Critical Health

SEPTEMBER 1993 NO. 44

Typesetting by Critical Health

Critical Health is published by an editorial collective:
PO Box 16250
Doornfontein
2028
South Africa
Tel: (011) 484 3078
Fax: (011) 484 3557

Thanks:
Malcolm Steinberg, Robyn Berman, Morna Cornell, Clive Evian, Alan Fleming, & Shan Rowe and his assistants.

CONTENTS

Editorial

The world at large is grappling with the realisation that it is failing to control the further spread of the HIV/AIDS epidemic. This failure makes it important to reflect on our attempts to make an impact on the epidemic and to understand the lessons to be learnt from our efforts thus far. What are these lessons?

The most common response to the epidemic has been one of denial. Communities most at risk to infection continue to disbelieve in AIDS as a real problem. This situation is unlikely to change until individuals infected and sick with HIV/AIDS feel confident and sufficiently supported to speak about their experiences with the disease.

A further form of denial is evident in the lack of commitment of governments and political leaders to allocate sufficient resources to controlling the epidemic. The South African government is particularly guilty in this regard. Its own figures highlight the seriousness of the epidemic in this country. In 1990, 76 people in every 10 000 were infected. In 1991, the figure was 149 per 10 000 and, in 1992, it increased to 269. South Africa generates more wealth than most other African countries, yet the government spends less on AIDS per person than almost all these countries.

The epidemic was initially most prevalent in the white homosexual community, but is now spreading rapidly amongst heterosexuals. A close examination of who becomes infected has shown that the disease occurs most frequently in situations where it is difficult to maintain stable relationships. The societal factors that act to destabilise sexual relationships are not well enough understood, but there are perhaps two central factors. Migrancy between urban and rural centres, as well as within urban centres, leads to complex patterns of sexual networking. The subordinate position of women in our society, who lack the power to protect themselves in sexual relationships, exacerbates the spread of the disease.

The expectation that modern technology would provide a vaccine and a cure for this disease has not been met. It is now clear that this virus is changing more rapidly than most other disease-causing micro-organisms and is able to easily resist the drugs and vaccines that have been tried so far. Most scientists now agree that a vaccine and a cure is unlikely until the next century.

The fundamental lesson learnt from prevention programmes is that sexual behaviour change is very difficult to maintain. Initial successes achieved by gay communities, especially in America, to adopt safer sex practices and more stable relationships are now being reversed. New infections are spreading in these communities. Many reasons are put forward for this: new individuals, who are unfamiliar with the tragedy of AIDS and are not convinced about the need to protect themselves, have entered these communities; fewer resources are put into these communities; and those individuals who have witnessed so much death and suffering have lost the will to continue protecting themselves.

The relationship between other sexually transmitted disease and HIV infection has

become ever more clear as the epidemic has progressed. All sexually transmitted diseases, not only those causing open sores, lead to higher rates of transfer of the virus from one individual to another. HIV prevention campaigns cannot achieve any measure of success until other sexually transmitted diseases are brought under control.

Finally, there is a clear need to integrate HIV prevention and care programmes into already existing services and community initiatives. No single country in the world has been able to continue financing a pure HIV/AIDS programme. It is crucial that we achieve a degree of commitment from all sectors, both private and public, to address the prevention and care needs arising from this epidemic.

AIDS and Poverty

In this edition, Critical Health attempts to explore these lessons, with the view to enhancing our capacity to fight the disease. The first section starts with an article by Clive Evian, in which he argues that HIV/AIDS spreads particularly rapidly in poor and unstable communities. AIDS, in turn, further impoverishes these communities. The AIDS Consortium highlights the failure of the South African government to provide the necessary resources for prevention and care.

The next three articles critically assess some of the attempts that have been made to respond to the epidemic. Given the lack of government intervention, non-government organisations (NGOs) have a crucial role to play in providing much needed services. The National AIDS Programme evaluates its own achievements in this regard. Brouard, Goldstein and Tallis argue that certain counselling courses provide valuable participative training. However, there is a need for better selection of trainees and longer courses to prepare them for the problems faced in real counselling situations.

The Workplace Information Group (WIG) assesses the advances made by trade unions in developing their own AIDS programmes. The authors argue that the unions need to establish and strengthen their health and safety departments to overcome certain limitations in the programmes.

Options for Prevention and Care

In the second section, various options in responding to the epidemic are debated. Ron Ballard argues for the need to improve measures to control the spread of sexually transmitted diseases. The upgraded structures can be used for active partner notification of people found to be HIV positive when this becomes socially acceptable. In a response, Evian and Schneider emphasise the social implications of HIV infection. They suggest that HIV positive people, especially women, who notify their partners face unforeseeable consequences.

South Africa has been slow to prevent HIV spreading and we now face the challenge of caring for the growing number of people with AIDS. Our photo essay depicts two HIV positive men at a hospice, comforting and caring for each other. It

shows that institutional care can be humane. It also shows HIV positive people living, not with death, but with change in their relation to others. Mary Crewe points to the merits of home based care. It can cater for the needs of HIV positive people, by encouraging family and community support. It is cost effective and allows families to improve their understanding of AIDS.

AIDS and the Sexes

Worldwide, HIV is spreading fastest among women. A group of South African women met for a number of weeks of therapy and Robyn Berman documents how they gradually came to share their feelings and experiences and, in the process, became friends.

There are three articles on safer sex. Anne McKay suggests that unsafe sex practices are related to the fact that women tend to be more responsible in their approach to sex, but that men tend to be more assertive. She argues that partners need to get to know each other and become assertive about responsible sex. Beverly Oskowitz stresses that sexuality education must be based on the understanding that sexuality is about our whole being, about feelings, identity and beliefs. In order to discourage risky sex practices, educators must encourage the best in people's expression of their beliefs. Critical Health attended the launch of the Congress of South African Students' (COSAS) National AIDS Campaign, at which speakers emphasised the need for AIDS and sexuality education. COSAS is establishing links with other organisations in order to meet this need.

Critical Health provides a resource list of organisations in South Africa which are responding to the epidemic. We also include a short reading list of books on HIV/AIDS and people living with AIDS.

Health Care for Workers, Radical Welfare

In the first article in the general section, Yogan Pillay looks at trade union responses to the crisis in state health services. Some unions are looking to health maintenance organisations to provide health care for their members. The author argues that workers should rather fight for state provided services for all.

Last year, we published an edition on developments in the welfare sector. Ann Ntebe encourages further debate by calling for a radical transformation of the welfare system. She locates welfare problems within a broader socio-economic context and argues for the need to address basic human needs. Her argument finds resonance in the call for comprehensive primary health care, a topic we intend to cover in future editions.

Section A

AIDS AND POVERTY: GOVERNMENT AND ORGANISATIONAL RESPONSES

HIV/AIDS spreads fastest among those most affected by decades of social dislocation under apartheid. Is government funding sufficient to slow the pace of the epidemic? To what extent can the present efforts of NGOs and trade unions counter the negligence of government?

Poverty
The Social Basis of AIDS in South Africa

Clive Evian

Aids has become the predominant health problem of the nineties. It is likely to influence health and social agendas into the early part of the next century. As the epidemic spreads and its epidemiology becomes clearer, one of its most striking features is its relationship to poverty. It is people most afflicted by poverty, who are most affected by HIV and AIDS. It is, therefore, not surprising that the fastest growth in the AIDS epidemic is in Africa, South America and parts of Asia.

It is necessary to understand the link between poverty and AIDS, as the nature of the disease and its transmission are inclined to promote discrimination and rejection, usually based on moral prejudices. A better understanding of this link will help minimise prejudice and promote acceptance, compassion and support for people affected by HIV/AIDS. Understanding will also open the way to more appropriate prevention strategies.

What are some of the more important links between poverty and a high level of multi-partner sexual activity - a level sufficiently high to fuel an epidemic from an organism of relatively low infectivity?

Migrancy, Money and AIDS

In modern times cash and income have become essential as a means for survival, even for communities which previously depended on a subsistence based economy. There are few communities able to survive outside of a cash economy.

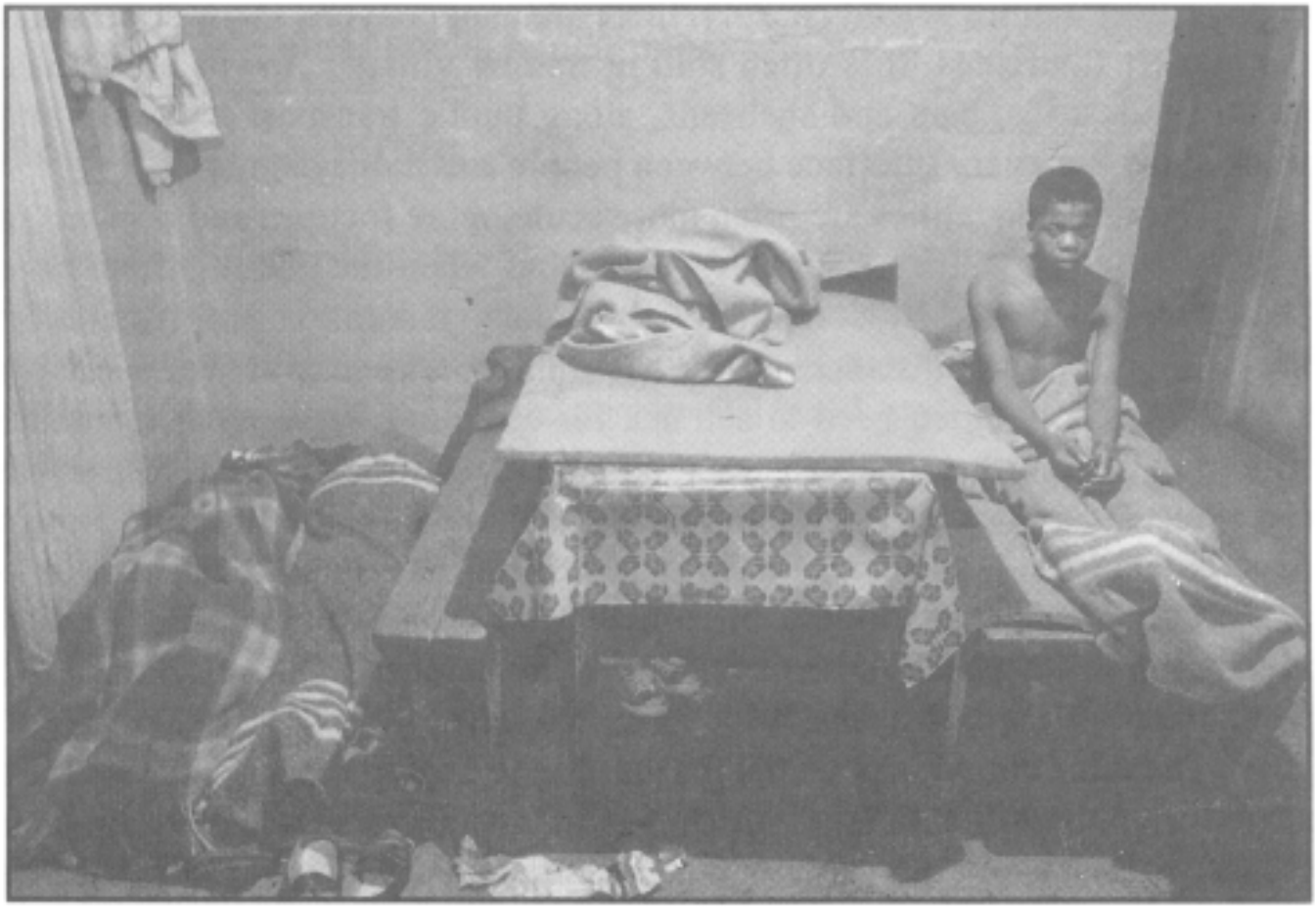
Men and women living in poor circumstances, often need to leave home to seek work elsewhere. Such work is often only available in distant towns and cities, so in poor communities migration has become common practice. However, one does not only leave a physical home. One leaves a family, loved ones, familiarities, friends, comforts, traditions, cultures - essentially all the aspects of life that make people feel needed, wanted, alive, human and part of a community. These are the social and emotional forces that cement communities. The community also develops values and norms which keep sexual activity in check. Values and norms which help individuals and their commu-

nities maintain a basic sexual 'integrity', a sexual 'culture' which serves many purposes, such as preventing epidemics of sexually transmitted disease. When people leave home, their base of sexual and emotional stability starts to break down.

Away from Home

Finding suitable and fulfilling work is often difficult. Accommodation is lacking and often of poor quality. There are many others seeking work and shelter. One faces strong competition for scarce opportunities and resources. The environment is hostile, alienating and depressing.

The migrant comes from a place as a 'somebody', well located within structures and practices and becomes a 'nobody' in a 'nowhere place', anonymous, alien, foreign and devoid of the essential traditional, cultural mores and constraints. In South Africa, single sex hostels often provide this form of accommodation. Although the hostel may meet urgent accommodation needs, they fall short of providing a satisfactory environment for normal human living.



This is not a humanising environment. ***Photo: Afrapix***

Sex is a basic human need. Sex provides satisfaction, pleasure, intimacy and even security. Adults often want sex and need sex and will always seek sex. Sex (together with alcohol) can also provide a rapid, short lived escape from an otherwise mundane and hostile environment.

And so we find when men and women leave their familiar surroundings, a common casualty of this process is a loosening of personal and community sexual constraints and the development of indiscriminate multi-partner sexual practices. The displacement of people and the cycle of poverty creates a 'cultureless' and a more loose and amorphous society. Poverty and urbanisation have erased values which previously regulated sexual behaviour. In these circumstances, sexually transmitted diseases have become rampant.

Sex for Sale

For many women living in poverty, sex becomes a commodity which they can sell. It becomes a convenient means of obtaining desperately required money, a means of satisfying hunger, even starvation, feeding, clothing and educating children and getting hold of some scarce cash for other essentials. Sex is exchanged for jobs, food, transport, school fees, tuition and other favours. Sex in poverty situations is sold cheaply, there are many buyers, many sellers and the market flourishes. It is often sold in trading villages, towns and cities, around industries, bars and shebeens, along public transport networks and truck stops - at every interface between people and money.

Gender inequalities are often more acute, more focused and obvious in patriarchal communities. This is especially so when the communities have been further stressed by community and family disruption and instability. Women in these circumstances are even less able to take control over their own sexual lives. If women need to sell sex for economic reasons, their gender subordination further exacerbates their already powerless and vulnerable situation. Even in stable communities women have little meaningful control over their sex lives, and much less in disrupted communities which are open to exploitation and abuse. In these circumstances sexual exploitation of women is common and especially so in poverty stricken societies. Scarce resources and wealth are available to a small elite in the society.

There is enormous potential for the elite to exploit the poor masses, and sexual exploitation flourishes in these circumstances. Therefore, in poor communities it is not only the poor who succumb to AIDS, but the rich and elite as well.

When people leave home they leave behind loved ones and other social familiarities. ***Photo: Afrapix***

Access to Services

In poor conditions people have less access to health care. In the context of HIV transmission, less access to the detection and treatment of sexually transmitted disease and availability of condoms. STDs are known to be a major co-factor aiding the transmission of HIV and poor genital health promotes the transmission of HIV and other STDs.

Even when the people in low socio-economic circumstances do get health care or access to mass media, their poor educational background and illiteracy make it difficult for them to gain a clear understanding and appreciation of the seriousness of the silent nature of HIV infection, the many complexities about AIDS, its transmission and the relevance of this information to their own lives.

The situation becomes more involved, with few opportunities for leisure and entertainment sex, frequently combined with alcohol, used as a substitute, as a means to 'transcend' the mundane and the daily struggle and to gain, however fleeting, a sense of pleasure, comfort, intimacy and even belonging.

Social Crisis and AIDS

The high levels of urban violence, crime, unrest and uncertainty, promotes fatalism and despondency within communities which is extremely detrimental to any AIDS prevention effort. Expecting an individual to take initiatives to prevent an infection today which will remain silent and only cause ill health in seven to ten years time is possibly expecting too much. The day to day struggle together with the prevalence of violence and crime mitigates against initiative to prevent HIV/AIDS.

AIDS Causes Poverty

AIDS in turn also promotes poverty. Job and income loss, rejection, discrimination and stigmatisation, and finally ill health and death all contribute to individual and family misfortune, and to the overall cycle of poverty.

The many links between poverty and AIDS, combined with biological features of the epidemic such as the lengthy, latent and yet infectious nature of HIV infection, the paralysis of the body's immune system, vertical perinatal transmission and the association of HIV infection with other STDs, highlights the complex and forbidding nature of the epidemic.

It is of little surprise, therefore, that preventive efforts are not making a significant impact on the pandemic. Inevitably, we face an epidemic with devastating and tragic consequences.

