level of education and being infected with HIV. Indeed, among Black Africans, 21.1% of those with a matric were HIV positive compared to 8.7% of those with no schooling.

- **HIV prevalence by locality:** Several studies including the NM/HSRC study have shown that in South Africa HIV prevalence levels are not significantly different between urban formal (15.7%) and tribal rural areas (12.8%). This indicates that South Africa does not have the same rural/urban differential in HIV prevalence levels as occurs in many other African countries. This may be due to the superior transport networks that exist in South Africa permitting easier traffic flow between urban and rural areas.

However, there is a significantly higher prevalence of HIV among those people living in urban informal areas (28.6%) (“Squatter Camps”) indicating the link between deprived socio-economic circumstances and an increased vulnerability to HIV infection. The NM/HSRC study also showed that apart from a higher HIV prevalence, residents in informal areas also tended to have more concurrent sexual partners,

were sexually active at a younger age and had a higher prevalence of STIs than people from other locality types.

- **HIV prevalence by gender:** The data in the NM/HSRC study is compatible with other studies that have also shown that HIV prevalence rises rapidly among young women and peaks in the 20 to 30 year olds whereas it rises more slowly among men and peaks in a slightly older age group. Overall, the prevalence among women was 15.0% compared to 11.5% among men ($p=0.01$). This gender imbalance is the norm in countries that have generalized heterosexual HIV epidemics and stands in stark contrast to the epidemics in the US and Europe, where substantially more men than women are infected.
- **HIV prevalence in the youth:** An encouraging finding from the annual antenatal sero-prevalence surveys is the continual decline in HIV and syphilis prevalence among the under 20 year olds. Age specific analysis of antenatal data shows a modest decline in HIV infection rates among 15-19 year old antenatal clinic attendees from 21% in 1998 to 16.1% in 1999 and down to 14.8% by 2002. Although the decline in HIV is not statistically significant the trend is encouraging and at least shows stabilization among this age group. However, the HIV prevalence remains extremely high in the 20 to 30 year old age group, particularly among women.

Gender differences in the youth are pronounced with female youth having a two fold higher HIV prevalence compared with male youth. This reflects the influence of biological, social and economic factors that place women at increased risk for HIV infection.

- **HIV prevalence in working populations:** An increasing number of businesses are conducting HIV prevalence studies among their workforces for the purposes of risk assessment and strategic planning. Table 1 lists certain of these companies and it shows a wide variation in HIV prevalence levels. However, it must be noted that crude data from companies is not directly comparable as each has a different workforce structure in terms of age, sex, skill level and race. In general, however, the prevalence of HIV amongst the employed population is lower than that measured among antenatal clinic attendees or in the general population in the same area.

Evian et al (2004) in a review of the prevalence of HIV in workplaces in KZN report an average prevalence of 14.4% which makes it the province with the highest levels among the employed population.

This lower prevalence among employed people (in comparison with the general population) may be because they are less vulnerable

because of greater access to information, condoms, health care and, importantly, particularly for women,

2.4. *What is driving the HIV/AIDS Epidemic in KwaZulu-Natal?*

In order to design and implement appropriate interventions to prevent the transmission of HIV, it is important to know what is driving the epidemic in the local setting. The HIV/AIDS pandemic is not homogenous across the world and even within a country. For example, the rapidly advancing HIV epidemic in Russia is almost exclusively occurring among inner city injecting drug users, whereas in the US the majority of infections occur among gay men. In Africa, HIV is almost exclusively spread through heterosexual sexual intercourse. However, the question as to why sub-Saharan Africa has been so severely hit by the epidemic remains incompletely answered.

Figure 3 lists the key distal and proximal risk factors for the spread of HIV and it is probably the particular mix of these factors in southern Africa that has resulted in the rapid and extensive spread of infections.

There is overwhelming evidence from around the world that the HIV/AIDS epidemic is expanding most rapidly among the poor. The interaction of poverty and HIV/AIDS is a vicious cycle as shown in figure 3. The poor are more vulnerable to acquiring HIV for a myriad of reasons including having less access to information, condoms and health care, experiencing greater gender inequities and being forced into trading sex for the means of survival. At the same time, a case of AIDS in a poor family can drive the family deeper into poverty.

There is no doubt, therefore, that the long-term solution to the HIV/AIDS epidemic is to alleviate poverty, which is the overall goal of this project.

However, poverty alone cannot be held solely responsible for the spread of HIV as demonstrated by the fact that Botswana is one of the richest countries in Africa and yet has the highest HIV prevalence rate of any country in the world.

Civil strife in KZN during the 1980 and 1990s and the continuing migrant labour system have wreaked havoc with the structure of family and community life. Men and women displaced by violence or the need to find work are going to be more susceptible to having multiple partners and casual sex.

Table 1 HIV Prevalence levels in various companies surveyed in 2003

Sector	Year	Workforce size	Number tested	% HIV +ve	Men	Women	African	White	Asian	Coloured
Chemical	2002	320	272	18%	+	+	46/197 23.3%	0/45 0%	0/24 0%	0/24 0%
Chemical	2003	215	162	17%	5/131 19%	2/31 7%	26/83 31%	0/41 0%	1/3	37%
Chemical	2004	137	133	10%	8/91 9%	3/35 9%	+	+	+	+
Manufact	2001	+	161	12%	+	+	+	+	+	+
Manufact. Head office	2003	888	757	2.1%	5/303 1.7%	10/450 2.2%	14/107 13%	1/307 0.33%	0	0
Manufact.	2003	350	266	35%	32/105 31%	6/161 37%	+	+	+	+
Manufact.	2004	200	163	19%	+	+	+	+	+	+
Retail storage	2001	422	358	8%	8%	8%	21/124 17%	0/39 0%	3/170 2%	+
National parastatal	2002	+	745	13%	+	+	+	+	+	+
National parastatal	2002	+	396	25%	+	+	+	+	+	+
National parastatal	2003	+	685	22%	+	+	+	+	+	+

+ Not documented in the report.

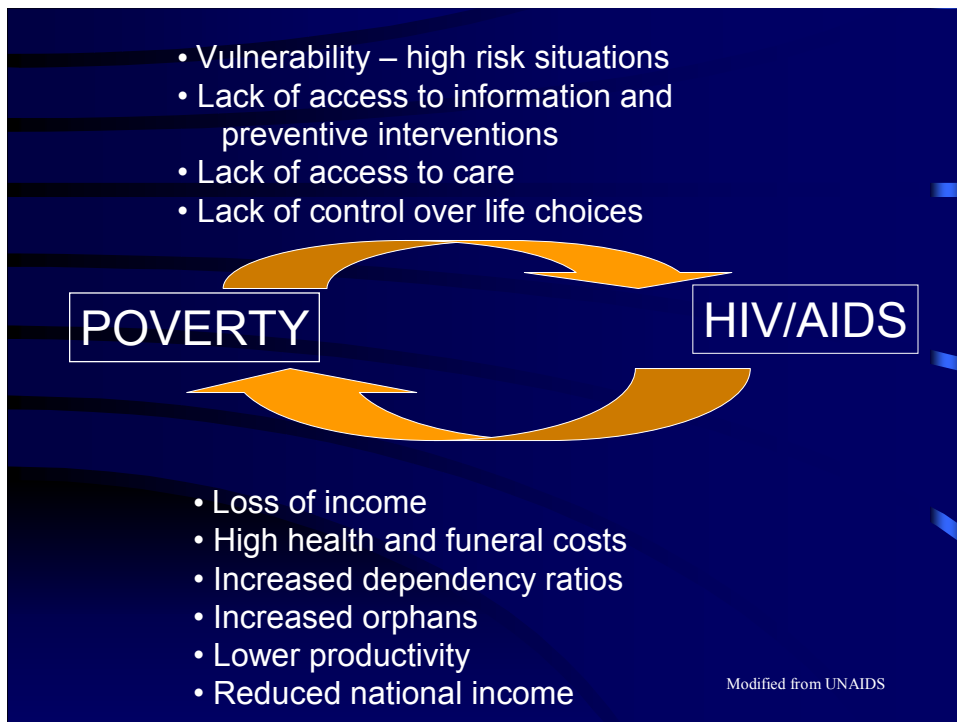


Figure 3: The HIV/AIDS poverty cycle

A politically difficult but important issue is that of culture. How much does the macho culture of our society and the low status granted to women contribute to spreading HIV? In a culture where it is widely accepted that men may have more than one sexual partner at a time, particularly younger women, it is not surprising that HIV is rampant. From a scientific viewpoint, it has been argued convincingly that by having concurrent (as opposed to sequential partners) the spread of the epidemic may be accelerated 5 fold. This is because newly infected individuals are highly infectious in the first few months after becoming infected and much less infectious afterwards. If a person is infected by one partner and has a concurrent sexual partner, he/she is highly likely to infect the concurrent partner. Other cultural issues such as the practice of “dry sex” may also play a part in exacerbating the epidemic.

The fact that race is so highly correlated to HIV infection in South Africa makes the issue highly politically charged and difficult to manage. The recent publicity given to the Blood Bank and their policies of racial profiling of blood donors highlights this fact. Despite attempts to determine what underpins the association of race and HIV, it cannot be simply explained away on the grounds of socio-economic status or education. In the final analysis, the explanation is likely to reside in a complex web of factors including cultural practices, prevalence of STIs and the residual impacts of the apartheid era including migrant labour, social dislocation and issues of self-esteem. However, as mentioned above, the epidemic exists in all population groups and so no group can consider themselves immune from the impacts of the epidemic.

2.5. *Tuberculosis in KwaZulu-Natal*

South Africa ranks number 9 in the world in terms of the total number of TB cases in 2003 (WHO, 2004) with an incidence rate of 558/100 000 population. There has been a steady increase in the number of cases since the early 1990s in spite of increased efforts to control TB. This increase has been ascribed to the HIV epidemic and TB is the commonest opportunistic infection among people with HIV-related disease. It is now estimated that in 60% of new TB cases the person is co-infected with HIV.

South Africa has adopted the WHO DOTS (Directly Observed Treatment) strategy and now 98% of the population is covered by a DOTS programme. South Africa has also moved towards integrating TB and HIV care in line with international trends.

Whilst it is estimated that around 90% of TB cases are now being detected and diagnosed, the measured cure rate ("treatment success") remains unacceptably low at around 65%. This low cure rate promotes the spread of TB and, in particular, of multi-drug resistant TB which is very expensive to treat and has a high mortality rate.

DOTS can be carried out either as a clinic-based programme or community-based. In the context of the KZN LED project, certain of the projects may be ideal sites for beneficiaries to receive their treatment via DOTS. For example, a manager in the business could be the official DOTS supervisor and could hold the drugs and administer them to employees. This would obviate the need for employees to take time off to go to the clinic for treatment and enhance productivity and case cure rates.

2.6. *Forecasts of HIV and AIDS Prevalence and Mortality*

Current HIV prevalence levels only tell us about what the situation is at present. However, for planning purposes, it is useful to have estimates as to how the epidemic will progress over time.

Since the objective here was to produce rates of prevalence, incidence and mortality, there was no need to apply the ASSA2000 projections to the demographic profiles of the four districts to obtain absolute numbers of people. But for interest, the demographic profiles of the four districts from the SA 2001 Census are presented in the 2nd worksheet – numbers of males and females by one year age bin. The first worksheet contains a map of KZN with the districts.

The worksheet HIV-Black-ZN contains the main results. Cells A1 – AB17 contain the table of projections for Blacks in KZN aged 15-49. Each row is for a given year, from 2000 – 2015. In the labels, the elements mean:

B	Black
M	Male
F	Female
-	HIV negative
+	HIV positive
Prv	HIV prevalence as a fraction
prv%	HIV prevalence as a percentage
New	New HIV infections
Ad	AIDS deaths
Nd	Non-AIDS deaths
Inc	HIV incidence (new cases per population) as a fraction
inc%	HIV incidence (new cases per population) as a percentage
Adr	AIDS death rate as a fraction
adr%	AIDS death rate as a percentage
Ndr	Non-AIDS death rate as a fraction
ndr%	Non-AIDS death rate as a percentage

The worksheets zn2000 – zn2015 are ASSA2000 projections for years 2000 to 2015 for all eight groups (race and sex) in the province. The label elements are: b – black, a – Asian, c – coloured, w – white, m – male, f – female. Cells A1:I468 contain ASSA2000 projected numbers of individuals per one year age bin, who are HIV negative, HIV positive, number of new HIV infections, numbers of AIDS deaths, and numbers of non-AIDS deaths. Tables in cells K3:R94 contain values as per the table above of age-specific prevalence etc per one year age bin. Prevalence's are percentages, the other rates are fractions. The values in worksheet HIV-Black-ZN are calculated from these worksheets.

In sheet HIV-Black-ZN there are several graphs. One is the HIV prevalence for males, females and total, in age range 15 – 49, plotted as a function of time. Another is the HIV incidence, AIDS and non-AIDS death rates. The other two graphs are progression of age-specific prevalence, for males and females, in five year intervals, for years 2000, 2005, 2010 and 2015, based on data from the worksheets zn2000 – zn2015. On worksheets for years 2000, 2005, 2010 and 2015, for interest, the population profiles are plotted. Separately for males and females, graphs are plotted showing total number of individuals per one year age bin, as well as number HIV positive.

The projections presented here are those of the ASSA2000 Provincial Version for KwaZulu-Natal, as downloaded 22 November 2002. The ASSA2002 Provincial Version is not yet publicly available. ASSS2000 model is an epidemiological and demographic model produced by the Actuarial Society of South Africa. It uses data on South African demography, fertility and mortality rates, and models the spread of infection amongst adults and to children, in population categories into risk groups ranging from not-at-risk to high-risk.

The projections are presented in a set of graphs below. The four graphs show:

1. HIV prevalence for the KZN population as a whole (ages 0 – 90), and for the age range 15 - 49, from 2000 to 2015.
2. HIV prevalence in KZN by age (one-year age interval), as a series of profiles for 2000, 2005, 2010 and 2015.
3. HIV incidence, AIDS death rate and non-AIDS death rate for the KZN population ages 0 – 90, as percentages of this population group.
4. HIV incidence, AIDS death rate and non-AIDS death rate for the KZN population ages 15 – 49, as percentages of this population group.

The HIV prevalence projection peaks in 2005 at 19% for the population, and 33% for the 15-49 group, and falls off to 15% and 25% respectively in 2015 as the curves start to plateau to an equilibrium situation.

The prevalence by age falls off in the higher ages groups as numbers of HIV positive individuals falls due to AIDS mortality, and the bulk of infections exist at younger ages.

HIV incidence falls to equilibrium values of 1.2% for 0-90 and 2.2% for 15-49, the non-AIDS death rate is understandably constant at 0.4% and 0.74% respectively, and the AIDS death rate peaks in 2009 at 2% and 3% respectively, falling by 2015 to 1.5% and 2.4% respectively.

These projections are broadly consistent with the 2002 antenatal KZN HIV prevalence level of over 30%, and with evidence of a slowing of the infection rate since 2000. As HIV infections progress to AIDS, the AIDS death rate is predicted to peak about 10 years after the peak in HIV infection rates. The bulk of AIDS deaths are predicted to occur over the next decade (2005 – 2015), reaching an alarming 3% among sexually active adults, 6 times the rate of non-AIDS deaths for this group.

As mentioned above, the version of the model was ASSA2000 for KZN, and not the latest ASSA2002 version, which exists for South Africa as a whole, but not for KZN. Results of the ASSA2002 Model for South Africa are presented in “The Demographic Impact of HIV/AIDS in South Africa, National Indicators for 2004”, by Dorrington et al [1]. In this report it is stated that:

“The ASSA2002 model predicts that some five million South Africans were infected with HIV in mid-2004. This is about a third lower than estimates produced using the earlier version of the model.”

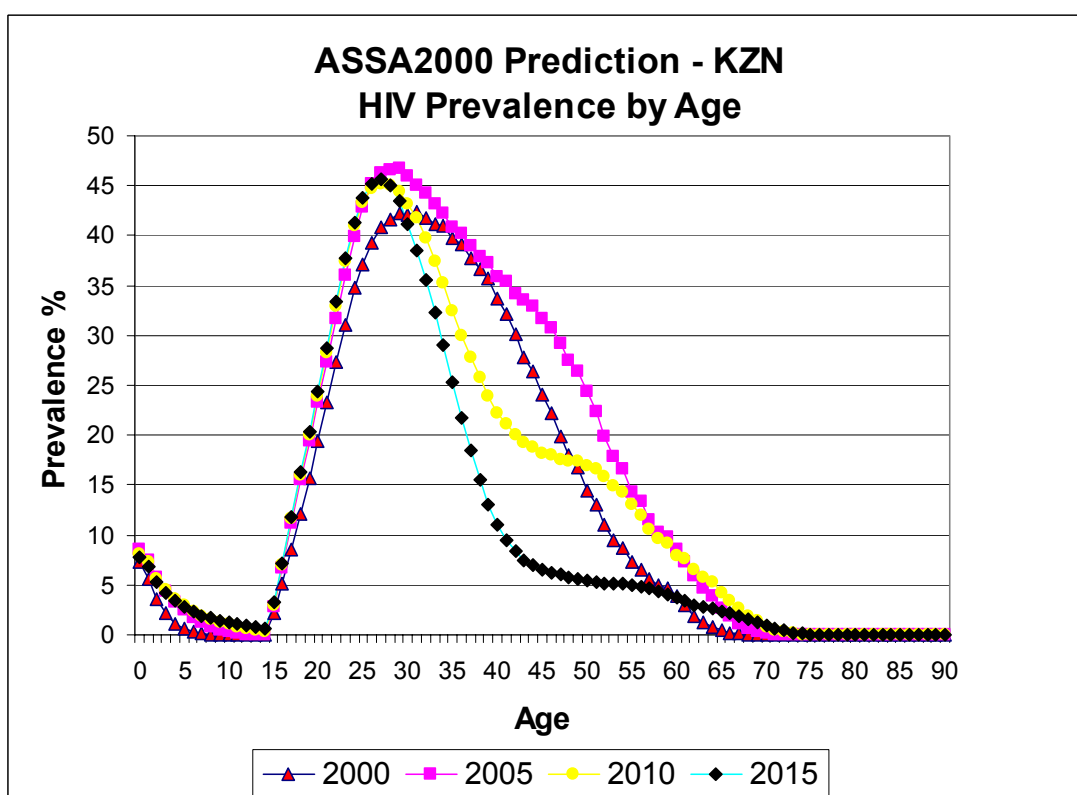
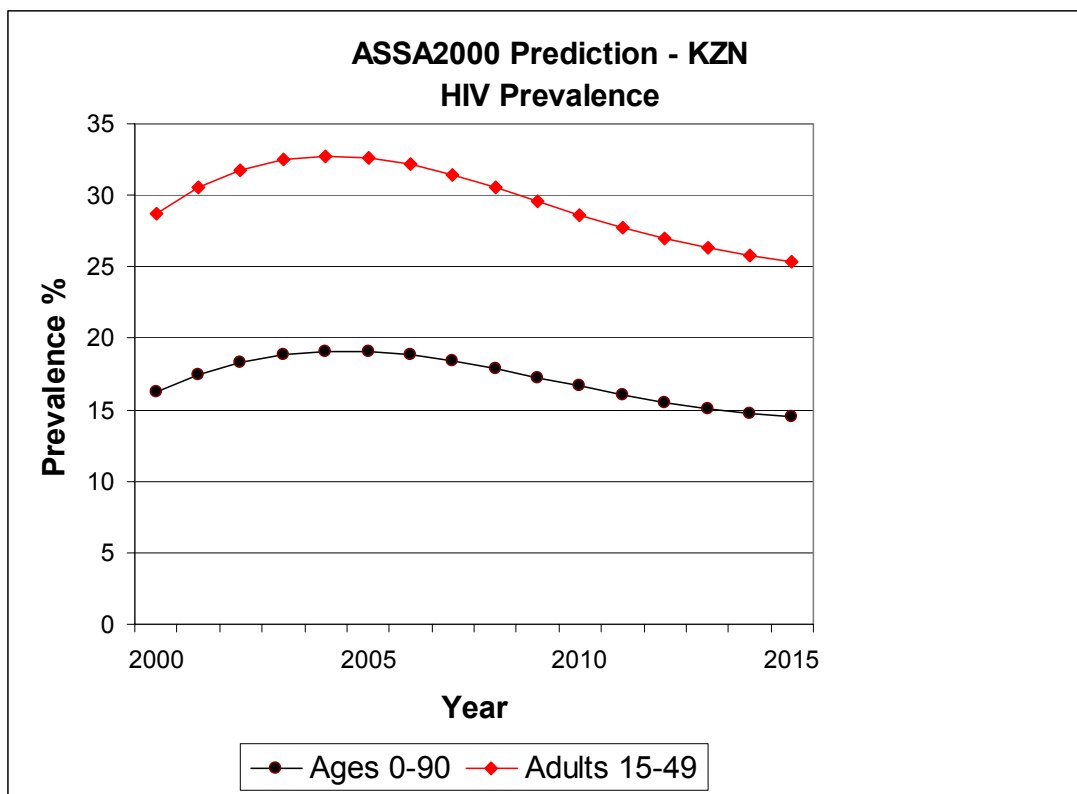
This is attributed to improved epidemiological data used in the model. The ASSA2002 model includes a number of new features not present in the ASSA2000 model, including amongst others: staging of HIV-AIDS, inclusion of ARV and other interventions, and phasing in of sexual debut for youth. Furthermore, the ASSA2002 model is calibrated using antenatal prevalence data for 2001 and 2002, whereas the ASSA2000 model uses data up to 2000.

Unfortunately ASSA2002 is only available in the “lite” version, i.e. for South Africa as a whole, and not for individual provinces. KwaZulu-Natal has a higher level of HIV infection than the average for South Africa, so applying the ASSA2002 model as it stands will not give a better projection for KZN than the ASSA2000 model. Therefore, the best way to interpret results from the ASSA2000 model for KZN is to regard them as a “worst-case” scenario, without interventions, in comparison to the ASSA2002 model.

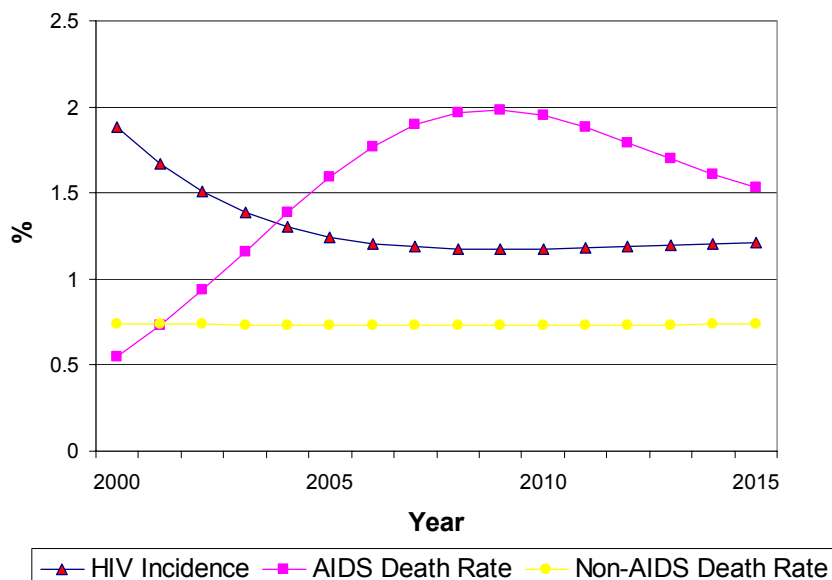
However, all these projections (including United Nations projections) have quite large margins of uncertainty. The size has not been rigorously determined, but once calculated, margins of 5% to 10% will not be surprising. I.e. if a prevalence in a given group is projected to be 30% in 2015, then if the true value turns out to be in the range 20% to 40%, it will not come as a big surprise.

The ASSA2000 projections for KZN, even if somewhat higher than the ASSA2002 KZN projections will be, and even if there are significant margins of uncertainty, nevertheless give a good indication of the pattern and scale of the epidemic, and how prevalence and AIDS are distributed by age, sex and race. A more accurate picture of the present and future state of the epidemic may be obtained by an in-depth study, including analysis of a range of prevalence and demographic data, and more detailed macro and micro projections.

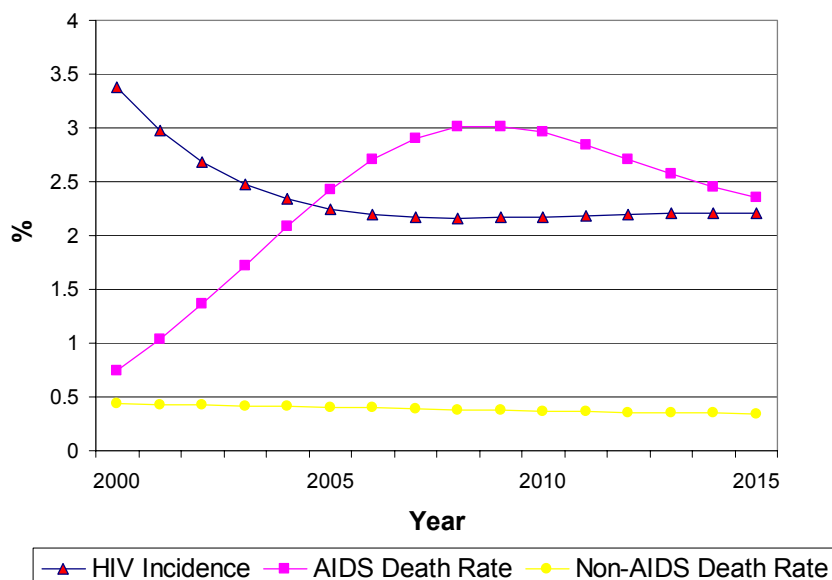
2.7. Projections



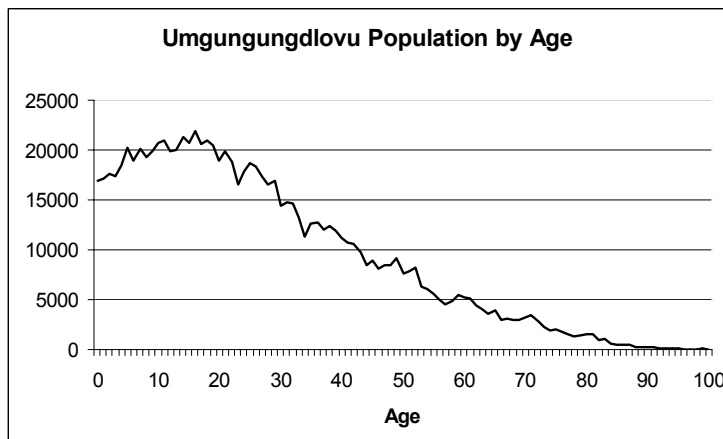
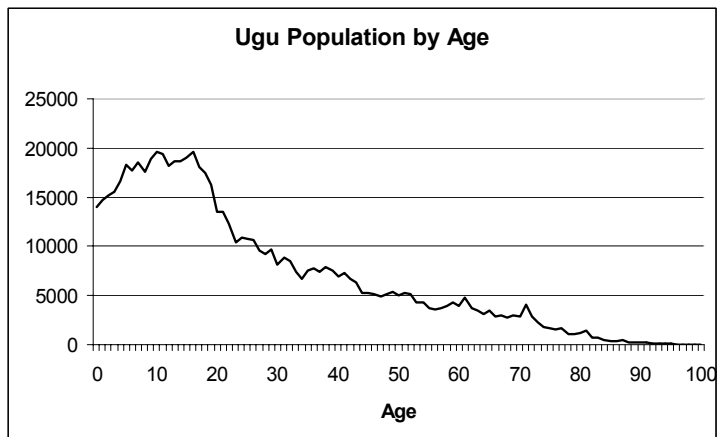
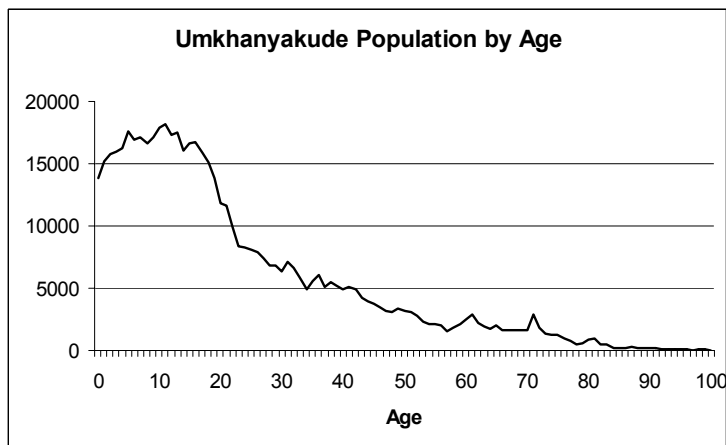
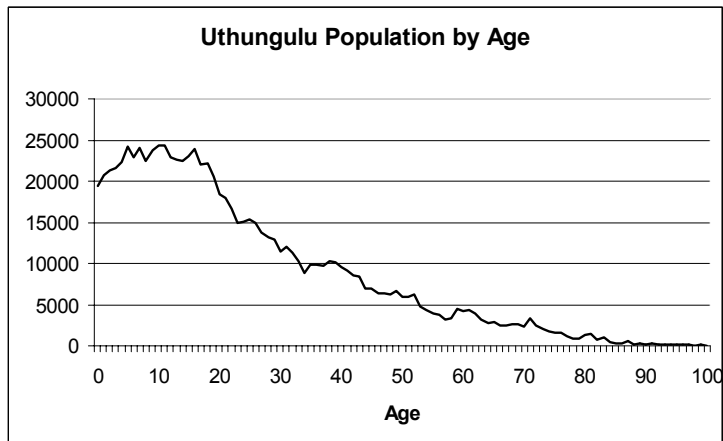
ASSA2000 Prediction - KZN
HIV Incidence, AIDS Death Rate, Non-AIDS Death Rate
Ages 0 - 90



ASSA2000 Prediction - KZN
HIV Incidence, AIDS Death Rate, Non-AIDS Death Rate
Ages 15 - 49



Populations of Districts by Age



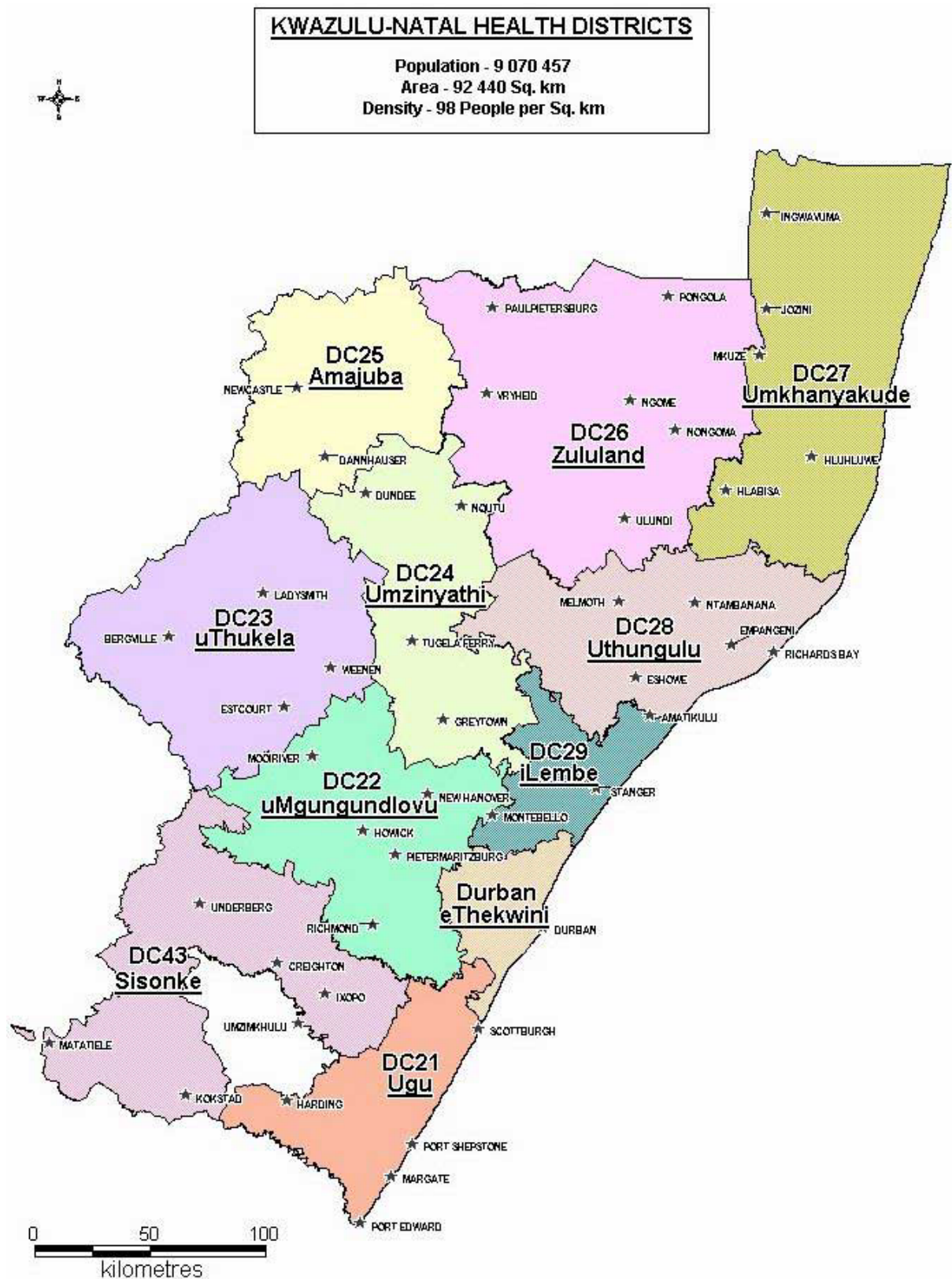


Figure 4: KwaZulu-Natal Health District

3. ECONOMIC DEVELOPMENT AND HIV/AIDS – THREATS AND OPPORTUNITIES¹

3.1. *The impact of HIV/AIDS on the Economy*

KwaZulu Natal has the highest HIV prevalence rate in South Africa, with an estimated 37.5% of antenatal clinic attendees in KZN being HIV positive. This is higher than the national average of 27.9% (Department of Health Antenatal Clinic Survey, 2003), and poses significant developmental challenges to the province.

The long term effects of the HIV/AIDS epidemic on certain economic sectors (particularly education, health and social welfare) have been extensively studied, as have the impacts of HIV on households, who bear the brunt of the effects of the disease. Significant negative effects are also felt by businesses, as the effects of a shrinking and less productive labour force, increased personnel costs, as well as decreased demand for their goods and services impact on their productivity, turnover and profits.

3.2. *Impacts on Business*

The HIV epidemic affects businesses in various ways, impacting on both the supply and demand sides of the economic equation. The effects of these impacts on individual employers are considerable: decreases in productivity, increased costs due to staff illnesses and deaths, higher health insurance premiums and low employee morale all present great challenges to businesses. Data regarding the effects of HIV/AIDS on SMMEs in particular are not currently available, although the epidemic impacts all firms, regardless of their size. It is likely that SMMEs may experience these impacts more severely than larger companies because of their more limited resources and reduced capacity to absorb shocks relating to increased costs and labour losses.

One of the major effects of HIV infection and mortality is to reduce the labour force and decrease productivity. Demand for certain resources may also decrease (as those affected by HIV/AIDS divert expenditure to mitigating the effects of the disease), which may result in decreased turnover and reduced labour requirements. However, demand for other goods and services (such as medicines, health and welfare services and funeral benefits) tend to increase, increasing the production stress on businesses in certain sectors.

Another significant impact of HIV/AIDS on business is increased costs, which negatively affects profitability. In a 2004 survey, nearly 40% of KwaZulu Natal businesses surveyed reported that HIV is having a negative effect on their profitability. Costs incurred by businesses include direct costs, such as those associated with assisting employees mitigate the effects of the disease, costs

¹ This section is a summary of a longer report contained in Appendix 5

around training, replacing employees as required, expenditure on AIDS prevention and interventions such as HIV testing, counselling and condom distribution. Indirect costs are not borne directly by the company, but contribute to revenue or productivity losses. These include factors such as increased absenteeism (either due to sick or compassionate leave), a decline in productivity by employees who are ill and increased workloads for human resource personnel and managers as they deal with the effects of the disease on their employees. The combined effects of direct and indirect costs are termed systemic costs, and include non financial costs such as lower morale and cohesion in the workplace, a net loss of skills and institutional knowledge. Together these three categories of costs contribute to the quantitative and qualitative costs incurred by companies affected by HIV/AIDS.

In a 2004 survey, 14% of KwaZulu Natal businesses reported that HIV is having an impact on their business. Impacts reported by these companies included lower productivity and more absenteeism (58%); a higher rate of labour turnover (48%); a loss of skills and experience (42%); increased training and recruitment costs (39%) and greater employee benefits costs (46%) (Ellis L and Terwin J, 2004).

3.3. *Impacts on Households*

HIV affects populations from the macro level down to the level of the household, with consequent interdependent demographic, economic and financial implications for households. Changes in the population size and structure at macro level eventually trickle down to household level with consequent long term changes in household size and structure, although the epidemic also has immediate effects on households. These begin with the onset of illness of a member of the household and the loss of income of the ill person (who is often the main breadwinner). If the main caregiver is economically active, this is often accompanied by further income loss as this second household member stays home to tend the patient. This impact on the ability of caregivers to earn an income, and because of increased household expenditure on healthcare, the economic and financial stability of the household is further compromised. Household financial security is adversely affected in both the short and long term: Quattek (2000) estimates that domestic savings as a percentage of GDP drop to 2% lower with AIDS than in the absence of the disease.

As the total disposable income of employed household members affected by the disease due to illness in the household decreases due to a reduced ability to work regularly or productively, children may be taken out of school due to financial pressures or the need for caregivers at home, with consequent impacts on their educational status and prospects. This has potential future negative effects on the earning power and economic status of these individuals and households. Total debility or death of the ill household member results in permanent loss of their income, with associated costs such as funeral and associated expenses.

Increased household expenditure on healthcare and funerals also reduces the households' ability to produce and buy food. Food security is negatively affected not only by financial constraints, but also by the inability of household members (whether they are too ill, too young or too old) to tend subsistence food crops. Consequent malnutrition further increases vulnerability to HIV and opportunistic infections, creating a vicious circle of poverty and increased susceptibility to disease. As a result, food insecurity can become a major problem for households affected by HIV/AIDS, a phenomenon that has been termed "new-variant famine".

A study conducted in the Free State found that, compared to other households, rural households and those directly affected by AIDS tend to be larger and poorer, and have higher rates of unemployment. Significantly lower income and expenditure levels are also apparent in these households, both of which decreased faster over time than in unaffected households (Bachmann and Booysen 2003). The average household incomes and expenditures of AIDS-affected households studied were between 12% and 29% lower than those of households unaffected by the disease.

Apart from the direct financial implications of HIV on a household, the stigma associated with the disease in certain communities, which can lead to discrimination, alienation and persecution may exacerbate the household's already dire social and economic situation.

3.4. *Impacts on Government Sectors*

HIV/AIDS impacts all areas of the public sector, as increased morbidity and mortality disrupt public service and result in higher personnel costs (with regard to, for example, pensions, healthcare and death benefits). While government revenues decline as the tax base expands more slowly (or fails to expand at all) and tax collection rates fall, there is a concomitant increase in government expenditure, particularly in the health and social welfare sectors (Haacker, 2002). Key sectors which will be significantly affected by the HIV/AIDS epidemic are health, transport, mining, education and water (Bollinger L, Stover J, 1999). In KwaZulu Natal, the long term effects of the HIV/AIDS epidemic on the education, health and social welfare sectors have been extensively studied due to the significant impacts HIV is predicted to have on these sectors in the province

Education

HIV/AIDS is impacting on the education sector in various ways, resulting in fewer teachers and pupils attending school, a decrease in the quality and availability of education for learners, and lower revenues for the sector as a result of fewer school enrolments and non-payment of school fees. Essentially, a reduction in both the supply and quality of educational goods and services (teachers and schools) and demand for education (pupils) is predicted, a combination which has long term implications for the economic development of the province.

Although declines in enrolment figures are leading to a decrease in demand for teachers, because the current rate of educator attrition is higher than this decrease, demand for skilled educators is actually increasing due to increasing AIDS mortality and the recruitment of teachers by the private sector. (Badcock-Walters 2000 and Badcock-Walters et al, 2003).

The combined effects of lower enrolments and educator attrition is predicted to lead to fewer secondary school learners and matriculants, with consequent negative impacts on the number of school leavers eligible for tertiary education, and long term impacts on the skills base in the province (Badcock-Walters, 2000). The combined effects of lower enrolments and educator attrition is predicted to lead to fewer secondary school learners and matriculants, with consequent negative impacts on the number of school leavers eligible for tertiary education, and long term impacts on the skills base in the province (Badcock-Walters, 2000).

Health

The effects on the public health sector relate not only to supply variables such as hospitals, personnel and the provision of medicines and care, but also to demand for healthcare goods and services by patients. The HIV epidemic increases the demand for both public and private healthcare services, and decreases the number of healthcare workers available to care for them due to HIV-related morbidity and mortality amongst healthcare personnel.

Apart from the costs of providing antiretrovirals to those who are eligible, HIV also requires additional expenditure to be incurred for palliative care, prevention of opportunistic infections and clinical treatment. Given that numbers of AIDS patients will continue to increase due to increasing infection rates and the fact that ART extends the lives of those infected, the number of patients requiring ART will continue to expand in the future, necessitating long term expenditure increases in the health sector. The total cost (including prevention and treatment) is estimated to exceed R19, 500 per patient per year (Haacker M, 2002). With an estimated 450,000 people in KwaZulu Natal in need of ART (Cullinan, 2004), this has significant cost implications for the provincial healthcare budget.

Social Welfare

Social welfare services are provided in various ways, including financial support to both public and private sector welfare institutions, the provision of grants for social security, support of community-based initiatives in order to promote income-generating projects for those not covered by social security, child support for poor and severely disabled children, and state pensions for the elderly. Apart from direct financial assistance, both adults and children affected by HIV may become dependent on the state to provide them with other support such as care, food and shelter.

The potential impacts of AIDS mortality on population growth and HIV-associated reductions in fertility are not reducing demand for state welfare

services, with the result that the already overburdened social welfare system is under extreme stress. HIV/AIDS will impact on the ability of the state to provide effective services to the needy in various ways, as HIV mortality reduces the number of people available to care for children and the elderly, and greater financial burdens on households as a result of increased poverty will increase reliance on state welfare services. The vulnerability of women and the youth to poverty and their reliance on state provided welfare will increase, whether through infection themselves or that of family members. The Department of Social Development predicts that the increasing number of people affected by HIV/AIDS will lead to continued growth in demand for state support.

4. SITUATIONAL ANALYSIS OF CURRENT PREVENTION, TREATMENT, CARE, AND MITIGATION PRACTICES IN THE FOUR LEARNING AREAS

4.1. *Introduction*

In section 2 we outlined the extent of the HIV/AIDS epidemic in KZN and listed the driving factors behind the explosive spread of HIV in our population. In this sector we discuss how various sectors have responded to the epidemic within the four learning areas. It must be noted that conducting a situational analysis for large geographical areas in the limited time available was a challenging task and the time limitations mean that an in-depth understanding of the situation was not possible. For example, even when considering a single, small NGO in one district, it was possible to obtain widely divergent views on how the NGO was functioning. It would take days to actually evaluate the functioning of such an NGO but, instead, we had to assess whole district in a few days.

As a result of these constraints, it is possible only to paint a relatively superficial picture of the situation in each district. However, the description that follows will provide the KZN-LED Support Programme with an accurate idea of the state of the response to the HIV/AIDS epidemic and who the main role players in each area are in each district.

This chapter begins with an overview of the role of local government in combating the HIV/AIDS epidemic and this is followed by a review of the situation in the four learning areas. This review serves to compare and contrast the district-specific situational analyses. Finally, for each of the four learning areas, a report on the local situation and response is presented.

4.2. *The Role of Local Government in combating the HIV/AIDS epidemic*

The development and implementation of HIV/AIDS policy at provincial level has in the past been heavily influenced by central government, with the national Department of Health playing a dominant role. National and provincial government jointly processes legislative and executive powers according to the constitution. The *National HIV/AIDS Strategic Plan* lays out procedures for all provincial policies in accepting the socio-economic dimension to HIV/AIDS. Provincial programmes seek to provide necessary social security, as well as to establish poverty alleviation projects in partnership with the private sector and NGOs/CBOs. However, provinces still heavily depend on central government, particularly for funding for their HIV/AIDS programmes, as their capacity to raise local revenues is substantially limited. Local government is responsible for promoting and creating a safe and healthy environment conducive to socio-economic development and growth. Furthermore, the implementation of the

national strategy against HIV/AIDS relies on the involvement of local government for the efficacy of the strategy.

Since 1994, all spheres of government have undergone a sea change that has resulted in a redefinition of their roles within the new political context. Local government has undergone a radical process of demarcation with newly defined boundaries and a transformed mandate, as well as new economic units. While previously the main functions of local government had mostly been focused on service provision and regulation, post-apartheid local government legislation requires local municipalities to promote democracy, maximise job creation through socio-economic growth; embark upon sustainable rural development; promote poverty alleviation strategies; and ensure the provision of services to communities in a sustainable manner. In order to pursue this, the main instrument used by local government is the Integrated Development Plan (IDP) that aims to promote economic development and address spatial and transport planning, infrastructure, development and regulation. Under the Municipal Systems Act, all local authorities are required to prepare annual and five-year IDP's that set out development targets with detailed projects and programmes.

While the constitution requires all three spheres of government to cooperate with each other while functioning independently, the mandates for local government's response to HIV/AIDS are not clearly articulated. The national HIV/AIDS strategy, the *Strategic Plan* is considered to be fairly comprehensive yet the development of this national strategy has not been matched by the development of capacity to deliver at local level. Until recently, national responses have on the whole have been centralised in the national Department of Health, with other centres of government, provinces, businesses and local government playing little or no part.

4.3. Overview of the Situation in the Four Learning Areas

A striking feature of this study has been the huge variation that is found in capacity and impact between districts and even within the same district. This pattern holds when considering the response of local government, business or the NGO/service sector.

When considering how local government is responding, there is, on the one hand, a case of national "best practice" in the case of Msunduzi municipality (see Box 1) but, on the other end of the scale, many other municipalities are doing virtually nothing. It appears as if those municipalities that are situated in metropolitan areas and are better funded and staffed, are the ones that have managed to mount a more effective response. These municipalities are also characterised by having high level political support for the programmes, usually from the mayor or deputy mayor, and by having a powerful individual who is able to drive the programme.

Box 1. An example of local government “best practice”

A local best practice example is the Msunduzi HIV/AIDS strategy currently being implemented, where key stakeholders are drawn in, partnerships are formed, and local government supports the strategy.

The Msunduzi Municipality comprises the city of Pietermaritzburg and the surrounding peri-urban and semi-rural areas with a population of slightly over half a million. The Msunduzi HIV/AIDS strategy has, since soon after its inception in November 2001, been hailed as an example of “best practice” when it comes to local government responses to the epidemic. Significantly more detail about the Msunduzi strategy and its impacts are available from the references listed below and so are only summarised here.

1. **High level political support.** From the beginning and through difficult times, the deputy mayor of Msunduzi has played a visible, strong and supportive role and also chairs the AIDS Steering Committee.
2. **Strategy had broad based support.** The strategy arose out of a workshop that was representative of key stakeholders such as local government and NGOs. It was based on a “continuum of care” principle meaning that it covered all issues from prevention through to care and support.
3. **Solid management structure.** Coordination of the Steering Committee was undertaken by the MOH, and has 6 Councillors, 6 representatives from NGOs and 2 business representatives. The committee has met monthly since inception.
4. **Accessing funding.** An R8 million budget was funded from council and through partnerships with NGOs, international donor and the private sector. This has enabled the Steering Committee to implement many projects.
5. **Partnership with NGOs.** The municipality has strong working relationships with NGOs and, in particular, the CINDI network of over 80 member organisations.
6. **Ward-based strategies.** A unique aspect of the Msunduzi Strategy has been the development of ward-based responses in 26 wards. The method was to use the local councillor to bring together local community members in a workshop where they discussed local issues and potential responses. AIDS Committees were formed and in many instances have developed into small CSO's and are now able to deliver services such as awareness raising and HBC.

It was of concern to notice in some districts that competition between municipalities undermined the potential for cooperation between them. For example, in one district the mayor from the district municipality and the mayor from the main metropolitan municipality are both vying to be mayor of the district. This causes friction, competition and “turf wars” between the structures and works against effective cooperation. In another district, party political differences appear to be undermining effective networking and cooperation.

It is apparent that there is a trend developing within municipalities towards the setting up of District AIDS Councils. The overall purpose is to coordinate the response within the district. In some instances, where the council has been established for sometime, the impacts are becoming evident (see Box 2). However, in other cases the AIDS Councils are still nascent and appear to exist on paper only with little obvious impact and few signs of effective networking.

Box 2. Effecting policy change through an AIDS Council

In one municipality, it was noticed by councillors and human rights NGOs that orphans were being evicted from their homes once their parents had died because they could not pay rent. Councillors and the NGOs brought their concerns to the AIDS Council on which they all were members and together drew up recommendations for policy changes to be considered by the Municipality. The District Local Government subsequently pushed through amendments to the legislation in order to protect orphans from such evictions and there is now a moratorium on such evictions.

The response to the HIV/AIDS epidemic by business in the four districts is similar to the pattern discussed in Section 3, i.e. that the bigger corporates tend to have HIV/AIDS programmes but smaller firms are either doing very little or approach the situation in an *ad hoc* manner. The response from the corporate sector arises largely out of enlightened self-interest in that there is a widespread belief that AIDS will negatively effect the “bottom line” of companies through impacts on worker benefits, decreased productivity and other costs. An effective HIV/AIDS prevention and mitigation plan can be highly cost effective if new HIV infections can be averted and the impacts of existing cases mitigated.

However, among smaller firms, many believe that the epidemic will not seriously impact on their operations because they do not have high worker benefits and take the attitude that unskilled labour is easily replaced. Other small firms are aware that the epidemic may negatively impact on them but they simply lack the capacity to mount an effective response. In this sector the response to the epidemic, where present, is often driven by humanitarian concerns more than from concerns about the impact on the company. So, for example, there were several cases where the owner/manager had agreed to put staff onto expensive antiretrovirals without planning for the long-term costs that will be involved. These *ad hoc* responses, while commendable at one level, tend not to be comprehensive (prevention interventions are frequently not considered) or sustainable. In only one municipality was there a programme specifically aimed at SMMES by the local chamber of business.

Turning now to the NGO/CBO sector, there has been a rapid increase in the number of organisations that are providing services related to HIV/AIDS. In some cases, NGOs/CBOs were set up specifically to address HIV/AIDS-related issues whereas in other cases the organisations initially had other aims, but have moved into this field because of the perceived needs. The size and reach of these NGOs/CBOs varies from small groups of 5 or 6 women in rural areas providing home-based care to large institutions with multi-million rand budgets providing a comprehensive range of services.

In a number of settings, this sector appears to be dominated by one or two large NGOs with both positive and negative implications. On the plus side, these institutions are able to provide reliable and high-standard services to business and the community. They frequently also tend to function as the hub of an HIV/AIDS network which effectively brings together the role players and allows more efficient use of resources in the area. A good example of effective networking is demonstrated by the CINDI network in

Pietermaritzburg, which has played a major role in building capacity within member organisations.

One potential negative impact of the mega-NGOs is that they tend to attract the bulk of funds and recognition and this causes resentment among the smaller organisations. They are perceived as dominating the field in the area and are seen as “gate-keepers” rather than as facilitators.

4.4. *Situation Analysis of the Four Districts*

This section of the report will provide a brief snapshot of each of the four learning areas of the EU KwaZulu-Natal LED programme. The overview of each learning area is drawn from two sources: census data for 2001 and 1996, as well as from interviews conducted within the four regions with local government, NGOs, CBOs, large and small businesses, and other stakeholders. The census data is used to provide a broad context for an analysis of more detail information regarding how the HIV/AIDS epidemic is being dealt with in each learning area.

The boundaries of the four learning areas correspond to the boundaries of the four of the ten district municipalities that fall within KwaZulu-Natal. The programmes four learning areas are as follows:

- Ugu
- uMkhanyekude
- uMgungundlovu
- uThungulu

Ugu District

The Demographic Context

The Ugu district is located on the south coast of Natal and stretches from the southernmost boundary of the eThekweni municipality southwards to the Umtamvuma River, which also serves as the KwaZulu-Natal/Eastern Cape border. The Ugu District contains six local municipalities:

- Vulamehlo Local Municipality
- Umndoni Local Municipality
- Umzumbe Local Municipality
- Umuziwabantu Local Municipality
- Ezingoleni Local Municipality
- Hibiscus Coast Local Municipality

According to the 2001 census, the population of the Ugu district is approximately 704 000 people. Figure 5 below provides a breakdown of how the population is distributed across the district. While non-Africans are present in all the municipalities, they tend to occur more commonly in the more urban coastal municipalities (uMndoni and Hibiscus Coast). The population of the municipalities in the rural hinterland is predominantly African, as is the Umzumbe Municipality which has a small coastal section.

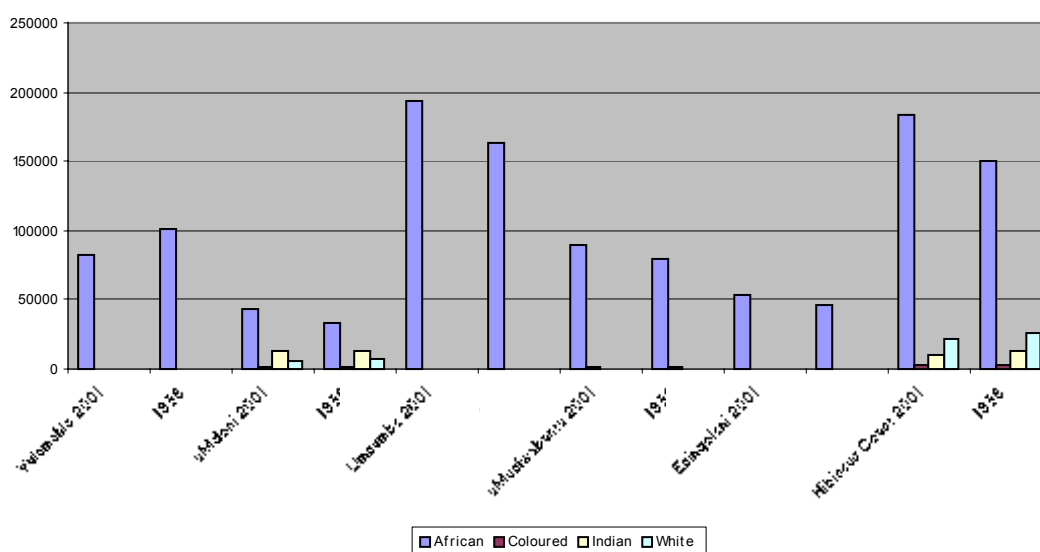


Figure 5: Population by local locality and race

The age structure the district changed very little between 1996 and 2001, as Figure 6 below illustrates. The potentially economically active portion of the population consists of between 55% and 57% of the total district population. The proportion of pensioners (people over the age of 65) is very small at 6% of the total population. This age cohort, along with women in general, tends to bear the burden of care for PWLHAs and their dependents.

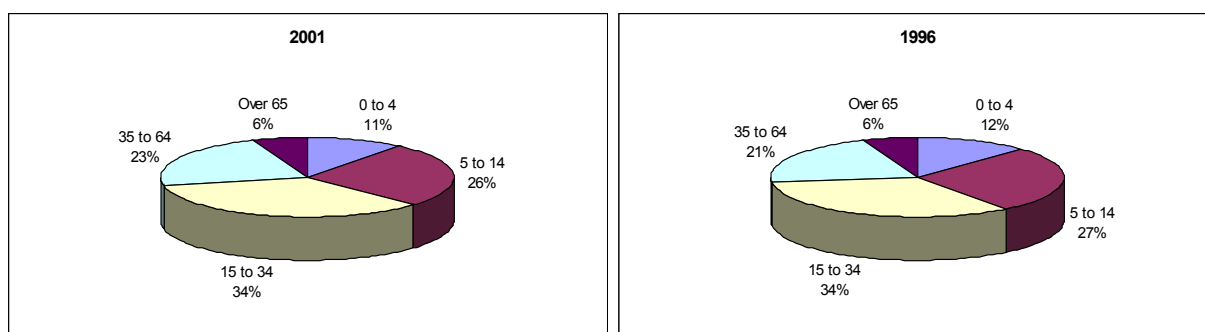


Figure 6: Ugu Population Age Structure 1996/2001

Figure 7 illustrates the education levels of the population aged 18 and above across the district. While levels of education have generally rose across the district between 1996 and 2001, the numbers of people with no schooling also rose. This suggests that the development of education facilities is keeping pace with the rate of population growth, but is not occurring fast enough to eradicate historical backlogs in education.

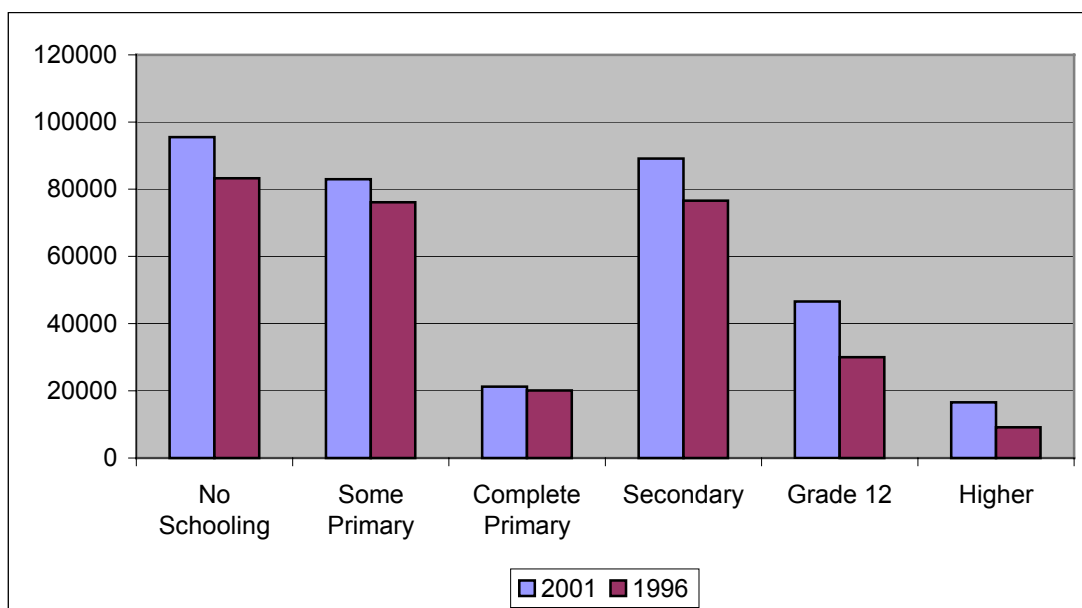


Figure 7: Ugu District Level of Education (Population Aged 18 and above)

Figure 8 below illustrates how the two key benchmark levels of education are distributed across the district. Large numbers of people in both the rural and more urban areas have no schooling, while the better educated portion of the population are better represented in the urban municipalities.

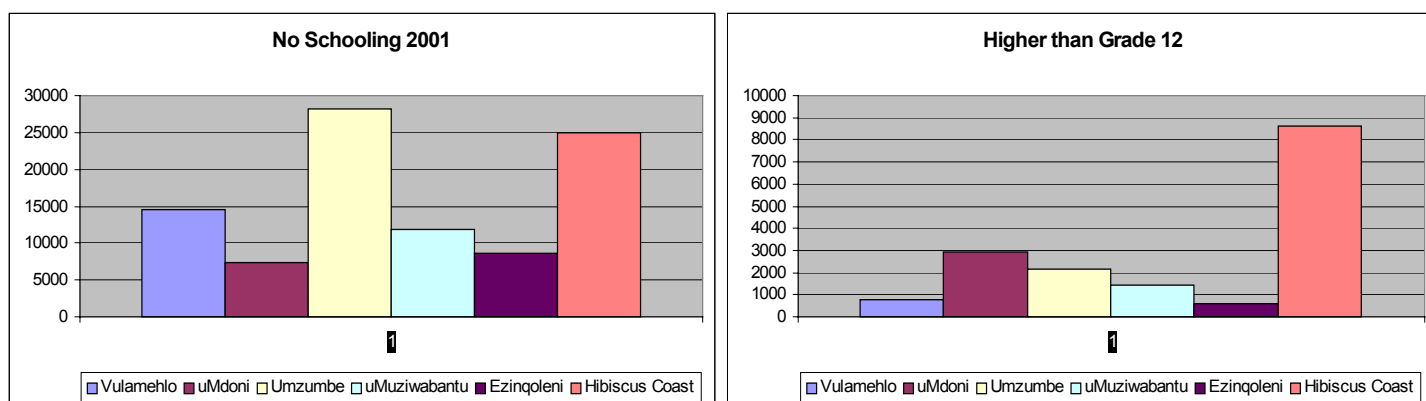


Figure 8: Comparative Levels of Education between Municipalities

As Figure 9 illustrates employment in the district remained stable or decreased slightly between 1996 and 2001, while unemployment increased in all the municipalities. The district economy displays similar characteristics to the national economy in its inability to absorb a growing labour market. While levels of unemployment are highest in the most urban municipality, the adjacent Umzumbé municipality also has high levels of unemployment.

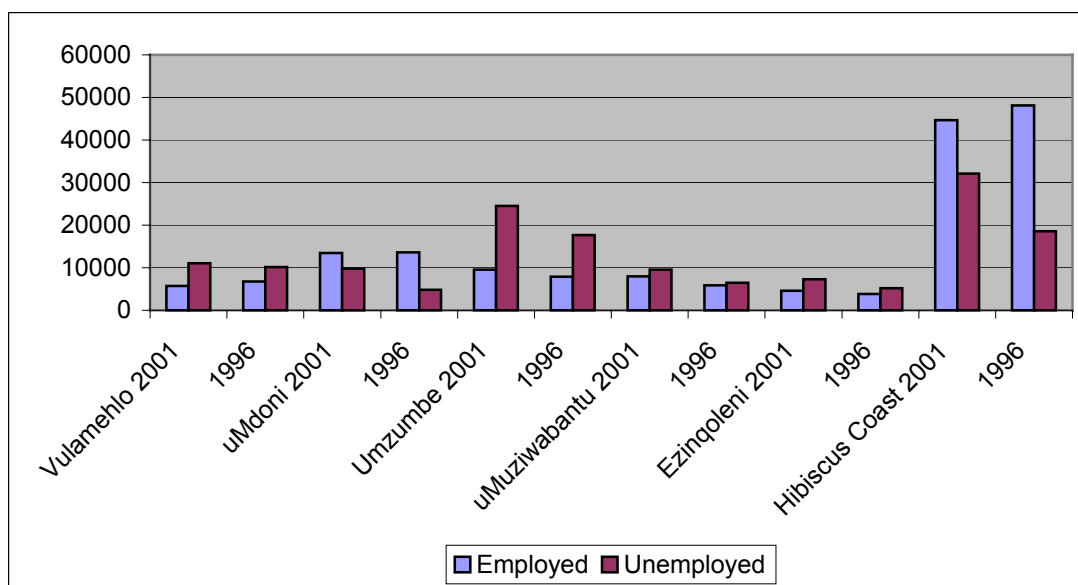


Figure 9: Employment in Ugu

As Figure 10 illustrates, the sectors of the Ugu economy showing the largest growth between 1996 and 2001 have been the Community/Social/Personal and Transport/Storage/ Communication sectors. The period between 1996 and 2001 saw an expansion of local government across the country and it is likely that the growth in the Community/Social/Personal sector is as a result of this. The growth in the Transport/ Storage/ Communication sectors is probably as a result of the growth of the communication component of this sector, as Internet technology has become more pervasive. Key sectors that are often looked to as indicators of the health of an economy, such as manufacturing and construction were in decline between 1996 and 1997, but the growth of the Financial/ Insurance/ Real Estate/ Business sector suggest that the economy overall is not in decline but rather becoming more sophisticated with a greater focus on the service industry.

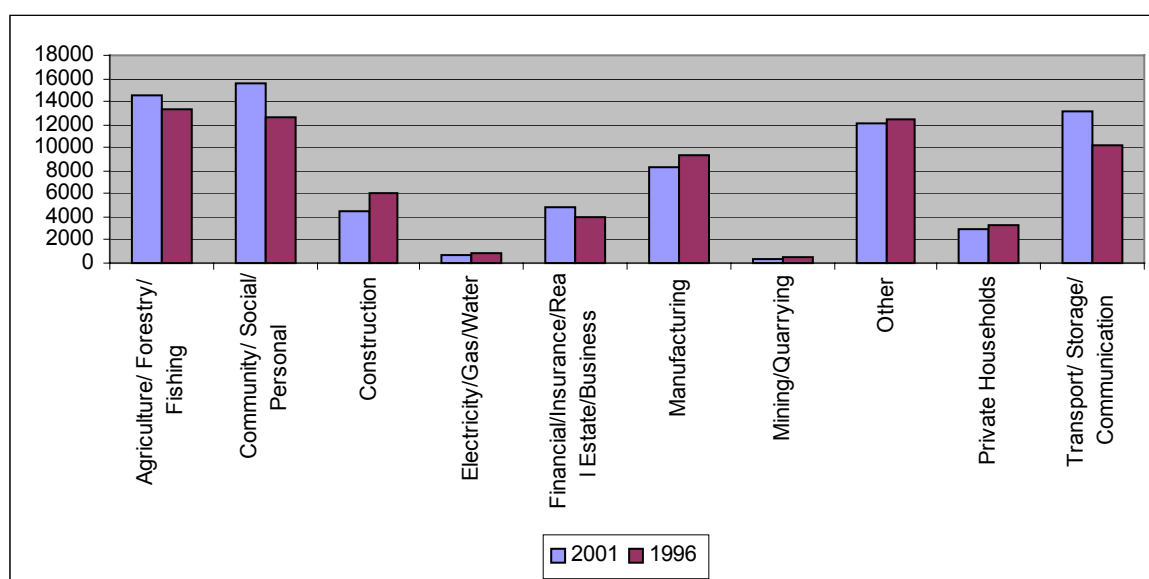


Figure 10: Employment by Economic Sector

HIV/AIDS Service Providers

Most NGOs and CBOs in the district have realised that in order to be effective in their efforts in combating the HIV/AIDS epidemic they need to become part of a network. This allows them to extend their reach and enhance their effectiveness through co-operating with organisations offering complementary services. There has also been the development of “mega” NGOs such as the South Coast Hospice and Ziphakamise, that act as conduits of national and international funding, and that co-ordinate activities between NGOs operating in local communities and CBOs. These “mega” NGOs also provide important support services in terms of training and capacity building.

Box 3: Murchison Hospital – The Retro Team

Murchison Hospital serves approximately 200,000 people in Southern Natal (along with a number of other hospitals). Murchison was originally a mission hospital but was taken over by the government in the 1970s. HIV/AIDS prevalence rates are 39% according to the ante-natal survey and 23% according to other surveys. Prevalence in the area appears to be stabilising.

The main example of best practice promoted by Murchison Hospital is the palliative care programme known as the “Retro Team”. This programme was developed in house in partnership with South Coast Hospice in 2001 in response to a recognition of the fact that the hospital would in the future be overwhelmed by increasing numbers of terminally ill AIDS patients.

The approach is based on the fact that AIDS patients coming to the hospital are usually accompanied by relatives. The dedicated retro team (i.e. only deals with HIV/AIDS cases) interact with relatives while admitting, counselling and treating the patient’s opportunistic infection. Relatives receive counselling and training with respect to home based care and prepared for taking the patient home within a few days when the patients begins to respond to the OI treatment.

Management of the patient is taken over by South Coast Hospice when the patient leaves the hospital. This approach has reduced the in-hospital stay of HIV/AIDS patients by half, freeing up beds for other patients, it has increase morale amongst hospital staff and equipped both relatives and patients with the skills and knowledge needed to undertake caring activities.

Some NGOs have also recognised that one of the key drivers of the spread of HIV in the District is poverty. Furthermore, there is also a growing recognition that the illness does not only have an impact on the infected individual, but also has impacts among the broader community. Consequently, increasing numbers of NGOs and CBOs are adopting a developmental focus and undertaking programmes that also result in benefits accruing to the wider community, as well as providing care and support to PLWHA. For example, NGOs often promote food gardens within communities. In addition to providing people with constructive activities (thereby dealing with some of the psychological aspects of AIDS), food gardens also contribute to enhancing the nutritional status of the community (another key intervention in the management of PLWHA).

Box 4: South Coast Hospice - First, Last and Everything

South Coast Hospice was founded in 1983 with a specific mandate to provide care for cancer patients. Since then the focus of their mission has shifted and although they still deal with the same number of cancer patients, the bulk of the patients cared for are HIV+.

South Coast Hospice was one of the 'first movers' in positioning themselves to deal with the HIV/AIDS epidemic. Consequently they have built up a large body of institutional knowledge of how to undertake HIV/AIDS interventions, which they have formalised into a range of training courses. Their 'first mover' status and the rigour of their training programmes has attracted the attention of international funding agencies, and the Hospice is looked to as a key source of knowledge and capacity in dealing with the epidemic. Interviews with stakeholders in the other three learning areas revealed some level of input at some stage in their development from South Coast Hospice.

While the Hospice has made an invaluable contribution to building capacity and transferring skills, it has been criticised from some quarters for attracting funding that could go towards the development of smaller NGOs and CBOs because of its reputation and status.

The coverage of NGOs and CBOs seems to be most concentrated along the coastal strip where most of the economic activity is concentrated. However, there are some NGOs providing services in the poorer rural hinterland. These tend to be the larger more established NGOs and they frequently work with community groups in these areas.

Most of the activities undertaken by NGOs and CBOs are concentrated on dealing with the social welfare aspects of the epidemic. In this respect these organisations assist both the state sector and local communities. NGOs and CBOs provide assistance to households in acquiring the documentation needed to apply for grants such as identity documents and birth certificates, as well as assisting in applying for the grants themselves. NGOs and CBOs also form part of an early warning system alerting the government departments to the existence of newly orphaned children and assisting the Department of Health in post-treatment activities (See Box 3 and 4).

Box 5: Ziphakamise - The Supportive Networking Model

Ziphakamise have used a model of intervention whereby they try as far as possible to remove the administrative burden from CBOs and NGOs, and in so doing allow these organisations to concentrate on their core activities. Ziphakamise provides secretarial support for CBOs and NGOs, accesses funding on their behalf and assists with training and capacity building in terms of HIV/AIDS interventions. This approach while enabling NGOs and CBOs to maximise their impact has come in for some criticism by groups that feel that it creates a culture of dependency among NGOs and CBOs and does not contribute to the long term sustainability of these organisations.

Business

The economy of the Ugu District is characterised by a large number of SMMEs focussed on the tourism industry and related support services located largely along the coast. According to the Hibiscus Coast Chamber of Commerce, most of these businesses are very small (with less than 10 employees) and consequently don't have the internal infrastructure to offer even basic education and awareness raising with respect to HIV/AIDS issues.

The Chamber of Commerce provides small business with access to a training kit produced by SACOB that includes a video, worksheets and a programme that businesses can run themselves.

The higher levels of absenteeism associated with the HIV/AIDS epidemic has a high impact on the productivity of small businesses and their ability to plan their productive activities. Furthermore, the combination of frequent absenteeism combined with the unwillingness of people to test for HIV or disclose their status has caused small business to view the epidemic as more of a labour relations issue rather than a medical one.

The epidemic is also having indirect impacts on small business particularly with regards to the amount of red tape that small business needs to deal (by implication the effect of this in terms of the cost of doing business). For example, in many cases employees borrow large amounts of money and borrow frequently to finance the funerals of family members. Inevitably, this debt is defaulted on and the employee is taken to court, which issues a garnishing order requiring the employer to deduct a portion of the employee's salary every month in order to pay the employee's debtors. The extra work that this requires has resulted in some small businesses having to employ someone to deal only with salaries and the legal issues around garnishing orders.

Local Government

Ugu is dominated, like many district municipalities in KwaZulu-Natal, by a single strong municipality, which is both wealthy and has high levels of capacity. In theory each local municipality should be in a position to run its own HIV/AIDS programme. In practice this is only being done by the Hibiscus Coast municipality, which has set up its own AIDS council, is supporting various NGOs and in collaboration with South Coast Hospice is running training programmes in stress management, counselling and nutrition.

The role of the district municipality should be to co-ordinate the activities of the local municipalities. However, due to capacity constraints very few local municipalities have developed their own programmes. In order to support these municipalities, the district has been very proactive in running workshops with local municipalities to assist them with the identification of priorities and possible projects. A plenary workshop is scheduled for the first half of 2005 where a HIV/AIDS programme for the Ugu District will be drawn up based on the priorities identified by the local municipalities.

The district municipality has recognised the higher levels of capacity in the Hibiscus Coast Local Municipality and provides funding support to their activities. There is an attempt by the District to try and move away from awareness raising activities towards a more comprehensive and integrated approach. Currently the poorer local municipalities HIV/AIDS programmes consist of a yearly rally, usually around World AIDS day, where local bands play and t-shirts are handed out. While not undermining the importance of awareness raising, the district municipality feels that HIV/AIDS programmes

need to go further than this and start helping HIV/AIDS infected and affected people manage the impacts of the disease at household and community level.

The person in charge of the HIV/AIDS programme for the District was also instrumental in setting up the internal programme for the district municipality. The internal programme is supported by both officials and councillors who have committed funding in the municipality's budget to run the programme for the next two years.

The only local municipality that seems to have an effective work place programme is the Hibiscus Coast Local Municipality. While having broad support from councillors and politicians, this programme is yet to be taken seriously or mainstreamed into the municipality. The programme has not been established as a cross cutting one, but rather oversight of its activities has been shifted between at least three departments in two years. Interviews with role players within the municipality left the impression that this was more due to a lack of capacity in terms of managing cross cutting programmes rather than a perception that the programme was not an important one.

uMkhanyekude District

The Demographic Context:

The uMkhanyekude district is located in Northern KwaZulu-Natal and stretches from St Lucia and Mtubatuba in the South to the Mozambican border. The uMkhanyekude District contains five local municipalities:

- Umhlabuyalingana Local Municipality
- Jozini Local Municipality
- Big Five False Bay Local Municipality
- Hlabisa/Impala Local Municipality
- Mtubatuba Local Municipality

Most of the land area covered by the District formerly fell under the jurisdiction of the KwaZulu administration.

Figure 11 provides an overall picture of the population distribution within the uMkhanyekude District. Jozini which has the largest urban in the north of the District has the highest population of all the local municipalities and appears to have the fastest growing population in the District. The Big Five False Bay Local Municipality has the lowest population at just above 20 000 people, which is consistent with the fact that large areas of this municipality are environmentally protect and form part of terrestrial and marine parks and reserves.

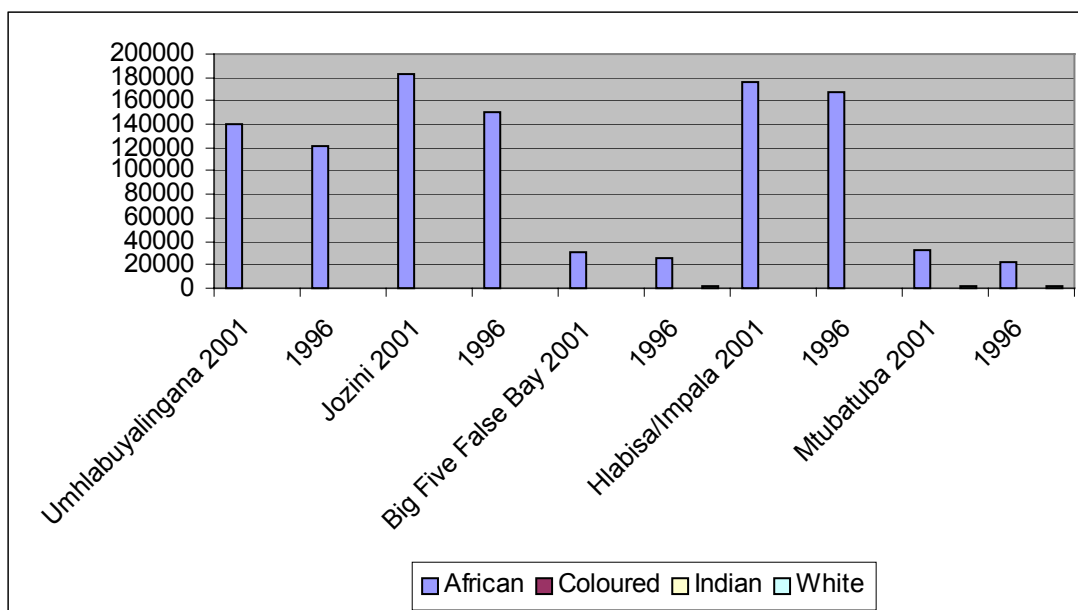


Figure 11: Population by Local Municipality and Race

Overall the population age structure in the uMkhanyekude District has been stable. Most people within the district municipality fall into the 15 to 34 years old age cohort. 52% of the population fall into the potentially economically active age group. This figure is slightly higher than the one recorded in 1996. Due to the overwhelmingly rural nature of the district rural nature most of the demand for employment arising from population growth is likely to be met outside the district

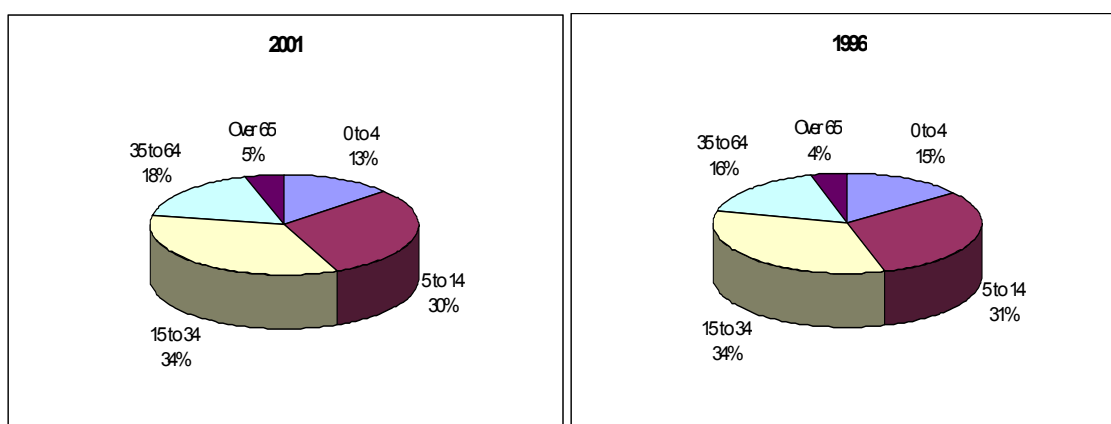


Figure 12: uMkhanyekude Population Age Structure 1996/2001

The largest age cohort in the uMkhanyekude District fall within the 15 to 34 age bracket. Between 1996 and 2001 there has been a noticeable change with the 0 – 4, 5 – 14 and 36 – 64 age groups dropping in favour of the 36 – 64 and over 66 age groups. The 15 – 34 group has remained unchanged. The economically active group rose from 50% in 1996 to 52% in 2001 indicating a rising need for employment activities.

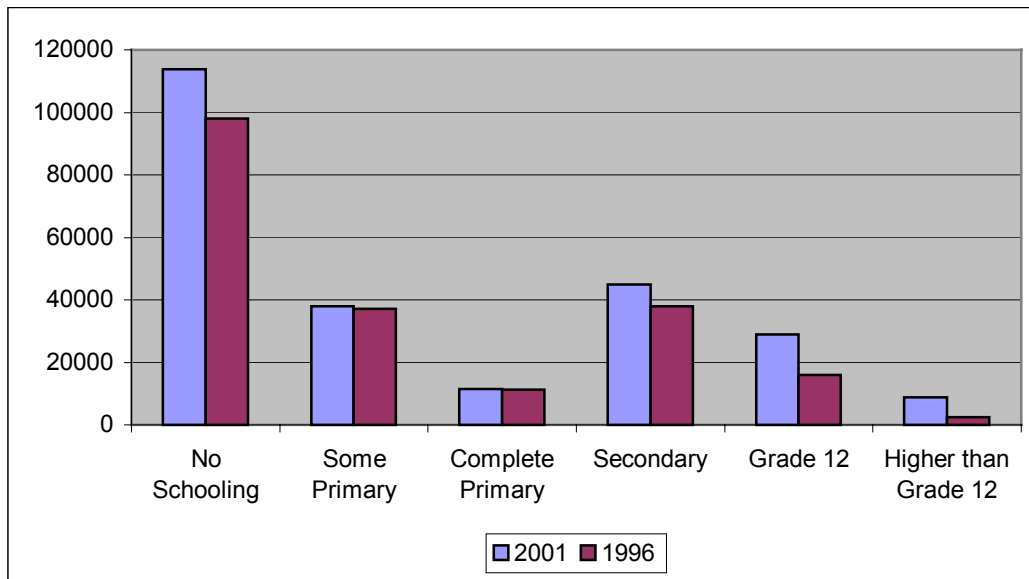


Figure 13: uMkhanyekude District Level of Education (Population Aged 18 and above)

Figure 13 above indicates that education levels generally increased between 1996 and 2001 in the uMkhanyekude district. The number of people with no schooling also increased.

As Figure 14 below illustrates how two key benchmark levels of education are distributed across the district. The southern, less remote areas of the District seem to have lower numbers of people who have had no schooling. Numbers of people with tertiary training are low compared with other areas of the province, and with the exception of the Big Five False Bay municipality, are evenly spread throughout the District.

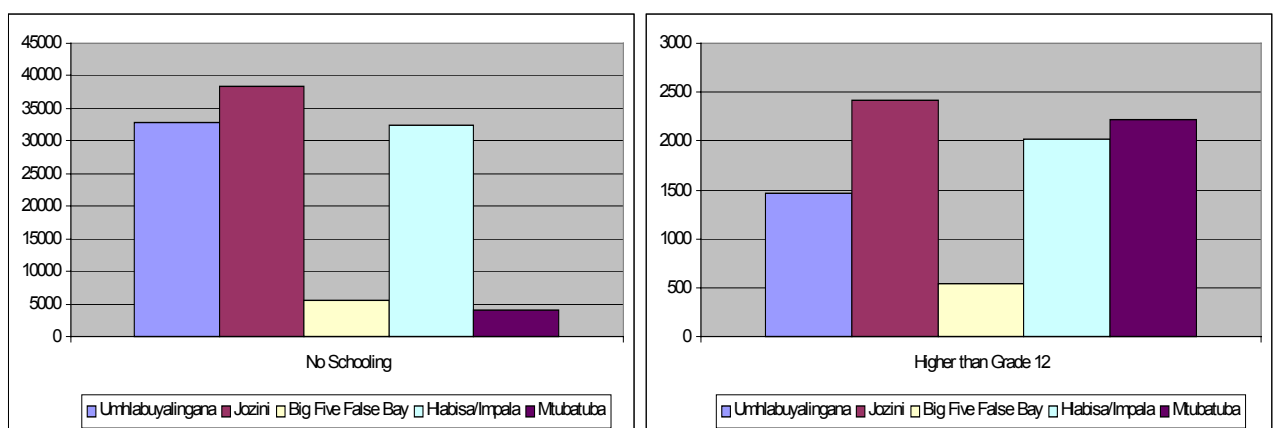


Figure 14: Comparative Levels of Education between Municipalities

Figure 15 illustrates very vividly the high levels of unemployment in the district. On the whole employment has been stable in the 5-year period between 1996 and 2001. All local municipalities in the uMkhanyekude district

have seen a increase in unemployment with the exception of Jozini Local Municipality, which has seen a large amount of investment since the mid-nineties and has developed into a vibrant urban node offering a range of retail, financial and government services.

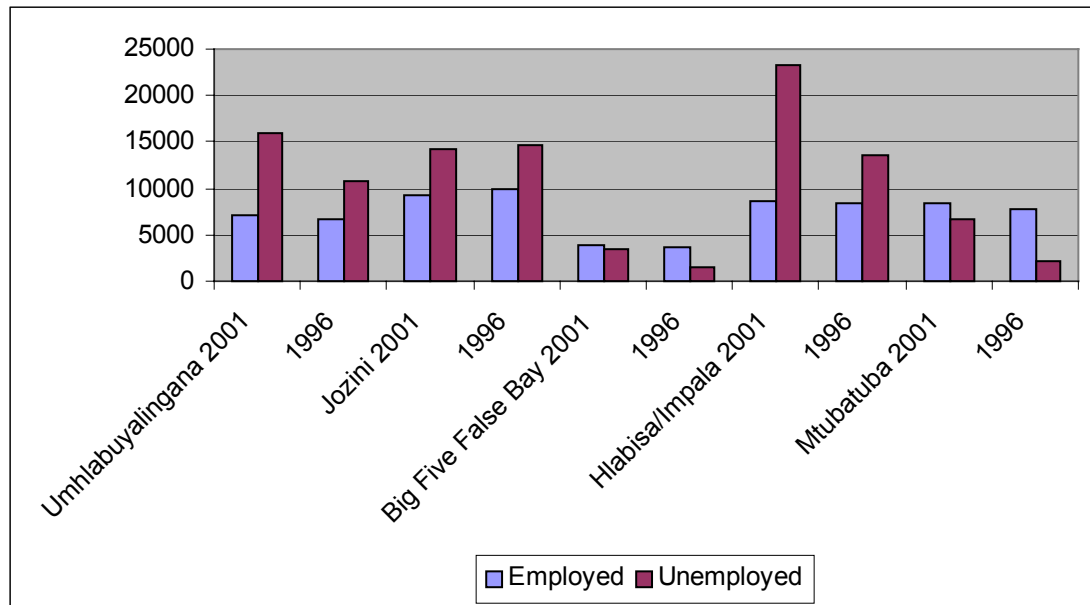


Figure 15: Employment in uMkhanyekude

As Figure 16 illustrates, the District has seen a decline in its role as an area of primary production, although the decline in employment in the Agriculture/ Forestry/ Fishing sector could be indicative of higher level of poverty as people move from commercial agriculture to subsistence activities. Post-apartheid government reform has resulted in a higher coverage of government services in remote rural areas and consequently an increase in the number of jobs in the Community/ Social/ Personal sector. The increase in employment in the Wholesale/ Retail sector is reflective of the high levels of investment in the town of Jozini and the subsequent enhancement of its role as a service centre for the northern part of the uMkhanyekude District.

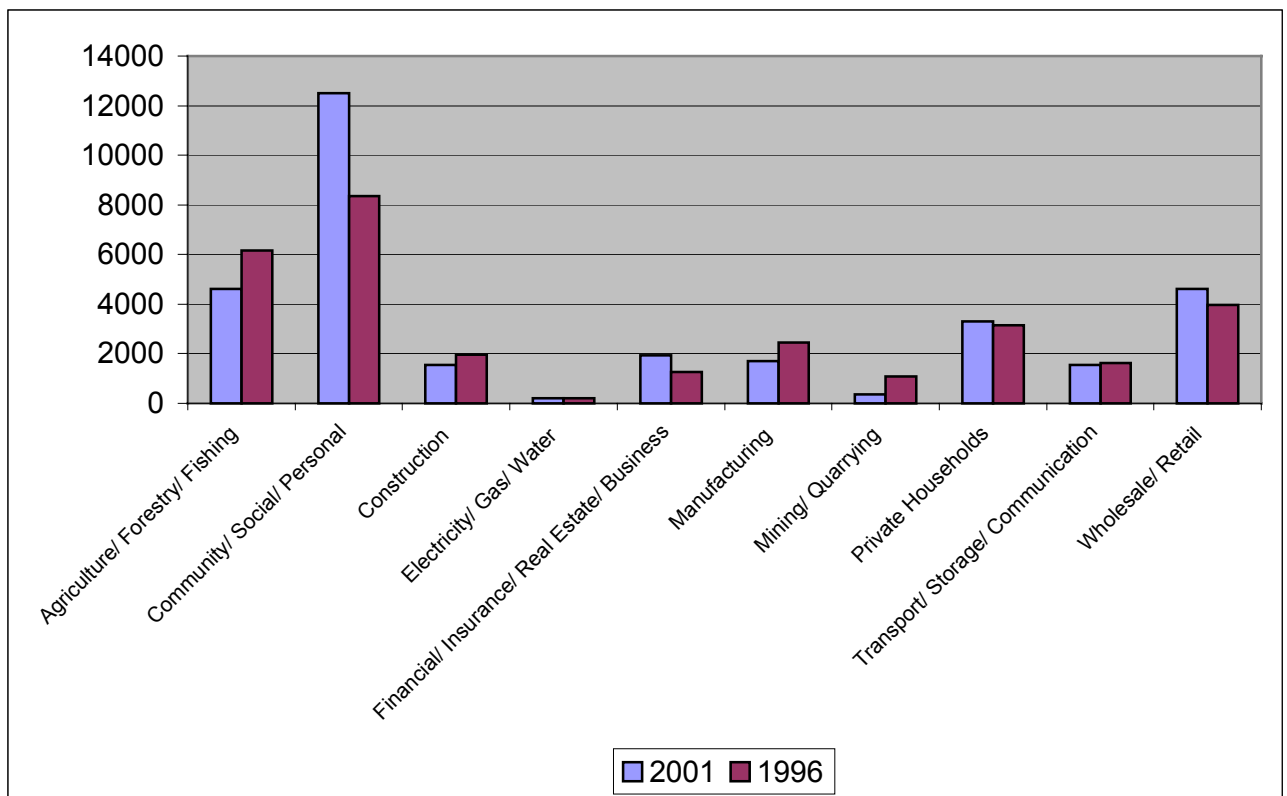


Figure 16: Employment By Economic Sector

HIV/AIDS Service Providers

It seems that there are relatively few service providers in this region. In the Josini area an NGO called Sibambisene coordinates efforts in the region, but they would seem to be the only operative coordination body at present(see Box 6).

There seem to be two distinct different views of Sibambisene

- One is seeing it as a valuable resource that has a clear coordinating role, providing a conduit for funding (Ingwavuma Women's Centre gets their funds (or a portion) through Sibambisene) and some other services.
- The other views Sibambisene as a gatekeeper that favours a small group of organisations and excludes some smaller organisations who are finding it difficult to raise funds directly for themselves, as funders prefer to fund through Sibambisene.

A definite gap exists between Sibambisene and the uMkhanyekude District Municipality. Both are supposed to perform overarching coordination, but political polarisation is obstructing communication.

Box 6 – The Sibambisene Project

Housed within the DoH “Drop In” VCT centre, is the “Sibambisene District Partnership” (SDP) which is an HIV/AIDS NGO that was only started about 9 months ago.

A notable aspect of this project is that it is very much directed at individuals and groupings in the community rather than being a centralised institution. There is also a remarkable integration of projects with referrals going between those providing HBC, the prevention activities and the IGA component.

Home Based Care

The manager of HBC works with 16 organisations doing HBC in the district. Her main responsibilities are to facilitate the organisations activities, budgets, technical support and assist in capacity building. SDP pays the stipends for 5 volunteers in each organisation although many of them have more than 5 volunteers.

SDP also provide HBC kits and liaise between the organisations and several government departments in the district. The manager also conducts site visits and conducts quality control. Volunteers from the organisations produce monthly reports.

The volunteers have good working relationships to the clinics and clients are referred between the volunteers and the clinics. The manager has a relationship with DEBA – ex miners organisations and this facilitates access to services by ex-miners who are sent home because of illness.

The volunteers may potentially be ARV supporters in the longer term but will obviously need training. Currently the volunteers encourage community members to go for VCT, and they facilitate disclosure by HIV+ individuals to their families.

In addition, the manager conducts advocacy activities such as negotiating with government departments such as Home Affairs to decentralise their services so that they are more accessible to the community.

M&E

The manager has a good working relationship with District DoH and the HIV/AIDS District Coordinator, Mrs T. Thwala in particular.

Education and Prevention

This projects main role is to facilitate, mentor, support, monitor and assist CBOs HIV/AIDS prevention and training activities. The manager assists in drafting activity plans and conducts monthly activity and financial monitoring by visiting areas where the CBOs in the area come in together to report.

Currently, there are 11 CBOs under this manager and most are linked to a PHC. As with the HBC initiative, this manager provides stipends to 5 volunteers per organisation although the organisations often have more than 5 volunteers.

The volunteers conduct education and prevention activities in a variety of settings including doing door-to-door visits, provide advice and referrals to VCT centres, give talks at schools, promote PMTCT and emphasise the “ABC” message. Most volunteers have been on 10 days basic courses that they have sponsored themselves but the DoH is now offering training to all volunteers.

The manager also has links with Traditional Healers and their associations and is having success in changing the notions that a person who is sick needs medical care and is not being bewitched.

This manager also has a Sunday slot on the local community radio station where invited guests or the local CBOs give talks on a variety of subjects such as VCT, PMTCT etc. People can phone in and ask questions and air their views.

Socio-economic Mitigation

The main goals of this project are to identify areas and groupings suitable for income generating activities (IGAs) and to provide support in training in business skills and financial management for the facilitators of each IGA. Currently there are 13 organisations involved in IGAs with most of the IGAs being involved in food production but increasingly becoming involved in producing broiler chickens, food processing, block making and sewing. Most IGAs are linked to hospitals and clinics so that sick individuals may be referred to an IGA to access food.

The criteria for becoming involved in a food production IGA are that the group has to have a garden of more than a hectare and grow not more than 3 crops on the site. Most IGAs have working relationships with HBC volunteers to supply ill people with food. The manager has also secured markets for food sales such as the upmarket Phinda reserve which will purchase a variety of fresh foods and negotiations are underway with Royal Food who have the catering contract with the 5 hospitals in the district. The next tender for organisations to provide food for SDP meeting will have a requirement that 50% of their food must come from IGAs.

Since June 2004, over R 800 000 has been disbursed to IGAs and another 7 organisations have been identified and their budgets submitted.

This manager also runs a micro-finance scheme which provides R1000 per person. There are currently 328 people who have accessed these loans. The criteria for accessing micro-finance is that the person must be a SA citizen, unemployed and have kids to support. This is because this initiative is aimed at assisting OVC. The SDP has a relationship with the Post Office who give 7% interest to groupings of a minimum of 5 people.

The purpose of the loans is to start a business such as ice cream selling and other hawking activities or to start other small businesses.

The micro-finance scheme is separate from the IGAs with the focus of this component being on individuals who belong to groups whereas the IGAs are targeted at groups.

The Ingwavuma Women's Centre is one of the more visible organisations in the area and its operations are summarised in Box 7.