South Africa has been one of the last countries in Africa to be affected by HIV/AIDS, but the legacy of apartheid's devastating impact on the culture and tradition of black family life, the cycle of poverty and migrant labour ensure that South Africa will be no exception and will face an enormous AIDS epidemic.

Clive Evian is the head of the Community AIDS, Information and Support Centre (CAISC), Johannesburg

The Government and AIDS
A Negligent Response

The AIDS Consortium

The South African government has failed to respond adequately to the HIV/AIDS epidemic. "South Africa had a unique advantage since 1985," according to Professor Alan Fleming, "when the nature of the pandemic in east and central Africa was revealed, and when the occurrence of HIV/AIDS among black South Africans was still extremely low. From 1985 onwards, AIDS control programmes, health delivery programmes and community support programmes could have been planned and implemented so as to contain the impact of the epidemic." It is difficult, says Fleming, to name one single positive achievement of government or parastatal organisations, apart from surveillance and the safety of blood transfusions. In 1993, this negligence on the part of the government continues. The government recently allocated a shockingly inadequate budget for AIDS prevention and care. This budget is critically evaluated below.

In May 1993, the AIDS Consortium sent a memorandum to the minister of health, Dr Rina Venter, protesting the lack of resources devoted to fighting AIDS in South Africa. The minister has acknowledged the memorandum but has not as yet responded.

The memorandum was a response to the announcement of the 1993/4 AIDS Control Programme (ACP) budget. This budget increased by less than 1% over the previous year's allocation, which represents, in real terms, a decrease in the government's AIDS programme expenditure. This is unacceptable, especially at this stage in the spread of the epidemic, when a real increase in resources devoted to preventing AIDS is needed.

South Africa's AIDS Budget: One of the the Lowest In Africa

The ACP budget is R21 million. If this budget is divided by the number of people living in the country, and compared with per capita expenditure in other African countries, one finds that, per person, South Africa's AIDS budget is not only one of the lowest in Africa, but also grossly disproportionate to the

country's wealth. Figure 1 shows South Africa's per capita ACP budget relative to other African countries, and Figure 2 gives an indication of South Africa's wealth relative to other African countries.

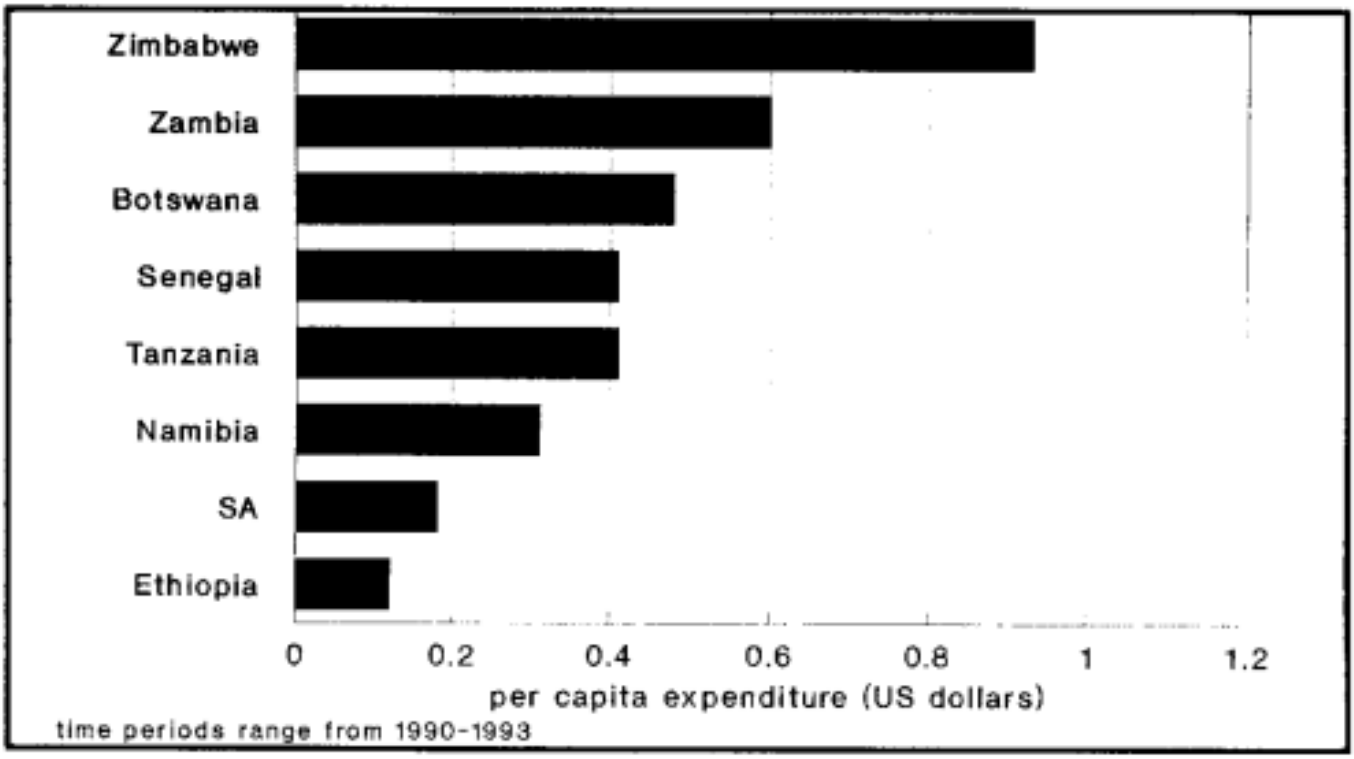


Figure 1: Annual per capita expenditure for AIDS control of various African Countries

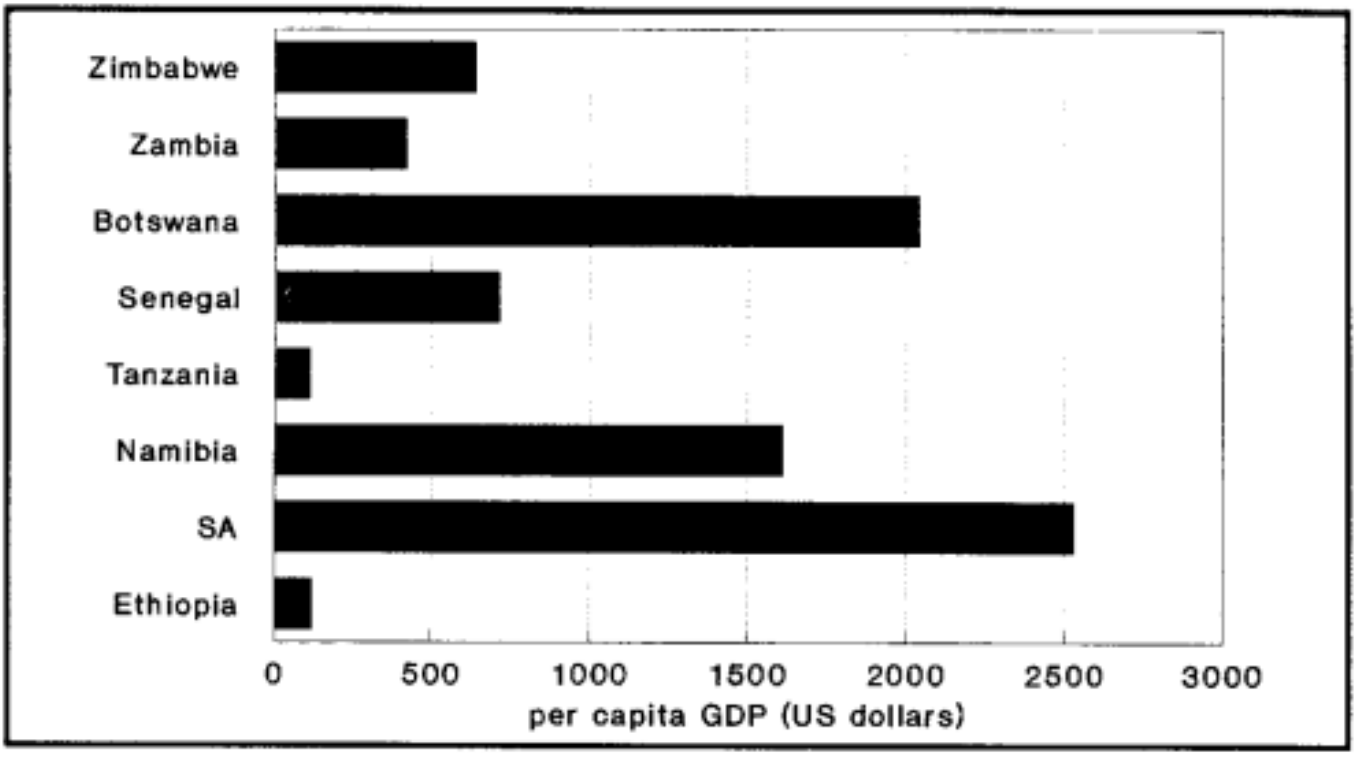


Figure 2: Per capita gross domestic product (GDP) of various African countries

A recent proposal to the World Health Organisation on the cost of AIDS prevention in developing countries, suggested that South Africa should have been spending about R150 million on AIDS prevention in 1993. This is seven times the current aids programme budget, but still represents only one percent of the total health budget.

Additional resources are urgently required for AIDS prevention, including resources in the areas of education, the provision of condoms, STD management and the availability of voluntary testing.

Education

The allocation to HIV/AIDS education is R7 million. Sixty percent of this amount is devoted to a mass media campaign. The remaining R2,7 million is totally inadequate to implement targeted education programmes, even when combined with the R5 million allocated to the AIDS Training, Information and Counselling Centres (ATICs). The AIDS Consortium agrees with the government that the youth are a key target group for sexuality education. However, a series of readers in the curriculum of black primary schools does not constitute an adequate youth programme. Other important target groups for AIDS education are sex workers, migrant workers, and people with sexually transmitted diseases (STDs) other than AIDS. There is inadequate coverage of these target groups.

Condom Provision

Three million rands has been allocated to the provision of condoms through the AIDS Programme. Condoms are also available through certain other health services. Evidence suggests that, for various reasons, the health services are performing this function poorly. While this distribution channel needs to be thoroughly investigated and upgraded, alternative channels are also needed. Non-profit condom social marketing programmes in other African countries, and recently in Natal, have shown that condoms can be made accessible and affordable to the majority of people. The existing budget is clearly insufficient to address this and other needs related to condom provision.

STD Management

The presence of STDs other than AIDS has been shown to enhance the transmission of HIV. This has prompted the integration of STD and AIDS

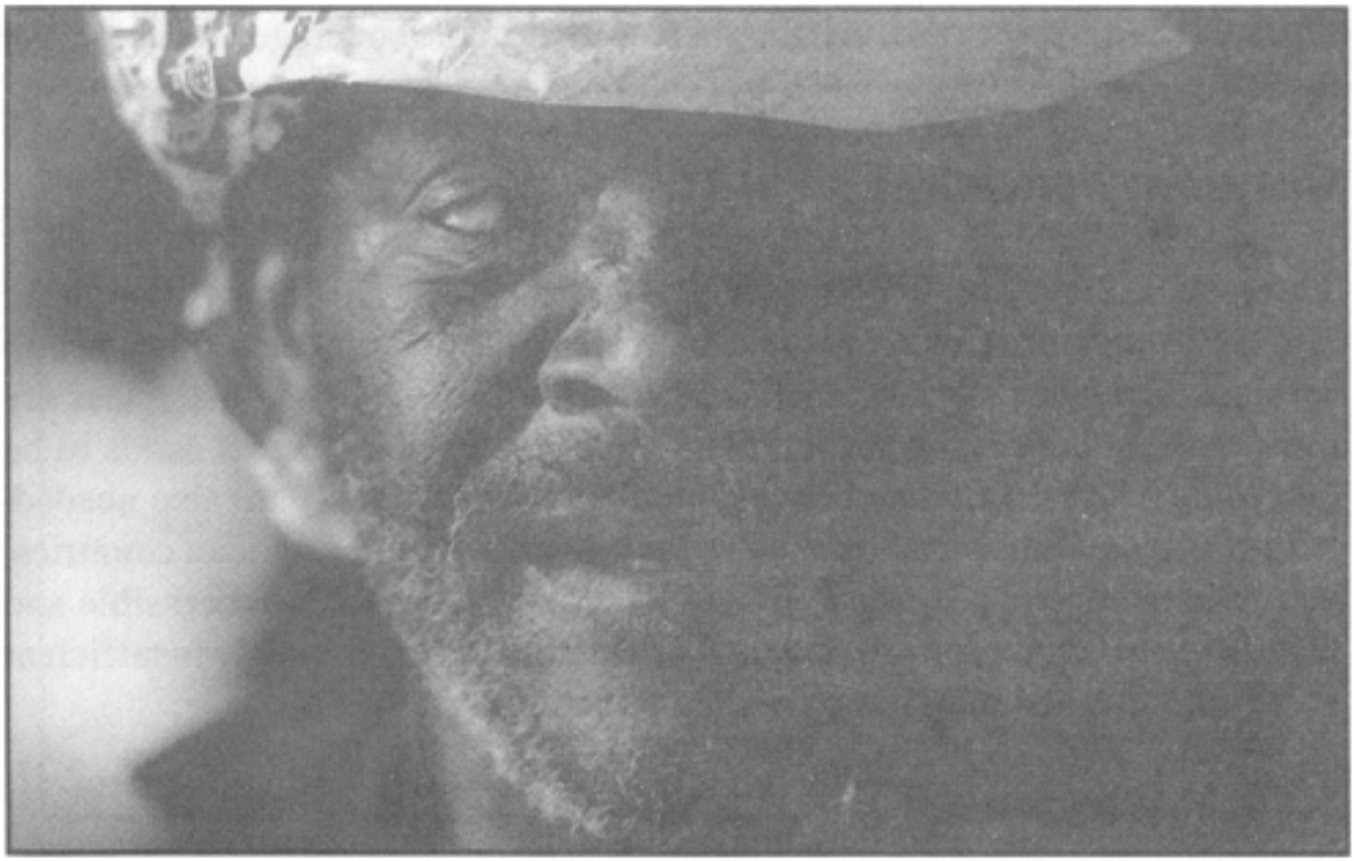
control in many countries. The Department of National Health presently subsidises the treatment of STDs other than AIDS through its Infectious Diseases Directorate. However, only local authorities are eligible for this subsidy. The AIDS Consortium believes this subsidy should be extended to all health services, public and private, so that STD care can be accessible and free to all.

Voluntary HIV Testing and Counselling

The experience of other countries suggests that a voluntary testing and counselling strategy is an important element of prevention. HIV testing and counselling are available only to a limited extent through the ATICs and the health services, and need to be made more widely accessible.

The Need to Prepare for Care Work

Apart from prevention, resources are also required to prepare health and welfare services to deal with the care of families and people living with AIDS. Public sector treatment and care of people with HIV/AIDS is provided by homeland and provincial health services. The government's AIDS Programme



If this man gets AIDS he will get the equivalent of R100 a year for treatment. ***Photo: Ismail Vawda***

has indicated that the four provincial administrations have set aside R15 million for the care of people with HIV/AIDS. No breakdown of this figure is available, but based on expenditure in 1992, we expect at least a third of this will be required to fund HIV tests. This will leave R10 million for all other aspects of HIV/AIDS care.

Using conservative estimates of 2000 AIDS cases and 300 000 HIV positive persons at the end of 1992. There is just under R100 per person with HIV/AIDS for 1993/4. The total direct costs of treating a person in the public sector for HIV/AIDS over an average period of six years is R15 000 to R20 000. The annual cost, per person, is R2 500 to R3 300. This is more than twenty times the present allocation by the provincial administrations.

This extremely low figure suggests either that the treatment of people with AIDS is totally inadequate or that there has been little or no consideration given by the provincial administrations as to the real costs of the AIDS epidemic. Despite predictions that AIDS will consume between 18% and 40% of total health expenditure by the year 2000, there appears to be no forward planning or budgeting for AIDS within the curative services.

This concern is underlined by the personal experience of AIDS workers within the public sector, where few additional resources have been made available for AIDS work. Counselling services are provided by staff employed in other positions, specialist clinics have been funded by private companies, and few, or no additional staff have been employed to deal with a rapidly increasing workload. By the end of this century we expect a large proportion of hospital beds to be occupied by people sick with AIDS, yet we see no attempts by provincial authorities to develop decentralised primary and home based care facilities for people with HIV/AIDS.

The Urgency of an Effective Response

One of the main effects of the AIDS epidemic is going to be a massive increase in numbers of people with tuberculosis (TB). The South African TB Control Programme is barely able to deal with the existing load. Unless drastic action to upgrade this programme is undertaken, it may well become completely overwhelmed by the increased load. Similarly, there have been no drug policies for care of people with HIV/AIDS except to exclude Zidovudine (AZT) and other anti-viral drugs. Although the latter are expensive, they may prove to be cost effective in limiting the need for hospitalisation. Failure to consider this and other issues related to the care of people with HIV/AIDS is to turn a blind eye to the eventual impact of the epidemic on the health services.