Box 7: Ingwavuma Women's Centre

This centre was established in 1999 as the Hlengizwe Women's Club with government funding. Funds now comes from BMS and NMCF via the Sibambisene network. About 350 women participate in the club and the focus is on craft manufacturing and selling including embroidery, basket weaving, bead goods, pottery and sewing. They sell bed nets to AMREF and are attempting to get contracts to provide the health services with linen and schools with uniforms.

The IWC also runs an HIV Support Programme which is linked to the hospital. The premise behind this group is that those on ARVs need money, partly to ensure good nutrition, so they need to look at income generating activities. The IWC wants to see that these women eat and also to potentially distribute ARVs from the IWC. The IWC also has Mrs Mkhonto, a retired nurse and Nokothula Gumede, a trained social worker who assist in the activities at the Centre.

The IWC is actually registered as a Drop-In Centre for Women. They are applying for more assistance from the Department of Social Welfare, but the only assistance they get at present is social workers who come when needed. The voluntary workers at IWC (trained lay counsellor, nurse, social worker) will follow-up with women and ask them if they have informed their partners of their status, and generally do counselling and advice around their condition.

IWC also assists women with obtaining grants and runs a school programme for victims of rape during the school holidays. This is more for self-esteem building. There is not enough capacity to run a full rape crisis centre.

IWC is keen to get a way to establish a micro-loan system in the area so that women starting businesses can get some financial assistance. The IWC has investigated options and one option is via the "stokvel" route

There are a number of other service organisations in the district including another women's project at Manguzi. The Ingwavuma Orphan Care Project operates in the same area as the IWG and they have contact with each other. Nakekelisizwe, based at Bambanana, is also involved with orphan care. They have a computerised network of information on the orphans they have identified.

Business

There are very few big businesses in the area but the larger ones do seem to have HIV AIDS programmes for their staff although our impression was that they were not very comprehensive when present.

One of the biggest employers in the region has noticed a considerable increase in deaths among staff at all levels. However, the company is currently going through an uncertain phase and this impacts on the companies operations and HIV/AIDS activities. Back in 1999, this company was leading the way in HIV/AIDS programmes and they had a very successful HIV surveillance and VCT campaign. A lot of effort was also put into reducing the prevalence of STIs among the workforce. However, the programme has contracted since 2000 along with a reduction in the number of clinic staff running it. A peer education programme is still functional, there are awareness raising programmes, employees have access to VCT and condoms are provided. However, employees do not have access to ARVs.

Local Government

A Strategic Plan for HIV & AIDS in uMkhanyekude was formulated, stating that there was a need to coordinate interventions to improve the results of the money and effort that was being spent in the area. As far as possible, the Strategic Plan was drawn up through a consultative process and the mechanism for implementation was the District AIDS Council. This really picked up on the initiative of the Dept of Health PAAU, which was trying to promote the establishment of these District AIDS councils throughout all the district level municipalities. It was also generally agreed that although HIV/AIDS are medical conditions, the solutions really lie in the socio-economic spheres, as the stigma and myths attached to the disease were, and are, fuelling its spread.

The District did employ an HIV AIDS programme director, who apparently left after six months and as far as we know, has not been replaced. It appears that the Director: Community Services has taken over the portfolio in the interim. It is also perturbing that the District AIDS Council seems inactive, and

contact with the HIV AIDS programme director is almost inexistent. Therefore, it appears that there is not yet anyone or any organisation that has picked up the mantle of coordinating efforts around HIV/AIDS.

Regarding the role of the local municipalities, it was observed that more information is needed but a political schism exists between the District and local level municipalities. Politics & power dominates activities in the district, not the least HIV AIDS efforts, but hampering progress in general.

Jozini have set up a series of counsellors for each of their wards, but the effectiveness of this initiative is difficult to determine. It is not known what the other municipalities are doing. All the municipalities participated in the Strategic Plan, but very little commitment within the local municipalities exists to coordinate it through the District. The ability of the District to perform this function is questioned.

In Hlabisa the Director of Community Services is in charge of rolling out the HIV/AIDS Strategic Plan. A year ago there was no such plan but after going on a week long HIV/AIDS course for municipal managers, the Director has been very active. The emphasis has been on holding large public "Awareness Days" that are of questionable value. These events are expensive to run and sceptics claim that the main function is to raise the political profile of certain individuals.

The general view is that the Department of Health has a strong role to play in dealing with the epidemic. Some individuals in DoH realise that some clear changes need to take place within the Department in order to steer it to more practical and effective operations. Staff seem to be on an endless round of workshops with very little follow-up or monitoring and evaluation of the work that has been done. There is a feeling that these awareness workshops should not be the main function of the Department's HIV/AIDS effort, but that this should rather be left to other organisations – for example NGOs.

This means that the Department of Health is not focussed on its core functions and demonstrates no monitoring and evaluation activities in order to benchmark progress in the HIV/AIDS Strategy implementation. Workshops are being held by the DoH and Hlabisa Municipality spent a significant amount on workshops with, it seems, scant evaluation of need or what to do next, or what the outcomes of these workshops should be, and suspicions point to political visibility as opposed to promoting the cause of HIV/AIDS.

Hospitals are trying to reach out to people on ARV programmes but there is lack of capacity in order to ensure holistic care. Potential ARV candidates receive a week of training in order to ensure that they are knowledgeable enough to withstand the rigorous treatment and its side effects. The fact that more hospitals in the region are ARV dispensaries is positive, since only 6 months ago Nongoma Hospital was the only hospital accredited as an ARV centre.

uMgungundlovu District

The Demographic Context

The uMgungundlovu district is located to the west of the eThekweni Municipality and straddles the N3 highway that links Gauteng with the port of Durban. The uMgungundlovu District contains seven local municipalities:

- uMswathi Local Municipality
- uMgeni Local Municipality
- Mooi Mpofana Local Municipality
- Impendle Local Municipality
- Msunduzi Local Municipality
- Mkhambathini Local Municipality
- Richmond Local Municipality

As Figure 17 below illustrates the bulk of the population in the uMgungundlovu Municipality are located in two local municipalities. The city of Pietermaritzburg is located in the Msunduzi Municipality, while the Mkhambathini Municipality straddles the N3 between the Msunduzi Municipality and the eThekweni Municipality. These two municipalities also displayed the highest levels of population growth in the district, most likely as a result of the concentration of economic activity in these areas.

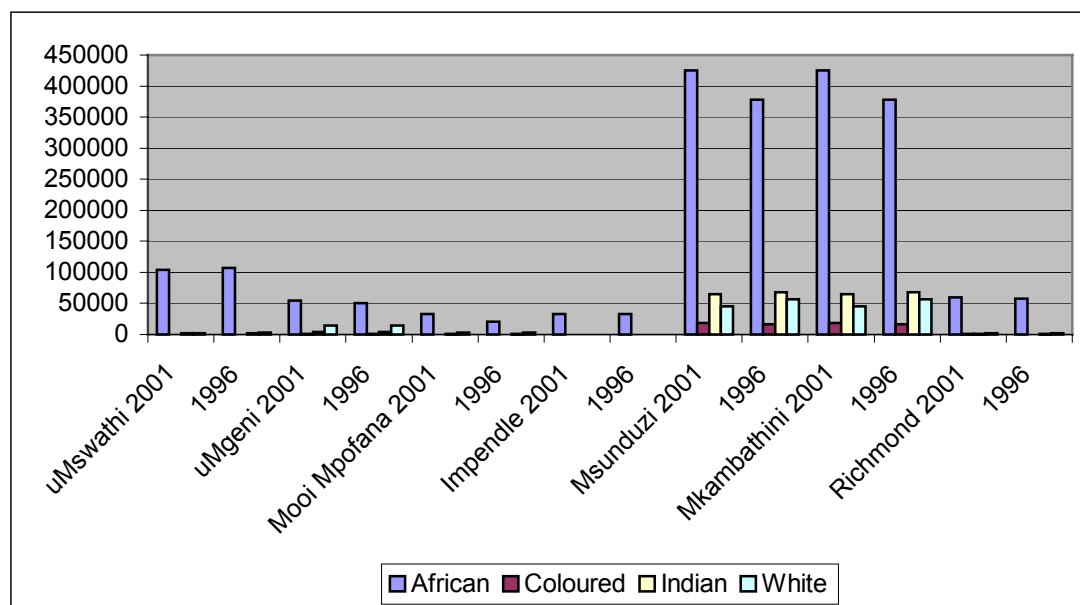


Figure 17: Population by Local Municipality and Race

The population structure of the municipality has remained stable between 1996 and 2001, with the size of the economically active population only growing by 1% during this period.

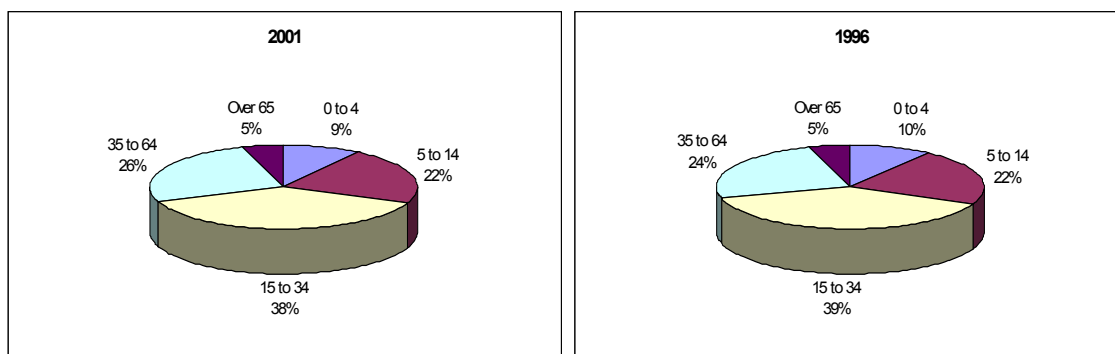


Figure 18: uMgungundlovu Population Age structure 1996/2001

As Figure 19 illustrates below, education levels in the uMgungundlovu Municipality are relatively high with a large proportion of the population having completed secondary education. Figure 20 indicates that the bulk of the well educated population is located in the Msunduzi and Mkhambathini Local Municipalities which are the two areas of the district that have the highest concentration of economic activity. The high levels of education in these two municipalities are reflective the needs of the economy of the uMgungundlovu District, which has the most sophisticated economy out of all the four learning areas.

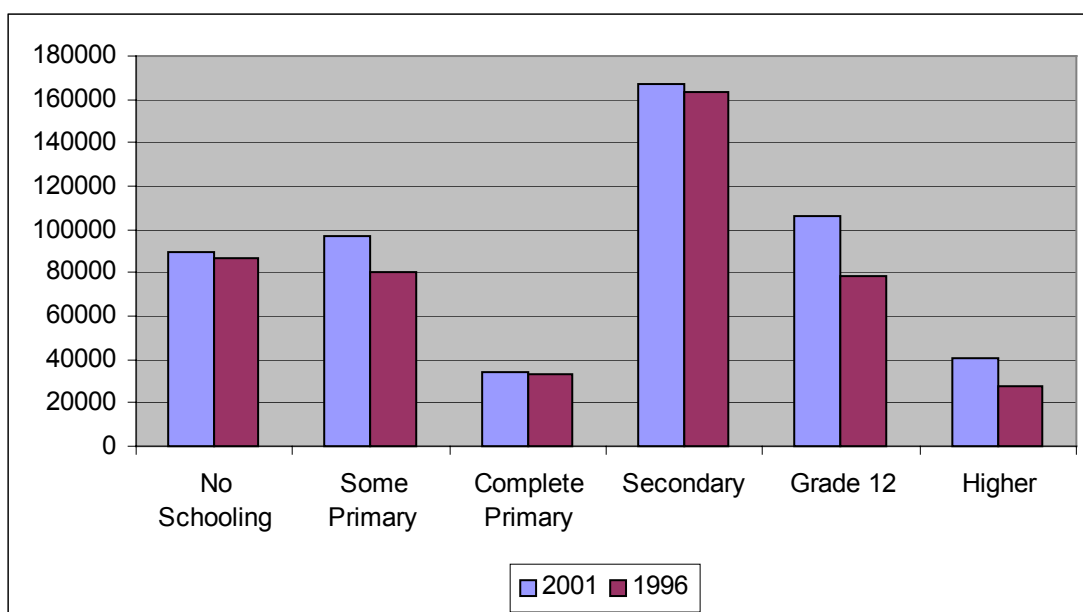


Figure 19: uMgungundlovu District level of Education (Population Aged 18 and above)

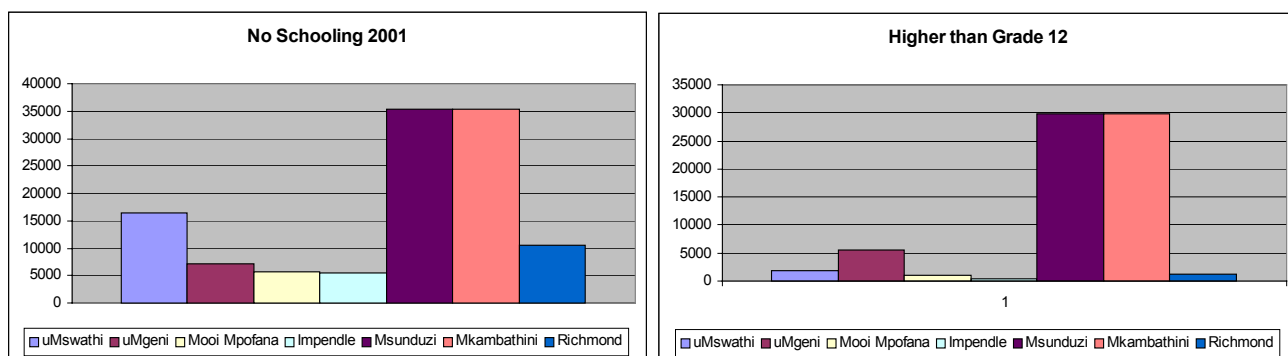


Figure 20: Comparative levels of Education between Municipalities

In spite of being the centres of economic activity, the Msunduzi and Mkhambathini Local Municipalities have both seen a decline in employment and a rise in unemployment between 1996 and 2001. While the level of economic activity in other local municipalities is relatively small, it is relative stable as employment and unemployment rates showed little variation between 1996 and 2001.

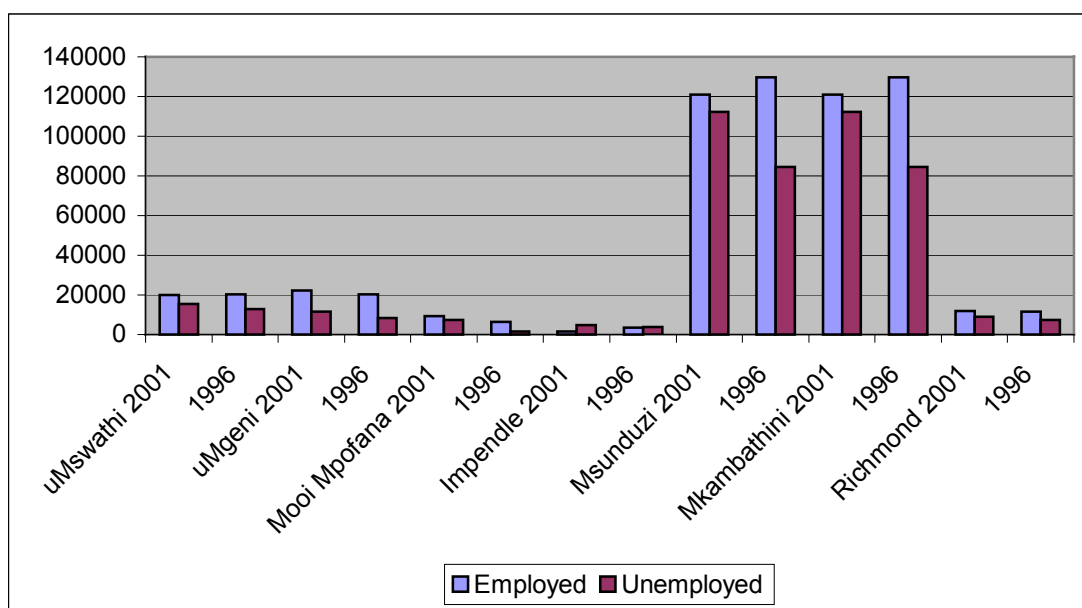


Figure 21: Employment in uMgungundlovu

In addition to being an important economic centre, the Msunduzi Municipality is also the location of the provincial legislature, as well as the headquarters of many government departments. The importance of the government sector in this municipality is reflected in the fact that Community /Social/ Personal makes an increasingly large contribution to employment in the District Municipality as Figure 22 illustrates. Figure 22 also indicates that the Agriculture/ Fishing/ Forestry sector is another key sector that makes an increasing contribution to employment. Employment in the Wholesale/Retail sector also expanded in the period 1996 to 2001.

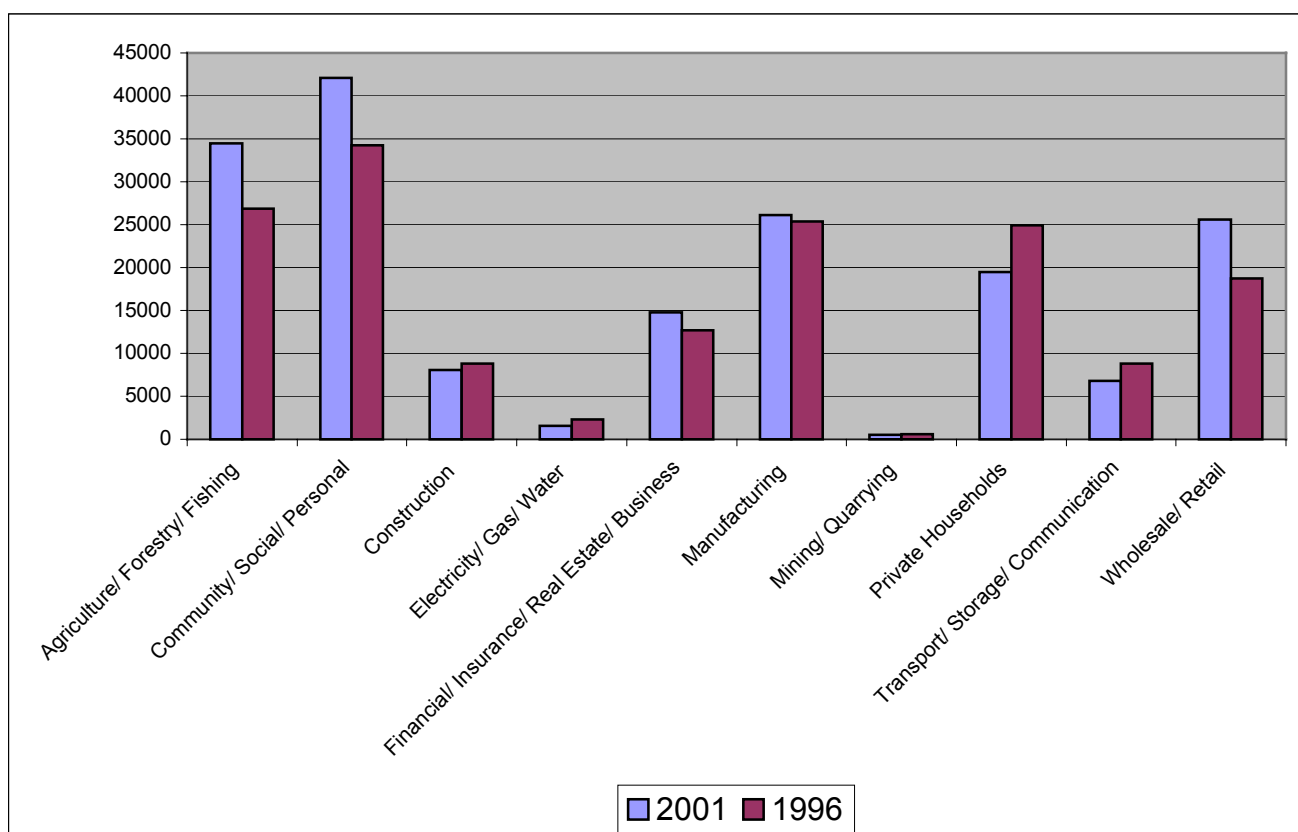


Figure 22: uMgungundlovu - Employment by Economic Sector

HIV/AIDS Service Providers

The district is characterised by a number of well-organised, multi-service organisations, mostly operating in and around the more urban areas of the district where the population is highest. The organisations include the uMgeni Aids Centre, CINDI and ATTIC. In addition to providing a range of HIV/AIDS related services to PLWHAs, these organisations also play a key role in supporting, training community level and building capacity within local NGOs and CBOs. As Box 8 illustrates the model used by the some of the larger service providers differs from that used in Ugu with a focus on the nurturing NGOs and CBOs to the point where they become self sustaining.

Box 8: The CBO Mentorship Programme -

In November 2002, Development Co-operation Ireland provided funds for a CBO mentorship programme. These funds were managed by CINDI. The programme was premised on a recognition that many NGOs are under resourced and struggle to provide adequate services at the community level where the impact of HIV/AIDS is most keenly felt. The main aim of the mentorship programme was to transfer skills from the mentor NGOs to CBOs empowering them to meet the needs of HIV/AIDS infected and affected people in a sustainable manner. CBOs need to develop to a point where they can administer themselves while effectively providing services in their community.

The programme saw twelve NGOs undertaking a mentorship agreement with twelve CBOs, and transferring knowledge as well as financial and other resources. The programme has only been running for two years and is largely considered to be successful. However, it is still too early to make an assessment on whether the desired result of an effective, vibrant CBO sector is achievable in the long term.

Service providers in the district have recognised the importance of networking and a number of large networking organisations exist.

A significant number of the leading organisations operating in the district were formed in the 1980s in response to the waves of violence that swept through the district. Over time the focus of these organisations has shifted from their original mission to having a strong HIV/AIDS component.

The bulk of activities seem to be undertaken around Pietermaritzburg-Hilton-Howick and towards Durban along the N3, where the highest concentrations of population are located. Coverage of service provision seems to be limited in other areas, although it is possible that the profile of the groups operating in these areas is not as high as those operating in and around the main urban centres.

There is also an increasing recognition that there is a need to take service provision beyond awareness raising, care and bio-medical interventions. Services providers are beginning to look at how they can intervene in reducing levels of poverty and economically empower communities and households economically. Economic empowerment has the potential to contribute to reducing infection rates in the long term. Furthermore, it will ease the burden of care and support in the short term, and enhance the survival prospects of PLWHAs.

Most service organisations provide their service for little or no charge and are reliant on grants and donations. Some service providers are concerned with the long-term financial sustainability of their organisation and provide services on an “ability to pay” basis, with income derived from providing services provided to wealthier clients being used to subsidise services provided by free to poor clients. Other service providers have taken a short-term view and are completely reliant on donor funding, which they feel will always be available in the medium to long-term. However, some have had their funding discontinued and are under increasing pressure to find alternative sources in order to maintain their activities.

Business

Level of awareness of HIV/AIDS issues in the business community seem to vary, with some actors feeling that it is not an issue at the level of the firm while others feel that it will have a significant impact on their business and have put in place various HIV/AIDS programmes.

According to Clive Coetzee (*pers. comm.*), a University of KwaZulu-Natal economist, the uMgungundlovu District has an oversupply of labour in the primary sector. The tertiary (services) sector is growing and attracting skilled people from outside the district rather than soaking up the surplus labour from the primary sector.

While the economy of the uMgungundlovu district is relatively sophisticated, 70-80% enterprises in the formal business sector are SMEs. These

businesses also account for a similar proportion of formal employment. Smaller companies face serious resource constraints in dealing with HIV/AIDS in the workplace, and it is likely that a large proportion of businesses in the district are not in a position to introduce HIV/AIDS programmes.

Where HIV/AIDS programmes do exist, they tend to have been put in place fairly recently and are usually fairly small. The key issue limiting the size of these programmes is perceptions around confidentiality of testing and treatment procedures. Employees feel that they will be disadvantaged if they test positive for HIV and management becomes aware of their status. The confidentiality issue is compounded by the fact that Anti-Retroviral Treatment (ART) programmes are often run through the company clinic in order to minimise the red tape involved in accessing treatment through Department of Health programmes.

The incidence of the epidemic in the district has also open up for some potentially exploitative economic activities as Box 9 describes further.

Box 9: Orphan Farming in Edendale

People caring for orphaned and vulnerable children are eligible to access child care grants from the Department of Welfare. NGOs have been reporting that there are some “entrepreneurs” in some of the areas around Pietermaritzburg that take children into care within minutes of their parents passing way, in order to access these grants. It was not possible to independently verify this but it is of concern that orphaned and vulnerable children may be exploited. In response to this, at least one NGO has put in place an early warning system, so that upon the death of the last adult member of the household, children were taken care of by either family members or state institutions.

Local Government

The Msunduzi Local Municipality relies on a partnership approach to develop their HIV/AIDS strategy. The core partnership is between councillors, the Municipal Department of Health, NGO's, religious organisations and the private sector. Representatives from all these sectors have formed the Msunduzi AIDS Steering Committee which aims to develop and support projects that fit within a continuum of care of people infected and affected by HIV and AIDS. There are a number of advantages of working in partnership with NGOs and CBOs including innovation, high level of commitment, flexibility and independence. Partnerships also enable the municipality as well as the partners to acquire funding that the organisations would not usually attain individually

Capacity in the District Municipality and the other local municipalities seems to be limited with the HIV/AIDS agenda being set by civil society.

uThungulu District

The Demographic Context

The uThungulu district is located approximately 100km to the north of the eThekweni Municipality and straddles the N2 highway which runs north-south

along the coast. The municipality stretches from the coast inland to the eMakhosini Valley. The uThungulu District contains six local municipalities:

- Mbonambi Local Municipality
- uMhlatuze Local Municipality
- Ntambanana Local Municipality
- Umlalazi Local Municipality
- Mthonjaneni Local Municipality
- Nkandla Local Municipality

As is the case with many district municipalities, the uThungulu District is dominated by a wealthy urban municipality surrounded by a poorer rural hinterland.

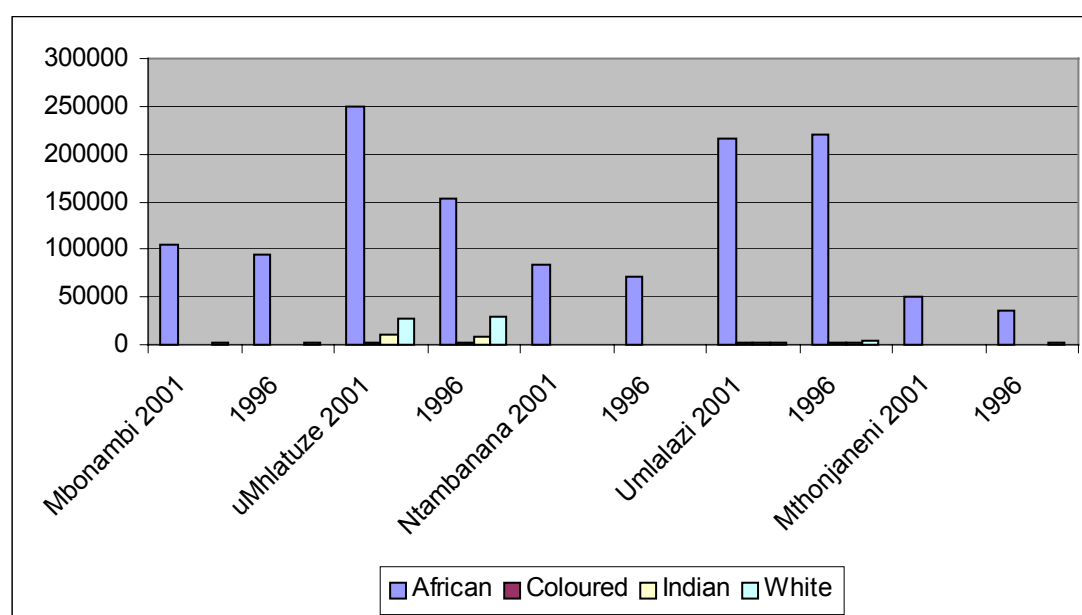


Figure 23: Population by Local Municipality and Race

As Figure 23 illustrates, the African population group dominates all municipalities in the uThungulu District. This population group saw a large increase in the uMhlatuze Municipality between 1996 and 2001. This municipality is the economic hub of the district and is characterised by large industries. It is likely therefore that this large increase in population number can be attributed to in-migration by rural residents looking for employment.

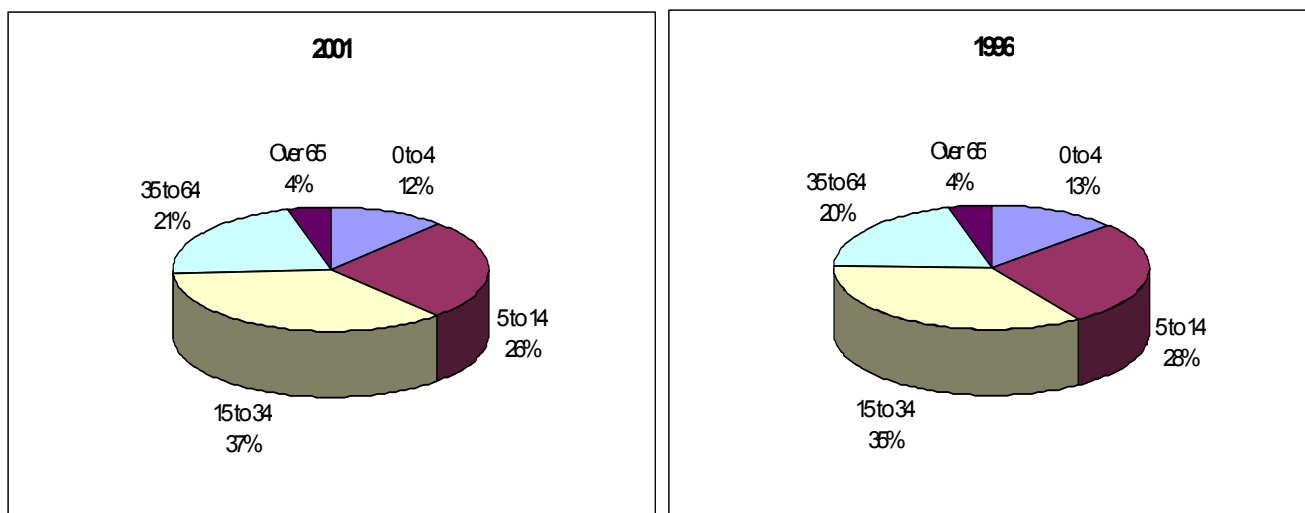


Figure 24: uThungulu Population Age Structure 1996/2001

Overall the population age structure has remained stable, as Figure 24 indicates. The potentially economically active population at 58% is fairly small relative the economically dependent group (42%). This has long ranging implications for the provision of social and welfare services in the district if the HIV/AIDS epidemic started having a huge impact on the life expectancy of the economically active population.

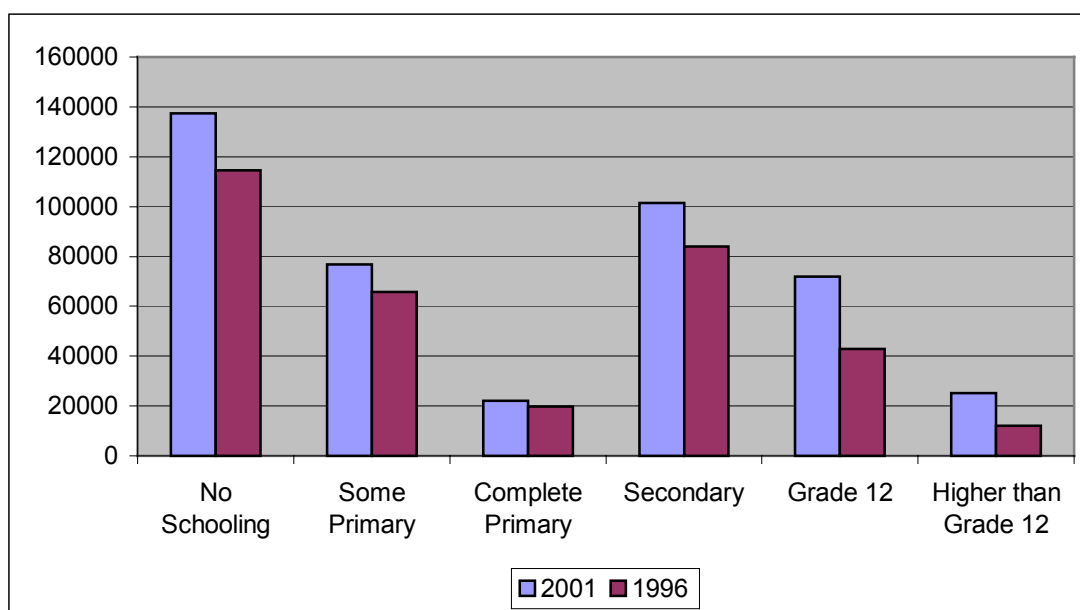


Figure 25: uThungulu District Level of Education (Population Aged 18 and above)

Large numbers of people in the uThungulu District have not had access to schooling and this number increased between 1996 and 2001, as Figure 25 illustrates. Taken with the low numbers of people with tertiary education implies that the skills base in the district is fairly low.

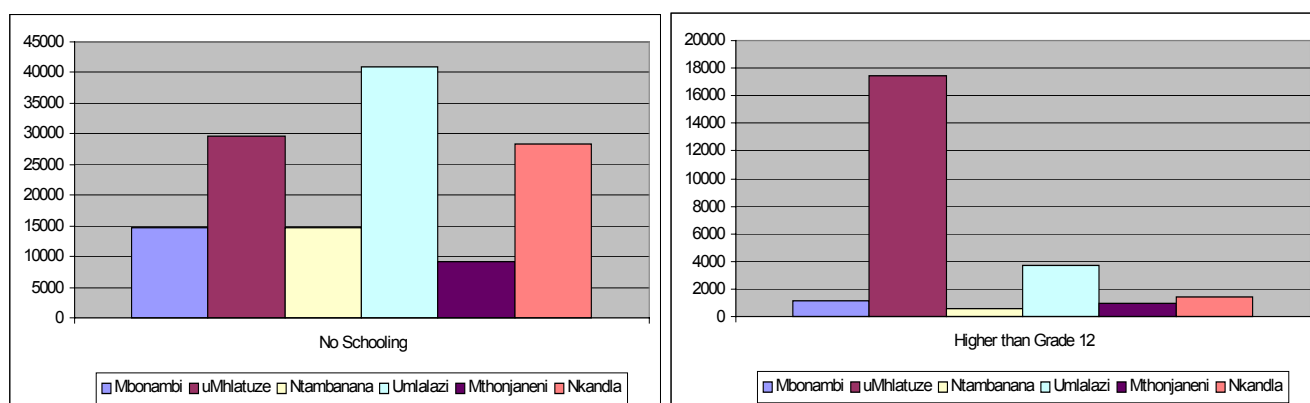


Figure 26: Comparative Levels of Education between Municipalities

As can be seen in Figure 26, people with tertiary education are most likely to be found in the uMhlatuze Municipality, which is the economic engine of the district. Low levels of education usually correlate strongly with low levels of income. The inference from this and the data presented in Figure 26 is that the rural areas characterised by poverty. The large number of people with no schooling in Umlalazi and Umhlatuze can probably be attributed to the presence of unskilled migrants looking for employment in the more urban areas of the district.



Figure 27: Employment in uThungulu

Using employment as an indicator of economic performance, Figure 27 suggest that the Umhlatuze economy is doing well overall. The corresponding increasing in employment is likely to be as a result of the attraction that a strong economy has for economic migrants. While the economy is growing it is unable to absorb the rising numbers of unemployed

people. In the other municipalities in the district, the general trend seems to be that employment levels have remained more or less stable, while unemployed has increased. In the Nkandla Municipality unemployment outstrips formal employment by a significant margin, this is indicative of the remote, “deep” rural nature of this municipality.

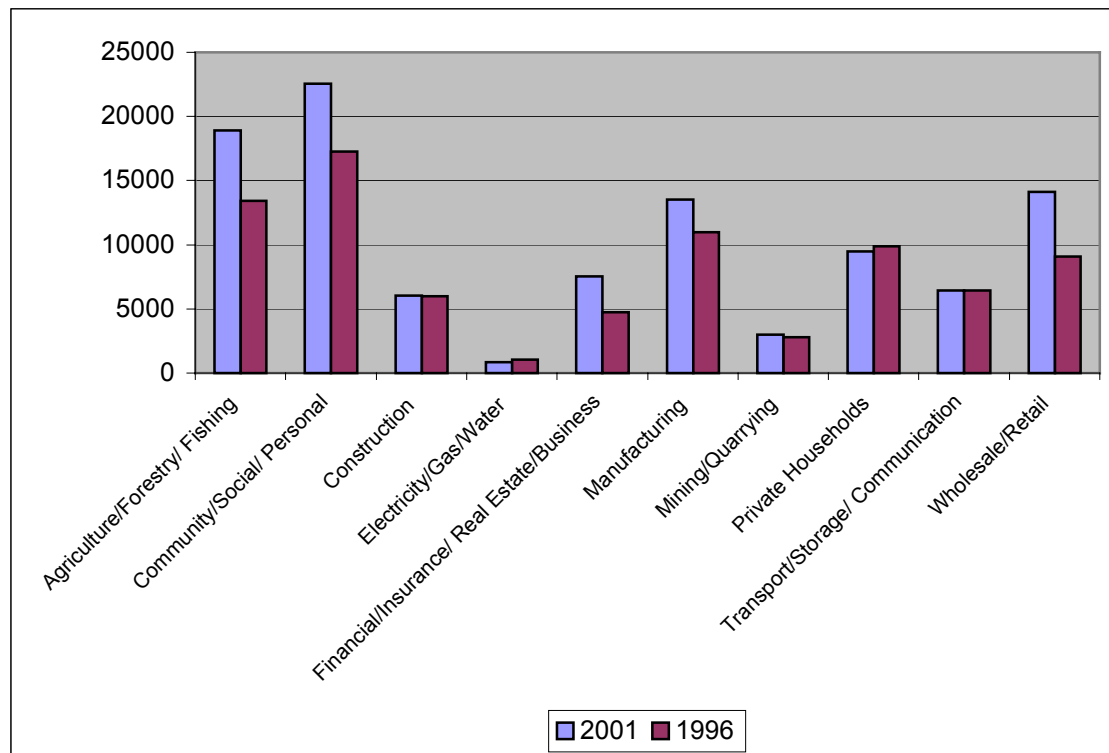


Figure 28: uThungulu – Employment by Economic Sector

Employment in the uThungulu District is dominated by the Community/ Social/ Personal sector, most likely as a result of the rollout of local government services over the five years between 1996 and 2001. The Agriculture/ Forestry/ Fishing sector also makes a significant contribution to employment in the district, but these jobs are likely to be low skilled and low paid. Figure 28 also indicates that sectors such as Wholesale/ Retail, Manufacturing and Financial/ Insurance/ Real Estate and Business sectors, which tend to create higher value jobs requiring higher skill levels, have also shown an increase between 1996 and 2001.

Dept of Health

As is the case with most deep rural areas in South Africa, there is undersupply of health facilities. The result of this is that the facilities that do exist have to provide a wide range of services. Nkandla Hospital which serves the most remote portion of the uThungulu District is has recently received accreditation as an ARV site and is beginning to implement the rollout of this programme. Previously people requiring ARVs had to travel over 80 kilometres to Ngwelezane.

Coverage of health facilities is a lot higher in other areas of the district where a hierarchy of facilities has been established along with a referral system. Capacity is sufficiently high within the uThungulu District Municipality's Department of Health, that they manage a number of clinics in eSikhaweni on behalf of the provincial department.

HIV/AIDS Service Providers

The economy of the uThungulu District is dominated by sugar and timber farming in the rural areas (on a large scale in the former Natal, and in the form of small outgrowers in the former KwaZulu areas. The Empangeni/Richards Bay node is the centre of manufacturing activity and is characterised by a few large industries supported by a large number of SMMEs. Many of the large industries use industrial processes that have potential to be highly polluting. Residents of the town have mobilised around environmental issues, playing a watchdog role and keeping pressure on these industries to perform. In order to improve their public image, particularly in the local areas, large industries make heavy investments in corporate social responsibility (CSR) projects.

Amangwe Village is one of the organisations to benefit from investment by industry in CSR, as funds are channelled to it through the Zululand Chamber of Business. Amangwe Village is well funded and in a position to undertake a wide range of HIV/AIDS interventions ranging from education, training and awareness raising to residential care, voluntary counselling and testing.

As is the case with the South Coast Hospice in the Ugu District the presence of a large civil society organisation, like Amangwe Village, dealing with HIV/AIDS issues has tended to crowd out the development of smaller NGOs and CBOs.

However the coverage provided by Amangwe Village is limited to the more easily accessible areas of the District. Other NGOs have been able to establish themselves in more remote areas of the District. Senzakwenzekhe ("doing it right") is an NGO started by the Catholic Mission in Nkandla in collaboration with Nkandla Hospital. There are no other HIV/AIDS organisations with a permanent presence in the area and therefore Senzakwenzekhe does not benefit from the advantages that networks of organisation can offer. As a result they find themselves trying to offer a comprehensive service using meagre resources. When external (to Nkandla) organisations do operate in the area, there is no mutual sharing of information between them and Senzakwenzekhe.

Business

Approaches to dealing with HIV+ employees seem to broadly take one of two forms. Some firms choose to deal with HIV+ employees in-house through their occupational health clinics. This approach carries the risk of high future costs should large numbers of employees test positive and require treatment. Alternatively some firms choose to manage the impact by externalising the

cost of treatment through insisting that all employees are members of a medical aid that covers ARVs. Medical aids, rather than the company, then bear the risk of large unexpected increases in future costs. Medical aids often cover family members as well, which internal ART programmes do not.

In both scenarios, the confidentiality issues arises with employees concerned that testing will result in their status being disclosed to management and they be retrenched or be disadvantaged in the workplace. Companies get around this by hiring in organisations such as Amangwe Village who act as honest brokers and undertake the VCT emphasizing the confidentiality of the process.

Small businesses are rarely in a financial position to undertake any sort of intervention other than basic education and awareness. The role of NGO and CBO networks then becomes crucial in supporting small business. However, in some of the smaller town these networks are not well established or have critical components missing and are therefore unable to provide a support function to small business. For example, Lifeline has recently established a permanent presence in Eshowe where they offer voluntary counselling and testing. However, should someone who comes for counselling test positive, the near free ARV rollout site is 70 kilometres, and commercially available stock are financially out of reach of the majority of the population.

The agricultural sector in uThungulu is overwhelmingly dominated by two crops viz. sugar and timber. Both of these sectors are under severe pressure resulting from depressed prices in the international market and a strong national currency. Both sector employ large numbers of unskilled labour, among which anecdotal evidence suggest the prevalence rate to be particularly high. As a result cane and timber farmers have large annual staff turnovers. Most farmers are struggling to get their operations to break-even and are in no position to finance HIV/AIDS interventions for their labour force. Due to the uneven coverage of the ARV rollout sites, labour has very few options in terms of accessing education, testing and treatment.

The type of work that labourers perform is unskilled and remuneration is set close to the minimum wage level. In mid-2004 some uThungulu farmers expressed the opinion that the epidemic would not have a real impact on the way they operate because “for every labourer that dies, there are another ten at the farm gate waiting to take their place”. Anecdotal evidence is now suggesting that some farmers are beginning to mechanise their cropping processes where topography allows as they are beginning to experience labour shortages.

Local Government

The establishment of District AIDS Councils is seen as a major step towards stepping up HIV/AIDS activities at the local level. The uThungulu District Municipality has been successful in accessing funds for R9 million from the United Nations Development Programme (UNDP) for developing the district's Integrated HIV/AIDS programme. The funds from the UNDP will be utilised

for the implementation of services that will be of assistance to those infected and affected by the disease. The District will fund an Awareness Creation Programme, which will involve the training of volunteers and supplementing services provided by the UNDP-funded programmes.

uMhlatuze Local Municipality forms part of uThungulu District and allocates funding to HIV/AIDS programmes through their IDP. External consultants undertook a impact assessment aimed at identifying what the future impact of the epidemic on the municipality's staff would be. This assessment formed the basis for the development of the internal workplace HIV programme. The implementation of this programme is monitored by a committee of representatives from each department along with three councillors. A lot of work had to be done in order to gain acceptance among councillors that an internal HIV/AIDS programme was needed. When the issue was raised Councillors tended to want to develop community programmes and could not see the need for a programme aimed at the employees of the municipality. The municipality's workplace programme now has full political support and has led to the development of an external programme, which will most likely be implemented through the UNDP funded AIDS Council at District level

5. MAINSTREAMING HIV/AIDS INTO DEVELOPMENT, BUSINESS AND GOVERNMENT

Mainstreaming HIV/AIDS means realising that we all work in a context more or less affected by the HIV/AIDS epidemic and analysing whether consequently we need to adapt our activities to this reality. It means thinking differently, wearing “AIDS glasses”.

It means all sectors determining²:

- how they may contribute to the spread of HIV
- how the epidemic is likely to affect their sector's goals, objectives and programmes
- where their sector has a comparative advantage to respond to and limit the spread of HIV and to mitigate the impact of the epidemic

Mainstreaming is about challenging the status quo by looking upstream to see the deep, developmental causes, and downstream to appreciate the wider impact of HIV and AIDS.

Mainstreaming HIV/AIDS does not mean:

- pushing HIV/AIDS into programmes where it is not relevant
- changing core functions and responsibilities in order to turn all co-operation activities into HIV/AIDS programmes
- simply introducing HIV/AIDS awareness raising in all our activities
- that we all have to become AIDS specialists
- business as usual

5.1. *Essential principles in mainstreaming HIV/AIDS*

1. There is no standard approach or universal recipe to mainstreaming HIV/AIDS. Approaches need to be designed according to the stage and nature of the HIV/AIDS epidemic in a particular community and adapted to the specific context, i.e. addressing the cultural context, challenges and opportunities in a given geographical area and sector. Using a cultural approach in mainstreaming is a key to success.
2. Mainstreaming HIV/AIDS is a relevant approach in all stages of the epidemic – also in low prevalence settings - but becomes increasingly urgent as the epidemic evolves.
3. Mainstreaming HIV/AIDS should be done in an integrated way throughout the management cycle and not be limited to punctual efforts.

² Source: Rose Smart in Elsey and Kutengule (2003).

4. A gender sensitive approach should be used when mainstreaming HIV/AIDS.
5. Following the principle of Greater Involvement of People living with HIV/AIDS (GIPA), first enunciated in 1994, a participative approach to mainstreaming based on human rights implies involving People living with HIV/AIDS (PLWHA). Fighting stigma and discrimination linked to HIV/AIDS should be a priority for all co-operation activities.
6. Building relationships, co-ordination, network and advocacy is always crucial for development work. In the field of mainstreaming HIV/AIDS, where experiences and good practices are still scarce, it is even more important not to work in isolation. Advocacy is crucial both inside an organisation and outside when working with other companies, consumers and the broader community.
7. As a rule, all mainstreaming activities should be in line with the national AIDS policy and international standards, such as those set by UNAIDS.

HIV/AIDS is an issue that every organisation must address directly, both out of enlightened self-interest, and out of concern for those at risk or already affected. There has been increasing talk within governments, multi- and bilateral organisations, and development organisations of “mainstreaming AIDS” into all sectors, and of “taking a multisectoral approach to AIDS.” This has seldom been accompanied by practical guidance on what a ‘multisectoral approach’ entails, or what an organisation that ‘mainstreams AIDS’ might look like.

People use the term ‘AIDS mainstreaming’ in different ways, so some clarity on what it involves is needed. ‘Mainstreaming’ HIV and AIDS involves bringing the issues into all strategic planning, and into day-to-day operations inside the organisation and in its relationships with others. The three broad aspects of mainstreaming, include:

1. HIV and AIDS in the workplace;
2. Mainstreaming HIV and AIDS into strategy and programming; and
3. Links with focused interventions on HIV and AIDS.

With respect to mainstreaming, each programme operating in a HIV prevalence area needs to assess how HIV/AIDS may affect its target group, activities, strategies, objectives and operations. The questions that need to be addressed are:

1. How will the HIV epidemic affect workplace programmes (in terms of target groups, objectives, strategies, activities, human and financial resources)?
2. How will workplace programmes (in terms of target groups, objectives, strategies, activities, human and financial resources) influence the HIV epidemic?

Thus programme elements can either affect or be affected by the epidemic. Each element can contribute to enhancing or reducing the spread and/or impact of the epidemic. On the basis of the assessment, strategies can be developed within the sector, within departments and within organisations.

Mainstreaming is about people, and therefore sectors and programmes can concretely mainstream HIV/AIDS into two inter-connected areas of responsibilities and domains:

5.2. *The internal or workplace domain*

Mainstreaming in the internal domain focuses attention on the vulnerabilities and risks for people within the organisation, sector, programme, project, etc. itself. The challenge of HIV/AIDS is addressed within this context by consciously formulating workplace/workforce policies and guidelines that inform day-to-day practice, thus contributing to the protection of the workforce and the deepening of an organisation's understanding of the multi-dimensional impact of the epidemic. "Charity begins at home", and successful internal or workplace approaches will most often lead to enlightened and supportive strategies for external target groups.

5.3. *The external or target community domain*

In the external domain, HIV/AIDS is mainstreamed into the core mandate, activities, and business of the sector, institution or project based on available capacities. HIV/AIDS becomes part and parcel of the interaction between these organisations and their target or client communities. Strategies informed by the organisation's understanding and internalisation of HIV/AIDS issues (see internal domain above) will tend to influence what is done externally. At the sub-national level, HIV/AIDS activity implementation is often a concrete and practical expression of a sector's mainstreaming HIV/AIDS into its core activities at the periphery of the system where services and communities meet. Mainstreaming at the sub-national level includes the mainstreaming of HIV/AIDS into existing programmes and projects. It is worthy of note that not all HIV/AIDS activities being implemented are the outcome of a mainstreaming exercise. Many are stand alone HIV/AIDS programmes and projects responding to a specific objective or set of circumstances.

5.4. *Context and Principles of Mainstreaming HIV/AIDS*

Mainstreaming is located within the wider context of a national strategic management process for HIV/AIDS responses as one of its primary aspects (see Figure 29). As part of the strategic management, mainstreaming is an iterative process that is revisited on a regular basis. This national process, however, can be adapted as a tool for the global and sub-national levels. Broad international experience and exchange has, up to now, produced five basic principles for mainstreaming HIV/AIDS, regardless of the level at which it is being undertaken. As inter-dependent issues these principles provide a

backdrop against which current mainstreaming experiences can be analysed and practices introduced.

Principle 1

Establishing a clear entry point or theme for mainstreaming HIV/AIDS assists with focusing subsequent actions and expected outcomes. Conversely, if mainstreaming efforts address a wide array of themes, they risk diffusing actions and potential impact. Without an adequate thematic focus, it may be difficult to identify the primary target community(s). Each sector, NGO, private sector entity, programme, etc., based on their relative comparative advantage, tries to determine where it can make the most valuable contribution to the national response.

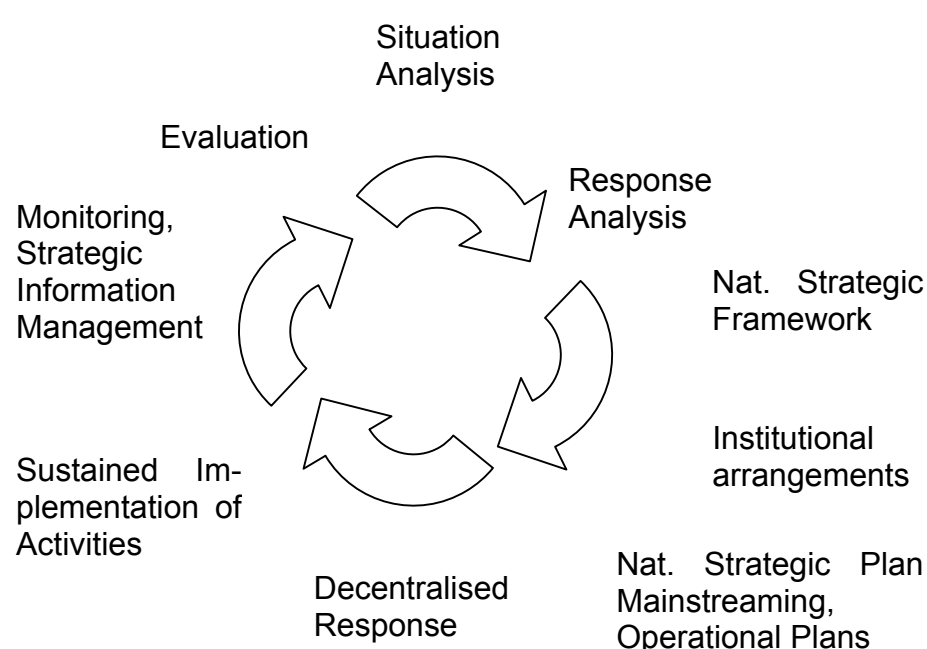


Figure 29: Strategic Management Process

Source: UNAIDS 2002

Principle 2

Where in place, global policies or National Strategic Frameworks (NSF) for HIV/AIDS should constitute the primary entry point and frame of reference for mainstreaming efforts (refer to Fig. 1). Stakeholders at all levels should avoid duplicating efforts by producing individual frameworks. Indeed, mainstreaming is a process through which policy makers, government institutions, sector agencies, international organisations and individual projects and programmes can operationalise a NSF within their own area of activity and scale-up the national response to HIV/AIDS. Mainstreaming must also rely on existing institutional structures in order to promote effective co-ordination and management.

Principle 3

The need for multi-sectoral and multi-level action against HIV/AIDS remains largely misunderstood. Thus, mainstreaming must be accompanied by advocacy and sensitization around HIV/AIDS that demonstrates the added value of action by all key stakeholders. In the private sector in Uganda, sustained advocacy was finally able to engage senior level management, resulting in greater private sector involvement in the national response through a range of activities. Furthermore, the conceptual understanding as well as the capacities to mainstream HIV/AIDS and undertake targeted activities are currently recognised as being relatively weak at all levels. It is important, therefore, that specific capacity building inputs are provided to increase current levels of implementation, possibly including organisational, technical and administrative capacities to undertake sustained action.

Principle 4

The development of mainstreamed HIV/AIDS action plans gives substance and direction to what might otherwise be merely an integration exercise. An important starting point is the development of a workplace prevention and care programme in the internal domain of an organisation, programme or sector. First, this addresses the risks and vulnerabilities of workers and staff and places them in a better position to appreciate what can be done within the external domain for their “clients”.

Principle 5

Experience has shown that no one sector, institution or individual can address all the aspects of the epidemic. Underlying this principle is the understanding that mainstreaming does not require sectors, programmes, projects, etc. to include all components of a comprehensive response to HIV/AIDS. Rather, mainstreaming uses a rational approach, which prioritises activities based on comparative advantage and human and technical capacity to implement. For example, within the internal domain, institutions can share much needed resources for the provision of services necessary for a workplace programme such as counselling and the development of IEC materials. Effective mainstreaming in the external domain also requires functional partnerships, networks and alliances to be formed for sustainable implementation and impact.

As this article focuses on the Mainstreaming within the workplace it is key to realise that employees of all organisations in Southern Africa are at risk of HIV, or are already HIV positive, or are affected by illness and death of others. These personal impacts in turn severely reduce the ability of the organisation to perform efficiently, effectively, and to meet objectives. This is true regardless of the type of work the organisation does; whether it is a government department, community-based organisation, international development agency, small business or corporation. Common impacts include greater absenteeism, reduced productivity, increased financial costs, higher staff turnover, lower morale, and falling levels of experience and quality. Unexpected illness and death strikes many organisations as a crisis; a proactive organisation anticipates and plans for likely problems, and can better avoid or minimise the impacts.

The objective of mainstreaming HIV and AIDS in the workplace is to enhance the ability of an organisation and its staff to anticipate, minimise, and cope with illness and death associated with the pandemic. This entails the need to understand and balance the interests of the staff and of the organisation.

A further aspect of mainstreaming involves the organisation's strategy and programming. Regardless of the work the organisation undertakes, some clients are affected by illness and death associated with HIV. Others are at risk, and some will eventually contract HIV themselves, or become directly affected by the illness and death of others. Given the dynamics of the epidemic, numbers of those affected are certain to increase.

In areas with high rates of HIV and AIDS, organisational ability to effectively and efficiently achieve goals is at risk. Activities in communities are left undone due to illnesses and funerals, key community members become ill or spend time in caring for others, and household composition changes – with women, youth, and the elderly assuming even greater burdens. The increasing load of illness and death in communities, and the resulting changes in roles, responsibilities and assets of affected families, mean that the organisation's operations may become less relevant to or accessible by affected people.

All organisations in all sectors need to take steps to ensure their core business is relevant to the changes in societies and families brought about by HIV and AIDS. This aspect of mainstreaming seeks to strengthen the organisation's core business, without changing the focus to health care. This may entail modifications to the organisation's overall strategy, and to its detailed programme planning and implementation.

Figure 30 provides a step by step guide to Mainstreaming HIV/AIDS.

A context and organisational analysis allows you to assess the impact of HIV/AIDS on the organisation and the programmes and to answer the second key question; How to do no harm? Steps 1 to 3 are linked as they are preparatory analytical steps that put you in a position to proceed to the response. Steps 4 and 5 explore possible contributions at the workplace and within the operational work. Crucially, monitoring and evaluation instruments should be developed from the beginning and experience capitalised and shared.

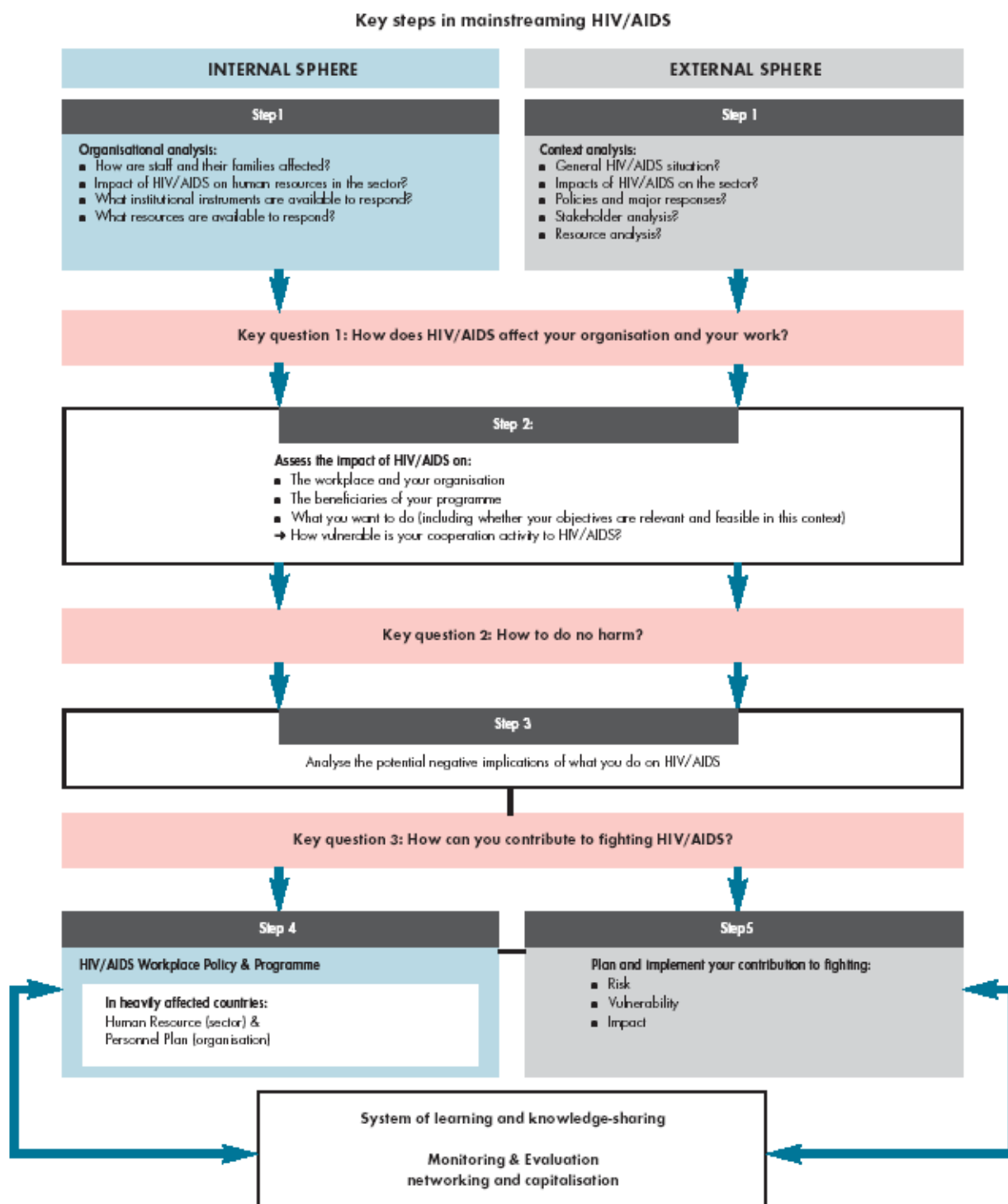


Figure 30: Key Steps in Mainstreaming HIV/AIDS

Source: SDC,2003

5.5. Context and Organisational Analysis

In order to answer the first key question; How does HIV/AIDS affect your organisation and your work? A programme should include a situational analysis, including context and organisational issues.

All mainstreaming strategies planned should be based on the findings of repeated analyses. Each analysis will be based on a different set of questions, depending on the geographic area, the sector/s one works in and the specific interests of the programme, etc. Ideally, both the context and organizational analyses should be an integrated part of the overall situational analysis which is done at the beginning of a programme. For the context analysis, one can usually draw on available information. It is not necessary, and in most cases it is not feasible either, to conduct specific surveys or studies. Good sources for local information on HIV/AIDS are usually the National AIDS Programme and the various government ministries, NGOs as well as bi-lateral and multi-lateral organisations (e.g. WHO or UNAIDS).

The compilation of a short report, based on the information available and in function of one's needs, can also be contracted out. The analyses should be as gender sensitive as possible. A gender perspective on mainstreaming HIV/AIDS involves recognising and addressing the gender imbalances that drive and characterise the epidemic.

'Do no harm?' is critical and should be one of the programme's essential principles. It is crucial to answer the second key question and analyse how your sector or your workplace might aggravate the spread or impact of HIV. This means looking at whether the planned or ongoing activities increase vulnerability or risk behaviour of staff, partners and beneficiaries or whether they might aggravate the immediate and long-term consequences of HIV/AIDS. This analysis is equally valid in low prevalence countries, as the primary aim is to prevent the epidemic from emerging further.

5.6. Mainstreaming HIV/AIDS- step by step

Addressing the Steps 1 to 4 will help to create awareness and deepen understanding of the relevance of HIV/AIDS to your co-operation work. It is important to be sure that planned activities will not do harm and increase HIV/AIDS vulnerability, risk taking or enforce its impact. Developing a workplace policy and related activities will greatly contribute to awareness raising amongst staff as they will feel concerned and cared for by the employer. This will empower them to get involved in addressing mainstreaming HIV/AIDS in the external sphere. Assessing current and future implications of the evolving epidemic should create additional commitment to mainstreaming HIV/AIDS leading a sector/project/programme to address the third key question; 'How can you contribute to fighting HIV/AIDS?' 'Where do you have a comparative advantage to limit the spread of HIV by reducing risk and vulnerability?' and 'How can you mitigate the impact of the epidemic?'

5.7. Conclusion

Mainstreaming HIV/AIDS involves bringing the issues surrounding the pandemic into all strategic planning, and day-to-day operations inside an organisation, in its programmes, and in its relationships with others. However, there is no single approach to mainstreaming HIV/AIDS, but analysing into various components and breaking it down into different steps can be helpful. However, it must be realised that this process is long-term and requires high commitment from senior management and staff.

6. “BEST PRACTICE” IN WORKPLACE HIV/AIDS PROGRAMMES

6.1. *Introduction*

HIV/AIDS is a concern for business in Southern Africa because of the impacts the epidemic may have on workforces and markets. Whilst many large corporations have embarked on ambitious interventions and implemented strategic programmes to mitigate the impact HIV/AIDS, others have been left defenceless through lack of resources, knowledge and an established infrastructure.

The availability of information on the epidemic and its impacts on the private sector has increased immensely in the last decade and there is now a substantial body of literature on this subject. However, there is less information on what companies are doing to prevent and manage HIV/AIDS, at what cost and too what effect. The lack of information within the public domain restricts the capability of businesses to take innovative, constructive actions to manage HIV/AIDS in the workplace and beyond.

In this chapter the concept of “best practice” is defined and the strengths and limitations of this approach are discussed. Appendix XX lists some of the key lessons learnt from identified local and international HIV/AIDS best practice in the workplace.

6.2. *What is ‘Best Practice’?*

‘Best practice’ is about establishing which ideas work in the real world and learning from the experience of their implementation. It means that lessons can be transferred so that other governments, employers and workers can be more effective in responding to issues and acting on agreed principles and standards. By providing clear information on successful experiences, best practice helps practitioners address their own particular and unique situations with the benefit of other peoples’ hindsight. It also allows knowledge and understanding of what works to be refined over time. It is not, however, about absolute statements, definitions of the ideal or ‘off the peg’ models – best practices need to be adapted to the specifics of each situation and owned by those who use them.

6.3. *Identifying Best Practice*

Best practice is not about ideas on paper. A best practice must have actually been tested in the workplace. It is most appropriately identified at the level at which it happens and in consultation with as many of the workers and managers concerned as possible because the people directly involved are ideally placed to determine what actually works and to describe the how and why of a practice. Key, too, is that it is made clear how ‘established’ the practice is and the extent to which it has been applied and evaluated.

Best practice should reflect generally accepted values and principles, such as those set out in the ILO Code of Practice, and be evidence-based with systematic evaluation built in. It should also meet locally appropriate criteria of effectiveness, efficiency and sustainability. An intervention that cannot be shown to work or that it is not value for money or that needs constant external donor support to function is not best practice. It must be ethically sound, and the idea of relevance is absolutely central. Best practice cannot be imposed in all situations without reference to what is specific and different in each nation, region, organization and culture. Best practices are not prescriptions of what to do, nor are they models to copy. Above all, they do not imply that a practice is *the* best of all possible alternatives. Rather, they provide ideas and pointers. They must always be reviewed, tailored and customized to meet the circumstances in which they are to apply and then evaluated again to establish that they work.

6.4. *How does best practice help to tackle HIV/AIDS in the workplace?*

Best practice is a relatively simple and eminently sensible tool for sharing what works. If customized and used properly, it can help companies and organizations avoid the painful and futile process of reinventing the wheel and can promote appropriate and culturally sensitive responses to HIV/AIDS at work. It has a number of overlapping, crosscutting uses and can:

- provide inspiration and ideas for those facing new challenges and flag up important issues;
- serve as an advocacy tool, persuading key players that they have a stake in responding to HIV/AIDS at work, demonstrating the advantages of action (in terms of the bottom line or staff morale) and creating a point of entry for involving stakeholders;
- highlight opportunities for partnership and the advantages of consultation and collaboration, not just in combating HIV/AIDS but in meeting wider organizational objectives;
- allow projects to be designed in light of what worked or didn't in the past, communicating lessons and pointers (although not definitive answers) and helping to identify factors that confer success on an intervention or hinder its uptake;
- help stakeholders think through an issue or a process holistically, regardless of conventional labels, helping to trace critical pathways and mapping how different social partners might interact in responding to complex challenges;
- contribute to the public good by passing on knowledge and evidence which can feed into the review of goals and objectives.

6.5. *Limitation of 'Best Practice' as a methodology*

Its strengths and its range of uses notwithstanding, best practice has limits. It follows on from the definition of goals through social dialogue - it does not

determine them. It fits into a hierarchy of measures as a way of describing systematically the actions that have been taken to fulfil the objectives and targets already in place and as part of a comprehensive package of responses by social partners.

Remembering, that best practice is a purported ideology premised on the 'practices' of others and determined and/or deemed 'best' practice based on a subjective set of standards and criteria. It is within this context that companies, while acknowledging what is deemed good practice, must adapt the principles, policies and programmatic responses only where it is applicable to that company. Therefore, best practices can and should only be used as a basis or as determining guidelines for a company response to HIV/AIDS which is tailored to suit the conditions and context from which that company operates.

Further to this, the custodians of that company response must have the capacity and staff to use evidence based planning which seeks to promote lesson learning and best practice. Any attempt at emulating another company's programme, while clothed in good intentions, must be done so with the utmost of caution. As it has been previously alluded to, each company will have its own unique characteristics on which any response must take cognizance of to ensure its optimum success.

Lastly, the notion of validating certain practices is an important one. No company programme is flawless and a 'best practice' case study will often dismiss the obstacles, cost and human capacity required to achieve that desired end product. Any company response to HIV/AIDS is bound to encounter obstacles and this must be taken into account when developing a programme.

6.6. *Implementing Best Practice – Lessons Learnt*

The reality of HIV/AIDS is enormously complex. Responding to the challenges posed requires a concerted and integrated series of reactions ranged along the continuum of prevention, treatment, care and support, based on the protection of rights. It also demands that the continuum of individual, family, community, workplace and economy be fully reflected in designing and delivering initiatives to tackle HIV/AIDS through workplace action.

In appendix 3 we review best practice lessons that have been generated by practical experience in the workplace and beyond, looking across sectors and at all stages of the process. For the sake of convenience it groups case studies and lessons, albeit loosely, despite the fact that each case study is multi-dimensional and the inter-connections between each should be recognized. There are five sections, followed by a summary of cross-cutting issues and lessons:

1. Policy and legal frameworks
2. Workplace policies and programmes: prevention
3. Workplace policies and programmes: care, support and treatment

4. Links beyond the formal workplace
5. Knowledge and evidence: data analysis, monitoring and feedback

Appendix 3 examines a few of the best practice examples generated in the world of work for each of these themes. The case studies selected reflect the diversity of workplace settings and their variation in size, structure, organizational and institutional capacity, finances, ties to community, and culture. It flags learning points and highlights the links between thematic areas, between social partners, the general rights and responsibilities of governments, employers and workers and their respective organizations and with the key principles set out in the ILO Code of Practice.

7. “MENU” OF SERVICE PROVIDERS

7.1. *Background*

One of the required outputs of this contract, was the construction of a “menu” of HIV/AIDS related service providers. A detailed listing by district of all key service providers is provided in Volume 2 of this report. The information is displayed in two forms. In one form, the full details of each service provider by district are presented. The alternative shorter presentation is a table on which selected key data on each organisation is listed.

7.2. *Purpose of the “HIV/AIDS Service Providers Menu”*

One important component of this project is the production of a “menu” of HIV/AIDS service providers that will assist role players in identifying NGOs, CBOs or commercial organizations that can assist in designing workplace HIV/AIDS prevention and mitigation programmes. These service providers range from large international organizations such as UNAIDS or the World Health Organisation (WHO) down to small community-based home-based care initiatives run by volunteers in a village.

It is anticipated that the “menu” will provide information on the contact details of each service provider and a description of their activities. When a consortium of entrepreneurs develop a proposal in collaboration with the Area Manager, they will be able to consult the menu and make a selection of potentially useful organizations that can assist them in developing an HIV/AIDS policy and work plan for their funding submission.

Over time, it is likely that skilled Area Managers will be learn which organizations in his/her area are the best for providing specific services and this knowledge needs to be translated into updates of this list of service providers.

7.3. *Types of HIV/AIDS Service Providers*

As can be seen from the attached menu, there are many NGOs, CBOs and commercial organizations that are providing services in the field of HIV/AIDS. For convenience, we have divided these organizations into the following categories: international, national, regional and local and each are discussed separately below. Note that where, for example, an international organization has a strong national or regional presence, it has been included as a national or regional organization. The German organization “InWent” is such an example because, although international, it has established a strong presence in KZN and has functioning, regional projects.

International Organisations

This category contains the major international players such as UNAIDS, WHO, the International Labour Organisation, World Bank and others. These organizations tend to be large, bureaucratic structures that typically interact at a governmental level and seldom form direct partnerships with communities or small-scale development projects. However, the international organizations are frequently a useful source of information, guidelines and “best practice”. Most of them produce documents that are available online and that are useful reference and resource guides and can be used as a “gold standard” against which to compare local initiatives.

The main weakness of materials produced by these organizations is that they are often very generic and frequently not appropriate for local conditions.

National Organisations

There are a variety of national organizations that operate across the country or in certain areas. The activities of these organizations usually incorporate more local knowledge and hence are more “customized” to meet the needs of South African clients but their lack of a permanent presence in the district often results in their services being less accessible than that of local organizations.

Regional Organisations

Several organizations in KZN operate in more than one of the four learning areas and hence are labeled as being regional. Strength of these organizations is that they bring their local knowledge linked to the potential to establish consistency of service across districts.

Local Organisations

In each of the four learning areas there are a variety of organizations that operate locally as either NGOs or CBOs and many of these organizations are community-based. Whilst a weakness common to many of these organizations is that they lack financial and human resources, locally run organizations also bring certain strengths. Community-based programmes are best situated to establish support networks between individuals, households and communities and collective action of this kind represents an autonomous, affordable response to the HIV epidemic. NGOs and CBOs can play multiple roles within HIV strategies, ranging from home-based care, counseling, and emergency support for families. They can also initiate training, employment and income generation programmes. They allow local resources to be used most effectively. Finally, community based organizations can assess and respond better to the full spectrum of needs of their particular community with an intimate understanding of local conditions and cultural practices. For all the above reasons, where a local organization is capable of providing the services that a particular client may need, it should be the first choice.

7.4. Notes on Working with HIV/AIDS Service Organisations

Free services versus paying for services: Obviously, where services are available for free, typically governmental services, these should be used wherever possible. For example, the state health services provide free condoms and HIV/AIDS-related literature. There is also limited access to free or very cheap antiretrovirals for HIV infected people who fulfill the criteria. However, in certain cases it may be more appropriate to use services that must be paid for or a combination of both. For example, if senior staff in an organization have access to medical aid, then they are more likely to be adherent to treatment if they receive it from a private specialist rather than queuing in a primary health care clinic.

It must be noted that it was very difficult to quantify the costs to a client of many services because organizations frequently do not have fixed rates but have an informal “sliding scale” depending on the client’s ability to pay. Also, the services that are paid for frequently cross-subsidise free services. For example, whilst the South Coast Hospice provides free home-based care, they charge companies for their awareness raising workshops.

Modus Operandi and Structure of Service Provider: Different service providers use different models and approaches in how they operate and the area managers and fund seekers need to select that which is most appropriate to their needs. In some of the districts, service provision is dominated by one or a few key organizations that are well established and have credibility. An advantage of working with such organizations is that their services are usually consistent and reliable. This is important, for example, when running an awareness-training programme for a consortium of small business entrepreneurs. However, if the need of a consortium of peasant farmers is a home-based care system for family members, then it may be most appropriate to link up with established, community-based HBC programmes that are already running in the community rather than accessing services from the local, urban-based hospice.

There is no one model that is right or wrong but instead each model and organization needs to be assessed on its merits and what the client’s needs are. Some organizations are strongly centralized and require clients to come to them to use their services whereas others are highly decentralized with their entire focus being on having a presence in the community. Some organizations provide comprehensive services with little capacity development of the client whereas others primary focus is on capacity building and mentoring.

7.5. Department of Health

Whilst employees in the corporate sector typically have access to medical aid schemes and private health care, the majority of the population obtains health care from government health services. In recent years, the spending on HIV/AIDS related health problems has expanded enormously and the

Department of Health (DoH) provides a wide range of services that may be accessed. Key services provided by the DoH in the context of this project consist of:

- Voluntary Counselling and Testing (VCT) for HIV
- Treatment of Opportunistic Infections (OIs)
- Prevention of Mother to Child Transmission (PMTCT) of HIV
- Highly Active Antiretroviral Therapy (HAART)
- Information, Education and Communication (IEC) services
- Condom provision
- Treatment of Sexually Transmitted Infections

7.6. *Voluntary Counseling and Testing (VCT) for HIV*

VCT has been labelled as the “gateway” to prevention and care. Knowing and coming to accept one’s HIV status enables more informed planning for the future, including for one’s dependents. If a person is HIV negative then he or she can rejoice with this knowledge and ensure that he or she is never again exposed to infection in the future through practicing “safe sex” 100% of the time. Alternatively, if a person is diagnosed HIV positive, he or she can now enter a comprehensive treatment programme and a diagnosis of HIV is no longer the automatic death sentence it once was. Programme experiences have also shown that VCT is one of the factors that help to reduce stigma and secrecy surrounding HIV/AIDS. For all the above reasons, facilitating access to VCT for LED beneficiaries should form a part of any workplace programme.

An interesting cultural phenomenon needs to be raised here and that is the widespread belief that knowledge of one’s HIV status hastens the onset of AIDS and death. For this reason, many people avoid VCT. Whilst it may be true that a negative mental state may accelerate individuals overall decline, with proper counselling, this should not occur, particularly in this era when treatment is increasingly becoming available.

At present, VCT is available for free at all government health facilities although the quality of counselling varies in different settings and there may be occasions when there are stock outs of HIV testing kits.

A limited number of NGOs and faith-based organisations also offer VCT and these services are included on the list of service providers by district.

Instead of encouraging individuals to go alone to a VCT clinic, another option is for a group of LED beneficiaries to engage the services of an organisation that offers a workplace VCT programme. The advantages of this approach are that the quality of counselling can be ensured and the take up rate of VCT can be improved. A disadvantage of this approach is that there are usually costs involved which vary upwards from about R 100 per person.

7.7. Prevention of Mother to Child Transmission (PMTCT) of HIV

In Africa, in the absence of a PMTCT programme, it is estimated that between 25% and 40% of infants born to HIV infected mothers become HIV infected and half of these children will die before their second birthday. In 2004 in South Africa, Dorrington (2004) estimated that there were 37 000 children born HIV infected and an additional 26 000 who became infected through breast feeding.

In the province of KZN, the provincial DoH has “rolled out” the PMTCT programme to the entire province and all women should now have access to the programme through government clinics and hospitals. The current provincial protocol for PMTCT provides for short course antiretrovirals (Nevirapine) around the time of delivery for the mother and child. Studies have shown that this intervention reduces HIV transmission at birth by up to 50%. In addition, as access to ARVs increases, mothers on HAART will have an even lower chance of transmitting HIV because their viral loads will be dramatically reduced.

However, an effective PMTCT programme is much more than simply giving Nevirapine to mothers and children and a comprehensive programme consists of:

- Prevention of HIV infection in mothers
- Prevention of unwanted pregnancies
- Prevention of HIV transmission to the infant

Prevention of transmission of HIV through pregnancy and breast-feeding includes:

- STI screening and treatment
- Prophylactic treatment with ARVs
- Avoidance of unnecessary invasive obstetrical procedures
- Alternatives to breast-feeding

All these services cannot be implemented in a vacuum and need to be situated a setting where there is adequate antenatal, delivery and post-natal care with ongoing support.

In the context of the KZN LED project, all beneficiaries need to know about the benefits of PMTCT and have their access to this programme facilitated. This may be achieved by:

- Informing all potential beneficiaries about the relevance and benefits of the PMTCT programme.
- Providing beneficiaries with information as to how they may access PMTCT services
- Ensuring that the policies and plans of beneficiaries facilitate women accessing antenatal and PMTCT services

8. POTENTIAL FOR JOB CREATION IN SMALL AND MEDIUM ENTERPRISES

8.1. *Introduction*

While the HIV/AIDS epidemic is having an effect on the economy at level of the household and the firm, and in a more aggregated way on the macroeconomy, an “AIDS Economy” has developed around intervening in the epidemic. In addition to adding to Gross Domestic Product at the macro scale, this economy has created opportunities for business development and job creation. This section looks at describes some of these opportunities and identifies possible areas where job creation can occur in supporting responses to HIV/AIDS.

Currently a large number of HIV/AIDS interventions are undertaken by organs of civil society on a non-profit or volunteer basis. Care needs to be taken to ensure that the good work done and jobs created by these institutions are not destroyed by a rush to create jobs through the establishment of commercial concerns undertaking similar activities.

8.2. *The Job Creation Matrix*

It has been increasingly recognised that the HIV/AIDS epidemic requires a holistic and integrated response. Consequently, there is a wide range of activities that can take place around the epidemic that have the potential to lead to job creation. The matrix on the following page identifies some broad groups of activities that can take place in this regard. Each of these broad groups of activities are broken down into more specific activities and are assessed in terms of a series of basic characteristics which are described below.

- *Sector:* This characteristic describes which the activity in question is undertaken in the formal or informal sector of the economy. Some activities may fall within in both sectors.
- *Level of Skill Required:* This refers to the level of technical skills required to undertake the activity. High means that a high level of technical expertise is required, whereas low means that little or no expertise is required.
- *Access to Training:* Most activities will need some level of training in order to ensure that they are undertaken in a consistent and effective manner. Activities requiring a long period of training at a tertiary institution are described as “accessible long term”, and imply a long lead-time before skills can be developed. Activities described as “accessible short-term” can be undertaken after a short training course by a service provider. Essentially this characteristic provides an assessment of how fast skills can be acquired and applied to the activity in question
- *Other Barriers to Entry:* This characteristic identifies barriers to entry other than the skills required and the accessibility of training. This

includes things such as access to capital and to specialist equipment. The comment column provides some more details on what the barriers are considered to be.

Activity Area	Activity Type	Sector		Level of Skills Required			Access to Training		Other Barriers to Entry			Comments
		Formal	Informal	High	Medium	Low	Accessible long term	Accessible short term	High	Medium	Low	
Research	Biomedical	✓		✓			✓		✓			Requires specialised equipment
	Social	✓		✓			✓		✓			
	Economic	✓		✓			✓		✓			
Consultancy	Monitoring and Evaluation	✓			✓		✓		✓			
	Policy Development	✓		✓			✓		✓			
Care	Private Hospitals	✓		✓			✓		✓			Requires specialised equipment
	Step Down Facilities	✓	✓		✓		✓			✓		
	Home based		✓			✓		✓			✓	
Drug Sales	Wholesale	✓		✓			✓			✓		Licenses required
	Retail	✓		✓			✓			✓		Licenses required
Counselling - General	Lifestyle	✓	✓		✓			✓			✓	Can be undertaken with basic training
	Bereavement	✓	✓			✓		✓			✓	Can be undertaken with basic training
Counselling and Testing	PLWHAs	✓	✓			✓		✓			✓	Can be undertaken with basic training
	Relatives	✓	✓			✓		✓			✓	Can be undertaken with basic training
	Sample processing	✓		✓			✓		✓			Requires specialised equipment
Education	Training		✓		✓			✓			✓	Can be undertaken with basic training
	Awareness Raising	✓	✓			✓		✓			✓	Can be undertaken with basic training
Supporting Environment	Vegetable production	✓	✓			✓		✓		✓		Can be undertaken with little or no training.
	Transportation of people	✓	✓		✓			✓		✓		Requires a vehicle, as well as special licenses
	Transportation of food and drugs	✓	✓		✓			✓		✓		Requires a vehicle
	Funerals and burial services	✓			✓			✓		✓		Requires a vehicle, as well as special licenses

Table 2: Job Creation Matrix

9. TOOLKIT FOR MAINSTREAMING HIV/AIDS INTO DEVELOPMENT, BUSINESS AND GOVERNMENT

Volume 3 of this report consists of the “KZN LED Toolkit for Successful HIV Workplace Programmes”. This is a comprehensive document and Excel-based programme that combines an HIV/AIDS leadership training manual and a usable toolkit for implementing HIV/AIDS programmes in any workplace be it local government, SMME or a large corporate. Whilst there are other toolkits available, such as the one being sold by SABCOHA, we believe that ours is the most comprehensive and user friendly one available.

The toolkit includes the following components:

1. KZN LED Toolkit for Successful HIV Workplace Programmes: A Guide for Project Coordination Units and Project Funding Applicants.

This toolkit includes a Word-based manual with

- An Introduction to the toolkit
- An overview of Sexual Health issues
- The guidelines to building strong communities
- The instructions for developing a successful HIV/AIDS Workplace Programme
- The core content of workplace education and awareness programmes.

Reading this manual will prepare PCU and applicant to develop their HIV and AIDS Workplace Programmes and to evaluate, and approve or reject with reasons the applicants and the PCU can understand, accept and learn from.

2 Covering letters: A letter to the PCU and also the Funding Applicant

3. Excel Based Tools

This toolkit includes Excel-based templates, checklists, scorecards and guides that

- Correspond to their counterparts in the manual
- Help applicants develop their HIV and AIDS Workplace Programmes
- Give applicants tools they can circulate in their organizations
- Help the PCU automate their evaluations (and give faster feedback to applicants and reports to PCU seniors)
- Gives the PCU a standard 10-point scoring mechanism of applications (and also lets the PCU set a minimum standard e.g. applications must get full marks in these areas, but the PCU can tolerate half-marks in other areas, or of course, the PCU can require them to get 100% in all 10 as the funds dry up and the PCU decides to raise the qualification criteria!)

- The most important tools for the PCU are at the end: 17, 17a, 17b and 17c. Using these tools (i.e. not printing them out and using them as a Word document), the applicants can self-assess their submissions, and the PCU can respond using the same template.
- Facilitate and accelerate steps (e.g. by scoring knowledge tests automatically and giving feedback to applications)
- For people with low education levels the PCU can assist with completing applications.

4. Budget Price List

This toolkit includes a price list of the common components of workplace Programmes. The prices understand that applicants differ in size and complexity, and also in their HIV/AIDS prevalence, so reflect an average of 80% of 2005 big-corporate-level prices. Use it to evaluate the costs in the funding applicants HIV and AIDS Workplace Proposal.

5. Budget Pricing Module

This toolkit includes an Excel-based budgeting template that allows applicants to identify their needs. The template helps them to quantify and the PCU to “sanity-test” their needs. Use it to assist funding applicant in developing a budget and/or evaluate the costs in the funding applicants HIV and AIDS Workplace Proposal.

10. THE WAY FORWARD – IMPLEMENTING AN HIV/AIDS STRATEGY FOR THE KZN-LED SUPPORT PROGRAMME

10.1. Introduction

This report has provided the PCU with a situational analysis of the HIV/AIDS epidemic in each of the four learning areas in the context of LED. In addition, the report has provided a framework, a listing of service providers and a “hands-on” toolkit for managing HIV/AIDS issues. This section provides a “road-map” of how an HIV/AIDS strategy for the KZN-LED Support Programme may be implemented and monitored over the next 6 years.

Implementation of an HIV/AIDS strategy should take place within the framework of “mainstreaming” because this approach will encompass both internal (i.e. workplace) issues and external (i.e. project implementation) issues. Chapter 5 provides details of the principles behind mainstreaming and how the KZN LED Support Programme can implement mainstreaming into their internal and external activities. Chapter 6 and appendix 3 deal with the issue of “best practice”, the strengths and limitations of this approach and how it can be used by the KZN LED Support Programme.

We are fully aware that the core function of the PCU is local economic development and poverty alleviation and not HIV/AIDS prevention and mitigation. Therefore, the intention here is not to attempt to subvert the functioning of the PCU nor to divert resources to non-core areas of activity. Instead, the aim is to develop a strategy that will ensure that the PCU is compliant with the law and is able to efficiently and cost-effectively address key HIV/AIDS prevention and mitigation issues that will surface during the life-cycle of this development project.

Below we list the core areas of intervention for the KZN LED programme and then discuss a number of components in more detail. Technical assistance will be needed for almost all aspects of the strategy and such assistance may be provided by a pool of consultants.

10.2. Core Areas of Intervention

Considering the core objectives of the KZN LED Support Programme, and the fact that the majority of funding support is for economic development programmes, the programme is not in a position to provide a comprehensive intervention into the HIV/AIDS pandemic in the province of KwaZulu-Natal.

The key purpose of the intervention of the programme in this area would be to:

- Ensure that the conditions for the spread of HIV/AIDS are not worsened by the economic development projects funded through the KZN LED Support Programme, and
-
- To develop a model for best practice on how issues around HIV/AIDS should be addressed in processes of economic development and more especially in grant funded economic development programmes.

As funds are limited, and in order to communicate effectively to the public the role and function of the programme in mitigating the effects of HIV/AIDS, the following core issues and activities will constitute the programmes' intervention:

Applicants will be asked to provide information on what HIV/AIDS policies and programmes are in place, either within a municipality or partnership group. In order not to disadvantage smaller and newer companies and partnership groups, applicants will not however receive additional evaluation points for having such policies and programmes.

The purpose of requesting this information is to assist the programme in assessing whether additional support in the area of HIV/AIDS mitigation is required.

With regard to receiving support for developing a response to HIV/AIDS, partnership groups, or members of partnership may secure support from Gijima KZN in the following ways:

If an applicant has both a fully fledged HIV/AIDS policy and programme in place, and provides information to this effect, they will not be required to implement an HIV/AIDS mitigating strategy unless the project they intend implementing will potentially increase the spread of HIV and their current programmes cannot account for this.

If a partnership group has neither an HIV/AIDS policy or programme in place, they will be required to implement the basic HIV/AIDS programme. The core elements of this programme are listed later in this chapter. Applicants must budget for this policy and programme development within their project application and identify the service provider they intend using for implementation. A selection of "preferred" service providers will be identified by the PCU and they will have agreed to undertake the implementation of this programme against set costs.

Given the nature of particular projects and the fact that certain areas may require a more direct intervention in HIV/AIDS, applicants may make a broader project application for funding in this regard. Funding of programmes to mitigate the spread of HIV/AIDS will not be considered for funding unless linked to an economic development project. The costs of the HIV/AIDS intervention may not exceed 10% of the total costs of the grant for which funds are being applied.

This limitation to funding an HIV/AIDS initiative will not apply to those income generating and sustainable projects which may be proposed in the sphere of the health industry and which may provide a service which would assist persons infected with HIV/AIDS, or a service which may assist in preventing the spread of HIV/AIDS.

The programme will also play an important role in the dissemination of information around economic development and HIV/AIDS. This will be in the form of actively disseminating information on these topics through inter alia, the programme, seminars and workshops.

The final area of intervention for the programme will be in facilitating the implementation of an HIV/AIDS best practice programme with the Department of Economic Development with the intention of replicating such interventions across other government departments.

Whilst the above areas for direct intervention by the programme should provide the core of the response of the KZN LED Support Programme, the PCU should where necessary play an active role in signposting applicants to other funders and service providers within the sphere of HIV/AIDS. Members of the PCU should be familiar with both these funding programmes and service providers within their area.

10.3. *Components of the Strategy*

Awareness Raising and Strategic Planning for PCU Staff

Because of the global impact of the HIV/AIDS epidemic and the massive resources being pumped into all aspects of it ranging from the molecular level to behavioural change programmes, it is almost impossible for lay people to be abreast of the latest developments. Our impression is that PCU staff are not well versed in HIV/AIDS issues and this potentially compromises their capacity and confidence in dealing with the matter. We therefore propose that there is a one day awareness raising and strategic planning session for PCU staff with the following aims:

1. To update staff on the basics and latest developments in regards to HIV transmission, prevention, treatment and mitigation.
2. To provide an overview of the current status of the epidemic in South Africa and KZN and how it is being responded to by all sectors.
3. To assist in mainstreaming HIV/AIDS issues into the operations of the PCU by discussing the development of an HIV/AIDS policy and developing consensus on how the PCU can most effectively manage HIV/AIDS issues as part of its development agenda.

Mainstreaming HIV/AIDS issues into the PCU

The one-day workshop will begin the process of policy development and mainstreaming within the PCU. However, the process cannot be completed in a day and it is envisaged that the PCU will need ongoing assistance to ensure that an appropriate HIV/AIDS policy is developed and implemented. This will be an iterative process whereby drafts are considered and amended until a satisfactory policy is produced. The policy will then need to be shared with staff so that all are familiar with its content and what the implications are for staff.

Following on from policy development will be the process of mainstreaming HIV/AIDS issues into the functioning of the PCU and developing an HIV/AIDS strategy. Key issues that the consultant will need to address with PCU staff will be the following:

1. What will be the potential HIV/AIDS-related negative impacts of PCU development activities on beneficiaries and the community?
2. What will be the threats and impact of the HIV/AIDS epidemic on the success of LED development plans and projects?
3. How can the PCU most effectively and efficiently use its competitive edge to prevent and mitigate the spread and impacts of HIV/AIDS? What can the PCU achieve alone and what can it achieve in collaboration with other role players?

The outcome of this process will be an HIV/AIDS strategy document that will serve to direct and focus the HIV/AIDS-related activities of the KZN-LED Support Programme.

The team has already had several meetings with KZN LED Support Programme staff members and terms of reference for a consultant to assist the Programme in mainstreaming HIV&AIDS issues have been drafted.

Incorporating HIV/AIDS into evaluation matrices

The PCU currently has decision-making matrixes that are used to assess whether or not BEF and LEF applicants will receive funding. After several consultations with KZN LED Support Programme staff, a list of HIV&AIDS-related criteria for inclusion into the matrixes was agreed upon. The purpose is not to penalise fund applicants who do not have HIV&AIDS policies and programmes but rather to “signpost” them as to how they should go about devising an appropriate response to the threat posed by HIV&AIDS.

A list of criteria and “check-lists” for assessing compliance with the criteria is contained in appendix 7.

Compiling a List of HIV/AIDS Service Organisation “Preferred Providers”

Most potential beneficiaries of KZN-LED Support Programme funds will need technical assistance in developing workplace HIV/AIDS policies and programmes. Such assistance may be provided by a wide range of local, regional and national organisations. However, because there is such a plethora of organisations, the quality and back-up of their services varies greatly. For this reason, it may be appropriate for the KZN-LED Support Programme to develop lists of “preferred providers” to whom fund applicants may be directed for assistance. Alternatively, the KZN-LED Support Programme itself could contract preferred providers to provide services to fund applicants. This latter approach will make it easier for the KZN-LED Support Programme to monitor service quality and compliance but will increase the administrative load on the PCU.

Consultants could assist the KZN-LED Support Programme in the following ways:

1. Compiling a list of potential HIV/AIDS-related service providers at a local, regional and national level.
2. Drawing up a call for “Expressions of Interest” from HIV/AIDS-related service providers and disseminating the call through direct mail and local newspapers.
3. Establish objective criteria for assessing service providers and to conduct the assessment in order to arrive at a list of preferred providers for all components of workplace programmes.

This differs from the type of general networking activities undertaken by organisations such as HIVAN, as it leads to some form of accreditation. The HIVAN database lists all organisations that wish to register, whereas this process will result in a listing of service providers who are able to deliver to a certain standard.