The age group most affected by AIDS are economically active adults. The effect of this is firstly, to deprive communities of their most energetic and productive age group, and secondly, the creation of a large population of orphans. The lack of evidence of government preparation for the enormous welfare needs which will be generated by the AIDS epidemic is symptomatic of its failure to prepare for the impact of HIV/AIDS on society generally. There is an urgent need for a co-ordinated response to the AIDS epidemic, encompassing all aspects of prevention, care and welfare, at the highest level of government. This is not evident in the current budget size or structure.

NACOSA

In 1992, the African National Congress (ANC) and the Department of Health (DNH) initiated the formation of the National AIDS Convention of South Africa (NACOSA). A wide range of organisations are represented including governmental, political, civic, church, business, labour, and non-governmental AIDS groups. NACOSA's purpose is to work towards a united national programme and strategy to fight HIV/AIDS in South Africa.

After its launch in October 1992, several sub-committees were established to draft proposals in the areas of education and training, counselling, preventive strategies, care, welfare, research, human rights and social, political and economic issues. This was to occur in parallel with the launching of regional NACOSA structures across the country.

For several months this year, all NACOSA activity was halted because of the lack of funds. However, funding from the DNH and the European Community was recently secured and the original momentum appears to have been regained. At the time of writing there has been progress in the subcommittees and a draft HIV/AIDS strategy is apparently nearing completion. Regional structures are in the process of being launched.

At present the role of NACOSA does not extend beyond the formulation of HIV/AIDS strategies and the co-ordination of HIV/AIDS efforts. The task of ensuring that these strategies become reality still lies squarely with government. And unless an adequate infrastructure is created to develop detailed plans and to implement them, the work of NACOSA may ultimately make little difference to the spread and experience of HIV/AIDS in South Africa.

The AIDS Consortium is a network of AIDS organisations campaigning for human rights and is based at the Centre for Applied Legal Studies, Wits University

The Role of NGOS
An Evaluation

Mbulelo Bungani & Clayton Manjome

Government alone, without the involvement of other role players, have not been able to cope with the HIV/AIDS pandemic. In most countries pressure had to be used to push for appropriate HIV/AIDS policies and strategies to be adopted. NGOs of different sorts have been formed and mobilised to tackle the issues. Apart from playing a watchdog role on the state, NGOs also have other important functions. They supplement state services through the provision of services and information. NGOs in some instances are better placed to reach out to communities which may not be easily accessible to state structures. They are not constrained by the bureaucratic obstacles inherent in state structures, and can make implementation of programmes move faster. Providing information on HIV/AIDS also requires openness with regard to sexuality and sex education. The government may find this difficult to achieve. More so because it must meet the conflicting interests and needs of society. NGOs may tackle this issue better.

In the South African context the illegitimacy of the state, adds another dimension to the issue. This has led to the formation of organisations fulfilling what should otherwise have been the function and responsibility of the state. The problem with this approach is that it can lead the state to absolve itself of responsibility. Thus, it is a source of great concern when state officials suggest handing over the government AIDS programme to NACOSA. NACOSA should influence the state programme, but the state should not be allowed to abdicate its responsibility.

Unlike the government, NGOs can reach communities effectively, while not substituting for the role of the state in providing an infrastructure and funding for prevention and care of HIV/AIDS patients. This article looks at a national effort by an NGO in HIV/AIDS work, evaluating its successes and failings, which may be of value to NGOs in general.

The Progressive Primary Health Care National AIDS Programme (NAP)

The NAP was formed on the basis of a mandate given to the PPHC at the Maputo conference of progressive health organisations in 1990. The mission

of the NAP is to empower communities to be active in preventing the spread of HIV. The NAP attempts to achieve this by promoting awareness; initiating and facilitating effective and credible community based educational training and media programmes; consulting community structures, progressive and educational organisations; and promoting appropriate support and care of people affected by HIV.

Our objectives are to raise awareness of AIDS and initiate and develop prevention programmes, to reduce the spread of HIV infection through education combined with other means of intervention; to develop a community-based AIDS intervention programme in the community through the training and support of credible community AIDS workers (CAWS); to improve the AIDS component in all primary health care delivery services (especially PPHC affiliated projects); to encourage and pressure government health services to provide good quality health services and curative care for people with AIDS, as well as to supply condoms as required to effect this intervention programme; and to develop community support structures for people with AIDS and promote community acceptance of these people.

Our strategy is to develop programmes and interventions in consultation with the community and work through existing community, political and other organisations; deal with the political nature of AIDS; build on existing organisational resources; network resources and skills; and develop on the inter-sectoral intervention approach to HIV/AIDS.

Community Consultation and Involvement

The key principle in the NAP strategy is community consultation and participation. This is realised through the CAWS and the formation of committees at local, regional and national levels. These community workers, who form the core of the NAP, are drawn from communities where they work. They are able to relate their work and the broader issues and struggles faced by their communities. It is their role to mobilise, educate and train members of their communities. The main function of committees is in planning and policy formulation. Composed of representatives of community organisations and concerned individuals they bring a sense of ownership of the programme to the community. Within these large communities, specific target groups are identified. Projects are then designed to address their needs with the full participation of the target group. An example of this is the project with Congress of South African students.

Before conducting any interventions, a community worker does extensive survey in the community, interviewing leaders and members of the

The future is in their hands. Scholars at the COSAS National AIDS launch. ***Picture: Ismail Vawda***

community, identifying needs with regard to knowledge and information, and possible strategies. This helps in ensuring that the project addresses needs. This is not an easy process given the low incidence of the HIV/AIDS problem in most areas.

Central to community participation is the empowerment of the communities through the provision of knowledge and skills. Members of the identified target group are trained to enable them to develop strategies and to conduct campaigns and programmes in their constituencies.

Another key element of this strategy, is the decentralised nature of NAP projects and activities. All projects are developed on the basis of the needs and issues identified at local or target group level. Only the areas of finances and human resources management are centralised. The national office only plays a co-ordinating function. It does not control the projects and activities.

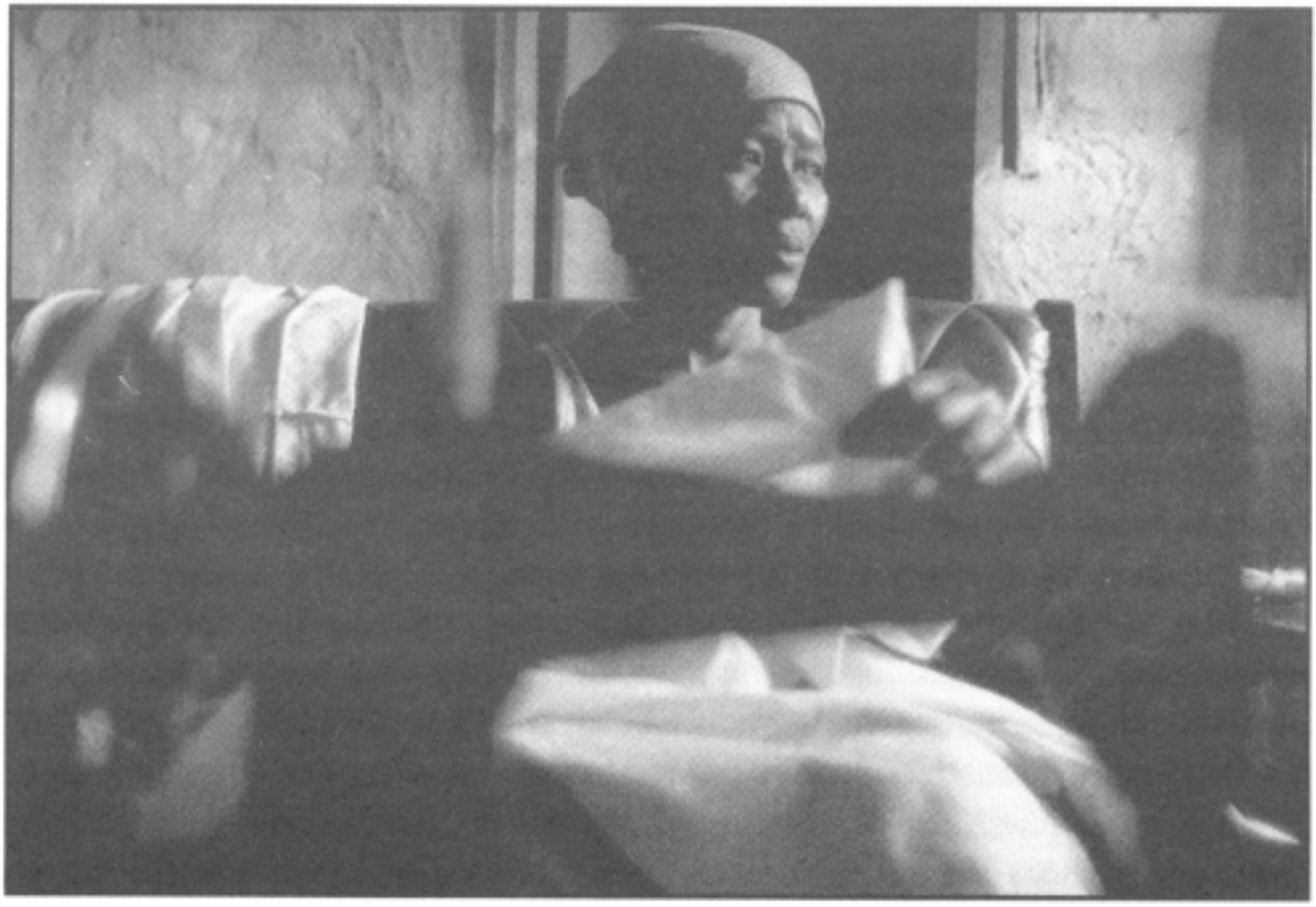
The approach defined above calls for strong ties with the community structures, where the NAP does not only provide HIV/AIDS services but becomes part of the community, engaging itself in the struggles and campaigns of the community. Through this approach the struggle against HIV/AIDS becomes an integral part of broader struggles.

Strengths and Shortcomings of the NAP

A strength of the NAP is its application of the principle of community participation. However, there has been a lack of national effort to work with PHC programmes, despite the aim of the NAP to improve AIDS services in PHC projects. One of the causes of this was the lack of clarity on the relationship between NAP and PPHC. Clarity was achieved earlier this year. The NAP is therefore poised to become a model of an integrated AIDS/PHC approach which links AIDS services to PHC projects through a nationally co-ordinated approach.

Policies and strategies of the NAP will be integrated with the PPHC through the newly established PPHC National Council which has substantial NAP representation. Also, at all levels of NAP/PPHC staff structure, meetings are held to ensure co-ordination between the two programmes.

At a local level, there has been close links between NAP community workers and primary health care workers from other NGOs, state structures, and local clinics. Examples of these are to be found in the western Cape



People's experiences should be documented. ***Photo: Afrapix***

(Khayelitsha); southern Transvaal (Soweto clinics) and various areas in the north eastern Transvaal. Another project planned is at New Hanover in Natal Midlands. This envisaged project aims to meet the health and welfare needs of this community through a PHC and development programme. Within this project, the NAP aims to help co-ordinate AIDS programme development, including placing a salaried PHC co-ordinator in charge of the AIDS projects.

The NAP has, in two years of its existence, achieved a national infrastructure composed of community structures, staff, offices, and other resources put together to fight the spread of HIV/AIDS. At the core of this force are CAWs, presently totalling 53, working within grassroots structures. These CAWs have conducted numerous educational activities in their respective communities to raise awareness and change attitudes. A workshop held earlier this year, attended by a delegate from each region shared experiences, identified common approaches in dealing with the community and also produced national guidelines to CAW training so that standard training could be implemented.

The formation of committees in eleven regions, bringing together individuals and organisations from different sectors is also an achievement. A national workshop on care held in June identified the alarming situation in the country with regard to the care and support of people with HIV/AIDS. This workshop produced strategies and policies to deal with the issue of care.

A media programme with the objectives of producing and testing media that will be used to support and reinforce the work of the CAWs is being implemented. The programme also aims to ensure that CAWs are trained to produce various media to meet their local needs by being culturally sensitive.

Response to Evaluation

The NAP undertook a major evaluation exercise at the end of 1992. External and internal evaluation teams carried out the evaluation. This process promoted reflection in the organisation. The NAP did not, however, accept some of the issues raised in the evaluation process. It also felt that the evaluation report over-emphasised our weaknesses, and said little of our strengths. In some instances the evaluation process tended to be counter productive, as it discouraged staff who had put a lot into the activities of the programme.

However, most of the recommendations of the evaluation have been accepted and implemented. As a result a major process of restructuring the organisation is underway at all levels.

The evaluation process identified shortcomings in the programme's

inter-sectoral approach. Among those highlighted was the need to place more emphasis on the needs of women. It also recommended that a welfare perspective be developed within the organisation. Its sole purpose would be to provide support for people with AIDS. This has since been addressed. A care training centre has been established in Pietermaritzburg.

A national care workshop was run there in June 1993. The evaluators also noted, with great concern, the absence of a sufficient documenting system for the programme's experiences. The evaluation encouraged the establishment of a close working relationship with other AIDS organisations in southern Africa. The rationale was to share similar experiences "so that the wheel is not completely re-invented" in South Africa.

The evaluation also showed administrative inadequacies at national office. It was noted that the national office ought to give more support to weaker regions.

The current situation in regions is that committees (volunteers) are responsible for developing the basic infrastructure before staff can be employed. In most regions, a regional committee had been in place long before staff were employed.

Contradictions are inherent in this system. In some regions, staff felt that the system unnecessarily slowed progress in implementing the activities of the programme. It is clear that in regions where staff is more active and allowed to be more creative in their work, they are more effective in doing AIDS work.

To counteract this situation, the evaluators recommended the professionalisation of the programme. When the new structures are in place after the employment of a national director, staff would be more accountable to the director than to committees.

The evaluators also identified a number of teething organisational problems in the human resources and personnel areas. The main concern among staff was the low salary scales and unstable work environment. Although the organisation has since taken steps to redress this adverse situation as portrayed by those interviewed by evaluators, the rest should be done by the director.

Mbulelo Bungani is the national coordinator of the PPHC National AIDS Programme and Clayton Manjome is the national media coordinator

AIDS Counselling Courses
What is their Value?

Pierre Brouard, Sue Goldstein, & Vicci Tallis

AIDS counselling courses are run in many centres around the country and they vary in length and content. Although the courses are different there are many issues which are common to all of them. This paper will highlight some of these commonalities, drawing on the independent evaluation of the Community AIDS Information and Support Centre (CAISC) course as an example. The CAISC is run by the Johannesburg City Council. The paper is intended to stimulate discussion around counselling and the training of counsellors and we would encourage everyone to think critically around these issues.

Selection of Counsellors

Many of the courses do not select people for training but accept all interested people. The people who are trained are usually healthworkers, personnel officers, community workers and a variety of other people. In the CAISC experience, two thirds of the people trained either worked for a local authority or a large company like South African Airways (SAA).

When people are selected for the courses, we do not set unrealistic standards. Most of the present courses attempt to meet the need for as many people as possible to understand the basics of counselling. Many healthworkers are seeing people with HIV and AIDS in their work and report that they feel unsure about how to work with HIV positive people. Other trainees have had no exposure to AIDS and are hoping that the courses will give them an insight into the problems that they might experience. Still others are required to attend courses as part of their in-service training and may not be interested in counselling at all.

Furthermore, the courses are seen as a crash course in counselling and not as an introduction to counselling principles and HIV issues. As a result there are unrealistic expectations of both the course and the trainee. Some trainees are even expected to offer a course to their colleagues when they return to their organisations.

Most lay counsellors at other organisations, like Lifeline, are carefully selected for their suitability as counsellors, undergo months of training by

skilled facilitators and are required to be evaluated at the end of the training. When no selection has taken place, it is not always reasonable to evaluate trainees.

In the CAISC evaluation it was repeatedly stated that the mix of people on the course was stimulating and interesting. On the other hand, some participants felt that the diversity of people held them back and that there should be separate courses for health professionals. One interesting comment was that the doctors were "too cynical".

Bearing in mind the urgent need for AIDS counsellors, coupled with the need for effective counselling, training organisations need to pay more attention to the selection of suitable people for training - these people also need to be evaluated and supervised.

Course Content

At present, there is some variation in the length of courses, ranging from 3 days to 2 weeks. While the content is fairly similar there are regional and other differences in emphasis. For example, some courses will spend more time on counselling theory and skills, while others will emphasise aspects like pre- and post test counselling.