District-based “HIV/AIDS in the workplace” orientation sessions

In order to bring potential beneficiaries up to speed in regards to HIV/AIDS workplace programmes, it is recommended that occasional briefing sessions are run at the district level. This could be structured along the same lines as the PCU awareness raising and strategic planning workshop but with more emphasis on the why and how of planning for a workplace programme. The HIV/AIDS-related criteria that are required to be met in order to access funding will be explained. The target group would include potential funding applicants as well as local government LED officials and potential service providers

Monitoring and evaluation of workplace HIV/AIDS programmes of beneficiaries

It is one matter to devise an HIV/AIDS policy and workplace programme but quite another to implement it effectively. The PCU needs to monitor and evaluate how the workplace programmes are implemented in practice. At the one level this needs to be done in a quantitative manner so that the PCU can have objective indicators with which to assess programmes and compare districts. Such indicators are likely to include measures of policy establishment, number and extent of employee training, number of condoms distributed, etc.

However, it will also be useful to do a more qualitative investigation into a cross-section of workplace HIV/AIDS programmes in order to draw out lessons, constraints and best practices. These can be shared across the districts so that obstacles to the successful implementation of HIV/AIDS programmes may be identified and managed and so that best practices may be shared, adapted and implemented.

It is recommended that monitoring and evaluation of HIV/AIDS related interventions be integrated into the broader monitoring and evaluation system that the PCU has put in place to manage the overall outcomes of the programme.

Reviews of international, national and district developments in the field of HIV/AIDS

As explained above, the field of HIV/AIDS is developing rapidly with new interventions ranging from new classes of drugs to innovative workplace behavioural programmes. It is recommended that every six months PCU staff are updated on new developments in terms of HIV/AIDS with a particular focus on issues pertinent to economic development and the workplace.

10.4. Determining and Costing a “Minimum Package” for Workplace HIV/AIDS Programmes

The size and scope of any workplace HIV/AIDS programme is dependent on the size of the organisation and on the nature of its activities. It would be inappropriate to require a small organisation with a handful of staff to have an elaborate HIV/AIDS programme with peer education programmes, impact assessments and such like whereas this is the norm for larger organisations.

Apart from size, the nature of an organisation's activities is also an important determinant of what kind of HIV/AIDS programme is required. For example, a sewing cooperative of rural, elderly women is unlikely to have much impact on the spread of HIV but a professional group of young, female lap dancers is likely to have an impact in the absence of a programme to keep them free of STIs including HIV.

In this section we define the requirements for internal HIV/AIDS programmes for a variety of organisations.

Table 3 lists the various components of a workplace HIV/AIDS programme along with the main service providers and some comments. Note that many of the services are free and so all except the larger or wealthier organisations can make use of free state sector services. Notes on each of the various free services and those that usually need to be paid for are contained below.

Service	Providers	Comments
Condoms	DoH Social Marketers, e.g. "LoversPlus"	DoH provides approved condoms for free Social marketers sell condoms at low cost
Information, education and Communication (IEC) materials	DoH Local ATIC* NGOs	DoH provides pamphlets and booklets for free but has a limited range
Voluntary Counseling and Testing for HIV	DoH GPs	All clinics and hospitals should have VCT programmes. GPs generally do not offer comprehensive counselling
Policy formulation	NGOs SABCOHA	Many draft policies are available to be customised
Awareness raising	DoH NGOs	DoH can give educational talks for free but as "one-offs" rather than a comprehensive programme
Peer Education programmes	NGOs	Involves establishing a peer educator programme and ongoing support of peer educators
Research	Universities, MRC, CADRE, NGOs	
STI Treatment	DoH General Practitioners	DoH uses the syndromic approach and uses the recommended drugs. GP treatment generally not advised.
Care and support	DoH NGOs CBOs	DoH provides health care including treating opportunistic diseases. Home based care is provided by many NGOs or CBOs.
Antiretrovirals	DoH Private Health Sector	DoH has at least one ARV site per health district. Eligibility criteria apply

* AIDS training and Information Centre

Table 3: HIV/AIDS Related Services and Service Providers

Condoms

Condoms are provided free by the government and all organisations should make condoms easily available to employees. These should be available in more than one setting and in places where they can be accessed in private such as rest rooms. In larger organisations that have retail facilities on site (e.g. take away foods, small shop, etc) may consider having one of the social marketing companies (e.g. Lovers Plus) selling their condoms through the retail outlets.

Information, Education and Communication (IEC) Materials

As with condoms, a limited range of these materials are provided for free by government in a variety of languages. As a minimum, even small organisations should access a supply of the key materials in order to make them available to staff. Larger organisations may wish to access additional IEC materials from NGOs or the private sector. Low levels of literacy limit the usefulness of pamphlets or books and so alternative and innovative approaches have to be used. For example, many institutions host theatre companies that have productions on HIV/AIDS-related themes.

Treatment for Sexually Transmitted Infections (STI)

South Africa has adopted the “syndromic” approach to STI treatment and it has been implemented across the country by the DoH in a systematic manner. Most government clinics stock the appropriate medications and nurses know how to treat people with STIs and so this makes government clinics the facility of choice for STI health care. Studies have shown that GPs are not likely provide the optimal treatment. This is in part due to the “perverse incentive” dispensing GPs have to face whereby their profit margins are increased if they give cheaper (and often inferior) medications. Staff need to know that STIs put them at greatly increased risk of transmitting and acquiring HIV.

Care and Support for People Living with HIV/AIDS (PLWHA)

Government has now committed itself to providing comprehensive treatment, care and support to PLWHA that includes treating opportunistic infections and providing antiretrovirals to those that need the drugs. There is also ongoing roll out of Community Health Worker programmes that are available to provide basic health care and appropriate referring.

There are strict eligibility criteria for people who wish to access antiretrovirals from the state sector. This is because of the cost of the medications but also because of fears around generating drug-resistant organisms. People who have steady work are more likely to access these drugs because they are usually living in stable conditions, earning money to buy food and can access their drugs

through the workplace to promote compliance. For example, many workplaces provide TB DOTS (or Directly Observed Treatment) for TB and HIV treatment.

Larger organisations may find it more appropriate and better for productivity to obtain antiretrovirals and health care from the private sector by facilitating access to medical aids by those that need care.

Voluntary Counselling and Testing (VCT) for HIV

VCT has been called the “gateway” to care and support and it is a critical component of any HIV/AIDS prevention and mitigation strategy. Larger organisations can provide VCT in-house through their clinics whereas others contract service providers to run a VCT service for staff. However, for smaller organisations, staff may have to rely on government clinics where a free counselling and testing service is provided. This is often preferred by employees because it is independent of the workplace which removes fears about confidentiality.

Peer Education Programmes

Research has shown that individuals learn better from peers than from “experts” who are parachuted into deliver talks. Because of this many larger institutions have implemented peer education programmes whereby a number of staff are trained about HIV/AIDS and receive ongoing support in order to provide an information service to their colleagues. A variety of NGO and private sector organisations provide these services in a variety of formats. The commonest problem with such programmes is that peer educators do not receive the ongoing support that they need which results in the impact of the programme dwindling.

Research and Policy Formation

There are a variety of research activities that institutions may deem necessary to help them plan for and mitigate the impacts of HIV such as HIV prevalence surveys, “knowledge, attitude and practice” (KAP) surveys, economic impact studies, etc. A variety of private sector, NGO and academic institutions offer these services at a range of costs. These organisations will also assist in interpreting the results and turning it into appropriate policies and implementation measures.

A Minimum Package for Organisations

Table 4 lists the minimum requirements for a workplace HIV/AIDS programme for organisations of various sizes. For the purposes of this project we used the following definitions for SMMEs that uses number of employees and annual r.

- Micro enterprise is 1-2 employees; <R100k;
- Very small business is 1-5 employees; <500k;
- Small business is 2-20 employees; <R500k-R24m;
- Medium business is 20-200 employees; R24m-R60m

Service	Micro/Very Small	Small	Medium	Large org.
Condoms	Yes	Yes	Yes	Yes
IEC materials	Yes	Yes	Yes	Yes
VCT for HIV	No	No	Possibly	Yes
Policy formulation	Yes	Yes	Yes	Yes
Awareness raising	No	Yes	Yes	Yes
Peer Education programmes	No	No	No	Yes
Research	No	No	Possibly	Yes
STI Treatment	No	No	No	Yes
Care and support	No	No	Some components	Yes
Antiretrovirals	No	No	No	Yes

* AIDS training and Information Centre

Table 4: Components of a Minimum Package for an HIV/AIDS Workplace for Organisations of Various Sizes

Approaches to Costing HIV/AIDS interventions

While the HIV/AIDS epidemic has the potential to decimate labour forces and slow economic growth, it has also resulted in the growth of a mini-economy with a focus on HIV/AIDS related research and service provision. Investigation in the conditions under which these interventions are a cost to the economy and when they benefit the economy is outside the scope of this project. The net benefit or cost of making HIV/AIDS interventions is likely to be dependent on a complex web of variables including geographic location, number of service providers, the type of services available, the accessibility of management, the strength and degree of unionisation of the labour force, the number of employees, and the cost structure of the industry in question. It is therefore difficult to make definitive statements about how business and other institutions should approach the issue of funding interventions.

The section that follows outlines some of the approaches used by NGO, local government and business institutions in the four districts forming the initial focus of the EU LED Programme. While no definitive statement can be made, the

fieldwork highlights some interesting approaches and solutions to challenges faced by service providers, local government and business.

The names of companies and people have been changed, and geographic locations are not referred to at all in order to provide the anonymity and confidentiality requested by some interviewees.

The Approach of Service Providers

The majority of service providers interviewed were either non-governmental organisations (NGOs) or non-profit organisations (NPOs) and were not focussed on making a profit. However, most organisations took different approaches to charging for service provision depending on the recipient of the service, and the nature of the service.

The Ability to Pay Approach: The core mandate of *Service Provider A* is home-based care, as well as associated services such as counselling and education. These services are provided free of charge to people living with HIV/AIDS (PLWHAs). *Service Provider A* also trains people and organisations in home based care, awareness raising and counselling. Community based organisations (CBOs) do not pay for this training. Other NGOs receive training at cost, while business organisations are charged a higher rate. The surplus generated by *Service Provider A* is then used to fund the free services provided to PLWHAs. In determining whether or not services should be charged for, and what that charge should be, the ability to pay principle is applied.

The ability to pay approach (see box above) is taken by most NGOs, particularly those whose access to donor funding is uncertain or in the balance.

The table below provides an indication of the cost to a business enterprise of some services provided by NGOs. In practice, the basis for determining the cost to a business of a particular service seems to be based on what the provider thinks that the client will be willing to pay.

Service	Cost (to the Client)
VCT	R200 per head
Peer educators training (5 day course)	R1000 per head
Counselling (5 day course)	R800 per head

A common approach to the provision of services in communities by NGOs is to provide training to groups of volunteers, who are then used to undertake HIV/AIDS interventions in the community. Notwithstanding the fact that the training benefits volunteers by providing them with much needed skills, the use of volunteers can be exploitative and ethically problematic. Volunteers are often poor rural women with high burdens of care, as well responsibility for securing the livelihood of their households. Volunteer activities are usually undertaken for no monetary gain or in-kind reward, which can lead to increase household vulnerability as a result of volunteers having less time to spend on livelihood maintenance activities.

In addition to services provided by NGOs in relation to care, counselling and education on a non-profit/limited profit basis, there are also organisations that provide mostly bio-medical services on a commercial basis. The table below provides an indication of the costs of these services.

Service	Cost (to the Client)
ARVs	R970 per month
Generic ARVs ³	R500 per month
Finger prick test and CD4 count	R120 per test
CD4	R100 - R140
Viral Load	R320 – R561
Finger prick test	R17

Costing Models used by Local Government

The cost of HIV/AIDS interventions at local government level is generally funded through the Department of Health or through the integrated development planning (IDP) process.

In some cases the municipality will be paid to operate clinics on behalf of the Department of Health (DoH). This is usually done when the DoH has limited capacity to provide service or restricted access to community infrastructure.

The other approach to funding HIV/AIDS interventions is more common. The municipality is required by legislation to draw up an IDP that will inform the municipality's activities on a year-to-year basis. The development of the IDP is linked to a budgeting process whereby the municipality allocates funding to the programme activities set out in the IDP. Most municipalities interviewed seem to be aware that HIV/AIDS posed a challenge to their developmental mandate and had allocated some funding to this issue.

In many cases the funding allocated for HIV/AIDS intervention is small and is often intended for awareness raising projects, although there are some municipalities that are looking at developing more comprehensive programmes with a more extensive reach. In deciding how large the funding allocation is to be, municipalities have to make trade-offs with other developmental programmes which are more visible and have a higher short term impact, such as the provision of roads, sanitation, water and housing.

Cost Models used by the private sector of ART

The assessment of the private sector and how their response to the epidemic had evolved is by no means exhaustive, but does highlight some basic approaches to funding HIV/AIDS interventions.

One of the biggest surprises coming out of the interviews with businesses was that where they had responded to the epidemic, this response had not been based on an economic assessment of the whether the short terms costs of

³ Some question as to quality, with a bumpy road reducing some generics to powder

providing an in-house programme would be outweighed by the long term benefits from a healthy productive labour force. The instigation of HIV/AIDS programmes was usually as a result of management compassion or management fear that it could result in future costs to the business.

The management of companies with less than 200 employees seem to have more intimate relationship with their workforce as a whole. Management compassion is often the driving force behind HIV/AIDS programmes, as some of the effects of the disease, particularly the way in which PLWHAs physically diminish in its final stages, are particularly visible and distressing to witness. However, no detailed impact assessment is done, which results in programmes that may not be sustainable as the case studies described below indicate.

Company A instigated an ART programme through the OH clinic. The programme was initiated at the request of a new expatriate CEO who was shocked at the physical condition of some of the HIV+ employees. The programme is proving very popular and management has requested that the OH clinic cut back on its awareness raising and VCT activities, as the company cannot afford to provide ART to everyone who needs it.

Company B operates in the retail sector and has a staff complement of less than 20 people. Currently only one staff member is HIV+ and requires ARVs, which are provided to him by the company free of charge. The owner of the business feels that even a small increase in HIV prevalence among the labour force would “wipe the company out”.

Larger companies, particularly those with a highly unionised workforce, are often under pressure to provide benefits to the dependants of their employees as well as employees themselves. Consequently, these companies see dangers in terms of largely unquantifiable future costs to the company and have taken a different approach to smaller companies, which tend to internalise their programmes, by transferring the burden of the future cost of providing treatment to an external third party. This approach is illustrated in the case study in the box below.

Company C employ over 2000 people, many of whom are drawn from deep rural areas and are traditional in their outlook, to the extent that many of the households they are part of are polygamous. In response to this potential for huge future costs, *Company C* responded by placing all their employees on medical aid schemes, and funding half of the monthly contribution. While this has increase *Company C*'s payroll costs in the short term, it has provided some certainty as to what the epidemic will cost the company in the medium to long term, and provided employees dependents with a safety net.

Finally, Table 5 sets out the costs of most of the components of a workplace HIV/AIDS programme that typically need to be paid for. Note that these are average costs obtained from a variety of service providers. The larger, “for-profit” companies tend to be more expensive than NGOs who often have certain of their activities subsidised by donors.

Programme Set up and implementation	Budget Cost exclude VAT	Notes
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Drafting of funding application for HIV and AIDS Workplace Programme	R 3,500	per application
HIV and AIDS Workplace Programme Toolkit Training	R 8,000	per 2 day workshop per workshop 1 day
Project Start-up Workshop	R 6,500	workshop
Executive Training	R 7,000	per 15 executives
Leadership Training	R 5,000	per 15 leaders per workshop 1 day
Trustee training	R 7,000	workshop
Policy development	R 5,000	per workshop 1 day workshop
<u>Research</u>		
KAP/Prevalence/VCT Study	R 175	per employee
Business impact report (basic)	R 25,000	per report
Business impact report (extensive)	R300,000 to 100,000	per report
Mainstreaming of HIV and AIDS report	R 20,000	per report
<u>Prevention Programme</u>		
Selecting Peer Educators Training (1 day)	R 4,500	Per workshop
Peer Education Training (5 days)	R 22,000	per 20 Peer Educators per toolkit per peer educator
Peer Educator training toolkits	R 950	
Peer Educator training toolkits training	R 4,500	per 20 Peer Educators Per month per 20 peer educators
Coaching of Peer Educators	R 2,500	
Peer Educator monitoring system (computer based up to 10 peer educators)	R 1,000	per month per site
<u>Treatment Programme</u>		
VCT Counsellor Course (Nurse)	R 4,500	per delegate
HIV Treatment in a workplace setting (Nurse/Doctor)	R 3,950	per delegate
Treatment monitoring	R 100	per patient per month
HIV test plus pre and post test counselling (VCT)	R 100	per employee
Treatment (HIV+ employees only)		per month per HIV+ person
Nutritional supplement	R 100	per month per HIV+ person
Vitamin and Immune boosters -	R 50	quarterly per HIV+ person
Lab tests (quarterly monitoring of CD4)	R 150	per month per HIV+ person
ARV treatment plus monitoring viral load and liver function	R 1,000	per month per HIV+ person
Counselling support	R 250	per hour
Nursing support	R 75	per visit
Doctor support	R 150	per visit

Table 5: Typical Costs Associated with Workplace HIV/AIDS Programmes

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APPENDIX 1

INTERVIEW GUIDELINES

HIV/AIDS and Development EU LED Programme – KwaZulu-Natal

NGO/CBO Questionnaire

Interviewee:

By: MC/DDT/TJH

Position:

Organisation:

Contact details:

Date:

Time:

District uGu/uMkhanyakude/uThungulu/umGungundlovu

1. Introduction to the EU LED Programme

2. The NGO/CBO

Name:

Areas of operation

Type of organisation International/national/regional/local/NGO/CBO/company

Activity:

Number of Permanent:
Employees: Part-time:

Casual:

Membership:

Annual Turnover:

Check that the contact details (phone/fax/address/e-mail/website) is correct or obtain a card

Background to the NGO/CBO?

- When was it established?
- What activities does it undertake?
- What is the NGO's mission statement/overall aim? What is "development philosophy/approach" underlies its activities?
- What financial info is available?
- Is there an annual report?
- Is the organisation part of a network? If so, which one?

3. Services

- What services does the NGO provide?

	Y/N
HIV/AIDS prevention activities	
Awareness programme	
Peer education	
Condom promotion and distribution	
STI Management	
VCT	
Infection control	
Wellness programme	
Supplementary interventions e.g. nutrition education	
Treatment for OIs	
Access to ARVs	
Access to ARVs for dependents	
Paralegal support	
Home based care	
Anything else?	

- Does the NGO use external service providers to implement aspects of their activities? Who? What do they do? How much does this cost?
- What are the advantages and disadvantages to taking this approach?
- Are activities undertaken in partnership with any other organisations? Who?
- What are the advantages and disadvantages to taking this approach?

4. Funding

- What is the cost of providing the services identified earlier
- How is this funded? (User fees, donations, in kind, sweat equity, donor funds, grants)
- In the case of donor funds or grants, is this funding part of a programme?
- Again in the case of donor funds or grants, is this money received annually, for the duration of the project, or as once off donations?

5. Key Projects

Ask the interviewee to provide some details of important projects that the NGO/CBO undertakes using the following headings as a basis:

- Project description
- Staffing
- Beneficiaries
- Duration
- Funding source
- Impact
- What can be done better?
- What is done well that can provide an example to other organisations?

HIV/AIDS and Development EU LED Programme – KwaZulu-Natal

Corporate and SMME Questionnaire

Interviewee:

By: MC/DDT/TJH

Position:

Organisation:

Contact details:

Date:

Time:

District uGu/uMkhanyakude/uThungulu/umGungundlovu

1. Introduction to the EU LED Programme

2. The Company

Name:

**Countries/areas of
operation**

Activity:

Number of Permanent:

Employees: Part-time:

Casual:

Ownership:

Annual Turnover:

Background to the company

- When was it established?
- What activities does it undertake?
- What is its business “philosophy”?
- What financial info is available?
- Is there an annual report?

3. Workplace/internal programmes

- Is there an HIV/AIDS policy? Can we get a copy?
- How was it decided that a policy was necessary?
- How was it developed?
- What does it cover?
- Does it have an associated programme? Is it being implemented?
- Who is responsible for its implementation?
- What activities are undertaken as part of the programme?

	Y/N
HIV/AIDS prevention activities	
Awareness programme	
Peer education	
Condom promotion and distribution	
STI Management	
VCT	
Infection control	
Wellness programme	
Has an HIV prevalence or KAP study been done	
Supplementary interventions e.g. nutrition education	
Treatment for OIs	
Access to ARVs	
Access to ARVs for dependents	
Paralegal support	
Home based care	
Anything else?	

Ask for an overview of each component of the programme.

- How is the implementation (i.e. the programme) financed?
- What is the cost of implementing the policy? (Try get actual monetary values for line items)
- Does the company use external service providers to implement the programme? Who? What do they do? How much does this cost?
- Where has the policy achieved its objectives? Where has it not achieved its objectives? Are there monitoring and review mechanisms?
- What does the company believe could be replicated in other companies?
- How would it be done differently if the company had to start again?
- Does the company take HIV/AIDS into account in its business planning activities? How? Ask for an example.
- Does the company belong to any HIV/AIDS business organisations (e.g. SABCOHA)?
- Is there a skills succession plan?

4. Outreach/external programmes

- Are there any external programmes?
- What are these programmes? What are the objectives of these programmes?
- Are these programmes part of a broader CSR/CSI programme?
- Are they done in partnership with any other organisations? Who?
- Do company employees benefit directly from these external programmes?
- What is the company's contribution to these programmes

HIV/AIDS and Development EU LED Programme – KwaZulu-Natal

Local Government Questionnaire

Interviewee:

By: MC/DDT/TJH

Position:

Organisation:

Contact details:

Date:

Time:

District uGu/uMkhanyakude/uThungulu/umGungundlovu

1. Introduction to the EU LED Programme

2. The Municipality

Name:

Number of Permanent:
Employee: Part-time:
Casual:

**Political breakdown
of council (% and
no.)**

Annual Turnover:

- Is there an HIV/AIDS component in the IDP? Can we get a copy?
- Can we get a copy of the annual budget?
- Can we get a copy of the annual report/state of the municipality report?

3. Workplace/internal programmes

- Is there an HIV/AIDS policy?
- How was it decided that a policy was necessary?
- How was it developed?
- What does it cover?
- Is HIV/AIDS *really* mainstreamed into the activities of the municipality?
- Is there political support for mainstreaming?
- Is there support for mainstreaming from the officials?
- Does it have an associated programme? Is it being implemented?
- Who is responsible for its implementation?
- What activities are undertaken as part of the programme?

	Y/N
HIV/AIDS prevention activities	
Awareness programme	
Peer education	
Condom promotion and distribution	
STI Management	
VCT	
Infection control	
Wellness programme	
Supplementary interventions e.g. nutrition education	
Paralegal support	
Home based care	
Anything else?	

Ask for an overview of each component of the programme.

- How is the implementation (i.e. the programme) financed?
- What is the cost of implementing the policy? (Try get actual monetary values for line items)
- Does the municipality use external service providers to implement the programme? Who? What do they do? How much does this cost?
- Where has the policy achieved its objectives? Where has it not achieved its objectives? Are there monitoring and review mechanisms?
- What does the municipality believe could be replicated in other municipalities?
- How would it be done differently if the municipality had to start again?
- Does the municipality take HIV/AIDS into account in its departmental planning activities? How? Ask for an example.
- Is there a skills succession plan?
- Does the municipality require its contractors to have an HIV/AIDS management plan? If yes, what form does it take?

4. Outreach/external programmes

- Are there any external programmes?
- What are these programmes? What are the objectives are these programmes?
- Are they done in partnership with any other organisations? Who?
- Do municipal employees benefit directly from these external programmes?
- What is the municipality's contribution to these programmes (monetary, in-kind etc)

APPENDIX 2

LIST OF INTERVIEWEES

NAME OF ORGANISATION	CONTACT PERSON	DISTRICT
Uthungulu District Municipality	Joe Muller Sipho Magwaza Elitza Marais	uThungulu
uMhlathuze Municipality	Fred Phillips	uThungulu
Senzakwenzeke	Dr. Maria Linder Dr Dennis Zulu Gcina Zulu	uThungulu
Richards Bay Minerals	Richard Nhlabathi	uThungulu
Black Managers Forum	Bongani Mqaise	uThungulu
Felixton	Sister Marrieter Mkovane	uThungulu
uMhlathuze Municipality	Ms. Ziphi Dladla	uThungulu
Edwards Pharmacy	Gerhard de Beer	uThungulu

NAME OF ORGANISATION	CONTACT PERSON	DISTRICT
Dr Desai- Private Practitioner	Dr. Moosa Desai	Ugu
South Coast Hospice	Kath Defilippi	Ugu
Practical Ministries	Nosipho Cwele	Ugu
Ugu District Municipality	Mabuyi Mnguni Nontsundu Ndonga	Ugu
Ntombifuthi Shomela	Inthuthuko Yabasha	Ugu
Terry Gilpin	Murchison Hospital	Ugu
NPC Cement	Sister Hill	Ugu
Doctors for Life	Heinrich Botes	Ugu
Hibiscus Chamber of Commerce and Industry	Di van Dyk	Ugu
Ziphakamise	Lynne Footit	Ugu

NAME OF ORGANISATION	CONTACT PERSON	DISTRICT
Thandanani	Nhlanhla Ndlovu	uMgungundlovu
ATTIC	Sanelisiwe Ndlovu	uMgungundlovu
Msunduzi Municipality	Julie Dyer	uMgungundlovu
Aberdare Cables	Ceri Duckworth	uMgungundlovu
Lawyers for Human Rights	Varshi Rajcoomar	uMgungundlovu
CINDI	Yvonne Spain Sixolile Ngcobo	uMgungundlovu
Msunduzi Hospice	Maureen Snowden	uMgungundlovu
Natal Rubber Compound	Sister Penny Arnold	uMgungundlovu
UKZN – PMB Campus	Clive Coetzee	uMgungundlovu
KZN Wildlife	Ms Hlengiwe Radebe	uMgungundlovu

NAME OF ORGANISATION	CONTACT PERSON	DISTRICT
Jozini Drop Off Centre	Sayinile Zungu Muzi Mthembu Sbusiso Mdamba	uMkhanyekude
Illovo Sugar Mill, Riverside, Mtubatuba	Sister Petra de Lange	uMkhanyekude
Hlabisa Municipality	Mr Eric Manqele	uMkhanyekude
Ingawavuma Women's Centre	Mrs Beni Williams	uMkhanyekude
Department of Health Umkhanyakude Health District	Dr Etienne Moolman	uMkhanyekude

NAME OF ORGANISATION	CONTACT PERSON	DISTRICT
Threshold (internet search)	Kevin Joubert	Gauteng
AREPP	Annette Brokensha	Gauteng
Soweto HIV/AIDS Counsellor Association	Happy Maseko	Gauteng
Save the Children UK	Andrew Challenger/Fiona Napier/Lynette Modonkuya	Gauteng
Unit for Social Behaviour Studies in HIV/AIDS	Mr Leon Roets	Gauteng

APPENDIX 3

EXAMPLES OF BEST PRACTICE IN WORKPLACE HIV/AIDS PROGRAMMES

Introduction

This document follows on from Chapter 5 “Identifying Best Practice”. In that chapter “best practice” was defined followed by a discussion on the strengths and limitations of the best practice approach. In this appendix a number of examples of *best practice* from local and international experience are discussed and the lessons learnt summarised.

Section 1: Policy and Legal Frameworks

Formally recognizing and structuring responses to HIV/AIDS is key to mobilizing societies and to moving from innovative individual efforts to a concerted response to this enormous global threat. Frameworks for action in the workplace are central in coordinating this response. These frameworks can be enormously varied and range from statements at the international level, like the UNGASS Declaration of Commitment on HIV/AIDS, through detailed agreements in sectors like mining which involve companies and unions, to legal provision protecting the rights of workers affected by HIV/AIDS. Reviewing the experience at all levels highlights the evidence of what works and what does not, and generates lessons that can support other initiatives.

Policy Framework – government-led national response

Case Study:

Technical Assistance Guidelines (TAG): The June 2003 the Technical Assistance Guidelines (TAG) on Key Aspects of HIV/AIDS and Employment was released. The TAG builds on the Code (of Good Practice set out in the Employment Equity Act) to set out practical guidelines for employers, employees and trade unions on how to manage HIV/AIDS in the workplace.

The guidelines also serve as a guide to ensure that individuals affected by HIV/AIDS are not unfairly discriminated against in the workplace. In essence, the TAG is based on the Department of Labour’s broad goals in managing HIV/AIDS in the workplace, inter alia, promotion of equality and openness around HIV/AIDS, creation of a balance between rights and responsibilities, and restoration of the dignity of persons affected by HIV/AIDS.

Lessons include:

- Regarding HIV/AIDS as above party politics and establishing broad, crosscutting support for government initiatives in the area can ensure long-term policy coherence.
- Working with different levels of government, regional and local, ensures that recognition of a national issue is translated into action throughout the system.

- Decentralizing authority and accountability to the 'lowest' appropriate level builds a sense of local ownership, facilitates implementation and enhances sustainability.
- Acknowledging the role of government as an employer as well as a policy-maker maximizes opportunities to protect workers and to promote best practice amongst those delivering services to PLWHA.
- Producing generic drugs, and taking an active role in debates on international trade agreements, has helped in the provision of affordable ARVs for PLWHA.

Legal framework

Legislation can play an important role in underpinning government policy and in supporting national, sectoral or workplace agreements. It can be used to protect the rights of workers affected by HIV/AIDS, ensure workplace prevention as well as social protection. Different legal initiatives can be used to help fight the epidemic in the world of work including specific HIV laws, labour legislation, disability laws, equity laws and social protection laws. The use of one instrument does not preclude the use of other instruments; rather, the opposite is often true. A multifaceted approach ensures that every issue is covered under the respectively relevant instrument. Legislation is particularly crucial in prohibiting discrimination on the grounds of (real or perceived) HIV status, banning mandatory testing of workers and job applicants, and protecting the confidentiality of HIV-related data. The protection of human rights is essential, not only to preserve the human dignity of people affected by HIV/AIDS, but also because the violation of those rights are major blocks to HIV/AIDS prevention.

i) Example of specific law on HIV/AIDS

Case Study:

Employment Equity Act: The Employment Equity Act No 55 was passed in 1998 in an attempt to create an environment of equality and non-discrimination in the workplace. It is particularly relevant because it is the only act that refers specifically to HIV/AIDS. The EEA will, because of its express protection for employees against unfair discrimination on the basis of 'HIV status', become the most important point of reference for decisions relating to the management of HIV/AIDS in the workplace.⁴

Section 5 of the Act aims to promote equal opportunity by eliminating unfair discrimination, directly or indirectly, and it prohibits unfair discrimination, directly or indirectly, against an employee in any employment policy or practice, on a number of grounds, of which one is HIV status⁵. An employer cannot, therefore,

⁴ Smart, R: 2001; 21

⁵ Employment Equity Act No 55 of 1998

refuse to employ a person simply because they are known or suspected to have HIV, this unfairly discriminates against them on the grounds of HIV status.

Section 7 of the Act prohibits medical testing of an employee except in circumscribed circumstances. Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court⁶. However, voluntary testing is allowed.

Rand Water has become the first South African company to be granted a court order for on-site voluntary HIV testing for all of its 3000 employees. Rand Water's reasoning behind the application was to assess the extent of the disease, the effectiveness or otherwise of planned interventions, the effect of the epidemic on the corporation as well as the likely cost scenarios.

In terms of the court order, Rand Water is permitted to conduct on-site voluntary HIV testing for a year, under the following conditions⁷:

- Testing is done voluntarily and with the informed consent of the employees to be tested;
- Testing will not be requested as a condition of employment, promotion or any other benefits;
- Testing will not be a job requirement;
- No prejudicial inference will be drawn from a refusal to submit to testing, nor will the company be informed or request to be informed of employees who have undergone testing;
- Testing will only be done after pre-test counseling has been given and will be followed by post-test counseling;
- The contractors conducting the tests will at no time reveal the results to anyone but the employee;
- The contractors will be required to sign a confidentiality agreement; and
- The result of any test will not be made known to any decision maker required to decide on any employment policy or practice concerning the employee.

Section 59 of the Act states that any person who discloses any confidential information acquired in the performance of a function in terms of this Act, commits an offence⁸. With confidentiality, the rules are the same as in the medical profession. If an employee informs the employer about their status, he/she can only inform other people with the employees consent. Telling other employees without the necessary consent is a breach of confidentiality and means that the employee can claim damages from his/her employer.

⁶ *ibid*

⁷ Independent author: 02 December 2001; *YES TEST! Rand Water gets nod for HIV tests* Sunday World

⁸ Employment Equity Act No 55 of 1998

An important issue to take into consideration is that should HIV/AIDS be classified in the future as a disability there will be other implications arising from the Act. For example, employers have responsibilities related to affirmative action in respect of people from 'designated groups'. These responsibilities include 'reasonable accommodation' which is defined as any modification or adjustment to a job or to the working environment that will enable a person from a designated group to have access to or participate or advance in employment. Designated groups are defined as 'black' people, women and people with disabilities⁹.

Lessons include:

- Consulting with a full range of stakeholders before legislation is passed strengthens it and encourages compliance. The authority and impact of legal provisions depends significantly on the culture in the country concerned.
- Including budget appropriation in the legislative framework can help ensure funds for implementation.
- Overly harsh punishment may be counterproductive, making it more likely that breaches of the law are overlooked by enforcement agencies.

ii) Example of adapted labour legislation

Labour law is widely used both to regulate employer-employee relationships and to establish the framework for workers and employers to regulate their relationship through collective patterns of interaction, such as collective bargaining. It also represents a clear reminder and guarantee of fundamental principles and rights at work.

Lessons include:

- Integrating provisions prohibiting HIV discrimination and screening into labour legislation can help protect the rights of HIV-positive persons at work, an environment where much discrimination occurs.
- Consulting on legislation with tripartite partners before it is passed strengthens it and encourages compliance.
- Protection against unfair dismissal can help people living with HIV to work as long as medically fit.

HIV/AIDS is a workplace issue and should be treated like any other serious illness/condition in the workplace" (ILO Code of Practice). This is not a neutral statement. It insists that the world of work is a crucial starting point in tackling HIV/AIDS and that governments, employers and workers should not permit HIV status being used as an excuse to isolate or stigmatize those affected.

⁹ Smart, R: 2001; 21

Tripartite framework and social dialogue

Responding to HIV/AIDS means going beyond traditional divisions of responsibility to involve all social partners in national, sector-wide and workplace agreements. It means building on tripartite links to create a wider social dialogue involving NGOs, international agencies, representatives of PLWHA and other stakeholders. The following three cases are not the only examples of social dialogue – on the contrary, this has been a criterion of selection throughout – but they encourage us to look specifically at collaborative processes and structures.

i) Sectoral agreement between multinationals and trade unions

Because of the economic threat posed by the epidemic, large, multinational corporations have often been at the forefront of workplace responses to HIV/AIDS. Trade unions, particularly in South Africa, have been all too aware of the impact of HIV/AIDS on their members. This case study illustrates the extent to which these groups can define common ground and work together to establish a framework, which is in the common interest.

Case Study:

Anglo American: has made considerable strides in developing a policy and implementing programmes aimed at mitigating the impact HIV/AIDS is having on their workforce. It was estimated that between 25% and 30% of its 44 000 South African employees, depending on the location, were HIV positive. The epidemic was believed to be adding between \$4/oz and \$6/oz of gold extra, to the cost of production. This led to the development of a comprehensive response and took the form of a three-tier mitigation strategy.

The first tier aimed at prevention management to restrict the spread of HIV/AIDS. This is being done through education, promotion of condom usage and the treatment of sexually transmitted infections. The second tier focused on the caring for those infected through voluntary counselling and testing, wellness clinics, the treatment of opportunistic diseases together with a compassionate ill-health retirement system for those employees who are unable to work. Thirdly, the program advocated health research by conducting fundamental research which sought to inform the company's management of occupational health which included TB and HIV/AIDS. In 2002 Anglo American took a landmark step in signing a comprehensive agreement on the management of HIV/AIDS in the workplace with 5 unions, including the National Union of Mineworkers (NUM). At the end of July 2002, AngloGold acknowledged that it had pursued the opportunities of conducting a feasibility study on the provision of antiretroviral drugs in partnership with other role players in the industry. This agreement ensures that the company together with the union undertakes to work together in order to accelerate these efforts. This has since culminated in the decision to

provide anti-retroviral therapy to those employees who are infected with the HIV virus¹⁰.

It is important to evaluate a programmes effectiveness, especially for large companies. The evaluation design, especially to assess behaviour change, can be difficult and companies are encouraged to use outside expertise to evaluate their workplace programmes.

Messages that can inform new initiatives include:

- Explicitly defining the aims, rights and responsibilities of different parties allows partners to be clear about where they stand in relation to each other and their commitments.
- Including specific references to best practice and quality standards allows for effective monitoring of progress and review of ethical standards.
- Integrating commitments on HIV/AIDS into the arena covered by collective bargaining does not mean that funds for prevention and care should be seen as interchangeable or 'in competition' with funds for pay or other remuneration or benefits.
- Extending partnerships between social partners to include NGOs and technical experts strengthens credibility and can be key in extending initiatives to the community.

ii) Employer and worker organizations at national level

Action may begin at the level of the workplace or of the company. It may also require a national grouping of unions or employers to come together to prompt action. Neither approach precludes the other, but where top-level agreements between social partners have been made they have often galvanized responses at the level of the workplace.
of national memberships.

Lessons include:

- It can sometimes be easier for employers and workers to find common ground at a national rather than a local level, and identify areas of mutual interest outside the dynamics of specific workplaces.
- Merging institutional structures forces the kind of proximity and communication that have been shown to confer success on team performance.
- Moving from separate to combined structures involves sensitivity and concessions as the number of 'roles' inevitably reduces, leaving some key figures without a formal position.

¹⁰ The full HIV/AIDS report entitled [Anglogold HIV/AIDS Report 2001/2002 - AIDS and South Africa](#) is available at www.anglogold.com

- Collective Bargaining Councils provide one avenue through which SMMEs can collectively pool resources (human resource capacity and money) and develop policies and programmes which although generic, will form the platform to manage the impact of HIV/AIDS on the company.
- iii) Tackling stigma and discrimination – building trust between the partners

The stigma and discrimination around HIV/AIDS are not only contrary to human rights but represent a major obstacle to successful workplace programmes. The fear of rejection, shame and discrimination undermines efforts to promote behaviour change, inhibits people from using VCT services or obtaining treatment, and prevents their seeking care for opportunistic infections. The non-discrimination policies noted above may help to create a non-judgemental and supportive culture, but extra steps are needed to make workers secure enough to address the issue.

Case Example:

Illovo Sugar, South Africa: Illovo Sugar has a combined prevention and care programme, which has involved a multi-stakeholder, multi-disciplinary approach. The company worked with unions, management, occupational health services and medical and academic experts to ensure that the programme was properly embedded in the organizational culture and could inspire trust. It provides access to condoms, educational activities, and care and support.

The key here is to bring on board all the key stakeholders and to utilize the expertise of those with experience in managing a response to HIV/AIDS. Within a SMME it is unlikely that one would find someone with these expertise and even if the capacity exists, it is unlikely that the individual has the time to adequately address this pressing issue. It is within this context that Employers of SMME seek the help of Bargaining Council, sector cluster or even Chambers of Commerce in addressing and responding to the pandemic. This is a far less costly exercise and one which should reap immediate dividends.

Lessons include:

- Involving stakeholders, and particularly unions, as early as possible helps build trust.
- A committee that actively involves all parties sends a clear signal that the initiatives undertaken are trustworthy and intended to support all workers.
- It is not necessary to create new structures where suitable vehicles already exist (e.g. a health and safety committee) as long as commitment to the new agenda is genuine. In the case of SMMEs, attain expertise externally from the company to limit productivity interruption and expense.

- Making explicit commitments to confidentiality from the outset by the committee is important. In the absence of the committee, commitment to confidentiality must be entrenched within a company's HIV/AIDS policy.
- Mass meetings that directly involve workers supplement the union's role and provide an additional route for information and a public statement of commitment and openness.

Section 2: Workplace policies and programmes

Prevention is of fundamental importance. It demands a combination of strategies, not least the provision of information and education so that people have the knowledge of how to protect themselves. Knowledge however, is not enough. There is powerful evidence that what people know in theory does not always determine how they behave in practice. They need support to really change their behaviour, both as individuals and in the context of the communities and societies of which they are members.

It is essential that issues such as stigma and discrimination be addressed if people are to avail themselves of the help available, and to protect themselves and their families. The workplace is doubly important in that policies can reduce discrimination, and at the same time be formative in changing the norms of group behaviour. The latter is critical in that evidence shows that behaviour change is hard to achieve except under conditions where group behaviour and norms are also modified appropriately.

Education and information

All social partners have a responsibility for education. The ILO Code, for example, charges governments with prevention and health promotion, employers and workers' representatives with information, education, and training. All are expected to identify needs and deliver responses. Education delivered by peers has in many settings been found to have more impact than more formal and hierarchical methods. Evidence about education programmes, particularly those using peer educators, is plentiful, providing ample best practice case studies that can be adapted to fit new national and institutional settings, avoiding the need to reinvent the wheel.

- i) Education and information with the involvement of peer educators

Case Study:

*Mondi Kraft; South Africa*¹¹: Development of information/training materials and training based on company needs. Here the clinic staff compiled a booklet called 'Living with the Consequences'. It was revised and translated into a language easily understood by the general population, illustrated, tested on a target

¹¹ Loewenson, R: 1999; 13

audience (family, office staff and workers) and comment sought from a group of medical consultants, unions and management. The final version of the document was translated into Zulu. The booklet is an easy to read, colourfully illustrated and informative account of HIV/AIDS. It focuses on general health, to avoid excluding people who do not consider themselves at risk from HIV. The booklet explores how people become ill, the difference between bacteria and viruses and the use of antibiotics. It goes on to discuss HIV and opportunistic infections, including TB. Booklets of this nature can and should include information on HIV prevention and transmission, but this should be determined according to the level of knowledge amongst the employees. (This can be determined by conducting a Knowledge, Attitudes and Practices survey). The booklet did and any booklet should cover the links between STIs and HIV/AIDS and issues of confidentiality. There is a further section on the importance of disclosing your status to your family and details on institutions that provide support for people who test positive. To support the use of this booklet, a training course was devised and the clinic staff were trained as facilitators. Training was also provided to all employees of the company. Importantly, Peer Educators are extensively used to facilitate this process.

Lessons include:

- The selection of peer educators should reflect their credibility with colleagues and their commitment to confidentiality and best practice, as well as their communication skills.
- Integrating training on HIV/AIDS policy into routine and on-entry training for new staff minimizes stigma and builds an accepting and non-discriminatory culture.
- Delivering training during work time makes messages more palatable.
- Making sure education and related campaigns are based on accurate and up-to-date information is important if credibility is to be sustained.
- Designing appropriate education and training materials is easier with a homogenous target group. Materials should be gender-sensitive, whether the group is male or female.
- This sort of training material can be funded through SETAs, Bargaining Councils or other formal or informal sector clusters. It is through this system that SMMEs are able to pool resources and develop training material which could service smaller companies within an entire sector. Should large corporates exist within these systems, then the cost of developing this training resource is even less of a cost burden.

ii) Education and information – peer educators in informal settings

The informal economy accounts for high levels of employment, and in many high incidence countries the vast majority of workers pursue informal economic activities. These workers often live at the margins of poverty, have little education and little capacity to cope with illness or the illness of a family member. Women

in particular have little control over their own lives and are especially susceptible to HIV infection due to social, cultural and economic factors. Typically, working conditions are poor, wages are low and unstable, and little health care or insurance is provided. In addition, informal economy workers have almost no formal representation and very few organizations are available to voice their concerns.

Lessons include:

- Building on existing informal sector organizations helps ensure the 'right' peer educators are selected and the 'right' materials are developed. It confers credibility and gives access to workers.
- Not all peer educators should be sub-sector or community leaders. Younger workers and apprentices will be most effective at reaching their contemporaries.
- Time is a major constraint for workers in the informal sector and this needs to be taken into consideration in planning training activities and in making demands on peer educators.
- Small amounts of funding can enable informal sector workers to spend time on peer education, including outreach work beyond their immediate circle of contacts.
- Activities in the informal economy must consider the context, the impact of poverty and the lack of health services. Including business skills in training programmes and linking projects to micro-finance schemes, can help attract interest and address wider issues such as employment creation, especially for youth.

iii) Education and information – peer educators and the community

Peer education is effective not only at work but in moving beyond the confines of the workplace to tackle risks that workers face in their own communities. This is particularly relevant in sectors where single men are concentrated in isolation from their families.

Lessons include:

- Delivering targeted interventions to susceptible populations through a mixture of relevant (informal) settings, like food and recreation facilities, helps reach vulnerable groups.
- Tailoring training to use appropriate language and a variety of media or techniques and to reflect the knowledge, culture and sensitivities of the target audience is crucial.
- Selecting peer educators with an appropriate background confers credibility on them.
- Integrating efforts to address gender issues and vulnerability factors with wider health promotion and community campaigns reinforces messages.

- Linking peer education to a wide range of issues, including TB, malaria, water, sanitation, and sexual and reproductive health, increases the effectiveness of prevention activities.
- Training for top management is a successful way of building commitment, and of signalling to the wider community the importance of the initiative.

Strengthening behaviour change

HIV transmission is preventable but this depends not just on an understanding of the processes of HIV transmission but also on individual action to prevent infection. There are many reasons why people do not take action to protect themselves and their families. As noted above, the scope for individual action is often constrained by social and other conditions. Workplace initiatives can support and empower individuals to make changes. Participatory education programmes, and practical supportive measures, can help people assess their risk, become aware of their attitudes, and change their behaviour.

- i) Behaviour change – personal risk assessment and change strategies

Case Example

BMW South Africa: BMW has a comprehensive programme to tackle HIV/AIDS, based on a policy agreed with the unions and supported at the highest level of management. It involves a range of elements, including the provision of Highly Active Antiretroviral Treatment (HAART). It also places considerable emphasis on prevention using a comprehensive communications strategy and various awareness-raising formats (workshops, events, theatre). BMW facilitates personal risk assessment for staff, particularly women, which empowers them by allowing them to review their own behaviour and exposure to risk, and to identify the elements they may want to change, as well as the blocks to and enablers of change.

Lessons include:

- Working in women (or men) only groups helps individuals express themselves with confidence and learn from each other.
- Personal risk assessments should include practical sessions addressing the reality of risk and issues like negotiating condom use, discussing HIV status with a partner and so on.
- Tools like role-play that allow people to ‘practice’ how to handle difficult situations are useful ways of allowing people to rehearse how they will respond to sensitive situations.
- Peer educators can facilitate risk assessment but need to be supported themselves, ideally through regular support sessions and through additional training.

- Trust is crucial to success and prioritizing privacy and confidentiality builds confidence.
- Providing HAART creates a significant incentive for VCT uptake and sustaining safer sexual behaviour.

ii) Behaviour change – self-help groups and partnerships for change

Case Study:

South African Clothing and Textile Workers Union: SACTWU has its own HIV policy and has trained shop stewards to be aware of the issues and to implement policy appropriately. It provides ARV treatment to prevent mother-to-child transmission (MTCT) and is developing policy for home care and orphan support. It works with employers and is actively involved in a series of partnerships with not-for-profit and non-governmental organizations. It collaborates with education specialists in designing and delivering training, with health NGOs to see that TB is addressed through the DOTS initiative, and supports the Treatment Action Campaign, which is lobbying for national ARV provision. Its support to community, workplace and campaigning groups facilitates self-help initiatives by PLWHA, which empower individuals and promote behaviour change.

Messages generated by experience with self-help strategies include:

- Those affected by HIV/AIDS or with a common interest can be highly motivated. Mobilizing them through self-help groups is effective in sponsoring behaviour change.
- Self-help groups are often most effective when focused on issues on which members have a direct stake and which play to their strengths.
- Incorporating self-help groups into multisectoral coalitions ensures that partnerships are informed by stakeholders' views and understand what is involved in changing behaviour.
- A forum for sharing the 'big picture' will help ensure that all players (not just those at the 'centre of the web') can see how they fit in and can pool relevant information.

iii) Behaviour change – condom use

This is often seen as an entry level response by companies in an attempt to mitigate the spread of HIV. However, companies often fail to acknowledge that the mere presence of condoms in strategic areas within the company will not automatically precipitate a change in sexual behaviour. Companies must recognize the stigma which is associated with condoms and must, through education and proper communication, dispel any fears associated with condoms and educate on the proper care and use of condoms.

Lessons include:

- Condom distribution benefits from being set in the context of a communication and education programme.
- Any intervention to encourage condom use must be based on an in-depth understanding of the cultural perceptions around condoms.
- Distribution of condoms must be accompanied by efforts to help individuals negotiate their use if the programme is to be effective.
- Providing condoms 'on site' can ensure they are available to migrant/mobile workers who may not be registered with health care services or have other entry points to formal systems¹².

iv) Behaviour change – safe use of needles at work

Much of the focus on behaviour change has been on safe sex and harm-reduction in intravenous drug use but it is also an issue of direct relevance to safety in the workplace. The ILO Code of Practice calls for a healthy work environment and includes in this a supportive setting in terms of physical and mental health and adaptation of work to the needs of PLWHA. It also demands that Universal Precautions are observed in workplaces where workers come into contact with human blood and body fluids.

Case Study:

The Democratic Nursing Organisation South Africa (DNO-SA): In seeking to promote a healthy working environment, the DNO-SA has highlighted the employers' responsibilities for ensuring that people change the way they work in contact with blood, and has actively sought to promote change around the handling of sharps. It has also made the links with prevention and nondiscrimination.

Lessons include:

- Introducing messages about safe working practices as early as possible in training helps change cultures and habits.
- Workers need time and resources if they are to change established practices and follow new safety guidelines.
- Any training or demands for behaviour change which touch on the risk of HIV/AIDS may provoke unexpected resistance because of stigma.
- Any measures to encourage uptake of Universal Precautions is an opportunity to widen discussion and tackle broader prevention issues.

¹² Reports from South Africa suggest that 'illegal' migrant workers are afraid to take advantage of condom distribution through the health system, as they fear being identified and deported.

HIV prevention and gender

Gender is a factor in the probability of becoming infected if exposed to the virus (i.e. physiological differences) and in determining the ability to control behaviours which exposes people to the risk of infection. Women are particularly vulnerable on both counts: they face multiple risk factors, including a lack of economic power and a lower social status, which translates into the inability to negotiate the terms of sexual relationships. However, men also face gender-specific risk factors, some of them related to occupational requirements, such as the mobility expected of transport workers. There is thus a need for gender-sensitive approaches to all aspects of prevention.

- i) The gender dimension – making space for men and women

Case Study:

Stepping Stones, Uganda: Stepping Stones is an educational programme and a series of tools developed by Action Aid Uganda which works with age and gender-separated groups in order to give people private time and space with their peers to explore their own needs and concerns". Stepping Stones is based on the analysis of experience and includes a number of sessions and participatory techniques based on very specific cultural understanding, which are seen as precursors to effective dialogue between men and women. This is very closely linked to the more popular discourse of the peer counselor. However, it is on a one-to-one basis and the 'peer' is someone who is of the same gender and within the same age bracket. This has found to illicit a better response than the selection of peer counselors based on seniority or perceived respect within a workforce. The other big difference is that the entire family is involved. In the context of a workforce, it is difficult to see how a programme can work logistically. The spouse of an employee is not necessarily readily available to receive counseling and/or support. However, this is an option for those companies who employ from a local community.

Lessons include:

- Involving one partner only is ineffective, but that working with partners separately before bringing them together can significantly enhance the dialogue that takes place.
- Educating men about sexual and reproductive health allows them to support their partners better and to be more effective in addressing their own needs.
- Peers are the main source of information about sexual matters, which amplifies the benefits of holding separate sessions for men and women.
- Abstinence is not a useful 'prevention' strategy or message in societies that value fertility, and where there is a tradition of monogamy only amongst women.

ii) The gender dimension – men's concerns

Case Study:

Ho Chi Minh City Labour Union, Vietnam: The Ho Chi Minh City Labour Union, together with the Vietnamese National University, the National AIDS committee, the Horizons Programme and the Population Council, targeted male workers in the construction industry who were highly mobile and deemed to be to particular risk of HIV infection. The initial phase, using female student social workers as health communicators and to distribute condoms, proved to be inappropriate and unsustainable. A revised approach proved to be more cost effective

Lessons include:

- Gender sensibilities need to be taken into consideration in designing interventions.
- 'Same-gender' peer-educators are more effective than 'expert' staff in many communication tasks, particularly where the issues being raised are sensitive, and that a match between educators and workers is more appropriate.
- 'Same-gender' peer-educators are a more sustainable source of education and condom-distribution because they can be expected to stay in touch with the target population for long enough to establish trust and to give a return on the investment in their training.
- Mobile workers can be effectively targeted at work, using participatory techniques.

iii) The gender dimension – women's concerns

Case Study:

Tata Iron and Steel Co. Ltd., India: Tata Iron and Steel is a company with a wider involvement in social responsibility. It tackles issues of urban and rural deprivation and has now included HIV/AIDS on its agenda. It has designed an approach to development work with women, which uses a 'Ladies Core Group' to carry out activities in support of family clinics and on HIV awareness. The Group is made up of the wives of local chief executive officers who are seen as having a greater ability to reach the marginalized, to engage in dialogue and to overcome inhibitions because, as women, they can access the target group.

Lessons include:

- Women will respond better to awareness-raising by other women, particularly in societies where the gender 'gap' is marked.
- Volunteers can play a useful role in prevention activities.

- Differences in status and caste ought to be considered in designing interventions.

All the case studies described match the ILO Code of Practice's understanding that HIV infection is preventable, particularly if culturally and gender-sensitive strategies are combined to change attitudes and behaviour. The evidence of successful action bears out the belief that social partners working together are more effective in combination than in isolation. Furthermore, the programme showed that action in the workplace helps to create an environment for sustained behaviour change.

Section 3: Workplace policies and programmes: care, support and treatment

The workplace is a logical entry point for care and support. People living with HIV/AIDS, when they are appropriately supported, can continue to have active working lives, to contribute to the national economy and to support themselves, their families and their communities. Occupational health services (particularly in countries with a poor public health infrastructure) provide a vehicle for VCT, for the management of opportunistic infections and for ensuring compliance with HIV/AIDS treatment regimes.

The workplace is also a useful setting for implementing social security and health insurance schemes. Providing care, support and treatment helps alleviate stigma and promote care-seeking behaviour, and can be targeted at vulnerable groups to address issues such as gender inequality.

Stigma and discrimination – confidentiality for prevention and care

Confidentiality policies are widespread, and in line with the ILO Code they tend to protect job applicants and workers, and all personal data relating to a worker's HIV status. These issues are more complex in an informal setting where self-employment and casual employment are commonplace: records will rarely be held, but personal confidences may be made and should still be bound by rules of confidentiality. The most useful learning points now tend to revolve around how to ensure employees feel that their confidentiality will be respected in practice and not just on paper.

Case Study:

De Beers, South Africa: De Beers provides HAART to workers and their partners as part of their comprehensive Wellness Programmes. Making treatment available has increased the uptake of VCT but misconceptions about HIV/AIDS and fears about the company's motives in offering testing initially prevented the

expansion of the programme. Workers receiving HAART also had concerns that complying with the rigorous treatment schedule would make it obvious to their colleagues that they were HIV-positive. This interfered with effective treatment, and has raised the spectre of growing drug resistance due to non-compliance. To offset these concerns, the company made confidentiality a priority.

Lessons:

- Confidentiality policies must be clear and widely communicated in appropriate language.
- Adapting facilities within the company to allow for private discussions can help instill confidence (a finding borne out at BMW – see earlier case study).
- Providing medical services through a network of practitioners outside the company can help workers feel that their privacy and confidentiality are assured. It can also help encourage compliance in those who have left the company due to ill health or retirement.

Additional activities are needed to convince workers that they should inform their partner/s so that they, too, can be included in testing and treatment programmes.

Voluntary counselling and testing

The ILO Code is clear that HIV/AIDS screening should never be required of workers or job applicants, and should not be a condition for contract-renewal. On the other hand, voluntary testing and counselling (VCT) is a key element in HIV prevention and is, as such, encouraged by many workplace programmes. Testing is, in fact, often the entry point for the provision of ARV and other therapies. Policy to protect workers from unwarranted testing is now widespread, but there is still much to learn from best practice in promoting VCT uptake.

- i) VCT – increasing uptake of services

Case Study:

Eskom, South Africa: Eskom has a long-standing HIV/AIDS programme but found that stigma was having a major impact on the uptake of VCT. The company used a detailed workplace study to understand workers' responses and to plan adjustments to their use of peer educators and community outreach initiatives to allay the fears.

Lessons include:

- Plans to introduce testing must be mindful of the fact that a positive diagnosis means people acknowledging that they may have a fatal infection - an extremely painful realization.

- Linking VCT to the provision of ARVs or HAART is a major incentive for testing, but accepting treatment may open an individual and family to discrimination and stigma.
- Addressing workplace discrimination is not enough, as workers may fear stigma more than losing their jobs and may face secondary stigma and discrimination at home and in the community. Outreach work in communities will, therefore, enhance the success of testing at work.
- Women face stigma even more than men, so efforts to increase VCT uptake should pay particular attention to addressing their specific concerns.
- Despite their complexity, VCT programmes are undoubtedly effective in terms of budgetary and other savings for enterprises.

Testing, whether linked to the provision of ARVs or not, may generate problems, causing fear and exposing people to stigma and discrimination. Even where treatment is available (and despite its significant benefits) people are often reluctant to have their status confirmed, unless they are pregnant and understand that doing so will protect their child.

Reducing stigma is important, therefore, for expanding VCT (as is improving communication about what VCT entails).

Treatment possibilities at the workplace

Treatment through occupational health services at the workplace includes programmes to provide ARVs and HAART, but it is not limited to antiretroviral therapy. The treatment of opportunistic infections, such as TB, and of STIs and other concurrent infections is also important. Similarly, the workplace can provide the setting for ensuring good nutrition which delays HIV progression, for delivering pain control and palliative care, and, when needed, for offering the psychosocial support that helps compliance with treatment. One of the objectives of activities under resource-constrained conditions is to ensure as far as possible that PLWHA are assisted in living positively.

- i) Treatment – responding to opportunistic infections through partnership

Case Study:

Pfizer – South Africa Alliance (Diflucan ® Partnership): Pfizer and the South African Ministry of Health have mounted a public-private partnership to address life-threatening, opportunistic fungal infections. The company donates treatment and supports training initiatives to ensure its proper use while the Ministry maintains the infrastructure for distribution and delivery. The experience provides lessons about partnership and about treating conditions linked to HIV/AIDS.

Lessons include:

- Access to drugs and the most up-to-date therapy is crucial to initiatives to treat opportunistic infections.
- Treatment is most effective when supported by a package of measures including advice on healthy living and nutrition.
- Workers often go to the health service as a result of opportunistic infections, and the contact established can usefully be exploited to address wider issues including VCT, the risk to family members and others, and prevention. When workers are not HIV positive, treating other infections can help reduce their risk of contracting HIV.
- Provision of drugs without appropriate training of staff can be counterproductive. Training should address treatment regimes and how to handle wider HIV/AIDS issues.
- Public-private partnerships benefit from a clear agreement on the responsibilities of each stakeholder, contingency plans to cover potential problems and regular meetings to update and adjust programmes.

ii) Treatment – a comprehensive approach to care

Case Study:

Anglo American: The roll-out of anti-retrovirals in Anglo American started in 2003 in partnership with a health service provider, Aurum Health Research. At the end of 2003 the company had approximately 4000 on the wellness programme with 1000 employees receiving anti-retroviral treatment. Since the inception of the programme eight percent of the infected workforce on the programme, declined treatment from the wellness programme, 10% dropped out after starting while 97% have gone back to work. It has been reported that approximately 90% of the workers on treatment adhered to the treatment regime, while 89% of patients have shown good viral suppression, and experienced an immune system recovery and weight gain.

Lessons include:

- Investment in early and systematic treatment can actually cut the direct costs of care by leading to a fall in hospitalization and other costs of treatment.
- Providing treatment contributes to significant indirect savings by allowing staff to remain active and symptom-free (in this case, 90% of those being treated by the company are healthy), reducing absenteeism and allowing workers to apply their skills and experience.
- Programmes that are seen to be caring and supportive of PLWHA increase employee satisfaction and improve the company's public image.
- Building on existing self-managed medical plans is an efficient way of delivering care.
- Combining centralized management, specialized technical personnel (a medical coordinator with occupational health expertise, specialists in

infectious diseases, marketing and education experts) and technical protocols to standardize care maintains efficiency, provided there is some flexibility for responding to individual needs.

Care, support and reasonable accommodation

Helping employees living with HIV/AIDS to stay in work may require 'reasonable accommodation', meaning that affected staff are switched to lighter duties or helped to work more flexibly, given additional sick leave, and allowed more time for breaks as needed. Ensuring continuity of employment in this way is consistent with the ILO Code of Practice, which calls for PLWHA to "be able to work for as long as medically fit in available, appropriate work." It is also a way of helping companies and organizations to benefit from the skills and experience of their workforce for as long as possible.

Case Study:

Heineken International in Burundi, Ghana, Nigeria, the Democratic Republic of Congo and Rwanda: Heineken has a comprehensive protection and prevention programme, treats STIs and provides condoms. It links VCT with ARVs and makes HAART available to staff at those sites with testing in place (and where drug supply can be maintained). Treatment is integrated into the company Health Support Programme and uses a directly observed approach combined with self-managed treatment at weekends, to promote compliance with drug regimes. The decision to provide ARV treatment was prompted by falling drug prices, the granting of private sector access to cheap ARV supplies, and a thorough review of the evidence on effectiveness. Treatment is linked to reasonable accommodation and to vigorous company policy on nondiscrimination, confidentiality and parity of HIV/AIDS with other serious conditions.

Lessons include:

- Adjusting working conditions to allow staff to take their medication and to attend locally appropriate counselling are important aspects of accommodating affected workers, and could be usefully applied even where employees are being treated outside the workplace.
- Requiring workers who receive treatment to make a 'reasonable' personal financial contribution (a small proportion of disposable income only) can encourage compliance with the treatment regime.
- Accommodating treatment at work can create conflicts. It raises challenges in terms of confidentiality¹³ and creates dilemmas around continuity, particularly in terms of restructuring. There may be a tension between reshaping the workforce and maintaining treatment, although

¹³ De Beers facilitates treatment through networks of practitioners in the community in an attempt to support compliance with treatment and maintain confidentiality.

continuing treatment after redundancy (as Heineken provides) resolves this.

- Transferring staff to lighter duties, allowing them time-off, and, in the case of women in particular, allowing time to care for relatives, all help extend useful employment. On the other hand, such measures are harder for small enterprises to manage.
- Ensuring access to social benefits and protection reinforces accommodation programmes.

VCT, treatment, care and support are all part of a continuum and all the best practice examples combine measures to keep PLWHA as healthy as possible for as long as possible. Acting early and using various entry points to reach workers (including STI and other clinics) and combining services enhances the effectiveness of interventions and keeps costs down. Links to communities and community-based programmes also enhance efforts to ensure appropriate provision of care. Taken together, these initiatives respond to the ILO Code and the commitment that “solidarity, care and support should guide the response to HIV/AIDS in the world of work”. However, they cannot guarantee the “affordable health services” and the access to “benefits from statutory social security programmes and occupational schemes” that are desirable – which is why the government’s role remains a necessary constant in the total equation.

Section 4: Links beyond the formal workplace

Just as it is impossible to neatly separate the world of work from the communities that provide its workers and make up its markets, so it is impossible to draw neat lines between the responsibilities of government, employers and employees at work and beyond. Prevention, mitigation, care, support and treatment need to be extended from the conventional or formal sector workplace to less formal settings. This is not just a way of reaching ‘hard to access’ networks of suppliers and distributors, but also helps to reinforce efforts by companies and organizations to protect their staff, since workers are at risk when interacting with the communities around them. This is particularly true in sectors where workers are isolated from their families, and interact with shifting communities of casual and migrant workers. These conditions open up the possibilities of sexual networking that are powerful forces in the spread of HIV between communities.

Links from the formal to the informal economy

In some countries, 90% of people working are involved in the informal economy, often in activities at the margins of poverty. The kinds of work they do range from farming, trading and small scale-enterprises, to casual factory work and construction, and home-based work. There is little in the way of legal protection, few or no structures to ensure non-discrimination or confidentiality, and almost no worker representation. There are some organizations that attempt to represent

informal workers but these tend to be concentrated in urban areas and around the more skilled or semi-skilled occupations.

Most informal workers have little voice and very little control over working conditions. They often have to combine a mixture of types of work and women are particularly vulnerable. Many women are heads of households living in poverty, and while they are not sex workers they may have to trade sex for money or favours, and are unlikely to have the possibility of insisting on safe sex. Initiatives to support workers in the informal sector are described in earlier case studies. Projects that attempt to link formal workplaces to informal ones and to government initiatives are set out below.

i) Managing the transition from formal to informal

Case Study:

Placer Dome Western Areas Joint Venture: The Placer Dome Western Areas Joint Venture workplace programme for the South Deep Gold Mine originally sought to help staff made redundant through reorganization. It now helps staff as they become increasingly unwell from AIDS to take on other economic activities. The initiative follows on from comprehensive efforts at prevention, care and accommodation. The intention is to help them find other, less arduous means of income-generation so that they can make a dignified transition from work¹. It provides training, business planning and loans to help 'retrenched' or 'medically repatriated individuals' to find more suitable employment or to start up small, entrepreneurial or income-generating activities whether in the formal or informal sector.

Lessons include:

- The initiative is made particularly effective if employees who are too ill to benefit from the programme are able to nominate a relative (male or female) to take up the training and so ensure that the family has some income-generating capacity.
- Paying attendance allowances makes it possible for individuals to participate in the initial training and counselling.
- Integrating a home-based care project (and the provision of monthly medical kits) with efforts to support income-generation helps ex-employees with AIDS stay economically active, and their families remain economically viable even after the death of the ex-worker.
- Involving local leaders and traditional healers helps ensure acceptance of the programme.
- Finding micro-finance to support small enterprises is extraordinarily difficult.
- Building a consortium (in this case of eight mining companies) and using a per capita funding model can help fund innovative initiatives and attract

external and government partners, but it does take time for partnerships to establish effective ways of working.

- ii) Informal structures – extending social protection

Case Study:

ILO Programme on Strategies and Tools against Social Exclusion and Poverty: The ILO STEP programme has tried to extend decentralized systems of social protection (DSSP) and health and micro-insurance schemes (HMIS) to informal sectors of the economy including those affected by HIV/AIDS. The model relies on solidarity and on mobilizing contributions from those who traditionally have no access to health insurance. Mutual health funds and HMIS are being created by cooperatives and community associations to protect workers and households without access to statutory systems of social protection. Although the health scheme is contributory, it does need some state subsidy to top up inputs from self-employed workers and those in the informal economy.

Lessons include:

- DSSP and HMIS are not just a form of financing but can also play a significant social and prevention role, building community capacity to take action for prevention and care.
- Workers in small enterprises and the informal economy actively want DSSP and HMIS. Funding is more difficult to secure and sustain than the initial model suggests.

Links from the workplace to the community

Outreach work to involve communities is key to prevention on a national level as behaviour and attitudes are formed there, and most care is delivered there. It is also important to companies and organizations (and to governments in their capacity as employers) as most of workers' exposure to risk is in a community setting. Initiatives and the entry points they use will vary just as communities are different in terms of culture and social organization. Reaching out to and involving communities is essential for reducing the risks facing workers and their families and, ultimately, for the success of workplace activities.

- i) The community – encouraging local entrepreneurship

Case Study:

Kahama Mining Corporation, Tanzania: Kahama Mining has a large number of expatriate staff who are isolated from their families and at risk in the community. The company runs a combined programme of prevention and care and has taken particular trouble to engage in community development. It sponsors a

programme of education and support, which targets women and youth and provides them with information on how they can protect themselves, combined with sexual and reproductive health services. It also helps women find alternatives to sex work by supporting small business development (including the production of mosquito nets), helps to improve small-scale agriculture (through training and support to infrastructure) and trains them in life skills. It sponsors home ownership initiatives to allow workers to live with their families.

Lessons include:

- Providing women with the skills to support themselves is more effective in curtailing sex work than moral exhortation or prevention messages. Nonetheless, further support may be needed to create financial autonomy and protect women from exploitation.
- Consultation with all stakeholders is key to effective links with the community.
- Leadership commitment within the company is essential for securing the resources needed to bring meaningful workplace community links into being.

ii) The community – treatment for STDs and social outreach

Case Study:

The Lesedi project: The Lesedi project is sponsored by Harmony Gold Mining and attempts to extend services to sex workers to encourage prevention and to break the cycle of HIV infection. It provides sex workers with clinics and peer educators to promote condom-use, and works with unions to encourage acceptance of condom-use amongst workers. There is presumptive treatment of Workplace action on HIV/AIDS: identifying and sharing best practice

Lessons include:

- Consultation and leadership are, as always, key and must include unions throughout.
- It is essential to monitor approaches that provide antibiotics as a rule of thumb, for they may lead to resistance and ultimately (and ironically) undermine condom use by creating a false sense of security in sex workers about HIV infection.
- Nurse practitioners should be given prescribing rights.
- Health Departments should be involved throughout, not least because they can help in removing constraints on nurse practitioners and also because they have a crucial role to play in monitoring and evaluating the chosen strategy.

- Initiatives to address health issues are more effective when integrated with social uplift schemes that include micro-finance schemes for alternatives to sex work.

Naturally there are other vulnerable groups such as sex workers, people living with HIV/AIDS, young workers (youth) and mobile workers who must be factored into when designing a comprehensive response to this epidemic.

Section 5: Knowledge and evidence: data-analysis, monitoring, and feedback

Best practice must, by definition, be evidence-based. This implies considerable investment in research, analysis and dissemination in such areas as epidemiology, virology, demographics, economics, communications and public health. Much of this knowledge-generation can be shared as a public good, and will often fall within the government's remit for maintaining clinical guidelines and clinical and behavioural research. However, in order to implement effective interventions, understanding of local conditions is needed, as well as the ability to determine which programmes are working and which are not. Data-collection on socio-economic conditions, situation and financial analysis, monitoring of trends in relation to the epidemic including HIV surveillance and other information, are all essential functions. Regular evaluation and feedback at project level are also key to getting best practice right.

Data collection and situation analysis

Data-collection and situation analysis are vital not as part of academic studies for publication but as ways of ascertaining practical needs and of identifying the stakeholders who must be involved in designing responses to those needs. Large organizations are well placed to conduct surveys (and need them because of the complexity of the multinational working environment) although they may be disproportionately expensive for SMEs. Small companies may be able to benefit from larger scale studies by other companies, universities and research organizations, NGOs and government.

- i) Situation analysis – understanding what is needed

Case Study:

Daimler Chrysler South Africa (DCSA): DCSA initiated a prevention and care programme in 1991, but it was not effective and infection rates and costs to the company continued to rise. A baseline survey of Knowledge, Attitudes, Perceptions and Behaviours (KAPB) found that people knew little about HIV infection or the services provided. This data helped in designing the response, including peer education, HAART provision, reasonable accommodation and guaranteed social security benefits, with evaluation built into the project. The

revised approach was both more successful and more cost-effective, protecting the business better and creating opportunities to link with contractors in the informal sector and with the community.

Lessons include:

- Survey work can help identify why service uptake does not meet expectations (in this case because of fears about confidentiality and a lack of 'marketing' of the help provided).
- A KAPB survey can guide detailed responses (how best to design and communicate features related to confidentiality) and provide a baseline for monitoring.
- Union involvement and top-level support help ensure open responses to KAPB surveys.
- Stigma is a major factor in discouraging VCT and seeking care, and needs to be better understood if information, education and communication campaigns are to combat it effectively.
- Setting specific targets for VCT, TB cure and STI recurrence can be useful for monitoring performance and for keeping costs under control.

Monitoring and feedback

No initiative can be designed without flaws or room for improvement, and no situation will remain static over time. Monitoring and feedback are, therefore, crucial if adjustments and adaptations are to be made which will allow best practice to move beyond the innovation stage. Lessons of best practice need to be documented if this experience is to be available to others who are contemplating workplace activities. It is, thus, essential that programmes have defined and assessable objectives and that systems for monitoring these objectives be established from inception.

Case Study:

The Ministry for Public Service and Administration, South Africa: The Ministry has some 140 departments and over a million staff. It recognizes the importance of HIV policy, particularly in terms of the impact of staff losses on its ability to carry out its core functions, as demands increase with the epidemic. There has been an attempt to identify core service areas, scarce skills and key posts and protect them through priority programmes. The policy development phase has opted for the creation of a set of minimum mandatory requirements to be incorporated into Public Service Regulations. Each of these requirements (including education, links with health promotion, establishment of an HIV/AIDS committee per department, non-discrimination, testing and confidentiality) is linked to a monitoring obligation and a set of annual reports.

Lessons include:

- Baseline information is needed before monitoring methods can be put in place.
- Setting tangible targets for deliverables and monitoring progress against those targets is a highly effective management tool that prompts action and highlights shortcomings.
- Setting too many overlapping targets can complicate monitoring and undermine efforts to track and enhance performance.
- Arranging for reporting intervals of a year detracts from the usefulness of monitoring tools. A straightforward set of indicators can be easily updated and can provide day-to-day management information (although more detailed annual reviews are also useful and worthwhile).
- Evaluation should involve all stakeholders, including unions/ workers' representatives, and should combine quantitative and qualitative elements if it is to be credible. Feedback must be clear and transparent if it is to inspire change.
- Governments can encourage monitoring, evaluation and feedback through example (as in this case) and by making their support of (or partnership in) any project conditional on proper monitoring and reporting measures being put in place.

Summary

Cross-cutting lessons: key messages for effective workplace action

The case studies above are only a brief selection of the huge range of best practice examples being developed by practitioners tackling HIV/AIDS in the world of work. They generate a number of lessons that overlap with each other and which allow some generalized statements to be made about how best to work across the continuum of prevention, behaviour change, treatment, care and support. These elements are grouped together below under headings which cut across the thematic divisions above.

i) Partnership, social dialogue and links across sectors

Initiatives are most effective when they involve all social partners, and partnerships are most effective when:

- Stakeholders are involved early.
- The definition of stakeholders is a broad one, including unions/ worker representatives, different levels of management, PLWHA and others who are not direct beneficiaries of the project.
- Public-private partnerships are specifically promoted, through government action, enterprise initiatives, the ILO's tripartite structure and/or international mechanisms like the Global Fund which encourages co-investment at country level.

ii) Consultation – involving workers and their knowledge

Initiatives informed by the experience of the target group have a higher chance of success. The fact that workers and/or community groups are consulted also helps build commitment from the outset, provided that:

- Consultation is seen to be genuine and those consulted believe they can exert influence on the design or implementation of the initiative being planned.
- The rules on confidentiality are clear and convincing and people being consulted feel secure expressing their views without risk of being stigmatized or discriminated against.
- Communities are helped to take part by proper attention to their sensitivities and by providing a suitable setting and adapting the tone of the consultation to meet the level of education and confidence of the group.

iii) Trust and ownership

Developing trust and ownership contributes significantly to the success of efforts to tackle and treat HIV/AIDS and, in particular, can help create conditions in which workers will use VCT and treatment provision. Particular lessons are that:

- Confidentiality procedures must be in place and be seen to be completely reliable by staff so that no one seeking testing or treatment can be exposed to stigma.
- Independent researchers can play a role as ‘honest brokers’ and help convince staff that evidence on testing and treatment is credible.
- Providing treatment (reliably and consistently) for opportunistic infections, for HIV/AIDS and to prevent MTCT, and accommodating the needs of PLWHA, are the ultimate tools in creating trust and will encourage people to address their HIV status and their behaviour.

iv) Leadership

Leadership contributes to the successful development and delivery of projects and of partnerships. It is clear that:

- Government leadership can motivate companies and organizations and shift societal norms.
- Top-level executive support communicates that a company or organization is serious about a scheme and expects managers and staff to take it seriously.
- The leadership of senior staff and the co-option of their personal networks can help ensure the success of an initiative.
- Union leadership can reassure workers, convey credibility, and support community outreach.

v) Communication and dissemination

Putting messages across so that they can be understood is central to the success of information and education campaigns. Effective communication means that:

- Messages state their purpose and are accurate, consistent and reliable, reinforcing other information initiatives.
- The language chosen is the right language and the level is tailored to reflect the literacy of the target group, their cultural and gender sensitivities.
- The entry point for communications are varied to include formal and informal settings, clinics, schools, community centres, bars, market places and sports facilities.
- Peer educators recruited to communicate prevention and behaviour change messages closely reflect in experience, age, seniority and gender the composition of the target group.

vi) Building on structures already in place – adapting to change

There is an enormous value in drawing on the systems and structures in place but it is also necessary to adapt structures and systems to reflect the specifics of the new epidemics. Experience suggests that:

- ‘Piggy-backing’ on HIV/AIDS services with existing occupational health services and structures is cost-saving and effective provided that there is a clear HIV specific focal point and a commitment to confidentiality.
- Involving health and safety committees in HIV/AIDS prevention can provide ready-made networks of management and shop stewards with appropriate skills to address the issues involved.
- Integrating HIV/AIDS issues into collective bargaining may be appropriate in a number of cases, although there may be initial resistance to moving in this direction.
- Incorporating training on prevention and non-discrimination into upon-entry training courses signals from the outset that the culture of the company or organization is supportive of workers living with HIV/AIDS while upgrading existing grievance and disciplinary procedures to prevent discrimination or victimization is a straightforward means of responding to new legislative demands. Many other training settings exist, from labour colleges to MBAs, where a component on HIV/AIDS could be included.

vii) Equity considerations: ensuring access for those in need

HIV/AIDS tends to hit the most disadvantaged the hardest. Targeting responses can help tackle inequality as long as:

- There is monitoring of who receives care and other services.

- The issue of which dependents receive coverage reflects the way definitions of family differ across cultures, although sustainability is of course a legitimate consideration.
- Care and support is extended following the termination of employment due to ill health and includes (where feasible) bereavement counselling for families and help in establishing them in some income- generating activity.
- Contractors and suppliers in the informal sector are included in efforts to tackle HIV/AIDS.
- Community outreach specifically addresses disparities in care, perhaps in conjunction with national programmes and/or international donors.

viii) Gender considerations

Gender is profoundly linked to the risk factors for HIV infection, and the way the epidemic affects individuals and families is also mediated by gender. This link is especially true for women, who are often expected to undertake most of the care of those infected and, thus, face intensified home and workplace responsibilities. Incorporating a gender dimension in all workplace activities is essential, and it is crucial to:

- Address women's economic position, through efforts to provide business skills, life skills and support for establishing small businesses like mosquito net production or agricultural cooperatives.
- Tackle the isolation of male migrant workers from their families by providing housing for families wherever possible, for example at mining sites.
- Use same-sex peer educators and self-help groups to share accurate knowledge and challenge misconceptions.
- Work with men and women (initially in single-sex groups but ultimately jointly) to understand and shift the power relationships in societies, which give women little or no control over their own bodies and make men subject to macho pressures.
- Provide health services that reflect the needs of men and women of reproductive age and allow for the cultural construction of fertility and sexual behaviour.
- Ensure that there is proper accommodation in the workplace to the needs of women, in terms that make it possible for them to remain productive and actively engaged in work despite increasing demands on their time.

Conclusion

It is unrealistic to expect all companies to implement all that has been discussed under the heading of 'Best Practices'. Each company will have its own unique characteristics, be it geographical, ethnic diversity, size or practice. It therefore becomes important for a company to carefully develop a policy and programme which will best suit the needs of its workforce.

SMMEs in particular face the daunting prospect of having to respond to HIV/AIDS with limited human resource capacity and little if any budget. Realistically a SMME should be expected to have a HIV/AIDS policy in place and this is set out in Appendix A which alludes to the intended outcomes, assessment criteria, range and capacity required to undertake the task. Following on from policy is an attempt at more ambitious projects like the development of a programme. Programmes start with awareness raising activities and include: condom promotion and distribution, peer education, VCT and the development of a wellness programme. However, a policy to which management is committed too, and one which employees buy into, is the first step to responding effectively to HIV/AIDS.

As stated, a policy document is the bare minimum, and the business sector is advised to have broad-based programmes which address issues of prevention, treatment, care and support. It is possible to redesign employee benefits to use the resources to target the needs of workers without a significant increase in contributions. A workplace environment should be safe for employees should they wish to disclose or come forward for company assistance. A community-orientated approach, which takes cognisance of the context in which employees live, contributes to an effective programme. Here there is much potential for partnerships with the NGO sector or close collaboration within bargaining councils, sector clusters and with Chambers of Commerce.

Companies, and especially SMMEs, require support and guidance as many of them are finding it difficult to cope with the basic fundamentals of running a business let alone dealing with the impact HIV/AIDS will have on their workforce. Successful programmes and policies can be replicated by those organizations that have as of yet (taking into consideration the limitations as stated earlier in this document), done nothing to mitigate the impact HIV/AIDS will have on their workforce.

Appendix A: Bare minimum response by an SMME

US Title	Specific Outcomes	Assessment Criteria	Range	Embedded Knowledge
Implement policies regarding HIV/ AIDs in the workplace	Describe legislation and national policies relating to HIV/AIDS in the workplace.	Generic assessment criteria	Guides to the scope and complexity of the specific outcomes and essential embedded knowledge are provided in ranges/points beneath each. These are prefaced by “for example” since they are neither comprehensive nor necessarily appropriate to all contexts. Alternatives must however be comparable in scope and complexity.	The person acquiring this unit standard should be able to demonstrate a knowledge and understanding of: 1. The nature and purpose of policy at organisational and national level. 2. National legislation and policies relating to HIV and AIDS. 3. At least one example of an organisational policy around HIV and AIDS. 4. More than one theory about the relationship between organisational policies and practices and the attitudes and behaviour of individuals. 5. Sources of information about HIV and AIDS.
	Describe and analyse policies around HIV and AIDS in the workplace.			
	Develop appropriate HIV/AIDS policy for workplace consistent with national requirements.			

References

Heywood, M et al. 2001. HIV/AIDS and the Law: A Resource Manual AIDS Law

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Smart, R. 2001. HIV/AIDS in the Workplace The AIDS Directorate, Gauteng Department of Health

Legislation

Employment Equity Act 55 of 1998

APPENDIX 4.

THE LAW AND HIV/AIDS

Introduction

In this section of the Report, the legal-ethical aspects of HIV/AIDS is brought into the context the research project, its outputs serving as a practical, user-friendly document or “checklist” to track and monitor legal compliance in the workplace. A brief review of the legislation is outlined, including its relevance to the disease outlined in brief. Following the legal perspective, the ethical background is explored. The outputs of the legislative framework analysis are envisaged to contribute to the development of a monitoring and evaluation planning process. A summary of each act, with a short description of how it relates to HIV/AIDS in general, and HIV/AIDS in the workplace in particular.

The Legal Perspective

On an institutional level of social control, any societal response to HIV/AIDS is driven greatly by the legal framework that exists in the society (Colvin, March 2003). Therefore, any response to the management of AIDS should be in compliance with existing legislation. At the most basic level, this means that adherence should be shown to the South African Constitution Act (Act 108 of 1996), as well as compliance with the related provisions including the Bill of Rights.

Legislative aspects of HIV/AIDS relate to how relevant laws are applied in the workplace, and why both employers and employees should foster an awareness of their rights and obligations. Unfair discrimination as a result of HIV/AIDS related issues is common in the workplace, however, legislation and judgments delivered by the courts, have evolved in recent years to a level of sophistication that demonstrates circumspection and fairness in the highest degree to both employers and employees.

Owing to social stigmatization and the attention the condition attracts, specifically in the media, as well as the varied settings in which discrimination against individuals suffering from HIV/AIDS takes place, it becomes a matter of necessity to explore relevant legislation and the role legislation plays in the societal management of the condition. Significant progress is observed regarding perceptions of HIV/AIDS on societal level in terms of alleviation and destigmatization, and this trend has advanced to legislative processes and the deliverance of judgments.

This trend is most noticeable in judgments regarding HIV/AIDS in the workplace, as illustrated in the matter between Irvin & Johnson Limited and Trawler & Line Fishing Union (other respondents included), where the aforementioned expressed a need for voluntary and anonymous testing for HIV/AIDS in order to perform realistic manpower planning in order to minimize the impact of HIV/AIDS,

mortalities due to the condition, and to enable sufficient support structures to cater for the needs of employees suffering from the condition, and to implement proactive steps in stemming the spread of HIV/AIDS. Negotiations with unions proved positive, and the labour court ruling allowed for anonymous HIV/AIDS testing under certain conditions.

Legislation relevant to HIV/AIDS in the workplace includes the application of the following acts:

- Labour Relations Act, Act 66 of 1995
- Employment Equity Act, Act 55 of 1998
- Occupational Health and Safety Act, 1993
- Compensation for Occupation Injuries and Diseases Act, Act 130, 1993
- Basic Conditions of Employment Act, 1997
- Medical Schemes Act, Act 131 (1998)

The desktop review of legislation will look at the contents of these acts in greater detail, and discuss their implications for the management of HIV/AIDS in the workplace. A review will also be undertaken of how the provisions of these pieces of legislation have been applied in practice.

In addition to legislation, there have been other responses to the epidemic in terms of its legal and ethical dimensions. The Department of Labour has set out a Code of Good Practice on Key Aspects of AIDS and Employment, linked to the Employment Equity and Labour Relations Acts. The University of the Witwatersrand has set up the AIDS Law project at their Centre for Applied Legal Studies, which provides legal support to people and organisations affected by HIV/AIDS.

Since, as already mentioned, societal responses to HIV/AIDS are driven, in part by the legal framework, this exists in a particular society (Colvin, March 2003). Therefore, any response to the management of AIDS should be compatible with existing legislation. This means that adherence should be shown to the **South African Constitution Act (Act 108 of 1996)**, as well as compliance with the Constitutional provisions including the Bill of Rights. Unfair discrimination is explicitly outlawed in the “Equality Clause”. Section 9 of the Constitution provides that every person is entitled to equality before the law and equal protection by the law, and prohibits both the State and any person from unfairly discriminating directly or indirectly against another person on various grounds, such as race, gender and disability. (HIV/AIDS Technical Assistance Guidelines, Department of Labour).

Legislative aspects of HIV/AIDS in practice involve how relevant laws are applied, specifically in the workplace, and why both employers and employees should foster an awareness of their rights and obligations in the workplace. For the purpose of this report, and on the basis of the research performed, it is observed that the most cases unfair discrimination relating to HIV/AIDS, have

taken place in the workplace. Legislation applied and judgments delivered by the courts, have evolved in recent years to a level of sophistication that demonstrates circumspection and fairness in the highest degree to both employers and employees.

Owing to social stigmatization and the attention the condition attracts, specifically in the media, as well as the varied settings in which discrimination against individuals suffering from HIV/AIDS takes place, it becomes a matter of necessity to explore relevant legislation and the role legislation plays in the societal management of the condition. Significant progress is observed regarding perceptions of HIV/AIDS on societal level in terms of alleviation and destigmatisation, and this trend has advanced to legislative processes and the deliverance of judgments. This trend is most noticeable in judgments regarding HIV/AIDS in the workplace, as illustrated in the matter between Irvin & Johnson Limited and Trawler & Line Fishing Union (other respondents included), where the aforementioned expressed a need for voluntary and anonymous testing for HIV/AIDS in order to perform realistic manpower planning in order to minimize the impact of HIV/AIDS, mortalities due to the condition, and to enable sufficient support structures to cater for the needs of employees suffering from the condition, and to implement proactive steps in stemming the spread of HIV/AIDS. Negotiations with unions proved positive, and the labour court ruling allowed for anonymous HIV/AIDS testing under certain conditions. Legislation relevant to HIV/AIDS in the workplace includes the application of the following acts:

- **Labour Relations Act, Act 66 of 1995.** Despite the fact that its perspective, scope, and application is wider than HIV/AIDS, this act creates a framework for the management of HIV/AIDS in the workplace. The application of this act in the workplace facilitates, for example, voluntary and anonymous testing for the condition in view of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job (Section 7(2), Section 50(4). Other conditions that the Act may specify include the provision of counselling, confidentiality, and, amongst others, vulnerability of sufferers.
- **Employment Equity Act, Act 55 of 1998.** The philosophy and application that this act considers is equality. This implies (and specifies) the prohibition of unfair discrimination and harassment against an employee or job applicant suffering from HIV/AIDS. This means that an employee suffering from the condition, should be, for example, eligible for promotion, that absenteeism from the workplace due to the condition, should not be held against the employee, and that employers should put realistic and fair support structures in place to compensate for employee absenteeism and turnover due to HIV/AIDS deaths. It also guards against stereotyping.

- **Occupational Health and Safety Act, 1993.** This act provides for the health and safety of persons at work and for the health and safety of persons in connection with the use of plant and machinery; the protection of persons other than persons at work against hazards to health and safety arising out of or in connection with the activities of persons at work; to establish an advisory council for occupational health and safety; and to provide for matters connected therewith, including HIV/AIDS in the workplace, with regards to health and safety issues. The Act also forbids victimization (by implication against employees suffering from HIV/AIDS). The Act also covers the matter of "*biological monitoring*" which means a planned programme of periodic collection and analysis of body fluid, tissues, and excreta or exhaled air in order to detect and quantify the exposure to or absorption of any substance or *organism* by persons, including HIV/AIDS. In the ambit of this act, the emphasis falls on the protection of the health of the employee.

- **Compensation for Occupation Injuries and Diseases Act, Act 130, 1993.** This Act provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases; and to provide for matters connected therewith. Disablement, which can be caused, by HIV/AIDS, as well as compensation is dealt with in this act.

- **Basic Conditions of Employment Act, 1997.** This act advances economic development and social justice by regulating the right to fair labour practices conferred by section 23(1) of the Constitution by establishing and enforcing basic conditions of employment; and by regulating the variation of basic conditions of employment. With regard to HIV/AIDS, this act prohibits discrimination against job applicants who have HIV/AIDS, including hiring and termination of employment. The purpose of this Act is to advance economic development and social justice by regulating the right to fair labour practices as referred to in the Constitution (in other words, apply fair labour practices to HIV/AIDS sufferers), and regulate variations of basic conditions of employment (therefore prohibiting changing conditions, for example, to terminate an employee's employment should the employee suffer a terminal illness, such as HIV/AIDS).

- **Medical Schemes Act, Act 131 (1998).** This act forbids any unfair discrimination, either directly or indirectly, against any person based on their age and health status, including HIV/AIDS. The Department has firmly closed the door on products where the only form of innovation [and/or research] involves discrimination against people who need health care the most. In the application of this Act, the debate about utilizing generic medicines is addressed, and medical schemes "ruthlessly" refuse

to pay for original medicines, only for the generic equivalents. This places HIV/AIDS medication, its cost and availability for the poor and sick in the limelight. This debate is still raging in South African society. Only recently Government has made generic HIV/AIDS drugs available to sufferers.

- The Department of Labour has set out a **Code of Good Practice on Key Aspects of AIDS and Employment**, which is linked to the Employment Equity and Labour Relations Acts, and provides a standard setting out the content and scope of an appropriate response to HIV/AIDS in the workplace. It further deals with the provision of creating a non-discriminatory work environment, HIV testing, confidentiality and disclosure, providing equitable employee benefits, dealing with dismissals, and management of grievance procedures.
- Currently, the University of the Witwatersrand (WITS) is conducting an **AIDS Law project** under the leadership of Mark Heywood. This project provides comprehensive information for both the uninformed that seek help, as well as those involved in specialized research on the Law and HIV/AIDS. It also provides information for those who know virtually nothing about the disease and support structures, to information for those who perform specialized and intensive research.

Generally speaking, Labour legislation demarcates the disease, thereby “legitimizing” its existence to enable society to deal with it in a structured manner. It enables transparency, which results in better coping mechanisms, as well as improved research and the provision of formal support.

HIV/AIDS is currently treated as a chronic disease, similar to cancer, since new, more effective drugs are produced which enables palliative treatment and provides the patient with the ability to live longer, enjoy a higher quality of life.

The legal perspective, however, is not the only perspective that will be explored in this study. A thorough investigation will be performed in order to outline and emphasize the ethical aspects related to HIV/AIDS. Ethical aspects related to HIV/AIDS include testing, treatment, and research. Key issues analysed include confidentiality, informed consent, and ending of life, research design, conflict of interest, vulnerable populations, and vaccine research. Ethical principles will be discussed (e.g. beneficence, confidentiality, [disclosure], informed consent for HIV testing, including special procedures for HIV testing, exceptions to informed consent, and pre-natal HIV testing. Additionally, end-of-life issues, research ethics, vulnerable participants, and ethical issues in vaccine research will be discussed briefly...

When a legal-ethical benchmarking instrument for HIV/AIDS in the workplace is developed, it has to be viewed from a macro point of view (institutionally). Then

the relevant legislation can be distilled into “checkpoints” for the employer to enable him to determine his status on the grid of compliancy.