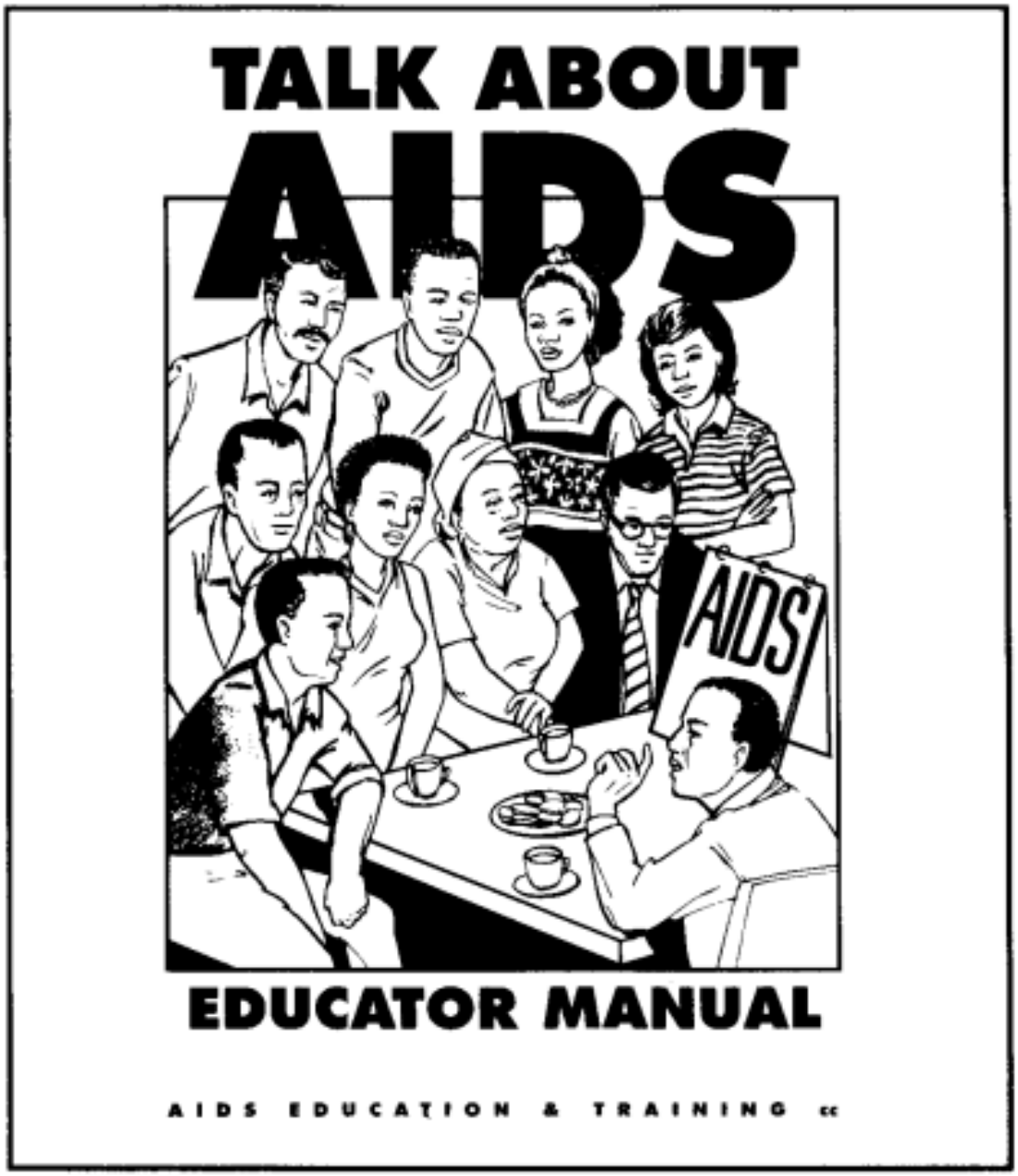
In general, the courses cover information about AIDS; counselling theory, skills and practice; pre- and post test counselling; attitudes and self awareness; death and dying; and sexuality (including safer sex). They tend also to use interactive teaching methods, which involve exercises and group work to draw out important themes. There is some debate about how to make counselling appropriate to South Africa and whether a non-directive approach to counselling is the most useful one. For example, many healthworkers are trained to tell their patients what to do rather than to spend time listening to their real needs. Courses aimed at them will need to challenge the traditional healthworker/patient relationship.

To what extent is counselling an existing part of people's lives and how can we make HIV counselling more accessible and less intimidating? Does it serve a purpose? Can it help to prevent new HIV infections? These are some questions which are being asked at the moment.

In the CAISC context, teaching methods were described as "marvellous" and "excellent" and "with the atmosphere that is created, you feel free with your instructors, and to air your views". While trainees often felt that they had personally grown through this course, more than 50% of problems experienced by CAISC trainees were related to lack of counselling skills. Some problems

experienced were"how to get through to reserved people","how to handle denial and resistance" and "moving beyond empathy and reflection". One interviewee also expressed the need for more discussion on"secrecy"and"morality"and saw the course as only"pushing condoms". It seems clear that issues like confidentiality and sex need a lot of healthy debate. In this way counsellors are able to enter the counselling situation having had a chance to"work through"their feelings about these issues properly.

It appears that what is needed is longer courses which are able to tackle issues in more depth. Perhaps courses which offer intermediate and advanced skills will also help to upgrade skills and bridge the gap between introductory courses and real life counselling situations. It is always important to remember our most important goal - are the needs of the client or patient being met?



Training involves interactive teaching methods. ***From Educator Manual of AIDS Education & Training cc***

Evaluation

Evaluation of counsellors, both after courses are completed and through ongoing supervision, is important. This evaluation maintains standards and supports the counsellors. One problem is that if many people are trained, follow up becomes very difficult. However, networking can allow appropriate referrals to take place and encourage counsellors to offer each other support. For example, while many counsellors find the work satisfying, a significant proportion of those interviewed by CAISC find it painful, emotionally draining or very sad.

It is also important to evaluate the trainers and the training courses themselves. This helps to ensure that training standards are met and that the courses are relevant. The ultimate goal must always be appropriate, to achieve meaningful counselling in institutions and in the community.

Organisational Issues

Organisational issues are often a barrier to the implementation of counselling. In CAISC's experience, half of the trainees contacted after completion of the course had not done any counselling since then. The most common reason given was a lack of opportunities to counsel. One trainee commented "the council sends us on courses, but we never get a chance to practice our skills, it then loses meaning."

Another organisational problem is the expectation that counselling can happen in a few minutes in crowded places. These are unrealistic demands to place on a counsellor and they reflect a disrespect for the counselling process and the needs of clients, such as confidentiality. Organisations sometimes do not recognise that counsellors need to have time for supervision, further training and support. If this is not built into work time, counsellors will become burdened by their work and will burn out.

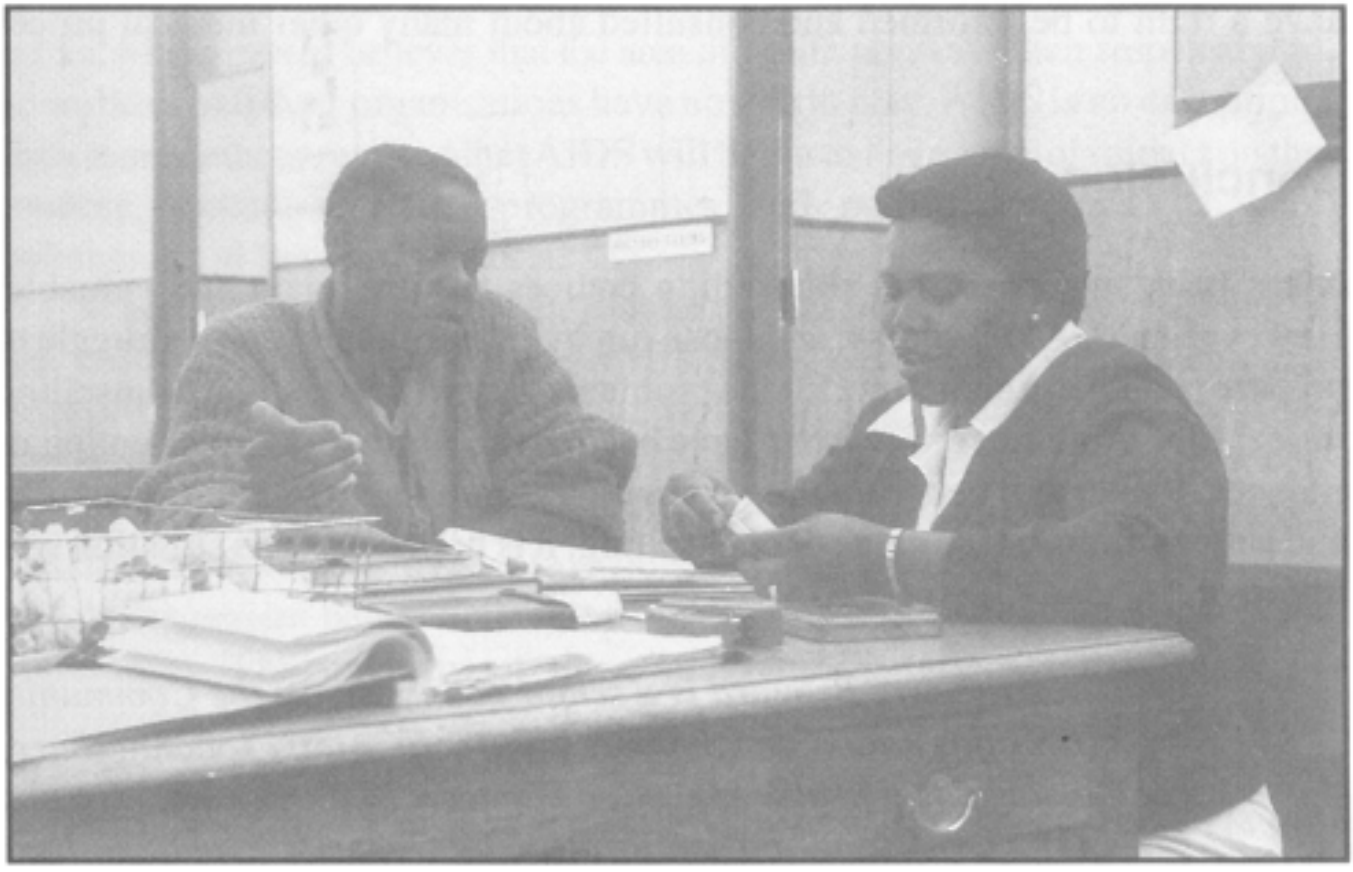
Clients

We also need to recognise that a counsellor may face a large number of different clients, with varying problems and situations. A lot of these situations confront counsellors' own attitudes towards sexuality, death and dying, and abortion. Some of these situations are unique to South Africa, and the question to be asked: can a short course fully prepare a counsellor for all these situations and challenge counsellor prejudice? In the CAISC evaluation, for example,

some comments were: "The course helped change my attitude from negative to positive"; "I got greater insight" and "This training should be given to all student nurses, everyone should have counselling skills and AIDS knowledge". While these comments show that the trainees were helped to see HIV and AIDS differently, their other comments quoted in this discussion show that they do not always feel equipped to deal with all the clients they see. Counsellor training, therefore, needs to challenge prejudice and must also locate HIV and AIDS issues in the real lives of all South Africans. This requires very skilful and sensitive training.

Controlling Bodies

Should all HIV/AIDS counsellors be required to join a professional body which would maintain standards and organise the counsellors? While there is no agreement at the moment on this issue, it is important that existing professional bodies (like the Medical and Dental Council) should maintain standards. A recent development has been the National AIDS Co-ordinating Committee of South Africa (NACOSA) initiative which is developing an AIDS strategy for South Africa. The counselling policy being developed by the NACOSA



Many healthworkers still need to be trained to counsel patients.
Photo: Ismail Vawda

delegates may also have suggestions about how HIV/AIDS counsellors maintains minimum standards.

What is the Value of Counselling Courses?

There are problems with counselling courses at present. But their value is in helping people with HIV or AIDS to be treated with compassion, sensitivity and dignity. Because the courses challenge prejudice, the person with HIV or AIDS is hopefully not also burdened with guilt and blame. Healthworkers are also more equipped to deal with the issues that their clients or patients feel, and are encouraged to be critical about the healthworker/patient relationship. Good counselling can help people to prevent HIV infection, it can assist people to negotiate safer sex and it can help those living with HIV or AIDS to live productive lives. It also reinforces the rights of people with HIV or AIDS and helps to develop a culture of human rights.

For example, many healthworkers question the need for pre- and post test counselling - they say no other tests require counselling. What counselling courses show is that people need to be prepared for a potentially terminal disease which has many social consequences. Also, they suggest that patients have a right to be informed and consulted about many other medical procedures.

Conclusion

It has been suggested that counselling courses are important and valuable. However, the CAISC course, and those run by other organisations, struggle to prepare people in a short time for the problems they will face when counselling in real life. A number of reasons have been given for this. With selection of trainees, longer and better training courses, a commitment to good standards, and a recognition of the value of counselling, it is hoped that this situation will improve.

Pierre Brouard is a senior counsellor at the Community AIDS Information and Support Centre ((CAISC, Johannesburg)
Sue Goldstein is a health education manager in the Health, Housing and Urbanisation Directorate, City Council of Johannesburg
Vicci Tallis is the regional manager of the Durban AIDS Training, Information and Counselling Centre (ATICC)

Workplace Programmes
The Trade Unions Intervene

Workplace Information Group

The issue of AIDS entered the agenda of trade unions approximately 5 years ago. The major problems workers encountered were testing without consent, dismissal of HIV positive workers and the unilateral implementation of AIDS programmes and policies at the workplace.

Those unions which were directly affected began to take up the issue of AIDS with the development of AIDS policies and awareness programmes within their structures. However, the limited resources available to the trade unions have limited the success of these programmes. This article will look at some of these activities, obstacles and how these could be addressed.

AIDS: A Union Issue

The issue of health and safety at the workplace has always been an area of conflict. Management believes that the area of health is always their responsibility and workers and their organisations have no role to play. AIDS is no exception. When management realised that AIDS will begin to have a major impact on the economy, unilateral AIDS programmes and policy development were implemented at the workplace.

When workers attended their routine medical monitoring programmes in some cases they were also tested for HIV. They were tested without consent and results were not kept confidential. In the mining industry, workers from neighbouring states who tested positive did not have their contracts renewed until the intervention of the National Union of Mineworkers. In some cases workers who tested positive were dismissed.

Management began to develop their own AIDS policies and education programmes. The majority of these programmes reflected the biases of management, were insensitive to the social and economic conditions, practises and beliefs of workers.

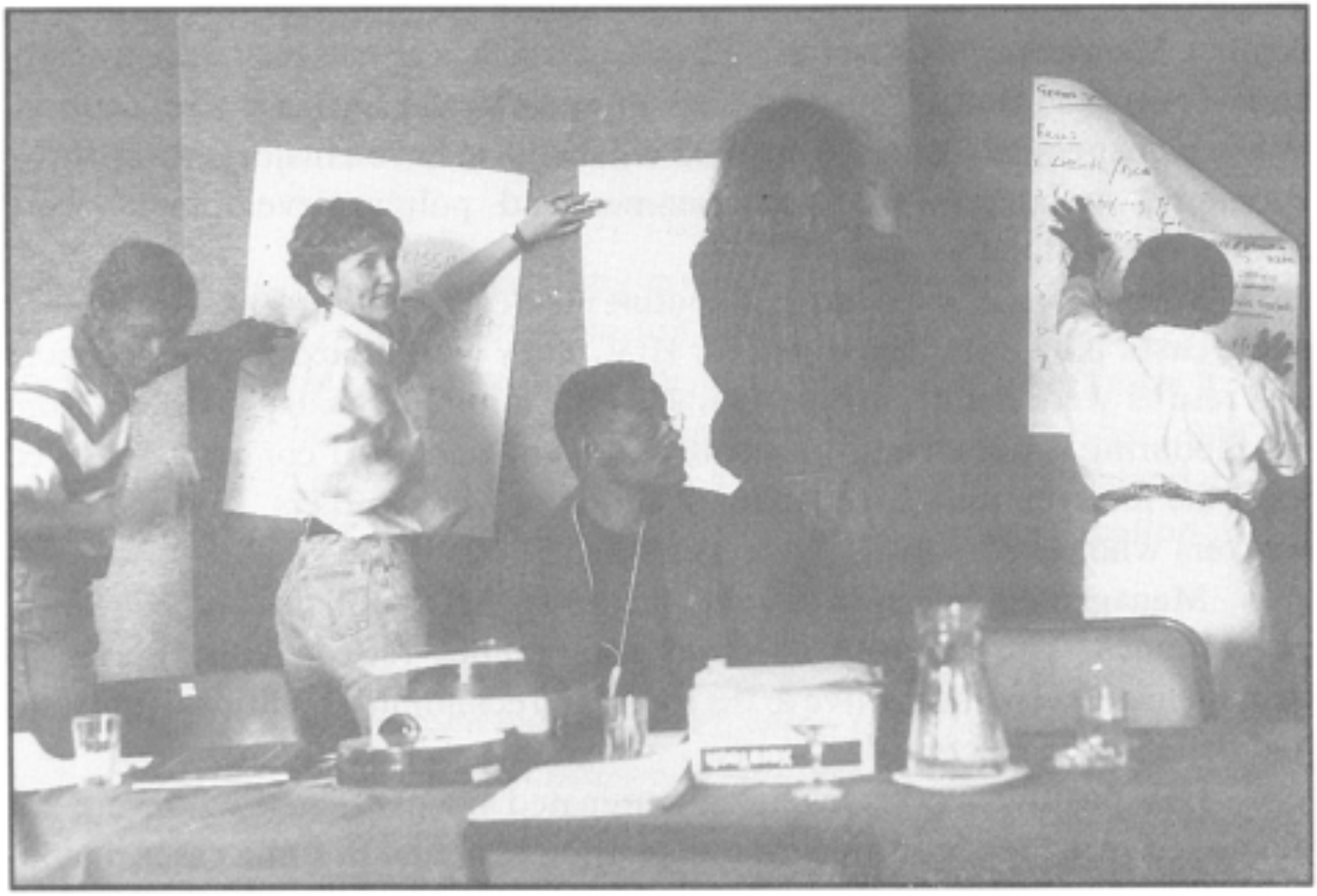
HIV positive workers were discriminated against. Those who were not dismissed faced reduced medical and pension benefits. In some cases, inadequate information led to victimisation of HIV positive workers by their fellow workers.