The governance accountability structure of the legal framework that has to be complied to is outlined below:

Table 6: Legislative Compliance Grid

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
Constitution Act, (Act 108 of 1996),	Bill of Rights - Equality Clause	Unfair Discrimination	Protection of the individual citizen by the law	<ul style="list-style-type: none"> ▪ <u>Formal over-arching HIV/AIDS Strategy and Policy</u> in place, stating the organisation's position on HIV/AIDS ▪ <u>Workplace Policy</u> and implementation structures regarding employees as equal by law, e.g. statement in <u>employment contract</u> with employee ▪ <u>Education and training strategy and plans</u> about unfair discrimination in the workplace. ▪ <u>Provision of legal services</u> for employees re unfair discrimination or grievances related to HIV/AIDS 	
			Prohibition by both the State and any person from unfairly discriminating directly or indirectly against another person on any grounds, such as race, gender and disability <i>[including a debilitating disease such as HIV/AIDS, TB, Cancer etc.]</i> .	<ul style="list-style-type: none"> ▪ <u>Workplace Policy</u> implementation structures regarding employees as equal by law, e.g. statement in <u>employment contract</u> with employee 	
Labour Relations Act, Act 66 of 1995	Management of HIV/Aids in the Workplace	Voluntary & anonymous testing Provision of counselling, confidentiality, protection of vulnerability of sufferers	Creates opportunity for employer to put in place support structures for employees suffering from HIV/AIDS and other debilitating diseases	<ul style="list-style-type: none"> ▪ Include, in Workplace Policy, the <u>implementation of support structures</u> where employees can volunteer for testing (or outsource it). ▪ Provide, if not present already, a <u>counselling clinic</u> and labour-related 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
					<u>medical/nursing facilities. Including medication</u>
Employment Equity Act, Act 55 of 1998	Equality	Unfair discrimination and harassment	<p>An employee suffering from HIV/AIDS must benefit from all rights, privileges and obligations that other employees benefit from.</p> <p>Stereotyping</p>	<ul style="list-style-type: none"> All day-to-day workplace issues, such as <u>absenteeism</u> (due to opportunistic illnesses), should be treated with objectivity and singular procedures, e.g. the requirement of sick leave certificates. Employers must ensure that sufficient broader <u>support mechanisms</u> exist in the workplace to sustain the employee in the organisation. Employers must ensure, in the employment contract, that all employees understand the <u>practical application of the phenomenon of stereotyping</u> and its consequences for employees in the workplace. 	
Occupational Health and Safety Act, 1993	Health & Safety of employees at the workplace	Creating a physically and mentally safe work environment protecting employees against health and safety hazards	<p>Establish <u>Advisory Council for Occupational Health and Safety</u>, and the provision for matters such as HIV/AIDS in the workplace regarding health and safety issues.</p> <p>The Act forbids <u>victimization</u> against employees suffering from HIV/AIDS.</p> <p>The Act also covers the process of “<u>biological monitoring</u>” (planned programme of periodic collection and analysis of bodily fluid, tissues,</p>	<ul style="list-style-type: none"> Employer must have <u>an Occupational Health and Safety Policy</u> in place. <u>Procedures</u> should exist that operationalise this policy. Produce monthly Safety, Health, & Quality <u>Reports about the workplace</u> <u>Proactively identify hazards and implement interventions</u> to minimize risks and enhance awareness through <u>Safety, Health</u> 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
			<p>excreta or inhaled air to detect and quantify the exposure to or absorption of any substance or organism by persons, including HIV/AIDS</p> <p>The emphasis in this Act falls <u>on protection</u> of the health and safety of the employee.</p>	<p><u>Environmental & Quality Audits, Investigations, and inspections</u> of the workplace</p> <ul style="list-style-type: none"> ▪ <u>Induct</u> and <u>coach</u> employees through an induction and training programme and curriculum for all new employees and contractors about OCHA ▪ Hold regular <u>safety meetings</u> with management and other stakeholders ▪ <u>Distribute correspondence</u> with external parties, Health and safety agreements, policy, safety packs and minutes to all employees ▪ Provide/supply <u>Personal Protective Equipment</u> to employees to ensure safety 	
Compensation for Occupation Injuries and Diseases Act, Act 130, 1993	Compensation	Compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees, or for death resulting from such injuries.	The Act provides for compensation due to occupational injuries, diseases, or death due to these events resulting from the workplace, and matters connected therewith, as well as disablement (which can/cannot be caused by the aforementioned.)	<ul style="list-style-type: none"> ▪ Check relevant <u>NOSA/ISO Certification and compliance</u> ▪ Ensure compliance to all industry & occupational <u>health and safety standards</u> ▪ <u>Implement Hazard Identification Risk Assessment through workforce training</u> ▪ <u>Implement an, e.g. "Safety Through Empowerment of People"</u> 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
				<p>(STEP)” programme and ensure training of workforce on this matter.</p> <ul style="list-style-type: none"> ▪ Ensure HIV/AIDS <u>Awareness Training</u> ▪ <u>Lease</u> with HR Functionaries 	
Basic Conditions of Employment Act (1997)	Advancement of economic development & social justice	The regulation of the right to fair labour practices conferred by Section 23(1) of the Constitution by establishing and enforcing basic conditions of employment.	<p>This Act prohibits the discrimination against the employment of job applicants suffering from HIV/AIDS, including the hiring and termination of employment.</p> <p>This Act advances economic development and social justice by regulating the right to fair labour practices as referred to in the Constitution. It also regulates variations of basic conditions of employment (thereby prohibiting changing conditions of employment, should the employee suffers from a terminal illness, such as HIV/AIDS, Cancer, etc.</p>	<ul style="list-style-type: none"> ▪ Ensure a clear, legally compliant <u>policy</u> for basic conditions of employment <u>inclusive of HIV/AIDS</u> ▪ Ensure that the policy is translated into clear <u>work processes</u> and <u>procedures inclusive of HIV/AIDS</u> ▪ Ensure that policies, processes, and procedures include <u>indemnity</u> on the part of the employer regarding HIV/AIDS ▪ Ensure, through thorough record holding, that <u>employment practices</u> reflect all basically disadvantaged demographic categories of employees, such as the blind, the deaf, etc. 	
Medical Schemes Act, Act 131 (1998).	Fairness in the distribution of any form of health care	Prohibition of discrimination in the distribution of health cares, as well as research and other processes where the usage of persons who represent the poorest of society and need health care the most.	<p>The usage of generic medicines against the original (upon years of research has been performed), is addressed in this Act.</p> <p>Medical schemes “ruthlessly” refuse to pay of for medicinal claims of the original medicine, but pay out willingly for generics, which are sometimes substandard, and much cheaper and economical to afford, especially chronic medicines for patients suffering from HIV/AIDS</p>	<ul style="list-style-type: none"> ▪ Ensure proper processing of medical claims ▪ Inform employees of their rights regarding medication for HIV/AIDS and the consequences of using alternative and generic medicines ▪ Include such information in HIV/AIDS Training and Awareness 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
			<p>suffering, amongst others, of HIV/AIDS.</p> <p>The cost and availability of these medicines is currently in the spotlight.</p> <p>The government is obliged to improve access to health care services, including essential medicines. The Treatment Action Campaign (TAC) has been lobbying and taking legal action to have cheaper HIV/AIDS drugs imported into South Africa</p>	programmes in the workplace.	
Department of Labour: Code of Good Practices on Key Aspects of AIDS and Employment	<p>The Code is based on principles and legal provisions contained within international law, the Constitution, labour legislation, other relevant acts and the common law.</p> <p>Equality and non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable illnesses;</p> <p>The creation of a supportive environment so that employees with HIV or AIDS can continue working for as long as possible;</p>	<p>The Code has two legally-related objectives:</p> <p>Firstly <u>to provide guidelines</u> on how to eliminate unfair discrimination based on HIV status in the workplace; and</p> <p>Secondly, to provide guidance on the <u>management</u> of HIV/AIDS in the workplace.</p> <p>The principles embodied in the Code have been drawn from <u>national</u> and <u>international</u> law as well as <u>best practices</u> in the management of HIV/AIDS in the workplace.</p>	<p>To set the scene in the broadest sense about the HIV/AIDS pandemic and how it affects morbidity, mortality, absenteeism, staff morale, the cost of benefits, products and services and investment.</p> <p>To minimize the impact of HIV/AIDS, it is imperative that every workplace in South Africa responds to the challenge of HIV/AIDS through prevention of further infections and implementation of management strategies.</p>	<p><u>Employment policies and practices:</u></p> <ul style="list-style-type: none"> Recruitment procedures, advertising and selection criteria: Recruitment and selection procedures and policies cannot exclude, directly or indirectly, people on the basis of HIV status, for instance, by insisting that only applicants who are HIV negative may apply. Appointments and the appointment process: The appointment process cannot unfairly discriminate, directly or indirectly, against applicants living with HIV/AIDS, for instance by denying appointments to those who test HIV positive as was done in the Hoffmann v SAA case. Job classification and grading: The policies relating to job classification and grading of employees should not 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
	<p>Protection of human rights;</p> <p>Ensuring the rights and needs of women are addressed in all policies and programmes; and</p> <p>Consultation, inclusively and participation of all stakeholders in all policies and programmes.</p>	<p>The most important of the international codes that have been used to inform and develop the Code are:</p> <ul style="list-style-type: none"> ▪ The SADC Code of Good Practice on HIV/AIDS and Employment (1997) ▪ HIV/AIDS and Human Rights: International Guidelines (United Nations: 1998) ▪ The ILO Code of Practice on HIV/AIDS and the World of Work (2001) ▪ South African law <p>The Code is based on principles and provisions contained in:</p> <ul style="list-style-type: none"> ▪ The Constitution; ▪ Labour legislation; ▪ The common law; and ▪ Related legislation. 		<p>unfairly discriminate against employees living with HIV/AIDS by for instance, denying them, directly or indirectly, certain types of employment for this reason.</p> <ul style="list-style-type: none"> ▪ Remuneration, employment benefits and terms and conditions of employment: Employees with HIV/AIDS may not be unfairly discriminated against, directly or indirectly, for instance by offering them lower rates of pay or denying them employee benefits, on the basis of their HIV/AIDS status. ▪ Job assignments: HIV/AIDS should not be a factor used to unfairly discriminate, directly or indirectly against employees in assigning jobs. For instance, an employee living with HIV/AIDS should not be unfairly denied the opportunity to take job assignments abroad. ▪ The working environment and facilities: Policies relating to the working environment and work facilities should not unfairly discriminate, directly or indirectly, against employees living with HIV/AIDS. For instance, employees living with HIV/AIDS should enjoy 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
				<p>equality of access to workplace facilities such as toilets and canteens.</p> <ul style="list-style-type: none"> ▪ Training and development: Training and development policies may not unfairly discriminate, directly or indirectly, for instance by denying training opportunities to employees living with HIV/AIDS. ▪ Performance evaluation systems: Systems and policies regarding performance evaluation should not unfairly discriminate, directly or indirectly, on the basis of HIV status, so that employees living with HIV/AIDS are evaluated on a fair and non-discriminatory basis. ▪ Promotion: HIV status should not be used as a factor to unfairly discriminate, directly or indirectly, against an employee in determining promotion opportunities. ▪ Transfer: Policies may not unfairly discriminate, directly or indirectly against an employee with HIV/AIDS. ▪ Demotion: HIV/AIDS should not be used to unfairly discriminate, directly or indirectly, against an employee by for instance, demoting someone who is known to be living with HIV/AIDS. 	

Legislation	Principles	Legal issue	Practical Purpose	Workplace checkpoints	Implementation
				<ul style="list-style-type: none"> Disciplinary measures other than dismissal: Policies and procedures regarding disciplinary measures should ensure that HIV status is not used to unfairly discriminate, directly or indirectly against employees in the application of such measures. Dismissal: Dismissal procedures may not unfairly discriminate, directly or indirectly on the basis of HIV/AIDS, for instance by dismissing employees who are known to be living with HIV/AIDS. 	

The Ethical Perspective

An investigation of the ethical aspects related to HIV/AIDS will also be undertaken. Ethical aspects related to HIV/AIDS include testing, treatment, and research. Key issues analysed include confidentiality, informed consent, ending of life, research design, conflict of interest, vulnerable populations, and vaccine research. Ethical principles to be looked at in brief will include:

- **Beneficiality:** In the case of beneficiality, the question that comes to mind, is, “*qui bono* - who benefits”? In other words, do each and everyone in South African society living with HIV/AIDS have equal access to services and medicines in order to lead, although diseased, a certain quality of life? Can everyone afford the expensive patented and generics in the market? The differential access to medicine has been in debate in the media constantly and does not have to be taken further in the context of this report, but the principle of beneficiality needs to be taken into account when organisations plan their HIV/AIDS Strategies and Policies.
- **Confidentiality:** Every person directly affected by the epidemic has a right to confidentiality and privacy. It can only be breached in exceptional circumstances, laid down by the Law, in this case the South African Constitution Act (Act 108 of 1996), as well as the Labour Relations Act, Act 66 of 1995. In the case where Health Workers have to deal with HIV/AIDS patients, it is their right to know the status of the patient in order to safeguard their own health.
- **Disclosure:** As with confidentiality, the principle of disclosure is one of individual privacy, in which case the individual will decide if he/she wants to disclose his/her HIV/AIDS status. All medical information generally is considered confidential and protected under the law. Because of the sensitivity of HIV-related information, other laws, specifically those related to circumstances in the workplace, provide additional protection to HIV-related medical records. For example, in many instances, HIV information may not be disclosed based on a general release of medical information-specific authorization for release of HIV-related information must be obtained.
- **Informed consent for HIV testing:** Because the physical risks are minimal, blood tests generally do not require extensive informed consent discussions, and consent often is implied rather than explicit. However, early in the AIDS epidemic, HIV testing was recognized as different from other blood tests because it presented serious psychosocial risks, such as rejection by family; discrimination in employment; and/or restricted or no access to health care, insurance, and housing. Moreover, because there was no proven treatment at that time, the benefits of early diagnosis to individual patients were uncertain. In recognition of these circumstances and to encourage testing, special procedures were adopted for obtaining

consent for an HIV test, such as pre-test counselling and specific informed consent. Special protections for confidentiality of HIV test results also were enacted.

- **Special procedures for HIV testing:** For the most part, special requirements for HIV testing remain in effect. Pretest counseling is advised, and many of these specify the information that must be covered, including the nature of the test, the risks and benefits of testing, how to prevent transmission, and the confidentiality of HIV test results. The pretest-counseling requirement typically is in addition to any requirements for informed consent. South Africa requires specific informed consent to HIV testing, and many of these require that consent be written. In addition, it is advised that the information that must be conveyed during the informed consent process, including information about the nature of the test, the nature of the illness caused by HIV, risk behaviours and prevention measures, the confidentiality of test results, reporting requirements and other circumstances under which test results may be disclosed, the voluntary nature of the test, the ability to withdraw consent, and the availability of anonymous testing. It is advisable to require that written information also be provided during the consent process.
- **Exceptions to informed consent:** In some instances HIV testing without informed consent can be performed under specified circumstances. For example, testing of patients without permission after a significant exposure to emergency response workers or health care workers occurs can be permitted. In South Africa, if emergency aid is performed at the scene of an accident, the onus is actually on the individual who is providing assistance, such as mouth-to-mouth resuscitation, to protect him/herself, although permission generally must be sought. In addition, a case can be made for the testing of prisoners and persons accused of sex crimes. Mandatory HIV testing of newborns, which indirectly reveals maternal HIV status, is also generally advised around the world. (Wolf & Lo, 2001)
- **Pre-natal HIV testing:** Mother-to-child transmission of HIV has been a priority area for earlier detection because transmission is significantly reduced if pregnant women identified as HIV-positive take antiretroviral therapy. It is generally known that pretest counseling and written informed consent requirements for HIV testing were barriers to prenatal HIV testing. The South African Government's programme to prevent mother to child transmission of HIV, already the largest on the African continent, is being expanded towards universal access to Nevirapine. (GCIS, Fight against AIDS, 2004)

- **End-of-life issues:** Early in the South African epidemic, before antiretroviral therapy was developed and shown to be effective, HIV infection often quickly progressed to a terminal illness. In the developing world, where antiretroviral therapy is generally less available, palliative care, which focuses on relief from suffering, is the only tenable goal. Severe resource constraints may render it difficult to provide palliative measures such as opioids for pain control. Under those circumstances, care may be limited to psychosocial support and helping patients make plans for such practical issues as burial and child custody and support. This focus will need to change as highly active antiretroviral therapy becomes increasingly available in developing countries. There have been many efforts to make HIV medications more available to the developing world by pressuring pharmaceutical manufacturers to reduce prices and permitting production of generic versions of effective therapies and providing funds for drug purchases. In South Africa, the HIV/AIDS budget (excluding allocations from provincial equitable shares) is set to increase ten-fold from R342 million in 2001/02 to R3, 6 billion in 2005/06. Pressure is also exerted on pharmaceutical companies manufacturing antiretroviral medication to drop their prices for the developing world.

- **Research ethics:** Research with human participants raises ethical concerns because people accept risks and inconvenience primarily to advance scientific knowledge and to benefit others. Although some research offers the prospect of direct benefit to research participants, most research does not. It is unethical to expose subjects to the risks of participating in a research study unless the design is sufficiently rigorous that the results will be valid and generalizable. To meet the ethical obligations for research, the study size must be adequate and appropriate study endpoints must be chosen. Clinical trials usually require preliminary laboratory and animal research.

- **Vulnerable participants:**
Some people may be at greater risk from research and are considered vulnerable. Traditionally, vulnerability in research has been defined by categories. For example, children, prisoners, pregnant women, mentally disabled persons, and economically or educationally disadvantaged persons as identified as vulnerable populations. It has been implied that, in consideration of research with human participants, that vulnerability should be based on characteristics of individuals, rather than on group membership or cultural group. Currently six categories of vulnerability are defined: cognitive, institutional, deferential, medical, economic, and social. In general, scientists conclude that vulnerable people require

special protection from research risks. Such vulnerability must be taken into account in research design.

Vulnerability is particularly important in the context of HIV-related research. Those infected with HIV may be medically vulnerable because of their infection. In addition, homosexuals, injection drug users, minorities, and women, who, for various reasons, may be at higher risk of HIV infection, are more likely to be socially and economically vulnerable because of historical attitudes and discrimination. Accordingly, investigators conducting HIV-related research must pay particular attention to vulnerability and take steps to protect potentially vulnerable research participants.

- **Ethical issues in vaccine research:** Some of the requirements for ethical research design present difficulties in HIV vaccine research because:
 - (a) a good animal model does not exist,
 - (b) HIV is highly variable and undergoes rapid mutation, and
 - (c) there is currently little information about how to build protection against HIV.

However, because of the enormous disease burdens of HIV, it is ethically appropriate to begin trials without fully understanding the correlates of viral immunity, provided the other requirements are met.

In May 2000, the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued a guidance document regarding HIV preventive vaccine research. The document contains 18 specific guidance points regarding the conduct of this research (Wolf & Lo, 2001).

APPENDIX 5

THE IMPACT OF HIV/AIDS ON THE ECONOMY

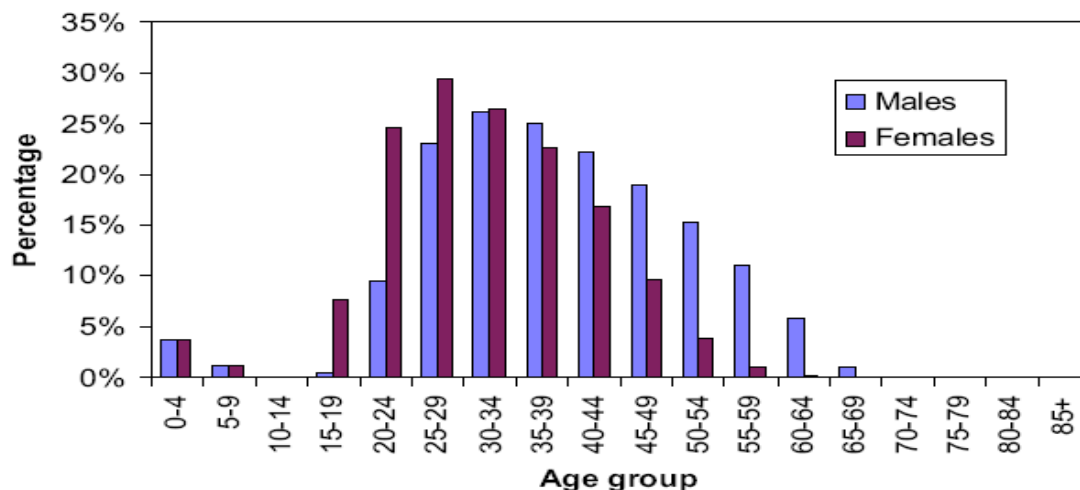
1. Introduction

The HIV/AIDS epidemic, which has multiple effects on regional and national economies due to its demographic and social impacts, is considered by many to be a significant hindrance to development (UNAIDS, 2004).

In the hardest hit regions and countries, the epidemic is undoing decades of progress in health, economic and social development, causing a slowdown in economic growth, increasing poverty and exacerbating food shortages.

The core of the economically active population, and particularly women, are most severely affected by HIV infection and mortality. Figure 1 shows that HIV prevalence amongst 15-54 year olds of both sexes, but particularly among women aged 25-29 years, is the highest of all demographic groups in South Africa (Dorrington et al, 2004).

Figure 1: HIV prevalence rates by age and gender in South Africa, 2004



Source: Dorrington et al, 2004

The most recent Department of Health Antenatal Clinic Survey, conducted in 2003, revealed that on average, 27.9% of women attending public sector antenatal clinics in South Africa were HIV positive. In South Africa, KwaZulu Natal has the highest HIV prevalence rate of all the provinces, and faces significant developmental challenges which are exacerbated by the HIV epidemic. As shown in Figure 2, indications are that the epidemic indeed appears to be most advanced in KwaZulu-Natal, with HIV prevalence of antenatal clinic attendees estimated at 37.5%.

Figure 2: HIV prevalence among antenatal clinic attendees by province.

HIV prevalence among antenatal clinic attendees by province (Department of Health)							
	1997	1998	1999	2000	2001	2002	2003
KwaZulu-Natal	26.9	32.5	32.5	36.2	33.5	36.5	37.5
Mpumalanga	22.6	30.0	27.3	29.7	29.2	28.6	32.6
Free State	19.6	22.8	27.9	27.9	30.1	28.8	30.1
North West	18.1	21.3	23.0	22.9	25.2	26.2	29.9
Gauteng	17.1	22.5	23.9	29.4	29.8	31.6	29.6
Eastern Cape	12.6	15.9	18.0	20.2	21.7	23.6	27.1
Limpopo	8.2	11.5	11.4	13.2	14.5	15.6	17.5
Northern Cape	8.6	9.9	10.1	11.2	15.9	15.1	16.7
Western Cape	6.3	5.2	7.1	8.7	8.6	12.4	13.1
RSA	17.0	22.8	22.4	24.5	24.8	26.5	27.9

Source: Ellis and Terwin, 2004

HIV/AIDS impacts the economy in various ways: the debilitating nature of the disease decreases productivity, HIV infection reduces life expectancy and mortality results in losses in human and financial capital.

The potential impacts of the HIV/AIDS epidemic on local economic development in KwaZulu Natal are far reaching, with the epidemic impacting both demand for and supply of goods and services. On the supply side, HIV infection and mortality result in a reduction in the labour force, lower productivity, and increased costs for employers. On the demand side, the epidemic has the effect of reducing demand for certain resources as consumers affected by HIV/AIDS who are employed spend more of their disposable income in mitigating the effects of the disease, while increasing demand for certain goods (such as medicines and coffins) and certain services (for example health and welfare services, healthcare assistance and funeral benefits). Total disposable income may also decrease for employees affected by the disease because they may take time off work due to their own illness, or have to tend the ill in their households. Ultimately, when they are unable to work at all, their income falls away completely.

2. Demographic Impacts

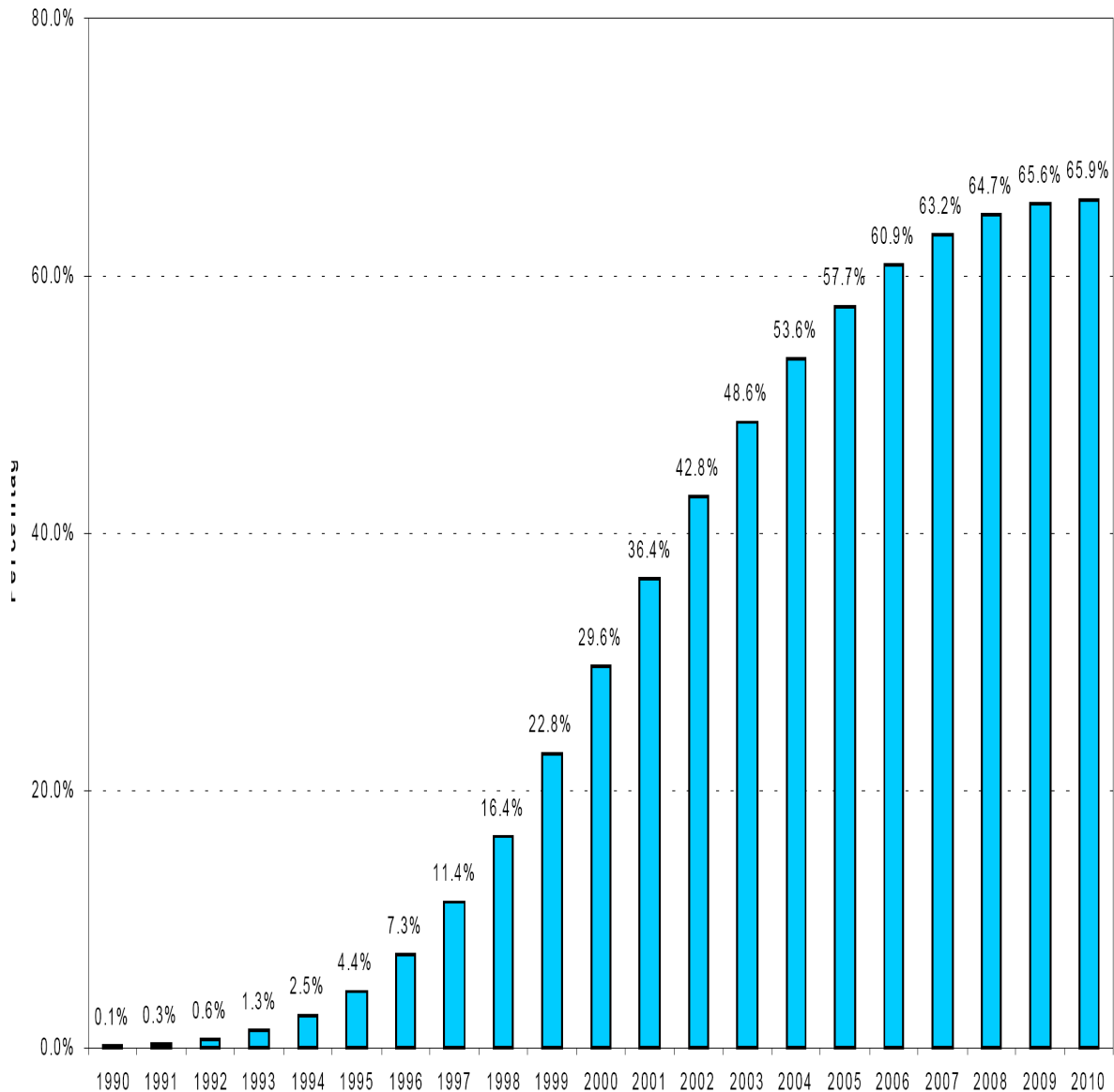
The impacts of HIV/AIDS on demographics feed into the ultimate economic impacts of HIV, particularly as the disease affects the economically active sector of the population most severely. Demographic impacts are apparent both at the macro (population) level and the micro (household) level.

2.1 Population level

As AIDS claims ever increasing numbers of lives, the epidemic is slowing down the rate of population growth in South Africa, a trend that is projected to intensify between 2004 and 2020. The Actuarial Society of South Africa (ASSA, 2000)

estimates that the percentage of deaths considered to be AIDS-related is rising steadily, from 0.1% in 1990 to 53.6% in 2004, a figure which is expected to increase to 65.9% in 2010 without interventions (such as the widespread provision of antiretroviral therapy for instance).

Figure 3: AIDS deaths as a % of total mortality – ASSA 2000 model (no interventions)

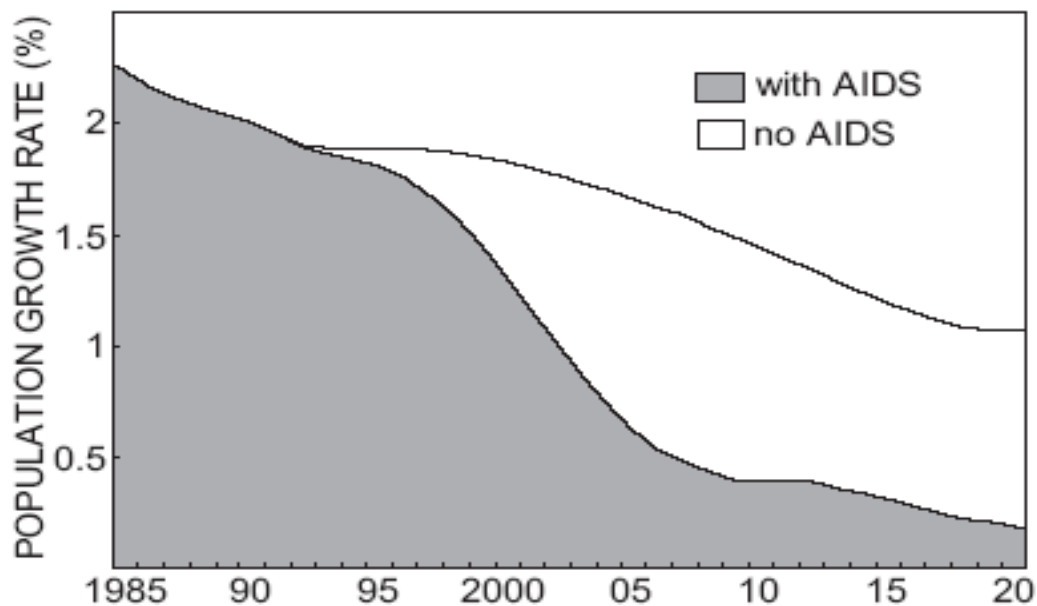


Source: Badcock-Walters, 2002

Figure 4 shows the difference in population growth rates in South Africa with and without the impact of AIDS. It is apparent that the epidemic is expected to cause

the population growth rate to slow considerably. Although a negative population growth is not predicted as a consequence of this slowdown, the total population size is predicted to decrease, resulting in a population that is 23% smaller than it would have been in the absence of the epidemic (Rehle and Shisana, 2003).

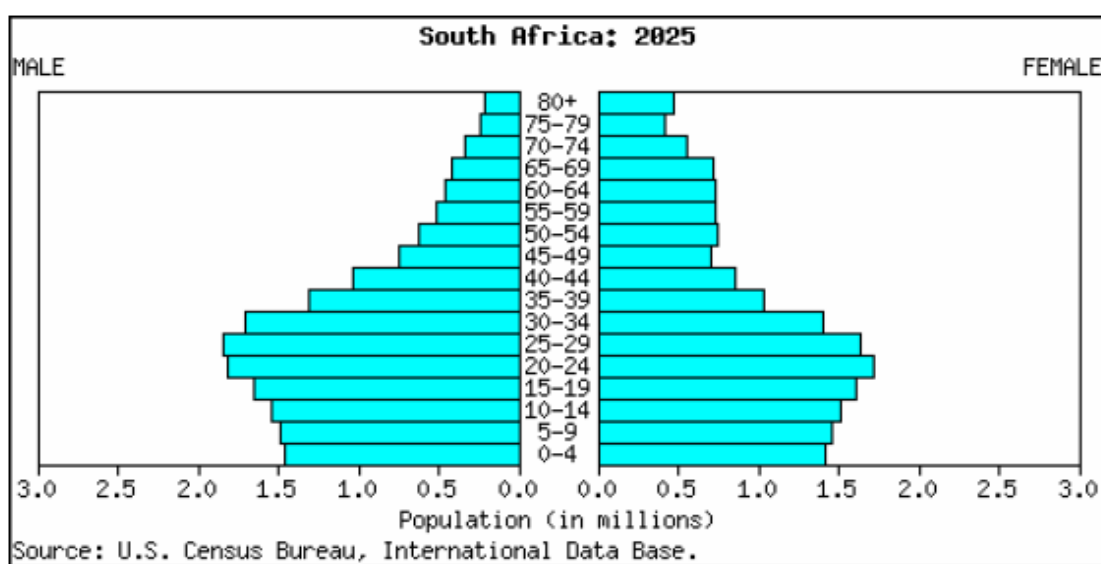
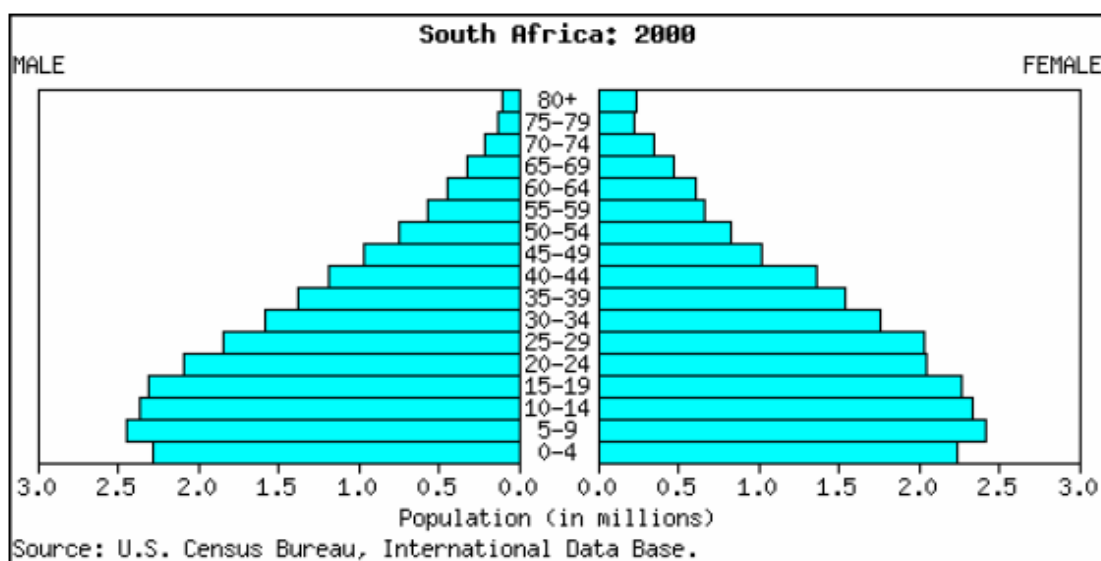
Figure 4: Past and projected population growth rate (% pa) in South Africa, with and without AIDS



Source: Rehle and Chisana, 2003

Figure 5 shows the changes that HIV/AIDS is predicted to have on the population pyramid of South Africa between 2000 and 2025. The impact of AIDS mortality is clear in the middle age groups, with these age cohorts hardly growing at all compared to greater increases in the numbers in younger and older age cohorts. Apart from decreasing the size of the economically active population, this trend is expected to result in fewer children being born in the next decade due to a consequent decrease in fertility. This in turn will contract the size of the economically active population in the next generation.

Figure 5: Changes in the population pyramid, South Africa, 2000-2025



Source: US Census Bureau, 2002

These demographic changes also have implications on dependency ratios, as it is these age groups that traditionally support those in the younger and older age groups.

The dependency ratio is defined as the ratio of the total number of people in the dependent ages (0-14 years and 65 years and older) to every 100 people in the economically active age cohort (15-65 years old). This figure does not, however, take into account actual employment rates, so some of the people defined as “dependent” may be economically active, and some persons included in the “economically active” cohort may in fact be economically dependent. In the

absence of other indicators, the dependency ratio can be a useful indicator of the economic burden carried by the economically active cohort of the population (Haupt A et al, 2000). The higher this figure, the greater the economic burden borne by the economically active sector of the population.

Figure 6 below shows past and projected dependency ratios in South Africa. Projections for 2011 onwards include a lower figure (without AIDS) and a higher figure (with AIDS). Interestingly, the high mortality projected for the economically active population appears to be offset by greater declines in fertility due to HIV, coupled with increased mortality in other age cohorts, leading ultimately to a decrease in the overall dependency ratios at both provincial and national levels.

It is worth reiterating that, because these figures are merely indicative of the number of persons in the 15-65 versus the 0-14 and 65+ age cohorts, they do not provide an accurate assessment of the actual economic burden borne by the economically active sector of the population, which may include children under 14 years old and elderly people over the age of 65, while at the same time many people between the ages of 14 and 65 may be unemployed and therefore economically dependent.

Figure 6: Dependency ratios in South Africa by province

Year	E Cape	Free State	Gauteng	KwaZulu Natal	Limpopo	Mpumalanga	N Cape	North West	W Cape	SA
1996	83.5	56.4	42.0	68.2	92.4	68.3	62.3	63.5	52.4	64.4
2001	75.7	55.4	38.1	64.8	81.8	64.6	56.4	57.0	48.2	58.7
2002	83.4	56.4	42.9	68.2	91.7	71.7	63.1	64.1	52.4	64.6
2003	73.3	55.0	36.9	63.6	78.7	63.5	54.6	54.9	46.8	56.9
2011	52.9	49.7	44.5	51.1	52.9	49.3	42.9	50.2	41.8	49.0
	61.8	58.7	52.4	59.7	61.8	57.5	48.6	59.5	46.6	57.2
2021	41.4	39.7	38.3	40.4	41.0	39.7	39.9	36.4	38.5	39.9
	52.4	49.7	46.0	49.7	52.2	49.5	46.2	50.4	43.3	49.3
2031	33.9	37.7	41.4	35.9	32.5	35.3	38.1	36.4	40.4	36.6
	43.7	47.1	48.6	44.7	42.7	44.3	44.3	46.2	45.1	45.3

Source: HST, 2004

2.2 Household level

Changes in the population size and structure at macro level eventually to changes in household size and structure.

Studies suggest, however, that these changes are difficult to quantify or predict. A World Bank study in the Kagera region of Tanzania, for example, found that the death of a member of a household often resulted in more members being added to the household (World Bank, 1997), while studies in Uganda and Thailand revealed decreases in household size after the death of an adult member (Menon et al, 1998; Janjaroen, 1998). Adult deaths may also result in

the total dissolution of a household (Mutangadura, 2000). Bachmann and Booysen (2003) found that households affected by HIV/AIDS were more likely to include people from outside the nuclear family, although the age and gender composition was essentially the same as unaffected households.

HIV-related illness and mortality give rise to novel household structures such as:

- Grandparent-headed households caring for young children;
- Child-headed households;
- Single parent households (either headed by a mother or a father);
- Foster care households, where children are cared for by neighbouring adult households;
- Households where children are abused or exploited by foster carers; and
- Displaced or homeless children who fend for themselves.

(Barnett T, Whiteside A, 2002)

3. Economic impacts

3.1 Macro economic impacts

The macro economic implications of the AIDS epidemic are difficult to assess, and studies report varying degrees of impact. A study by the World Bank of 30 sub-Saharan countries concluded that annual GDP growth could decline by between 0.8 and 1.4 % pa, with a 0.3% decrease in annual per capita GDP growth between 1990 and 2025 in this region. (Over M, 1992).

Country-specific studies undertaken in various sub-Saharan countries also suggest significant impacts on the macro economies of these countries:

- A simulation model of the economy of Cameroon concluded that, as a direct result of HIV/AIDS, the annual GDP growth may have decreased by 2% between 1987-1991 (Kambou G et al, 1992)
- AIDS is predicted to reduce total GDP in Tanzania by between 15-25% by 2010 (Cuddington JT, 1992)
- GDP in Kenya was projected to be 14% lower, with per capita GDP being 10% lower, by 2005, than it would have been in the absence of the disease (Hancock J et al, 1996).

Figure 7 summarises the findings of several macro economic studies undertaken recently in South Africa, which generally point to negative impacts on real GDP and annual GDP growth. In all of these studies, scenarios of macro economic impacts excluding AIDS and including AIDS are envisaged. In the latter scenario (with AIDS), a smaller labour force, decreased production, increased costs to business, and higher government expenditure (especially on health and social welfare) is assumed.

Figure 7: Summaries of major macroeconomic studies in South Africa

Study	Results
Bureau of Economic Research, 2001 [5]	Real GDP will be 1.5% lower by 2010 and 5.7% lower by 2015. Declines in average annual GDP growth: 0.1% (2002-2005); 0.3% (2006-2010); 0.9% (2011-2015)
ING Barings, 2000 [6]	Real GDP will be an average 3.1% lower in 2006-2010 and 4.7% lower in 2011-2015. Declines in average annual GDP growth: 0.4% (2006-2010); 0.3% (2011-2015)
Arndt and Lewis, 2001 [7]	Real GDP will be 20% lower in 2010. GDP growth rates will decline from the late 1990s to 2008 (maximum difference in growth rate 2.6% in 2008). GDP growth will rebound slightly 2009-2010.

Source: Whiteside A, 2004

The knock-on effects of losses in the labour force and decreased production include reduced government revenue due a smaller tax base and consequent reductions in capacity to achieve developmental targets, which contribute to a cycle of unemployment, poverty and reduced economic and social development. Regional economies are strongly affected by the epidemic, the extent being dependent on the major economic sectors underpinning the region and degree of HIV prevalence within each sector.

Several features of the epidemic will impact on South Africa's economy by affecting factor returns, employment rates, distribution of income, savings rates and labour supply. As HIV prevalence is generally higher in the economically active population than among the population as a whole, the illness negatively influences the productivity of the labour force (Quattek, 2000), although infection rates also appear to differ by skill class. A 1999 ING Barings report suggested that semi-skilled and unskilled workers have nearly three times the peak infection rate than that of highly skilled workers. The current abundance of unskilled labour and a scarcity of highly skilled labour means that this difference in infection rates will have long term impacts on demand for both labour and capital, as well as relative factor return rates. AIDS-related mortality rates are also consistently higher for unskilled workers than for highly skilled. Another mitigating factor in the HIV epidemic's macroeconomic effects is the slow progression of disease. The median term between infection and death due to AIDS is assumed in the ING Barings study to be 8-10 years, with the productivity of an individual being affected only marginally at first, but the disease resulting in increasingly negative impacts on productivity in its terminal stages. (ING Barings, 1999 and 2000; cited in Arndt C and Lewis J, 2000).

Specific impacts on the macro economy include:

- AIDS slows population growth and consequently labour supply, although with different effects on different labour classes;
- Illness due to HIV amongst workers causes a decrease in productivity, especially when progression to full blown AIDS has occurred;

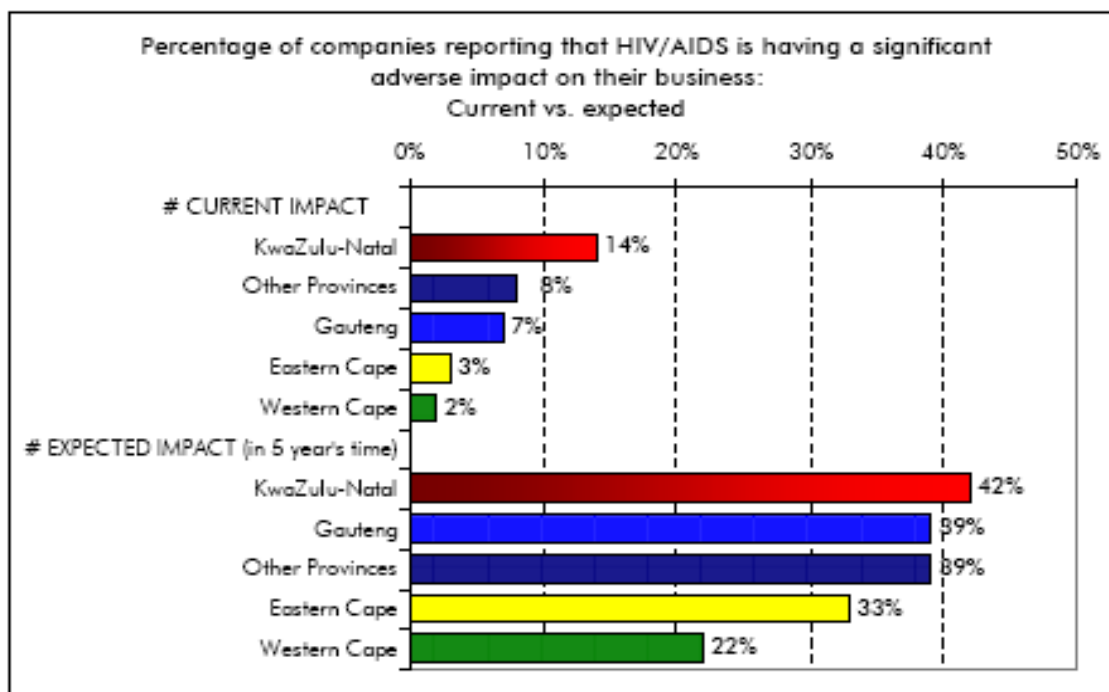
- HIV prevalence negatively impacts productivity as a result of an increase in time and money spent on training and recruitment.

3.2 Company level impacts

Impacts on individual employers are considerable, translating into productivity losses and increased costs to firms and companies due to staff illnesses and deaths, higher health insurance premiums and low employee morale. In addition, demand for goods and services may decline due to lower income and consumption levels, resulting in decreased turnover and reduced labour requirements. The HIV/AIDS epidemic impacts large corporates as well as Small, Medium and Micro Enterprises (SMMEs) in similar ways.

According to a national survey conducted by the Bureau for Economic Research (Ellis and Terwin, 2004) amongst 1,008 companies, more firms in KwaZulu Natal are experiencing significant adverse impacts on their business due to HIV/AIDS than any other province, with predictions being that these impacts will affect a greater number of companies in the next 5 years (see Figure 8).

Figure 8 : Companies reporting adverse impacts due to HIV/AIDS



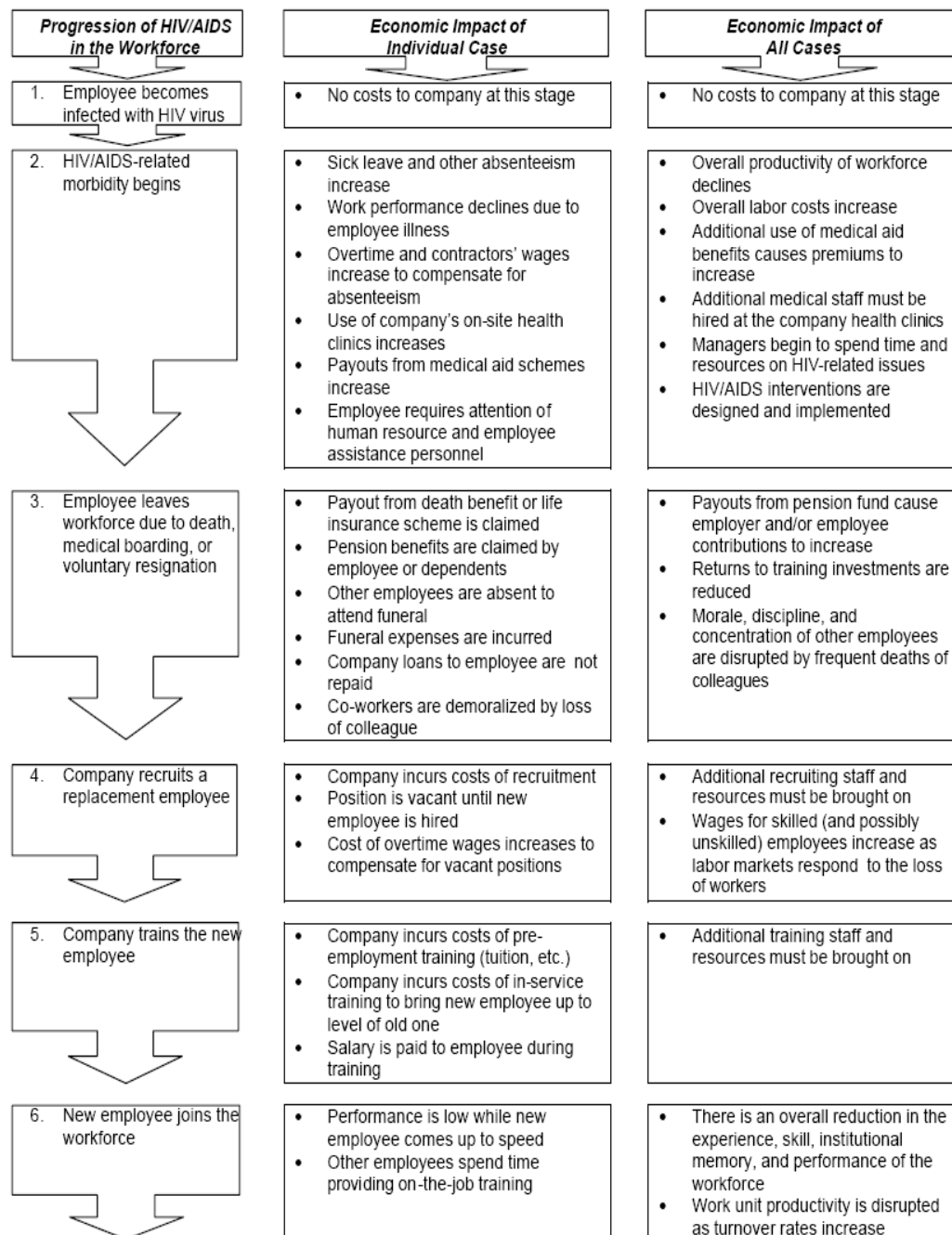
Source: Ellis L and Terwin J, 2004.