Unions Take Up the Challenge

The growing conflict on the shop floor forced unions to take up the challenge to address the concerns of their membership. At a federation level, both COSATU and NACTU developed policies. In addition, NUM, FAWU, MEWUSA, SACWU and TGWU began to engage employers on the issue of an agreement. For most unions, this proved the beginning of a long and arduous task.

The agreements covered areas which directly affected the membership of the unions. The areas included: testing, job-protection for HIV positive workers, care counselling, medical support, education and training, and confidentiality of medical results.

The various trade unions began to conduct education and training within their structures. Awareness raising pamphlets, posters and videos were produced for the membership. Some unions held national conferences bringing together hundreds of delegates from all parts of the country to discuss and debate policy guidelines. In some cases, the health and safety service organisations in various parts of the country assisted in union education.



SACCAWU workshop - unions engaging health/AIDS NGOs.
Photo: Ismail Vawda

In the early 1990s, unions began to develop AIDS education programmes. These programmes have looked at two major aspects, that is, basic AIDS information, policy and workplace issues. Thousands of workers have been through these training programmes. The service organisations alone trained over 3000 workers during the last 5 years. Over the last two years, trade unions have been developing AIDS trainers for their programmes.

During 1992, COSATU produced two videos: "AIDS a Union Issue" and "Women and AIDS". Both were screened on SABC-TV. The Workplace Information Group has been involved in two major AIDS projects over the last three years. The first project was a proactive survey which was conducted amongst trade union members from various unions throughout the Transvaal and the second was a joint project with the Transport and General Workers Union.

The proactive survey interviewed 77 workers to determine their knowledge, attitudes, and perceptions about AIDS. The survey identified that approximately 25% of the respondents had misconceptions about how the disease was transmitted and only 5% of the respondents had an AIDS policy at their workplace. Forty five percent of the respondents indicated that management was not doing anything about AIDS.

The survey amongst long distance truck drivers also indicated similar trends. The results from this survey were used to develop a trainers programme for the union. Approximately 20 trainers were trained in each of the union's 7 regions.

AIDS Programmes: A Difficult Path

The trade unions have placed the issue of AIDS firmly on their agenda. Awareness seminars and workshops are a regular feature of some unions' education programmes. Thousands of workers have attended trade union based education workshops.

Major successes include the negotiation of agreements between unions and management at various workplaces. These agreements protect workers against discrimination, and grant workers the right to training programmes acceptable to the unions. Recently, agreement was reached between the National Union of Mineworkers and the Chamber of Mines.

However, these successes have been mostly limited to the well organised unions within COSATU and NACTU. Even within these unions, the programmes have been hampered by the lack of adequate structures, limited financial and skilled human resources. The capacity for unions to develop and

implement AIDS education programmes will ultimately depend on the structures existing within the union, the resources available and the skilled personnel available to the union.

Structures and Resources

Most unions do not have developed health and safety departments. The implementation of the AIDS programme becomes the responsibility of the already burdened education and training departments. These structures have to deal with the various other issues high among the priorities of unions. The focus of most education programmes are on the economy, political negotiations, violence, wages and, lately, voter education.

The labour movement has a responsibility of ensuring that it contributes and exerts an influence in debates and discussions about future government and policies. Hence, COSATU and NACTU are currently engaged in discussions at different forums - for instance, the National Economic Forum, National Manpower Commission and National Housing Forum. COSATU has also initiated a voter education programme which is gaining momentum, in preparation for the coming elections. Rank and file membership is also contributing to these crucial matters, and attention is absorbed by such discussions. These are all urgent matters, where decisions must be taken within strict deadlines.

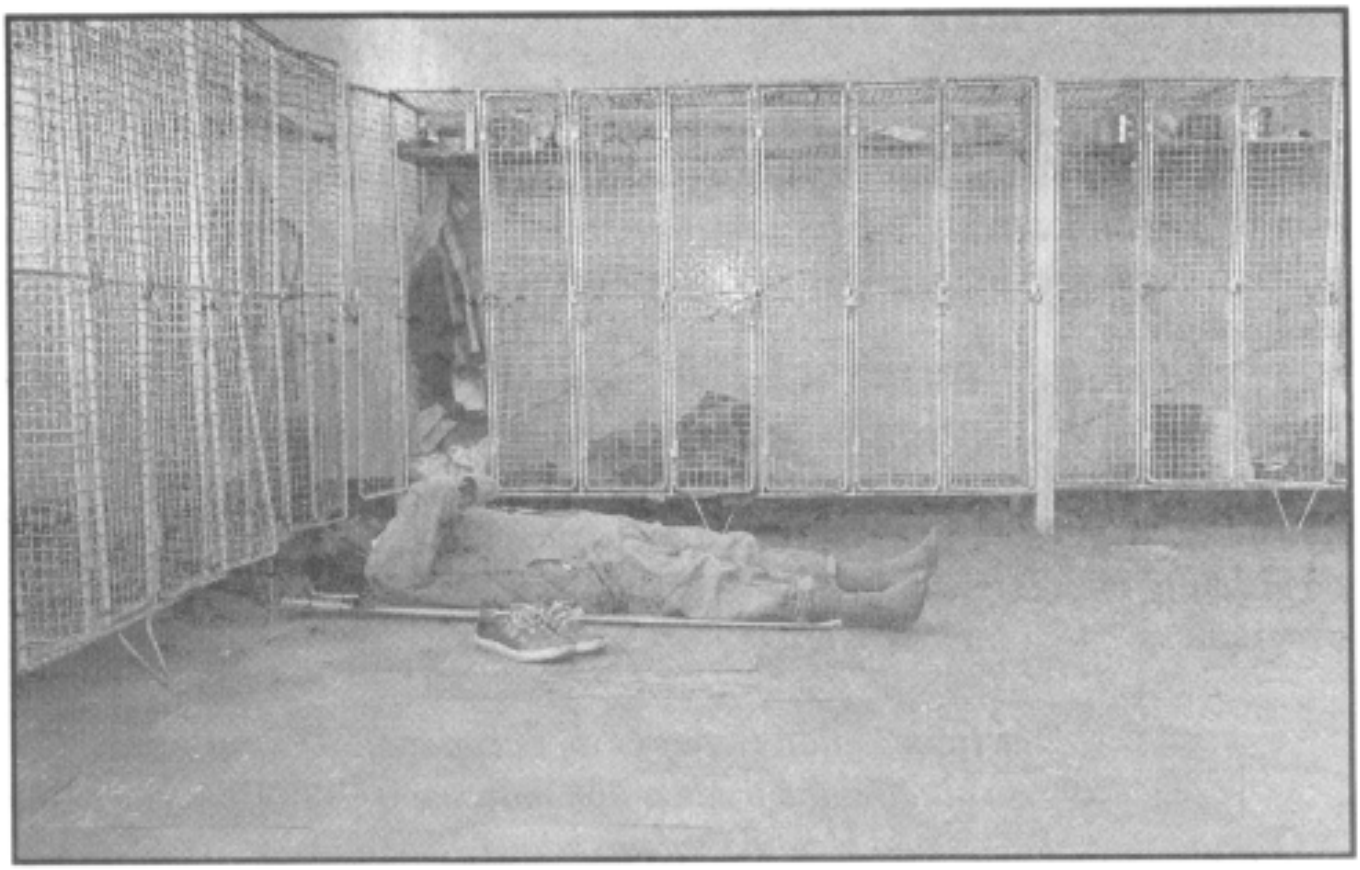
Political issues tend to have an immediate effect, whereas the impact of the AIDS epidemic is yet invisible in our communities and the workplace.

Access to resources also poses a major problem for union programmes. Adequate AIDS programmes require a massive amount of resources, including financial and skilled human resources, both of which are not easily available to the trade union movement.

Training programmes require that workers have paid time off to attend such programmes, or they would have to forfeit a large portion of their meagre wages. In addition, these programmes also require the services of persons trained in the field. There are very few skilled persons who are willing to work for unions.

Addressing the Difficulties

The development of successful AIDS programmes will require unions to develop their capacity to implement these activities. Their capacity building will require the development of adequate structures to develop, implement and



Workers must get time off to attend programmes. ***Photo: Medico***

evaluate AIDS programmes. These structures should, where possible, be linked to union health and safety structures.

In the long term, unions should develop a skilled human resource pool. In the meantime, however, they should determine how they could best use the skills available within service organisations, primary health care groups and even state and management personnel. These structures could be used for basic AIDS education. Organisational issues should, however, still be dealt with by union structures.

The important aspect of this relationship is that workers and their unions should be integrally involved in the development of these programmes and in the evaluation. In this way, unions would be able to develop the capacity to undertake these programmes themselves.

Unions could negotiate for funds from a number of sources. However, many of these sources may pose problems for workers and the content of the AIDS programmes. The sources for funding could include foreign trade unions and funding agencies, state funding and funds from the company. In some cases workers have successfully negotiated for management to pay for AIDS education programmes. Strategies should be developed on how to deal with each of these agencies. However, the over-riding principle should be worker control of the content of the programme.

Health and Safety Structures

AIDS programmes within trade unions are obviously at an elementary stage. While there have been impressive successes, a number of obstacles stand in the way of greater success. Suggestions have been made on how some of these obstacles could be overcome, so as to facilitate progress in implementing AIDS programmes.

The issue of HIV/AIDS, in the context of the workplace should be inseparable from the broader health and safety issues that affect workers. Emphasis should be placed on the importance of developing viable occupational health and safety structures within trade unions. Without this, it would be virtually impossible to initiate or sustain any health and safety (or AIDS) programmes.

Workplace Information Group is an occupational health and safety service organisation to the trade union movement. It is affiliated to the Occupational Safety and Health Organisation of South Africa (OSHOSA).

Section B

FIGHTING AIDS: STRATEGIC OPTIONS

The high prevalence of HIV infection in Africa is linked to that of other STDs. Should HIV be screened in the same way as other STDs? How can people with HIV help each other to live with dignity? How do we implement home based care as an alternative, humane and cost effective approach to care?

Should HIV Be Treated as Another STD?

Ron Ballard

The co-existence of HIV infection and conventional sexually transmitted diseases (STDs) is not purely a result of behavioural factors common to both diseases. This is also the result of a dynamic interactive process whereby certain conventional STDs increase the rate of transmission of HIV. It has become evident that, under normal circumstances, HIV is an infection of low transmissibility. Under these circumstances the vaginal walls and epithelium of the penis act as effective barriers against HIV transmission. The risk of infection with HIV is probably less than 1% per episode of heterosexual intercourse and greater than 5% per episode of anal intercourse. In comparison, the risk of gonorrhea is 80% and chlamydial infection 50%. However, in many developing countries, notably those of Africa (including South Africa), South East Asia and South America, where STDs are common, this barrier is effectively overcome by high rates of genital ulceration and inflammation as a result of infection with conventional STDS.

Effective AIDS Control

This relationship between HIV infection and other conventional STDs offers opportunities for implementation of effective AIDS control, based on sound scientific and medical principles which takes into account the epidemiology of both diseases. This could include extending conventional control measures normally undertaken for conventional STDs to include HIV/AIDS patients.

The normal principles which are applied to control conventional STDs include vigorous case-finding, treatment of cases, active tracing of possible contacts, and testing and subsequent treatment of latent infections. These principles are not applied in the case of HIV infection and AIDS for a number of reasons, resulting in a major dilemma for health care workers whose main aim is the control of HIV/AIDS. This dilemma arises from the possible conflict which the physician has, on the one hand, of respecting the right to confidentiality of the person found to have HIV and, on the other, his/her duty to warn those who may have run a significant risk of acquisition of infection. In

addition, since the disease is of considerable public health significance, the physician may feel that he/she has a duty to implement conventional public health 'ideology' in order to protect the community at large.

Current Approaches to Aids Control

Reasons given for not extending the 'conventional' disease control approach to HIV/AIDS include not only issue of confidentiality, but the long incubation period of the disease and its asymptomatic nature, the possibility that the disease could become more stigmatised, the fact that there is no curative treatment available, and that HIV-positive persons could increasingly become the victims of considerable discrimination. Many of these reasons have become etched in stone in HIV/AIDS folklore, but I believe that they reflect badly on our society, which has reacted to the threat of AIDS either by distancing itself from those who are HIV-positive, or by using the HIV/AIDS issue as part of an agenda to highlight existing discriminatory practices within our society.

Partnership Notification

However, the question of active case finding and subsequent partner notification can be justified on a number of grounds. While no curative treatment is available, it may prompt those who have been placed at risk to seek HIV counselling and possibly testing. If found to be positive, these individuals may benefit from early treatment interventions and the provision of prophylactic treatment for opportunistic disease. In addition, if infections are detected early there are distinct possibilities that regular sexual partners may be protected from subsequent infection by appropriate counselling, modification of sexual practices and/or use of condoms.

Even if initial objections were overcome, there remain major concerns about formal adoption of active partner-notification proceedures following diagnosis of HIV infection in an index case. These include the high cost of the exercise, both in terms of the financial burden of additional testing and the training of large numbers of personnel required to carry out the sensitive interviews required if the system were to be effective.

Another concern is that, if existing attitudes to HIV/AIDS within the community are perpetuated, then partner-notification programmes may actually discourage people from presenting for HIV testing. This ultimately would depend on the acceptability of the system to the general population and how

they perceive their risk of infection. Obviously those who perceive themselves to be at risk will find any system more acceptable than those who consider that they are not at risk.

HIV/AIDS Control: An Urgency

In view of these restraints and the urgency of the situation, I believe that, on balance, it is necessary to address the problem by steering a middle course. There are ways in which those persons at greatest risk of HIV/AIDS can receive all the benefits of early screening and partner notification without many of the attendant problems. STD control in South Africa has, almost traditionally, been poor. These diseases have long been the 'Cinderella' diseases of medicine. There is no recognised medical speciality, few formal courses are given in the undergraduate medical curriculum, and only recently have short courses been offered to qualified nurses. The facilities provided at public sector clinics are often inadequate and the workload overwhelming. Clearly there is a need for drastic upgrading of public clinic and other facilities, where patients present with STDs, to make them more user-friendly. There is also a need for the development of a national STD partner-referral system for STDs. These existing facilities, if upgraded could provide the initial base from which a more rational approach to HIV control could be provided in the future. Unfortunately, while central government has provided the funding for subsidisation of STD therapies and has issued guidelines for the treatment of these diseases, very little effort has been made in the field of STD prevention. It is at this point where NGOs with appropriate HIV prevention experience could play a major role in providing STD/HIV education and counselling. A true partnership between formal and informal sectors is undoubtedly required in order to combat these interrelated problems.

As time goes by society may change and demand a more traditional approach to HIV/AIDS control as people recognise that there is no reason to stigmatise this disease. When that happens, structures could be in place whereby a serious effort could be made in preventing the spread of this infection. One thing is certain, our present structures, and current approaches and attitudes are not making any impact on the evolution of the HIV epidemic.

Professor Ron Ballard is head of the STD unit at the South African Institute of Medical Research (SAIMR) in Johannesburg

More Caution Needed
A Response to Ballard

Clive Evian & Helen Schneider

The control of STD's in South Africa is a major public health issue. We agree with Professor Ballard that there are important strategies for the control of conventional STD's which also apply to HIV/AIDS control. However, whilst there are many similarities between HIV and other STDs there are also many clear and indisputable differences which demand different approaches.