These adverse effects may be quantitative, such as increased costs, in particular higher healthcare costs and burial fees, as well as additional costs associated with the recruitment and training of replacement staff; and decreased income due to staff lower productivity and a decline in demand for goods and services. Quantitative impacts include increased staff absenteeism and high staff turnover,

low staff morale, a decline in productivity and losses of institutional knowledge and skills (Bollinger L, Stover J, 1999).

Figure 9 shows the progression of HIV in the labour force and the impacts this progression is likely to have on a company's costs and labour productivity.

Figure 9: Progression of Cases and Costs of HIV/AIDS in the workplace (internal effects only)



Source: Simon J et al, 2000

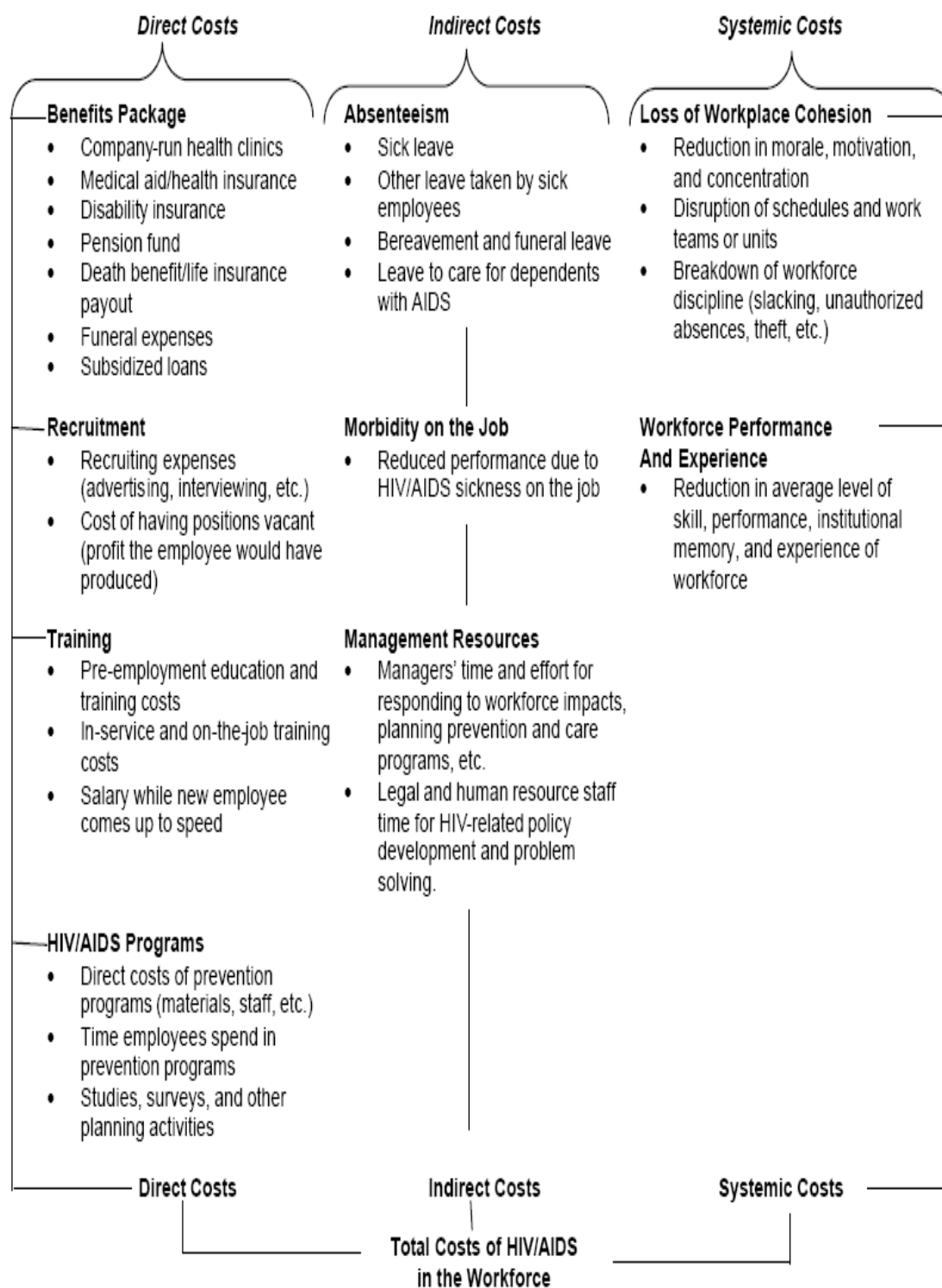
Costs to businesses include direct costs incurred by the business in assisting employees mitigate the effects of the disease, as well as costs incurred in training and replacing employees as required. Other direct costs relate to the prevention of AIDS in the workplace, and include expenses such as awareness training, condom distribution and research and planning of AIDS awareness and prevention programmes.

Indirect costs are not borne directly by the company, but effectively cause the company to experience a loss of revenue or productivity. These costs include factors such as increased sick leave taken by employees, a decrease in productivity by sick employees, compassionate leave to care for ill relatives or attend funerals, and increased work for human resource personnel and managers as they deal with the effects of the disease on their employees.

Systemic costs are effectively the impacts that the direct and indirect costs ultimately have on the business, and include non financial costs such as lower morale and cohesion in the workplace, a net loss of skills and institutional knowledge.

Together these three categories of costs contribute to the quantitative and qualitative costs incurred by companies affected by HIV/AIDS. These costs are illustrated in Figure 10.

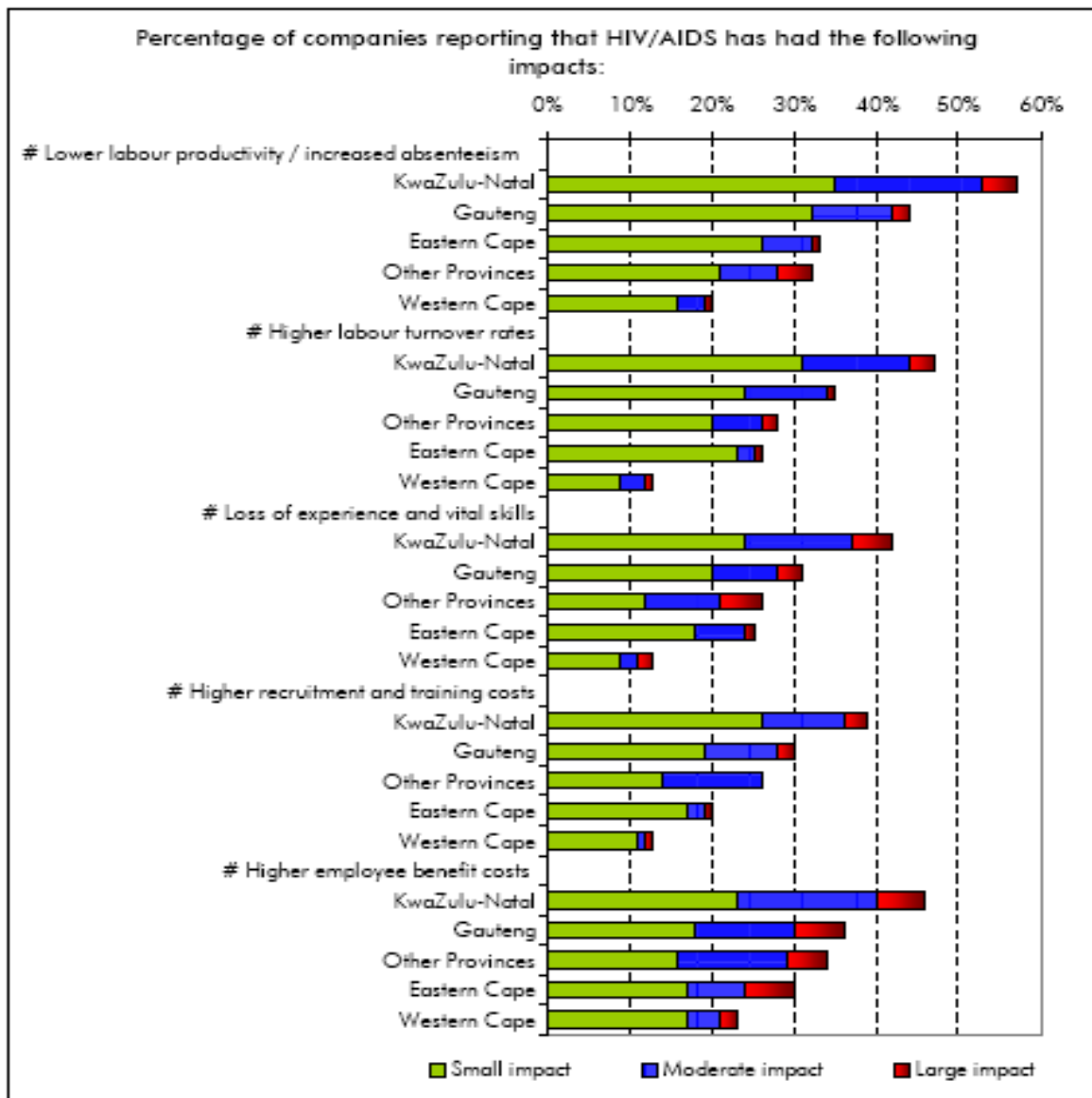
Figure 10: The Economic Impact of HIV/AIDS in the workforce (internal effects only)



Source: Simon J et al, 2000

Although companies are experiencing higher labour turnover rates with a consequent loss of skills and experience and increased costs due to recruitment and training due to HIV/AIDS, the major effect appears to be on productivity and worker absenteeism, and to a lesser extent, employee benefit costs (Ellis and Terwin, 2004). As Figure 11 shows, companies located in KwaZulu-Natal are bearing the brunt of the disease in South Africa.

Figure 11: Specific impacts of HIV/AIDS on companies in South Africa

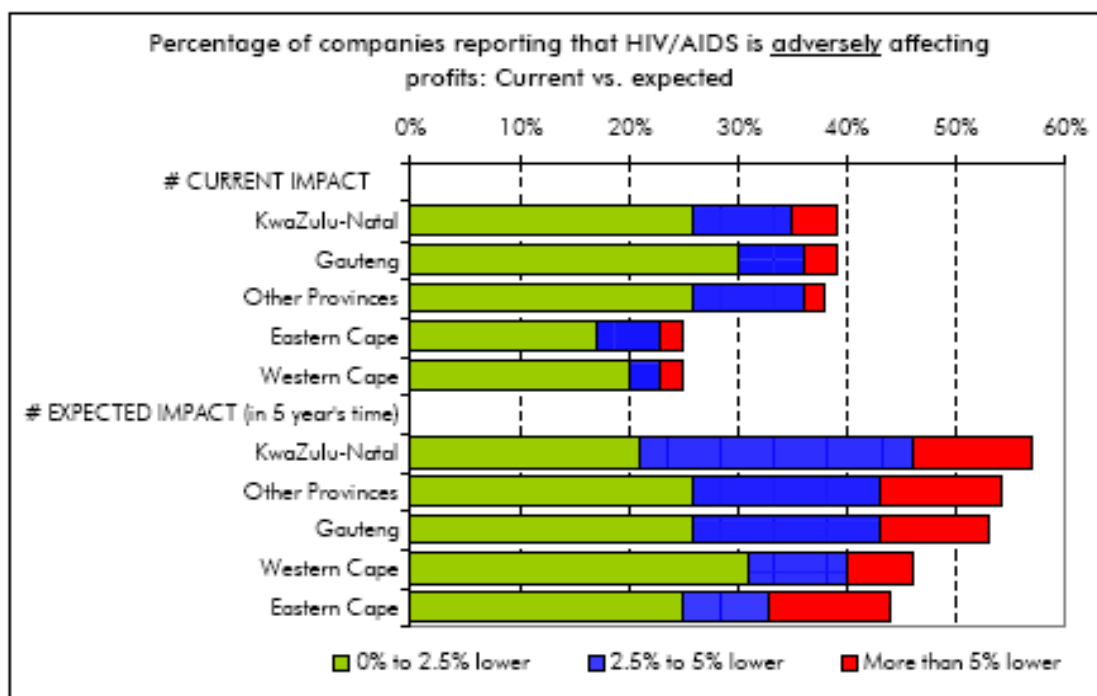


Source: Ellis L and Terwin J, 2004

The epidemic is also affecting companies' profitability. As Figure 12 shows, the impacts are greatest in KwaZulu Natal, with nearly 40% of KZN companies surveyed reporting that the disease is having an adverse affect on their bottom

line, and approximately 57% predicting that these negative impacts on profit will have intensified in 5 years' time.

Figure 12: Impact of HIV/AIDS on profitability of companies



Source: Ellis and Terwin, 2004

Although the impacts of HIV on larger companies are not insignificant, these businesses generally have enough capital and resources to cope effectively with the costs associated with the disease. One of the strategies employed by larger firms was found to be a shifting the burden of responsibility for mitigating the impacts of the epidemic from the private sector to the public sector (Rosen et al,2003). An Old Mutual survey conducted amongst large employers in South Africa in 1999 found that 78% of companies surveyed had shifted more healthcare costs to employees through capping of company contributions and/or reducing benefits. As a result, 36% of eligible employees had opted out of medical aids due to the increased costs to them.

Detailed studies on the effects of HIV/AIDS on SMMEs in particular are not currently available, although the impacts of the epidemic are undoubtedly felt by all businesses regardless of their size. It is likely that SMMEs may experience these impacts more severely than larger companies because of their more limited resources and reduced ability to absorb financial and labour shocks.

3.3 Government sector impacts

HIV/AIDS has ramifications on all areas of the public sector, as illness and increased mortality disrupt public service and result in higher personnel costs

(such as pensions, healthcare and death benefits). This has a knock-on effect in terms of cost increases in the provision of basic infrastructure and services. Government revenues decline as the tax base expands more slowly (or fails to expand at all) and tax collection rates fall. At the same time, government expenditure increases, particularly in the health and social welfare sectors, in an attempt to mitigate the effects of the epidemic (Haacker, 2002). Key sectors which will be significantly affected by the HIV/AIDS epidemic are health, transport, mining, education and water (Bollinger L , Stover J, 1999). In KwaZulu Natal, the long term effects of the HIV/AIDS epidemic in the education, health and social welfare sectors have been extensively studied due to the significant impacts HIV is predicted to have on these sectors in the province.

3.3.1 Education sector

The extent of the impact of HIV on this sector is not clear as data relating to HIV prevalence rates amongst both staff and learners is not readily available. As a result, the consequences of HIV's impact are poorly understood, and so mitigating interventions have not been planned for. The factors contributing to the education sector's vulnerability may be summarized as:

- The already dysfunctional nature of the education system at many levels;
- Social instability associated with the education sector;
- High levels of attrition amongst learners between Grades 1 and 12;
- Extensive repetition of academic years;
- Enrollment of over-aged learners; and
- High levels of HIV prevalence in educators.

(Badcock-Walters, 2000)

The combination of these factors leads to an under resourced sector in which managers and educators are required to deal with large numbers of learners of varying ages, many of whom are from disadvantaged backgrounds and homes marred by violence and social turbulence.

HIV/AIDS is impacting on the education sector in various ways, resulting in fewer teachers and pupils attending school, a decrease in the quality and availability of education for learners, and lower revenues for the sector as a result of fewer school enrolments and non-payment of school fees. Essentially, a reduction in both the supply and quality of educational goods and services (teachers and schools) and demand for education (pupils) is predicted, a combination which has long term implications for the economic development of the province.

Temporary losses of educators occur due to absenteeism, with concurrent declines in productivity due to illness or personal trauma. Permanent losses of skilled staff as a result of mortality, retirement or chronic illness adds to the already high attrition rate in the teaching profession. In addition, because other sectors experience similar staff shortages and may offer more rewarding financial and career prospects than the public sector, teachers may relocate or change careers, resulting in a net loss of skills and experience to the education sector.

In KwaZulu Natal in 1999, 5,300 educators were permanently lost, representing 6,7% of stock in the province. Increased demand for new educators due to staff losses has cost and institutional implications on the sector, while unpredictable decreases in teacher numbers lead to difficulties in strategic and staff planning for the sector. The decrease in the number of skilled teachers also has potential impacts on teacher:pupil ratios, which are likely to worsen as fewer teachers have to cope with big classes. The quality of education provision may suffer as a result.

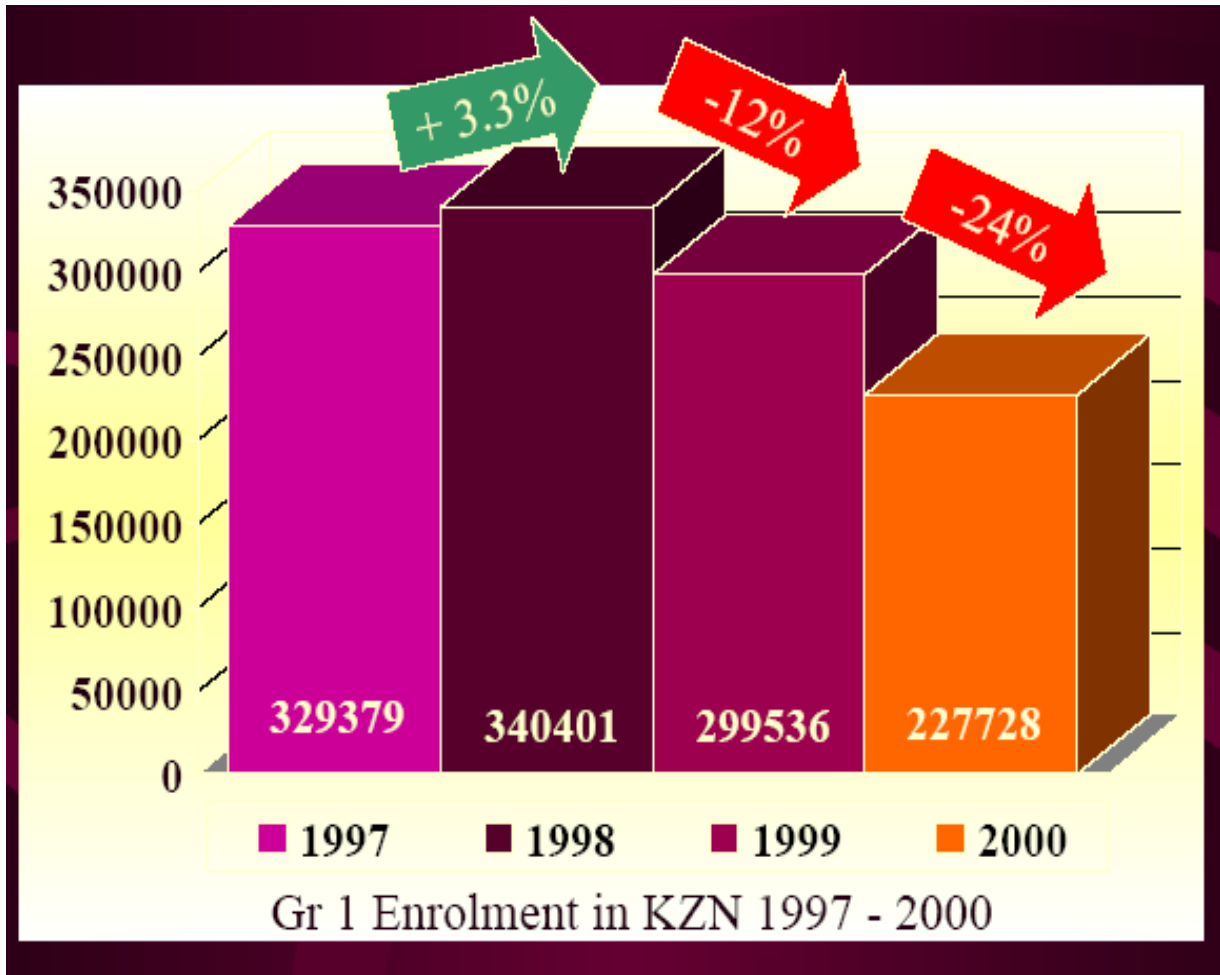
A decline in revenues the education sector may also be predicted, partly because household funds are diverted to pay for health care, funerals and family support instead of school fees, and partly because school enrolments are decreasing.

Enrolment in schools has been declining since the 1980s. In 1999, Grade 1 enrolments in KZN decreased by 12%, a figure which worsened to 24% in 2000. It is assumed that at least some of this decline may be as a result of HIV/AIDS-related factors such as higher infant mortality, HIV-reduced fertility, orphaning and associated increased duties at home. Decreasing enrolment has potential negative impacts on smaller facilities and farm schools which risk becoming unviable (Badcock-Walters, 2000).

In most districts in KwaZulu Natal, declines in female enrolment numbers are greater than those for males. In 1998 there was a growth of 3% in the Grade 1 enrolment of males, with a 4% growth for females. This had become a decline of 12% for males and 13% for females by 1999. Female enrolment by 2000 had declined by a further 26% as opposed to a decline of only 22% for males. Females are more likely than males to be required to provide assistance at home, whether to do housework or to tend ill family members and may thus be the first to be removed from school when fees cannot be paid, with negative impacts on the educational status of females in the province. Orphans are also more likely than children with parents to drop-out, due to a lack of family support structure and financial resources (Badcock-Walters, 2000).

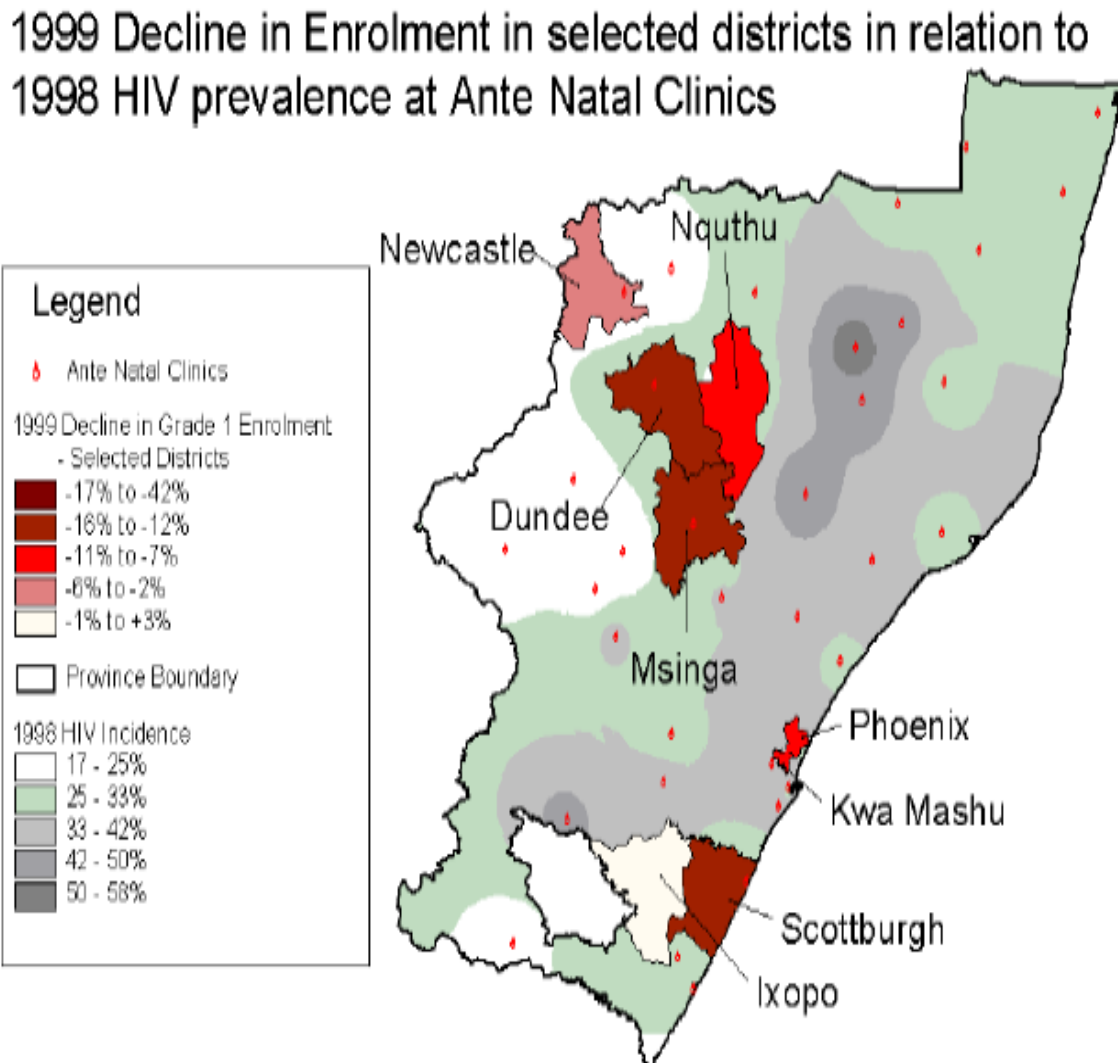
Figure 13 shows the declining numbers in Grade 1 enrolment in KwaZulu Natal schools between 1997 and 2000, while Figure 14 shows the relationship between HIV prevalence (as measured at antenatal clinics) and school enrolment figures in KwaZulu Natal.

Figure 13: Grade 1 enrolment in KwaZulu-Natal, 1997 – 2000



Source: Badcock-Walters, 2000

Figure 14: Decline in school enrolment in selected districts in KwaZulu Natal in relation to HIV prevalence at ante-natal clinics



Source: Badcock-Walters, 2000

Some correlation can be seen between areas of higher prevalence (based on ante natal clinic surveillance) and nearby areas experiencing a decline in Grade 1 enrolment, for example in Dundee, Msinga and Scottburgh, where antenatal clinic prevalence rates are between 25-33% with enrolment declines of between 17-42%. In Newcastle by contract, antenatal clinic prevalence is between 17 and 25%, with enrolment figures declining by only 2-6%. This would suggest that decreasing enrolments are indeed related to HIV prevalence rates in certain areas in KwaZulu Natal.

Although declines in enrolment figures are leading to a decrease in demand for teachers, because the current rate of educator attrition is higher than this decrease, demand for skilled educators is actually increasing. This trend is expected to intensify by 2010, fuelled by AIDS mortality and the recruitment of teachers by the private sector. (Badcock-Walters 2000 and Badcock-Walters et al, 2003).

The combined effects of lower enrolments and educator attrition is predicted to lead to fewer secondary school learners and matriculants, with consequent negative impacts on the number of school leavers eligible for tertiary education, and long term impacts on the skills base in the province (Badcock-Walters, 2000).

3.3.2 Health sector

Similar to the impacts in the education sector, the effects on the public health sector relate not only to supply variables such as hospitals, personnel and the provision of medicines and care, but also to demand for healthcare goods and services by patients. As can be expected, the HIV epidemic increases the demand for both public and private healthcare services, and decreases the number of healthcare workers available to care for them due to HIV-related morbidity and mortality amongst healthcare personnel.

In provincial public hospitals across South Africa, although total patient numbers have not increased significantly due to HIV/AIDS, there has been an increase in the average number of HIV-related admissions to hospitals since 1995 (HST, 2004). This impacts on workload for healthcare personnel, who report that caring for HIV/AIDS patients is more time consuming than other patients, mainly due to the extra precautions that have to be taken when caring for HIV infected patients. (HSRC, 2002).

Approximately 88% of the population of KwaZulu Natal depend on state health services, which are already under severe stress due to underfunding and a lack of staff. According to SSA (2004), 16.7% of public sector health posts in KwaZulu Natal were vacant in 1996, and KwaZulu Natal currently has a shortfall of 6,000 nurses and 2,000 doctors (Cullinan, 2004). It is estimated that in order to cope with the demands placed on the healthcare system by HIV/AIDS, training of doctors and nurses will have to increase by 25-40% (Haacker, 2002).

Healthcare personnel are severely affected by HIV, especially where they are required to tend to more patients during amidst staff shortages, absenteeism, and increased workplace hazards due to a higher risk of HIV infection. A comprehensive study conducted by the Human Sciences Research Council (HSRC) in 1992 amongst 1,922 health professionals throughout South Africa revealed that impacts on healthcare personnel include:

- Health workers have to provide healthcare to an increasing number of patients. This is partly due to a lack of volunteers and specialised facilities such as hospices to care for HIV/AIDS patients, and partly because HIV/AIDS patients require extensive attention, resulting in increased workloads and associated declines in performance.
- Staff shortages and a lack of resources, such as medication and other equipment, exacerbates these impacts.
- As conditions worsen, more staff are likely to leave the health professions and the country, impacting negatively on the quality of healthcare available to patients (HSRC, 1992).
- The availability of government-subsidised health services to patients with non-HIV related conditions is predicted to decrease (HSRC, 1992)

One of the major impacts on the healthcare system in any epidemic is the need to provide treatment to needy patients, in this case the provision of antiretrovirals to those who are eligible. HIV also requires additional expenditure to be incurred for palliative care, prevention of opportunistic infections and clinical treatment, with costs to the government of providing 10% coverage of antiretroviral therapy amounting to an estimated 0.2% of South Africa's GDP (Haacker M, 2002). Given that numbers of AIDS patients will continue to increase due to increasing infection rates and the fact that ART extends the lives of those infected, the number of patients requiring ART will continue to increase in the future, necessitating in long term expenditure increases in the health sector. This expenditure includes not only ART, but also palliative care and prevention strategies.

Figure 15 shows estimated costs of HIV treatment and prevention programmes, which are significantly greater in higher income countries (which includes South Africa). The total cost per patient per year in higher income countries is estimated to exceed \$3,200 (approximately R19,500). With an estimated 450,000 people in KwaZulu Natal in need of ART (Cullinan, 2004), this has significant cost implications for the provincial healthcare budget. Proceeding on the basis that 88% (396,000) of these people would require state assistance for healthcare, this would cost the state an additional R 7,722,000,000 per annum.

Figure 15: Costs of HIV treatment and prevention

	Costs per patient per year	
	Lower income countries	Higher income countries
Palliative care	\$25.80	\$25.80
Prevention of opportunistic infections	\$36	\$79
Clinical treatment of opportunistic infections	\$359	\$698
Costs of HAART (drugs only)	\$1,400	\$1,400
Costs of HAART (support)	\$600	\$1,000
TOTAL	\$2,420.80	\$3,202.80

Source: Haacker M, 2002

Increased expenditure on healthcare by government also diverts funds from other development initiatives, which further hampers sustainable and balanced economic development.

3.3.3 Social welfare sector

The Department of Social Development (DSD) is responsible for the financial, emotional and physical care of those made vulnerable by the HIV/AIDS epidemic and delivers social welfare services to these groups through a variety of programmes including:

- Social Assistance and Social Welfare Services: providing financial support to both public and private sector welfare institutions;
- Social Security: provision of grants for social security;
- Social Development or Poverty Relief Programme (PRP): support of community-based initiatives in order to promote income-generating projects for those not covered by social security;
- Child support for poor and severely disabled children;
- The Poverty Relief Programme (PRP), which targets the poorest 20% of the population, providing assistance to various groups including households affected by HIV/AIDS and neglected children.

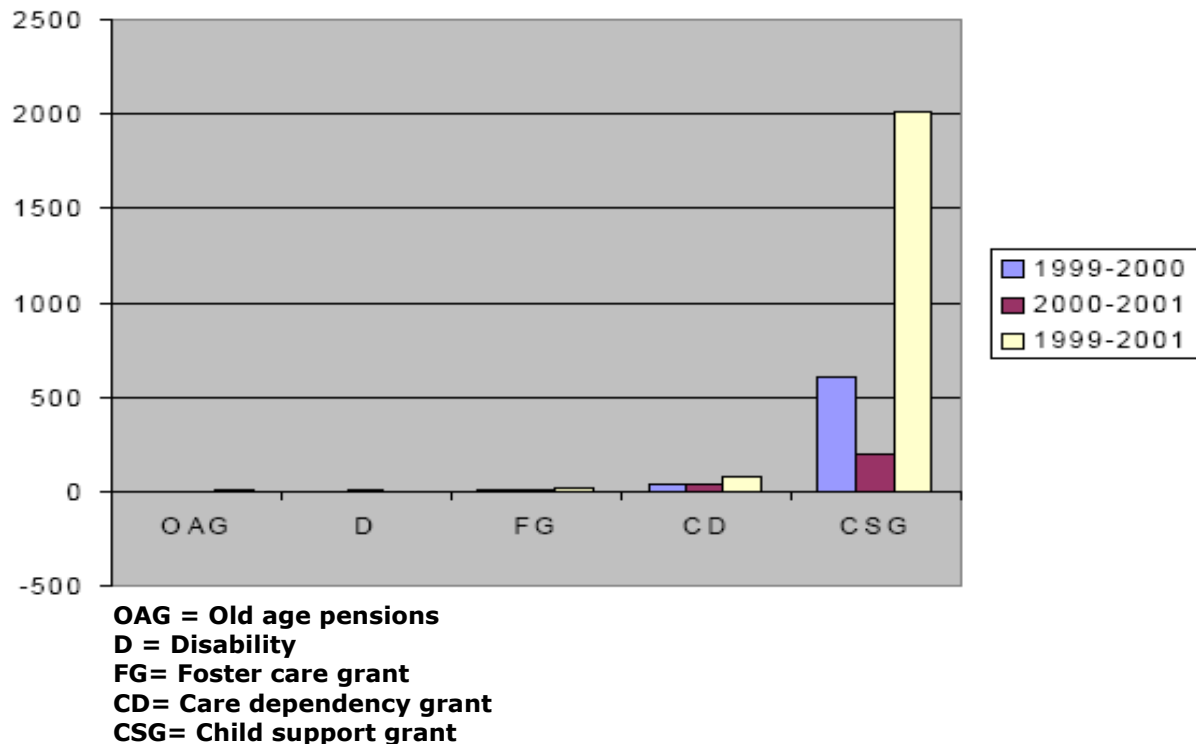
(Adams J et al, 2001)

The social security system in South Africa is structured around five main grants, which are paid to beneficiaries by provincial governments, although in some provinces private consultants assist provincial government with these payments. People affected by HIV/AIDS are entitled to various grants, including financial assistance for medical costs, foster care, and assistance for child support. (Adams J et al, 2001).

The potential impacts of AIDS mortality on population growth and HIV associated reductions in fertility are not reducing demand for grants. Instead, as Figure 16 shows, demand for grants, especially child support grants (CSGs) is increasing. The Department of Social Development predicts that the increasing number of

people affected by HIV/AIDS will lead to continuing growth in demand for these grants.

Figure 16: Growth rate in grant payments between 1999 and 2001



Source: Adams J et al, 2001

One of the results of higher mortality amongst young adults due to AIDS is an increase in the number of orphans, caring for whom places additional demands on the social welfare system. Even in regions where HIV infections have levelled off, the number of orphans continues to rise due to the time lapse between infection and death of parents. An estimated 18% of South Africa children are orphans, with the MRC predicting that at least 5.7 million children could lose one or both parents to HIV/AIDS by 2015. (IRIN, 2004). The DSD predicts that an increased number of orphans in need of care and fewer carers available to care for them will negatively impact on the availability of state support and care for orphans (Adams J et al, 2001). In KwaZulu Natal, it is estimated that there are more than 660,000 children have lost one or both parents to AIDS, a figure which is expected to quadruple by 2008 (Clarke, 2004).

Apart from direct financial assistance, both adults and children affected by HIV may become dependent on the state to provide them with other support such as care, food and shelter. However HIV/AIDS will impact on the ability of the DSD to provide effective services to the needy in various ways:

- HIV Mortality will result in a decrease in the number of people available to care for the elderly;

- Greater financial burdens on households as a result of increased poverty will increase reliance on state welfare services;
- The vulnerability of women to poverty and their reliance on state provided welfare will increase;
- Youth will be increasingly affected by the disease, whether through infection themselves or that of family members;
- Service delivery will be generally affected due to the impacts of the disease on welfare personnel. These impacts include decreased productivity either due to illness, caring for sick family members, low morale and eventually higher mortality amongst staff (Adams J et al, 2001).

3.4 Household level impacts

The household impacts of HIV begin with the onset of illness of a member of the household and the loss of income of the ill person (who is often the main breadwinner). If the main caregiver is economically active, this is often accompanied by further income loss as this second household member stays home to tend the patient. This impacts on the ability of caregivers to earn an income, while this decreased household income is coupled with increased household expenditure on healthcare.

Household financial security is adversely affected in both the short and long term: Quatteck (2000) estimates that domestic savings as a percentage of GDP drop to 2% lower with AIDS than in the absence of the disease. As a consequence, children may be taken out of school due to financial pressures or the need for caregivers at home, with consequent impacts on their educational status and prospects, which has potential future negative on the earning power and economic status of these individuals and households. Death of the patient results in permanent loss of their income, funeral and associated expenses and, in some communities, stigma and discrimination, which exacerbate the already dire economic situation of the household

The economic impacts of the HIV epidemic on households in KwaZulu Natal have not been extensively studied, although a cohort study conducted by Bachmann and Booysen (2003) in the Free State found that rural households and those directly affected by AIDS tended to be larger and poorer, and have higher rates of unemployment than those households not directly affected and urban households.

Affected households were also found to have significantly lower income and expenditure levels than their unaffected neighbours. Household income and expenditure in affected households also decreased faster over time than in unaffected households. As Figure 17 shows, the average household incomes and expenditures of AIDS-affected households were between 12% and 29% lower than those of households unaffected by AIDS.

Figure 17: Income and Expenditure in AIDS- affected and unaffected households in the Free State

Table 4: Ratios between affected and unaffected households' income and expenditure: linear regression models

Outcome	Crude model			Adjusted for household demography and employment*			Adjusted for household demography, employment, morbidity and mortality**		
	Ratio Affected: Unaffected	(95% CI)	P	Ratio Affected: Unaffected	(95% CI)	P	Ratio Affected: Unaffected	(95% CI)	P
Baseline									
Household income	0.71	(0.57 – 0.88)	0.002	0.80	(0.65 – 0.97)	0.024	0.84	(0.65 – 2.09)	0.17
Income per person	0.61	(0.49 – 0.76)	<0.001	0.75	(0.62 – 0.89)	0.002	0.85	(0.68 – 0.48)	0.18
Adult equivalent income per person	0.65	(0.52 – 0.80)	<0.001	0.77	(0.64 – 0.92)	0.004	0.85	(0.67 – 1.07)	0.16
Household expenditure	0.78	(0.64 – 0.95)	0.013	0.82	(0.68 – 0.99)	0.036	0.89	(0.70 – 1.14)	0.31
Expenditure per person	0.68	(0.56 – 0.83)	<0.001	0.78	(0.66 – 0.47)	0.05	0.92	(0.74 – 1.12)	0.42
Expenditure per adult equivalent	0.72	(0.59 – 0.87)	0.001	0.80	(0.67 – 0.94)	0.009	0.90	(0.73 – 1.14)	0.36
Follow up#									
Household income	0.92	(0.77 – 2.50)	0.35	0.91	(0.77 – 1.07)	0.25	0.94	(0.75 – 1.17)	0.56
Income per person	0.90	(0.76 – 1.07)	0.24	0.89	(0.75 – 1.05)	0.17	0.95	(0.76 – 1.19)	0.68
Adult equivalent income	0.90	(0.76 – 1.07)	0.24	0.89	(0.76 – 1.05)	0.16	0.94	(0.76 – 1.18)	0.61
Household expenditure	0.85	(0.74 – 0.97)	0.02	0.85	(0.75 – 0.98)	0.02	0.88	(0.73 – 1.05)	0.16
Expenditure per person	0.85	(0.74 – 0.98)	0.03	0.86	(0.75 – 0.99)	0.04	0.92	(0.77 – 1.11)	0.38
Expenditure per adult equivalent	0.85	(0.74 – 0.97)	0.02	0.85	(0.75 – 0.98)	0.02	0.90	(0.76 – 1.08)	0.26

Adjusted for the respective baseline income or expenditure variable in all follow up models * Adjusted for urban or rural location, age and gender composition and percentage of household members employed. ** Adjusted further for baseline morbidity and mortality and, for follow up analyses, mortality and morbidity at follow up

Source: Bachmann M and Booysen FL, 2003

Expenditure was found to be a more sensitive indicator than income of the economic impacts of the epidemic on households affected by the epidemic (Bachmann MO, Booysen FL, 2004). In households affected by HIV, it was found that real expenditure tends to increase over time (mainly due to additional expenses such as health care and funeral costs being incurred), while real income remains static (Bachmann MO, Booysen FL, 2004). The percentage of income spent by affected households is also on average higher (72%) than unaffected households (53%). (Bachmann and Booysen, 2003).

Increased household expenditure on healthcare and funerals, however, impacts negatively on the households' ability to produce and buy food. Food security is negatively affected not only by financial constraints, but also by the inability of household members (whether they are too ill, young or old) to tend subsistence food crops. Consequent malnutrition further increases susceptibility to HIV and opportunistic infections, creating a vicious circle of poverty and increased susceptibility to disease. As a result, food insecurity can become a major

problem for households affected by HIV/AIDS, a phenomenon that has been termed “new-variant famine”.

The fact that many children have to leave school due to illness, financial constraints or to care for sick family members, impacts negatively on their education and future employment prospects, further exacerbating the negative impacts of HIV on the household.

In summary, the consequences of the HIV/AIDS epidemic on the economy of KwaZulu Natal are far reaching and severe, especially given that this province has the highest prevalence rate in South Africa. In mitigating the effects of the epidemic, funds that would otherwise have been employed in developmental projects are diverted to the more immediate needs of those affected by the disease, such as the provision of care and treatment. Furthermore, the long term impacts of the epidemic in the province include not only economic but social and demographic changes, a decrease in the number of economically active and skilled workers, increased costs to employers, a contracting tax base and potentially decreasing provincial GDP, higher unemployment, food insecurity and widespread poverty.

APPENDIX 6

EXAMPLE OF A STANDARD POLICY

HIV&AIDS POLICY FOR (YOUR COMPANY)

- 1) We will not discriminate against people who have HIV or AIDS with regards to
 - a) *Recruitment*
 - b) *Promotion*
 - c) *Salary increases*
 - d) *Training and development*
 - e) *Benefits*
 - f) *Sick leave*
- 2) We will not tolerate discriminatory or victimisation of employees who are HIV+ within the workplace.
- 3) We will not test for HIV as a pre-condition of employment without the permission of the labour courts.
- 4) We will not disclose an employee's HIV status to others without their written consent.
- 5) We will provide a safe working environment and train employees in universal safety precautions against HIV.
- 6) We will not dismiss employees solely on the basis of their HIV status. Where an employee becomes too ill to perform their current work, we will follow acceptable guidelines regarding dismissal for incapacity.
- 7) We will encourage all employees to be aware of their HIV status and to seek appropriate medical treatment and counselling if necessary.

APPENDIX 7

HIV/AIDS-RELATED CRITERIA FOR THE LOCAL COMPETITIVENESS FUND AND FOR THE BUSINESS ENABLING FUND

HIV and AIDS-related Criteria for the Local Competitiveness Fund and for the Business Enabling Fund

These criteria for the above funds will be incorporated into the relevant evaluation matrixes:

1. Has the applicant considered the potential impact of HIV and AIDS on the functioning of the business?
2. Has the applicant considered the potential negative and positive impacts of the business activities on HIV and AIDS?
3. Does the applicant have an HIV and AIDS policy?
4. Does the applicant have a draft HIV and AIDS plan and accompanying budget?

Notes on the criteria

1. The extent and detail of any documentation to support the fund application must be in keeping with the size, scope and impact of the proposed project. A large, industrial development project will require significantly more detail than the establishment of a micro-enterprise.
2. Simple check-lists for each criteria have been developed to assist fund applicants and fund managers in assessing the completeness of the documents.

KZN LED PROJECT – IMPACT OF HIV/AIDS ON THE ORGANISATION CHECK LIST

Criteria: Has the applicant considered the potential impact of HIV and AIDS on the functioning of the business?

1. Is there an impact assessment report available that considers what impacts the HIV/AIDS epidemic may have on the organisation?

☐

2. Has the impact of losing key staff to HIV/AIDS been considered?

☐

3. Has the impact of HIV/AIDS on productivity (decreased productivity through illness, attending funerals, etc) been considered?

☐

4. Has the impact on employee benefits such as pension schemes or medical aid funds been considered?

☐

5. Has the impact of HIV/AIDS on target markets been considered?

☐

KZN LED PROJECT – IMPACT OF THE ORGANISATION ON HIV/AIDS CHECK LIST

Criteria: Has the applicant considered the potential negative and positive impacts of the business activities on HIV and AIDS?

1. Does the organisation have a report available that comprehensively assesses how the organisation's activities may have either positive or negative impacts on preventing the spread of HIV or on mitigating its impacts? ☐
2. Have all potential negative impacts of its operations been reasonably assessed? ☐
 - 2.1. Will the organisation be bringing together employees into one place? ☐
 - 2.2. Is there going to be a gender imbalance in selection of employees? ☐
 - 2.3. Will any employees be mobile (i.e. working out of the office) frequently? ☐
 - 2.4. Is a male only workcamp going to be set up or will some employees be migrants from other areas? ☐
 - 2.5. Do any of the organisations activities have anything to do with the hospitality industry? ☐
 - 2.6. Will the activities of the organisation encourage other activities that may promote the spread of HIV (e.g. encouraging hawkers, sex workers, etc) ☐
3. Does the organisation's HIV/AIDS plan state how the organisation is going to mitigate potential negative consequences of its activities? ☐

KZN LED PROJECT - HIV & AIDS POLICY CHECKLIST

Does your policy include the following principles?

1. People with HIV&AIDS are entitled to the same rights, benefits and opportunities as people with other life threatening illnesses. ☐
2. Employee practices related to HIV& AIDS comply with legislation. ☐
3. Policy is based on proven scientific knowledge that people with HIV&AIDS do not constitute a risk of transmitting the virus to those around them through ordinary workplace contact. ☐
4. The policy makes mention of the need for endorsement by all levels of management, union and other leadership. ☐
5. The policy makes mention of the need for the policy to be communicated throughout the business. ☐
6. The policy makes provision for confidentiality of employees' medical information and HIV status. ☐
7. The policy discusses the need to educate all employees about HIV and AIDS and states that tolerance is then expected from all employees towards anyone being affected by the HI virus. ☐
8. The policy mentions that screening for the HI virus will only be done on a voluntary basis or as a legal requirement. ☐
9. The policy mentions that necessary training and protective equipment will be specifically provided for those employees exposed to great risk of infection. (for example, medical staff) ☐

KZN LED PROJECT - HIV & AIDS PLAN AND BUDGET CHECK LIST

Criteria: Does the applicant have a draft HIV and AIDS plan and accompanying budget?

1. Has an appropriate person been appointed within the organisation to manage HIV/AIDS issues? ☐
2. Does the organisation have a written plan or programme detailing how HIV and AIDS related issues will be managed? ☐
3. Does the plan follow the principles of "mainstreaming" HIV/AIDS issues into all relevant aspects of the organisations activities? ☐
4. Does the organisation have plans to raise awareness among employees? ☐
4. Does the plan describe how condoms will be procured and distributed within the organisation? ☐
5. Do employees have access to confidential and convenient voluntary individual HIV testing that is supported by pre and post-test counselling? ☐
6. Is there a nutritional support programme? ☐
7. Do employees have access to treatment for opportunistic infections? ☐
8. Do employees have access to antiretroviral treatment through the company? ☐
9. Is there an appropriate budget accompanying the plan/programme? ☐