Vigorous case-finding, active tracing of contacts and screening for latent infections, in fact, form the basis of public health measures to control many infectious diseases, not just STDs. They are most commonly applied to the control of tuberculosis (TB). However, applying them to HIV/AIDS, is a very complex and difficult issue.

Finding the household and work contacts of people with TB is very different to identifying sexual contacts of people with AIDS. There may be all sorts of repercussions for the person initially identified as being infected. That person is often a woman attending antenatal screening programmes. This places women who are dependent on men in a particularly vulnerable position. Professor Ballard does not specify whether active tracing and screening for latent infections be mandatory or involve consent. We do not believe contact tracing be done without their consent, and people with HIV have a right to total and complete confidentiality.

This confidentiality, however, does not prevent the clinician encouraging and exploring ways, with the patient, to inform or to contact any sexual partners and to provide the necessary support in doing so.

Further, people with HIV need a well developed medical and psychological support infrastructure. We agree that NGOs can play a role. However, the lion's share of this care and support should be the responsibility of the state.

STD services are not sufficiently developed or accessible to treat HIV like any other STD. Screening people for HIV without a clinical and psychological support infrastructure is courting disaster. One cannot assume if a patient knows that h/she is HIV positive, that the patient will inform their partner and/or change to safer sex practices. On the contrary, many people in South Africa, who know they are HIV positive, continue to keep this a secret and refrain from protective sexual practices, in order to avoid any suspicion

hat this might create. Many, especially women, are unable to tell their male partners for fear of violent or unfavourable responses. We would not encourage or promote indiscriminate or mass HIV screening without a well developed support infrastructure.

The issue confronting people with HIV infection go far beyond those facing people with diseases such as gonorrhoea and syphilis. The decision to have an HIV test, dealing with partners and relatives, dealing with a flood of personal loses including the ultimate loss of one's life, the wide range of medical care required, illness, dying and the fear, the potential for blame, shame, guilt, anger, depression etc, are all placing new pressures and demands on the health services. These needs cannot be met by merely treating HIV as another STD. However, by improving on the control of STDs we will, as Professor Ballard points out, significantly reduce the spread of HIV, and reduce the demands on the health services. The control of STDs must be part of a national AIDS control programme.

Clive Evian is the head of the Community AIDS and Information and Support Centre. (CAISC), Johannesburg. Helen Schneider is a researcher for the Centre for Health Policy at the University of Witwatersrand Medical School.

Living with Dignity
Sacred Heart House - a Photo Essay

all pictures by Graeme Williams

The Sacred Heart House hospice was opened in December 1990 in order to provide a sanctuary for people who suffer from AIDS-related illnesses and are unable to look after themselves. The hospice is situated in Kensington, in Johannesburg, and relies on donations from businesses and individuals. It can accommodate up to 14 patients and provides 24-hour nursing care and counselling.

Sister Cecelia, a Catholic nun from the nearby Assumption Convent heads a team of care workers who look after the patients.

Most of the pictures selected here depict HIV positive men at Sacred Heart sharing each other's time and taking care of each other. It shows HIV positive people as active agents of care and prevention, and no mere victims of a horrific disease. It is a reminder of an important remark made by Shaun Mellors, of Friends for Life, that HIV positive people should be encouraged to become involved in all structures and committees working in the field of AIDS care and prevention. As the tone of the pictures is of compassion between HIV positive people, it is fitting perhaps to introduce this photo essay with a poem by Shaun.

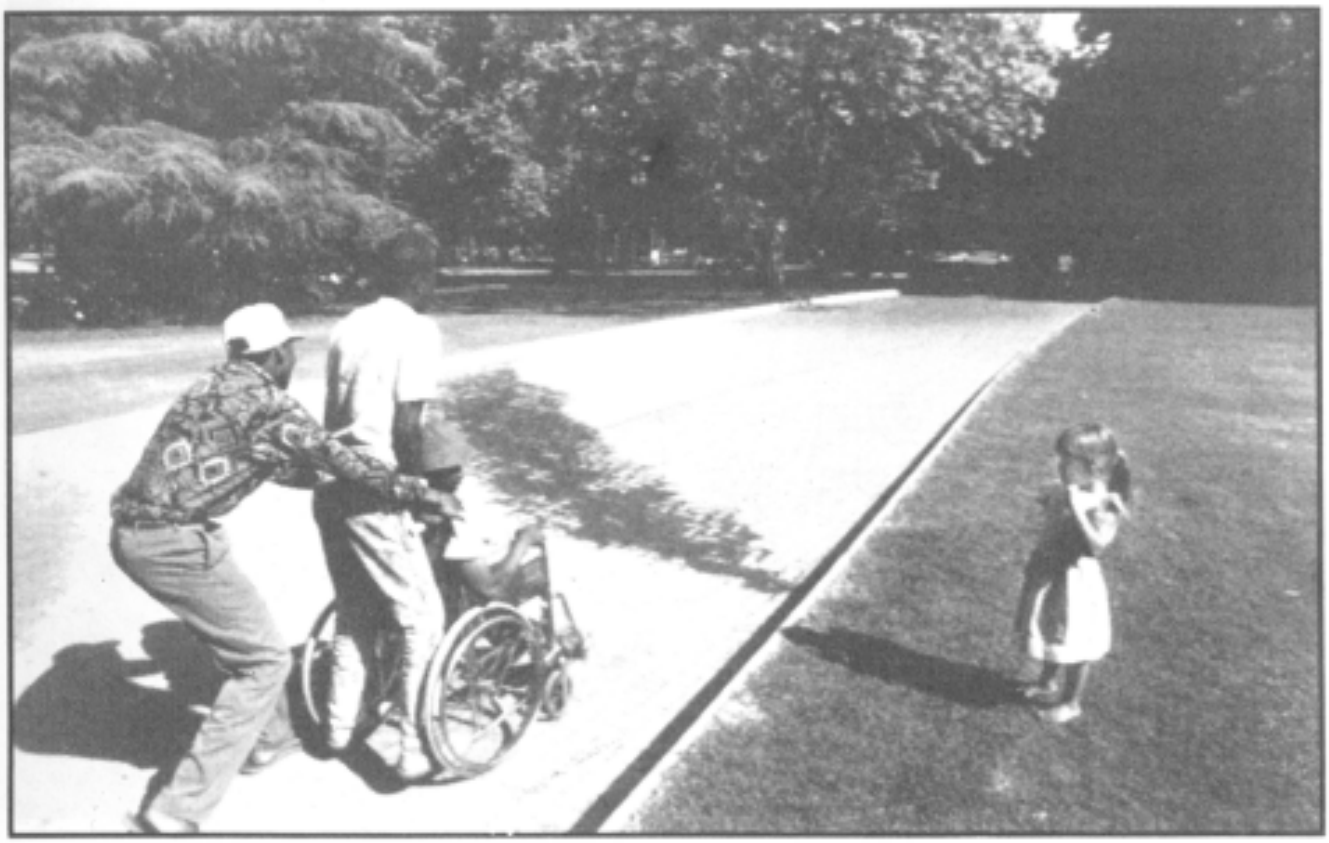
AIDS is so limited

It cannot kill friendship, nor cripple love,
as we befriend and love in return.
It cannot corrode faith, if we believe,
nor destroy confidence,
hope or silence our courage. We,
who are brave and proud.
It cannot kill peace, if we're committed
nor still the memory of lovers and friends
who passed before us.
It cannot invade the soul or reduce eternal life.
It cannot quench the spirit
or stunt the plant of hope.

Sister Cecilia washes Shadrack upon his arrival

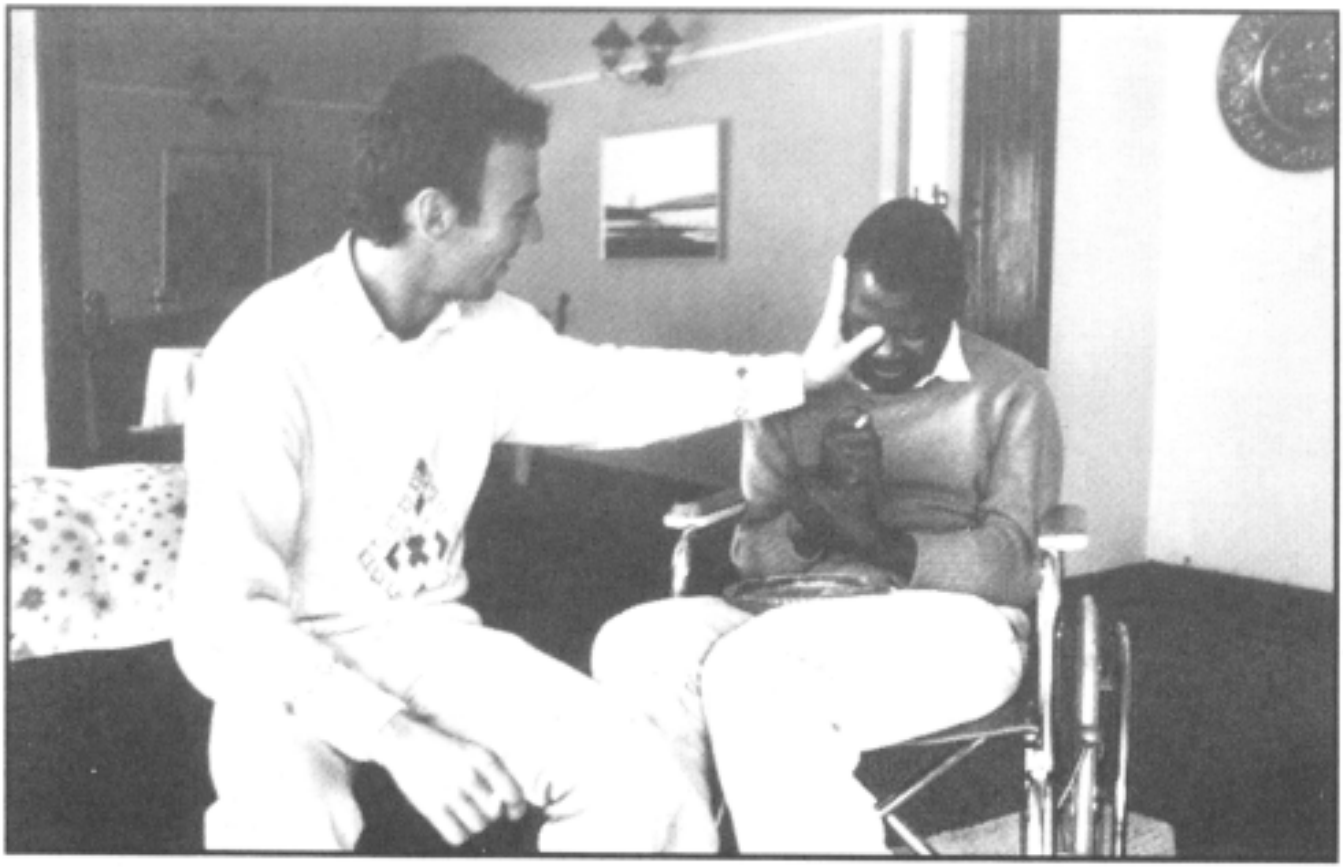
Pietro spends night with Shadrack

Pietro and Roger buy snacks at the local cafe



Volunteer Martin pushed Shadrack at the Johannesburg zoo

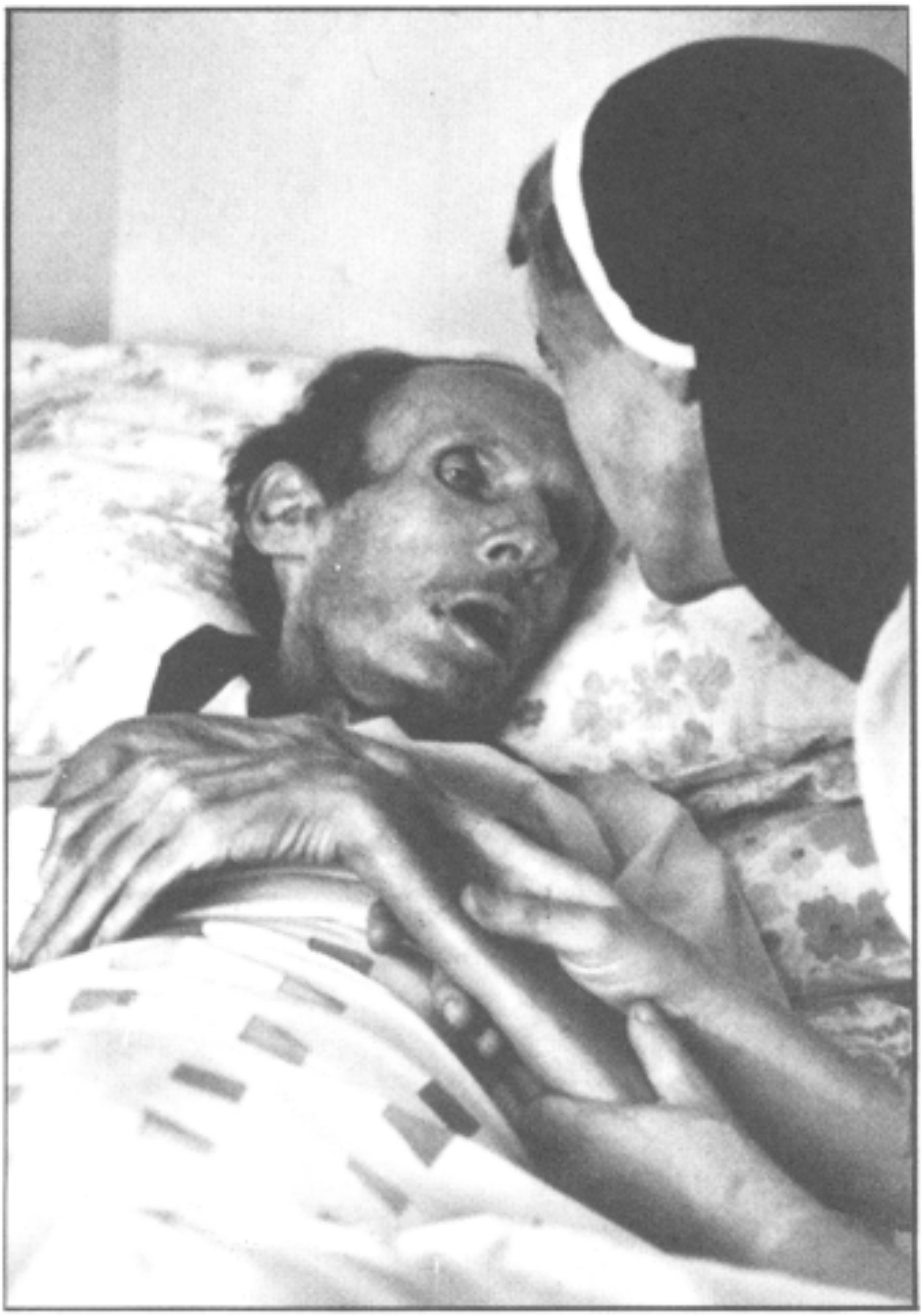
Pietro comforts Roger.



Pietro wipes a tear from Roger's face.

Roger and Phineas catch last sunlight before going in.

Andre struggles to breath while sister Val looks on.



Sister Cecilia with Andre a few hours before he died

Graeme Williams is a freelance photographer. These pictures are part of an exhibition held at the Market Theatre in Johannesburg late in 1992

Home Based Care
Same Epidemic, New Vision

Mary Crewe

Early on in the HIV/AIDS epidemic in South Africa, we were often reminded as latecomers to the epidemic, we had a time lag which could be used to our advantage. We would be able to stem the seemingly relentless pace with which the epidemic was spreading. We failed in that - for reasons which are well known - apathy, lack of understanding, lack of co-operation between groups and lack of political will.

Today, we are aware that we have to find innovative ways to care for people with AIDS. We are aware that in other countries, home based care programmes have been launched with varying success, in areas differing greatly in terms of resources and rates of infection. Yet again, we are unprepared. We remain ignorant of how such programmes were developed, implemented and sustained. We are at an early stage of prevention programmes development, and much remains at the level of talk. Very little is happening in terms of concrete action or indeed preparation for action. It seems as if we are determined to do nothing while we still have a little bit of time on our side. We seem satisfied to wait until we are faced with people needing care from families and communities, who are largely unprepared for the reality of this epidemic and the rigours of care.

Where Did We Go Wrong?

In part, this is a result of the failure of our education campaigns. Fourteen years on, we are still dealing with people who do not understand the epidemic, its routes of transmission and methods of prevention. We are still faced with large scale denial and a refusal by influential people to add HIV/AIDS to the political agenda. We still wait for a comprehensive and coordinated strategy to deal with HIV/AIDS in South Africa.

When we should be well into the establishment of care facilities, and training of care givers, we are still debating ways in which to get people to come to terms with the epidemic. We are now faced with moving into phase II of this epidemic, while phase I has barely shown any progress or success.

This lack of success in education and prevention programmes should not be a reason to hold back on the provision of home based care training modules, and facilities. From now on, such modules should be an integral part of all AIDS education and prevention campaigns. We cannot afford to make the same mistakes about care, as we did with education.

It is well known that as the HIV epidemic spreads, the majority of people with HIV and AIDS will not be cared for in hospitals or clinics, because of the nature of the illness and the lack of resources to cope with the numbers who will, at one time or another, require treatment and nursing. From this recognition has emerged the emphasis, world wide, on the provision of home based care services as an integral part of AIDS campaigns.

Is Home Based Care Viable?

From the evaluations done by the WHO of a number of home based care programmes, the benefits of home based care may include reduction in pressure on hospital beds, allowing other programmes to continue and develop; strengthening of family support for a person with HIV; reintegration of the patient into the community; preventative education taking place within the immediate family, the extended family and in the wider community; and the reduction of costs.

With the curent housing crisis how feasible is it to care for people with AIDS in the home? *Photo: Ismail Vawda*

While the WHO guidelines on the provision of home based care (see appendix) are concise, moving from abstract recommendations to action can be very difficult. As housing is one of the most serious problems facing disadvantaged people with HIV illness, what is meant by home based care must be decided. For many people finding somewhere to live can be an almost insurmountable problem, and for those with HIV infection these problems are magnified many times. People who are ill often have difficulty in keeping up their income to pay for accommodation, and people with AIDS suffer discrimination, rejection and harassment. It is practically very difficult to provide any sort of care for someone who has no where to live or for whom the only accommodation is over crowded or unsanitary or when the person is regarded as a burden by the rest of the family.

This situation has led many to suggest that we should not talk about home based care, but rather community based care. Although this debate is useful in highlighting the problems of inadequate housing and the lack of community commitment to understanding the epidemic, in the end one will be addressing both home based and community based care. The debates should, therefore, not deflect us from this. There has to be an overlap and connection between the two, and both services need the support of each other.

The Community's Role

The community needs to recognise that collectively, there are ways of dealing with needs arising from the epidemic. One is to get accommodation for people who do not have care at home, and to ensure that such accommodation and treatment offered is as close to a home environment as possible. Another is to organise the collection, storing, hiring or loaning of equipment, which families are likely to need when they have to get involved in home care. Communities should arrange the collection of bed linen, blankets, clothes, soap and cleaning materials, candles and lamps, towels, buckets and food so that they can become a resource centre for the families. This would go some way to resolving problems such as finding medical help for persistent diarrhoea and weight loss; problems in eating, skin problems, bed sores, chest pains; tuberculosis and a variety of other medical conditions; and the problem of material assistance to buy or acquire nutritious food, blankets, soap and basic medications such as soothing cremes.

Through the development of such community projects and services, much of the stress on home care could be alleviated. Likewise in very poor communities, such as squatter areas, it could ensure that the care of people was

Home based care needs to be linked with comprehensive PHC programmes. ***Photo: Ismail Vawda***

a community issue, that available equipment could be shared and that the very real problems of dealing with diarrhoea etc in communities with limited access to water and heating could be addressed through the community structures. Most current information on home based care assumes that certain basic services are available and that there will be adequate support from the health services. This is clearly not the case for many people in South Africa. We need to develop methods of home care in resource deprived areas which, as far as possible, do not compromise the care and comfort of the patient. In areas with inadequate water, sanitation and heating some of the most basic suggestions and advice for the care of people with AIDS will be very difficult to follow. We must find alternatives so that people offering care do not get demoralised when they cannot make the provision which is currently recommended.

In addition to material support, communities can be expected to help with the other needs of affected families such as emotional and spiritual support to cope with disease, impending death and fears of leaving dependents; advice on infection control; removing the fear of discrimination and rejection; financial and material assistance; relief from the extra work load of washing sheets, blankets, clothing and from the nursing of the patient, running the household; emotional and spiritual support.

Team Work

Home care teams, such as have been developed in Zimbabwe, Zambia, Uganda, Zambia and Kenya can operate in conjunction with hospitals, clinics, outpatient services and hospices. The objectives of such teams are to visit people with HIV infection in their homes to asses their physical, psychological, social and spiritual needs and to provide for these needs where possible; to do counselling and education within families and communities, providing personal support and promoting sustained behaviour change through community counselling; to assess the educational impact of AIDS management on people with HIV/AIDS and their families.

Home based care programmes and teams will need to be incorporated into the existing and planned programmes of primary health care (PHC). Planners seeking to establish home based care programmes should utilise existing methods of PHC delivery by utilising primary health care workers such as clinic based nurses and community workers. If such PHC workers are to be effective, they will need to acquire new skills through new programmes of training and be supervised by those responsible for operating the home based care services. Another challenge for health planners in the provision of home based and community care concerns the need for a multi-sectoral approach to the disease. The social consequences of AIDS cannot be adequately addressed through the conventional health care programmes. Alliances need to be formed between the health structures, community based and social welfare organisations, women and youth groups to ensure that the social and spiritual needs of AIDS patients and their families are not neglected.

Clinical and Social Advantages of Home Based Care

AIDS provides us with a unique challenge and opportunity to establish home based care programmes and community programmes which directly involve affected communities. This should lead to a strengthening of PHC. It is crucial that the provision of home and community care be recognised and supported by the national AIDS programme and becomes part of a national strategy. Resources will need to be fought for and diverted from the Department of Health, in order that socially based organisations can meet needs, obtain facilities, pay workers and provide support for volunteers.

Through the development of programmes, we can begin to challenge the conventional roles of members in the household. We can challenge the assumption that women must necessarily take on most of the care. We can train

World Health Organisation (1991): Home Based Care

"a programme that, through regular visits, offers health care services to support the care process in the home environment of the person with HIV infection. Home visits may be the only service provided, or they may be part of an integrated programme which offers the patient and her/his family services in the home, hospital and community.

Home care can mean the provision of holistic care at home including:

- medical and nursing care;
- training of the care giver in the home;
- counselling and social support;
- spiritual or pastoral support;
- material, financial and practical support; and
- referrals.

Consequently it should provide:

- training for family members to cope with the needs of the patient;
- psychosocial, spiritual, practical, financial and material support for the care givers and dependents; and
- the possibility of planning for the future with respect to orphans and other dependents.

Home care:

- allows patients to die at home in familiar surroundings;
- promotes support for the entire family, not just the patient;
- avoids the problem of transporting dead bodies;
- enables the family to understand AIDS better, which has important implications for prevention, and for coping with further AIDS cases in the family;
- promotes community awareness of AIDS prevention, and encourages supportive attitudes within the community;
- identifies families where there will be orphans and other dependents left behind, and facilitates the planning of future support; and
- frees hospital beds and reduces the cost to the health services."

volunteers who will both administer to the needs of the families, but also challenge the traditions and conventions that ultimately hinder AIDS work. We can also use AIDS to give new meaning to the tems community action and community structures.

Mary Crewe is the manager of the Community ATICC, Johannesburg

Section C

AIDS & THE SEXES

AIDS in Africa, as a whole, is a heterosexual disease. How do women, who know they are HIV positive, deal with its impact on their lives? How do our sex roles and identities, our stereotypes of being feminine or masculine, influence sex? Is honesty about our beliefs viable in sex education?

Women Living with HIV
A Group Encounter

Robyn Berman

A short-term support group for women with HIV-infection was run by the author and a co-therapist, at the Community AIDS Information and Support Centre in Hillbrow. The group met for six one-hourly sessions on a weekly basis. Most referrals were made from the HIV Clinic at the Johannesburg Hospital, although one member was referred from Rietfontein Hospital in Edenvale.

The group consisted of three black women, a white and an Indian woman. All the women could speak and understand English. They were aged between their early twenties and late forties. Group members came from both stable and chaotic backgrounds. Some of them were single parents, and others were in stable marriages. One member was pregnant and another had recently terminated a pregnancy. Another member was recovering from tuberculosis. The group included women who had left school early or had done matric.

The goals of the support group included helping women to cope with their situation and explore feelings arising from being HIV positive. It was also intended to help them realise that their situation and experience was universal.

Getting to Know Each Other

During the first two sessions the members introduced themselves and described when and under what circumstances they had been diagnosed. The HIV status of all the members appeared to create a sense of communality. The phrase "me too" was often heard, as one or another member spoke about a painful experience. Over the first sessions the group appeared to become a cohesive unit.

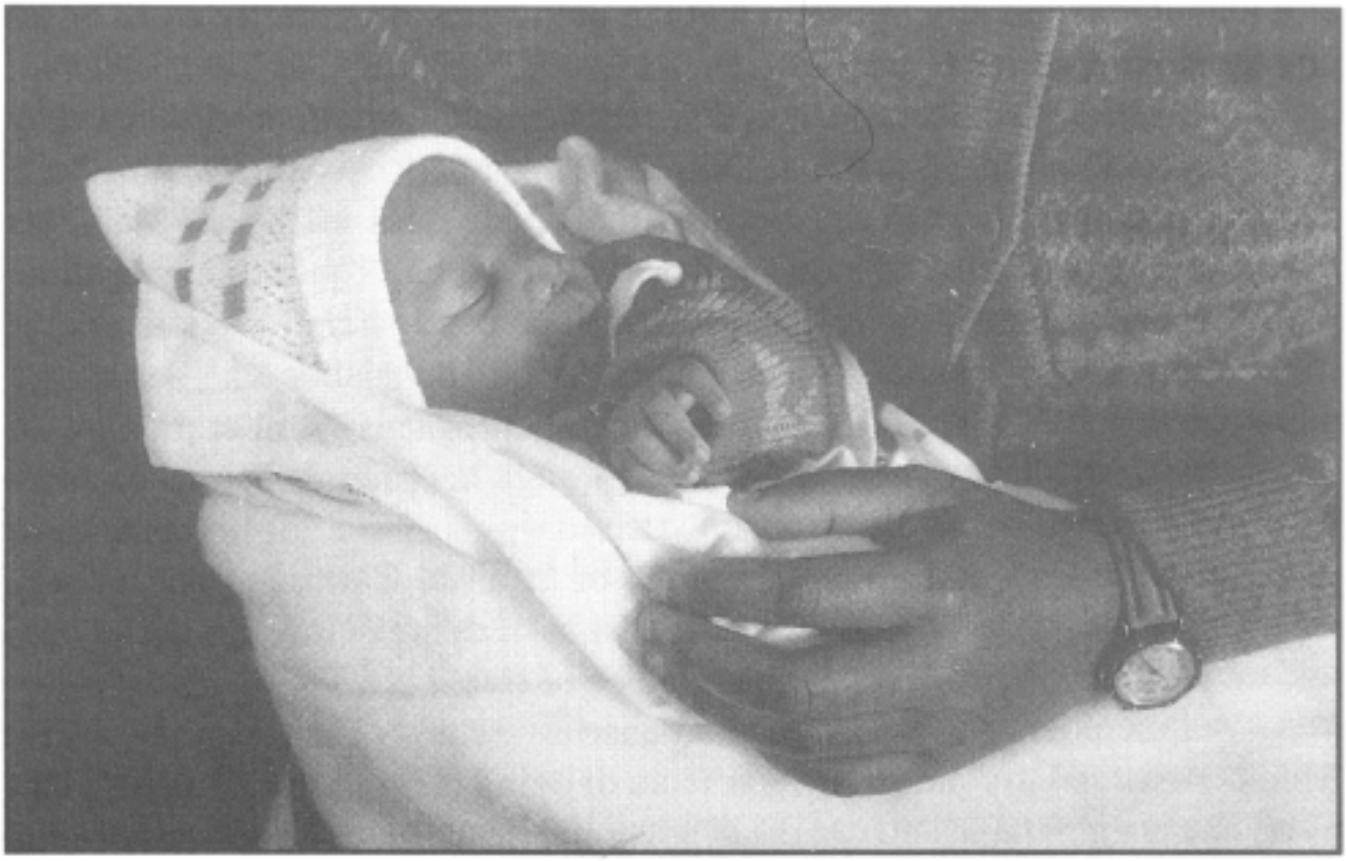
Initially it was difficult to end sessions, as members kept on talking after the hour had ended. It thus became obvious that the group experience was the first opportunity for members to speak openly about the disease without fear of rejection. Three members had not told their parents and children about their diagnoses. Their greatest fear was that people would not understand and would isolate them. There was almost no-one, outside the group, to turn to for support.

The reactions of hospital staff towards women with HIV-infection was a further area of concern for members, who often experienced a great deal of insensitivity from them. For example, a member found that after telling a nurse she was HIV-positive, the nurse suddenly put on two pairs of gloves in her presence.

During the second session, the group membership changed when a white woman entered the group and a previous member was absent. The co-therapist was also absent on that day. Instead of working with the issue of HIV/AIDS, the group focused on the process arising out of their absence. This illustrates to what extent cohesion had already occurred during the first session.

The new member also affected the group content and process in important ways. For example, her presence temporarily interrupted the flow and perceived self-identity of 'the group'. Members began to separate themselves into 'racial' sub-groupings, with comments such as "we blacks look at things differently". Boundaries had, therefore, to be expanded to include the new member.

The new member also required more attention from the other members and from the therapists, as she had just terminated a pregnancy. Initially, this seemed to confirm that new members should not be included in a group once



HIV positive mother and child. The child has a slim chance of living beyond the age of five. ***Photo: Ismail Vawda***

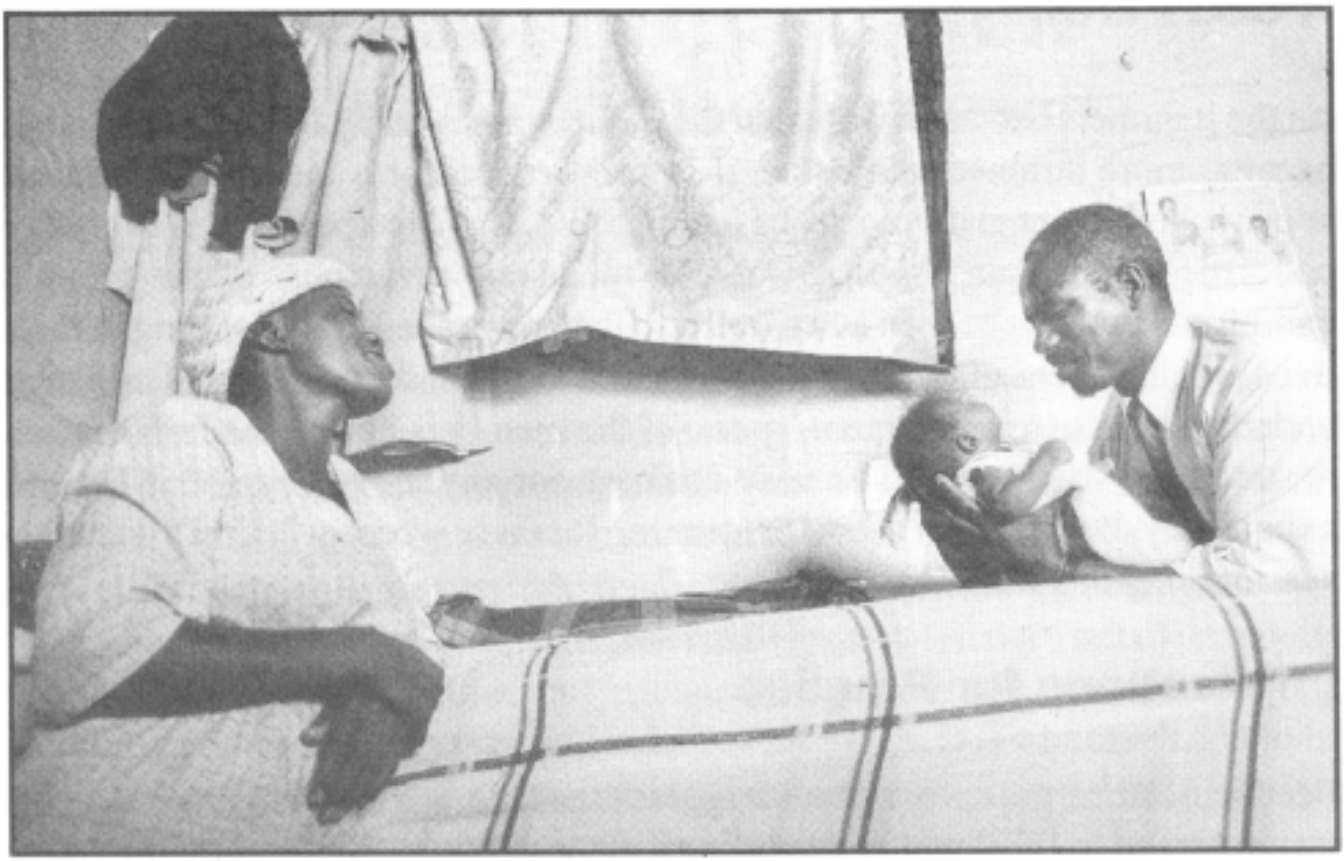
cohesion had progressed significantly. It later emerged that instead of becoming an obstacle to the development of the group process, adjustment to the new member contributed to the realisation of a communality, in that people of different race groups experience the same feelings and reactions from others when diagnosed with HIV.

Becoming Friends

At this point the catastrophic nature of the illness was recognised and members began to feel comfortable enough with each other to reveal deeper and very personal feelings of helplessness, fear and frustration concerning the illness. Most of the participants felt frustrated at not knowing when they would develop symptoms and how long it would take before they died. Members also spoke about the possibility of a cure. They discussed the frustration of feeling well and being asymptomatic, but simultaneously living with the thought that they could become ill and die at any time. They also expressed frustration at the medical staff for not being more exact about the onset of symptoms. It was apparent that group members lacked basic knowledge about HIV/AIDS and its transmission. Basic AIDS education had to be incorporated into the sessions, although it was initially intended that the group would primarily work on an emotional/supportive level.

Members discussed the suicidal feelings they experienced when they first heard about their diagnosis. One of the members was still dealing with suicidal feelings. This had a powerful effect on the other members. Members supported her and tried to suggest ways in which she could alleviate these feelings. For example, members suggested that it was helpful to keep busy, rather than think continually about the disease. The member who constantly experienced suicidal feelings was also the only pregnant member. In view of the extra responsibility she had assumed through her pregnancy, her feelings were understandable. It should be noted that a woman has a 25-40% chance of passing on HIV to a child in the womb or at birth. Children born already infected by the AIDS virus have a 25% chance of dying before the age of one, and an 80% chance of dying before the age of five.

All members wrestled with an intense awareness of the fragility of life. Members tended to rationalise their fears of dying early in life by saying that everyone is vulnerable and can die at any time. In addition, the group sessions became a context for re-enactments of current and historic conflicts. For example, members re-enacted with anger and rage their feelings towards other people who acted negatively towards them, because they were HIV-positive.



She needs her husband to understand that he has to take precautions so that he may survive and care for their children. ***Photo: Afrapix***

The effect of this 'acting out behaviour' was of very real value to members. There were also periods of great laughter, as members were able to see the absurdity and even humour of other people's reactions towards them on finding out that they were HIV positive.

During the fourth session, once members felt safe and accepted each other, they were able to discuss sexual issues. Members discussed how a diagnosis of HIV had affected their sex lives. Married members mentioned that their husbands' reactions to condoms was a problem, exemplified by one husband who consistently refused to wear a condom and wants to catch the virus and die with his wife. This member was very upset due to the increased burden, responsibility, fear and feelings of helplessness this placed on her.

The group, with the assistance of the therapists, reached out to this member and helped her to work through her feelings. Group members reacted with anger towards her husband's attitude and encouraged her to speak to him again and to try to encourage him to wear a condom. They also suggested that she make her husband understand that one of them needs to remain healthy in order to look after their three year old child.

A Sad Farewell

As the members became aware that the group was reaching its end, interaction became more strained, almost as if in preparation for a farewell. Members appeared reluctant to divulge their feelings and began to speak about everyday concerns, rather than about AIDS. The members' awareness of the group's ending can perhaps be seen as a parallel to their awareness of the ending of their lives and their fear of confronting this sense of impending finality. The group ended on a poignant statement by one of the members during the last session. A statement which would be very ordinary for anyone to say about her life expectancy, but was charged with meaning for these women: "I don't want this session to end, I want it to take long..."

Implications for Practice

Feedback from group members suggests that the greatest need the support group served to fulfil was in providing a place to reveal to others - without the fear of being ostracised or judged, that they had HIV/AIDS.

The support group also provided an opportunity for members to express anger about social and personal issues and provided opportunities for empowerment through suggestions as to how to channel anger into positive action.

The fact that the group was non-racial and served the special needs of women is unique. For instance, in this group, the process of inter-action implied that women were able to confront, explore and, in a sense, transcend several issues concerning patriarchy and racial hegemony.

In South Africa, there are very few organisations which specifically address the needs of women with HIV *(see resource list)*. As women often do not receive the information and support which would assist them take responsibility for their own lives and health, a women's organisation addressing the needs of HIV-infected could fill this gap. There is a need to develop a campaign to ensure that HIV-infected women are visible, and that the services and support needed by women are provided. Women infected with HIV can also play a crucial role in these organisations, in terms of counselling other infected women and thereby developing their skill at helping others.

Robyn Berman incorporated the above material in her Masters thesis in Clinical Psychology. She is a practicing psychologist.

Sexuality Education
A Value Sensitive Approach

Beverly Oskowitz

Sexuality education is a means of enabling people to make appropriate choices within the context of the sexual situations they encounter, with a knowledge of desired and undesired consequences. It is a way of empowering them with the skills with which to act on their choices within a moral framework of honesty, mutual respect, self-integrity and regard for our fellow human beings.

Studies have demonstrated that sexuality education does not make young people more sexually active, but encourages responsible decision making, including contraception usage and safer sex practices. It is a human right to be informed about sexuality and its implications for health and well-being before becoming sexually active.

There is broad agreement among AIDS educators that sexuality education is essential to a comprehensive campaign to limit the spread of HIV. This paper attempts to outline guidelines for a quality sexuality education programme, which would help people develop a sense of respect and comfort with their own bodies, as well enable them to make informed choices. It is hoped that these guidelines will provide a framework, while generating debate.

No Value Free Sexuality Education

How sexuality education is defined, who teaches or facilitates the programme, sexuality education content and the methods used to convey that content are influenced by the moral or ethical base of the educator. Sexuality education is not neutral or 'value-free'.

Terms like 'democratic education', 'adult education', or 'participatory education' are also value loaded. Many 'AIDS activists' espouse these concepts. Yet there is a concrete and hidden agenda which seems to be saying: "We want you to change your sexual habits. You must not get AIDS! So use a condom when you have sex. Abstain, or stick to one partner if you can."

Are we, AIDS educators, apologists when we try to come across as value-free? We do not want to be seen as moralistic, like those who blame the current spread of HIV on 'moral decadence'. But it is important to remember that

People should be enabled to determine their own values without succumbing to peer pressure. ***From NPPHCN/MRCs Roxy***

whatever we do or say has some or other moral base.

To be 'moral' refers to values or principles which guide us to aspire to what we believe is ethically correct. Morality is about what is considered good or bad in life. Sexuality educators need to endorse values and morals. We need to represent the highest aspirations of a potential democratic society. This implies speaking out against rape and exploitation and openly opposing racism and sexism. There is a vast difference between a 'moral' viewpoint and a 'moralistic' one, which encourages heterosexism. According to Kathleen Erwin, *International Journal of Health Services, vol 23, 3 1993*, the term

heterosexism "incorporates both the idea of dislike of homosexuality and gay people, and the societal and institutional-level discrimination against gays and lesbians". It is increasingly being used as an alternative to homophobia and other forms of discrimination.

Value-based sexuality education does not imply judgement of participants' behaviour in relation to the facilitator's values, but rather a framework from which the session is facilitated, enabling participants to face their own values without hiding behind culture, peer pressure, religion, law or nature. Instead of pretending as sexuality educators we are morally neutral, we need to be clear about our own morality. Educators do not want to be labelled as dogmatic, undemocratic, or manipulative. Yet some of the techniques used, foster dogmatic attitudes and manipulation under the guise of democracy and value-neutral education.

For sexuality educators to lobby effectively, we need to come together in support of comprehensive value-based sexuality education. We need to confront the confusion that exists among sexuality educators about values, ethics and cultural diversity.

Situating the Content

Studies have documented the underlying socio-economic causes of increased HIV infection, as well as the implications of sexual violence and sexual discrimination which make certain people more vulnerable than others. Yet are we addressing these issues, or are we prescribing the condom band-aid rather than addressing risk practices such as sex for money or favours, child abuse and rape? Perhaps under the guise of being value-neutral we are saying "be dishonest if you choose, cheat on your girlfriend or boyfriend as long as you do it with a condom".

Sexuality education programmes should address these questions: what is sexuality, what is sexuality education, who should teach it, what should be included in the curriculum, what educational methods are appropriate for sexuality education?

What is Sexuality Education? Who should Teach it?

Sexuality education is a part of comprehensive life skills training which prepares individuals for the emotional and physical changes they will be going through. Its starting point should be a clear understanding of what sexuality is. According to the Sex Information and Education Council of the United States,

From Johannesburg City Health Department Community Service's Love and AIDS comic

human sexuality is considered to be the totality of being a person, including all aspects of the human being relating to being a boy or girl, man or woman. It is subject to lifelong dynamic change.

Sexuality refers to the whole person including a persons thoughts, experiences, ideas, values, imaginings of a genital and general nature. Sexuality reflects our human character.

Sexuality education begins at birth, and continues as a lifelong process enabling us to adapt to the different sexual life stages that we encounter. This can commence with the physical exploration of the body, including the genital area. As vocabulary develops, questions are asked.

The purpose of sexuality education is to provide insight and eliminate fears in order to develop a rational basis for making decisions and examining our attitudes confidently. Through this education process we may gain insight into potential relationships and prevention of potential exploitation.

Initially the responsibility for sexuality education usually falls on the primary care giver, who has the task of answering questions and directing exploration as the need arises. Sexuality education also occurs through the

churches, schools and other societal institutions, sometimes directly, but most often through more subtle channels. There is a need for a multi-faceted approach to sexuality education, with the educators facilitating the learning and discovering process, rather than teaching from a perspective of the all knowing. Most people receive mythical sex education through their peers and the media. Adolescent peer educators are likely to be the most influential group of people in this regard.

Through insight into one's own ethics, the educator can become conscious about conveying ethical principals without being moralistic and judgemental.

In sexuality education sessions participants become aware of their own sexual orientation and values. This can give rise to guilt, anger and feelings of exploitation. It is important for the sexuality educator to have experience in counselling and know when to refer a participant to another source for help or follow up.

A Sexuality Education Curriculum

For people to have real choice they need access to accurate factual information, but as we examine human behaviour we see that it is influenced more by values and feelings than by factual information, and therefore our curriculum should reflect this influence. For people to act in their best interests they need skills. These include: assertiveness, decision making, negotiating, general communication skills and the ability to use safer sex practices.

Sexuality education needs to confront ways of enabling people to determine their own values without just succumbing to peer pressure.

Building relationships and developing communication skills are essential to sexuality education. Healthy, rewarding and joyful relationships include: mutual caring, being able to communicate with each other, sharing a sense of humour, playfulness, caring about groups and causes outside of the immediate relationship, individual and mutual friendships, tolerance, breaking away from gender stereotypes, sharing responsibilities, including necessary chores and sexual fulfillment.

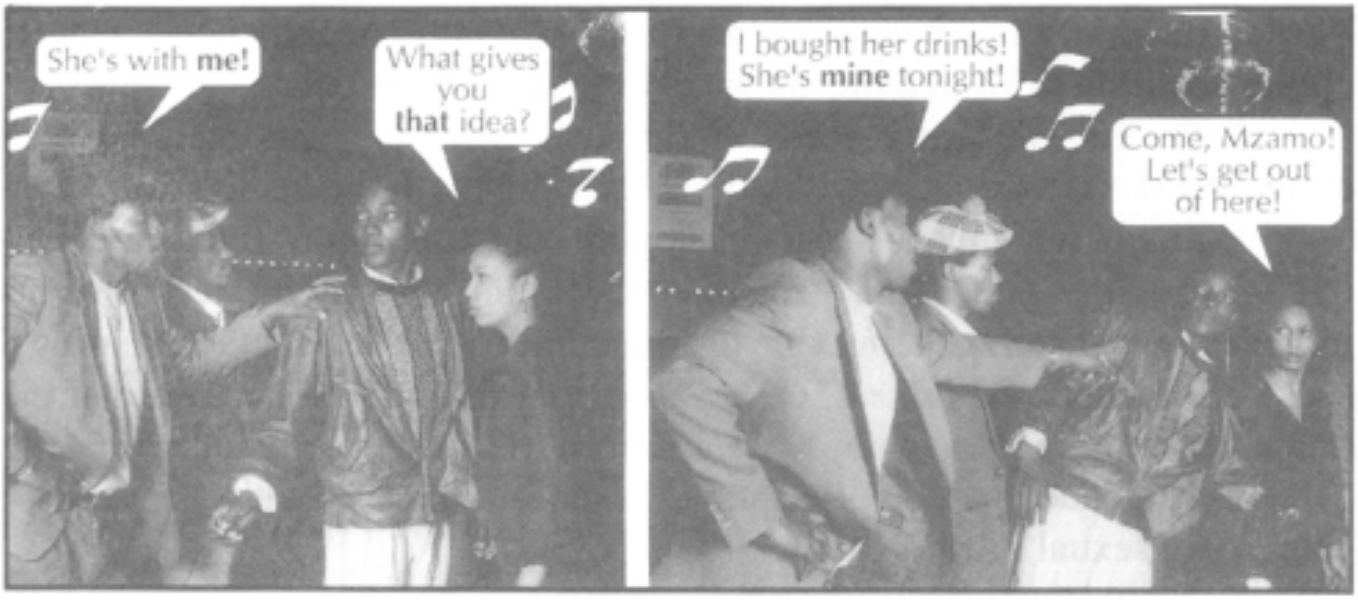
Sexual activity includes all actions that give rise to sexual thoughts or feelings. People should be able to explore the potential for pleasurable touches besides zoning in on sexual penetration, both anal and vaginal. There are a variety of low-risk sexual activities which people can try when developing their relationships. Sexual relationships may begin with warm feelings on sight, friendly smiles, talking, holding hands, hugging, kissing, touching,

looking and exploring each other's bodies and eventually touching the genitalia in a variety of different ways depending on the couples desires and interests.

Everyone should be aware of the consequences of coitus. We are all part of humanity and what we do sexually impacts on others. The potential consequences of coitus are desirable and undesirable ones, including pleasure and closeness, or pregnancy and sexually transmitted diseases. Sexuality education should impart knowledge of how to attain desired consequences and prevent undesired ones, including information about contraception, its usage and where to obtain it. Prevention of STDs and where to go for treatment.

Love and commitment are not essential for coitus. Although some sexuality educators may find it essential to stress that love and commitment are preferable, the fact is that they do not always accompany the act of coitus. It is through the mistaken coupling of love and sex that people resort to dishonesty and manipulation, both towards themselves and their partners. It should be made clear that people can love without coitus and you can have coitus without love. In other words feelings of sexual desire should not to be mistaken for feelings of love.

Regardless of gender all human beings experience a multitude of sexual attitudes, feelings and capabilities. Society and culture often determine what is gender appropriate behaviour, which can open people to unnecessary guilt or manipulation. All people are created equal and must have full rights to the



Tradition being invoked to justify forced sex must be challenged in sex education. ***From NPPHCN & MRCs Roxy***

pursuit of a fulfilled life of their choice. Sexuality education programmes need to examine gender relations and how manipulation of one gender by another has led to pain, disease and poverty. These consequences are similar to those of exploitation on the basis of race, ethnicity, class, gender and physical disability.

Sex education should start with where participants are at. We need to consider not only the socio-economic and political environment but also the attitudes, beliefs, values and cultural trends. This requires research into the specific situation and needs of participants. Research and education are inextricably linked, and sexuality education needs to be placed within the reality of the participants' environment. Research will reveal the extent of the cycle of sexual violence, breakdown in relationships and gender conflict, enabling the sexuality education content to include these aspects.

We need to consider factors in peoples environment that would enable them to carry out what they have learnt. For example, before teaching about condoms, one should ensure that they are available, affordable, acceptable and accessible.

A Safe Learning Environment

The learning situation needs to provide a safe environment for participants to examine and reassess values which may have been inherited through many generations. This includes assurance of confidentiality within the group, and the right of individual participants to withhold secrets. Personal attacks should not be allowed. The facilitator must ensure that members describe their own personal feelings rather than generalise their feelings to the group.

Although participants learn more from peers than official sexuality educators the educator can facilitate learning by setting the learning climate. This involves techniques such as circular seating arrangements, appropriate trust building ice-breakers and energizers and the use of buzz groups and small groups.

Education which deals with attitudes and feelings, requires an experiential approach, through dynamic small groups which allow for exploration and examination of individual ethical dilemmas. Techniques such as introspection through music therapy, art therapy or role play allow for self-examination of values whereas lectures lend themselves to preaching.

Sexuality educators should avoid hiding behind biological facts, and teaching in a didactic manner behind a mask concealing real feelings. Teaching facts is defended as being 'value-neutral sexuality education'. Sexuality

educators need to be able to use language frankly and openly when facilitating a sexuality education session. The facilitator must be sensitive to words which would be considered offensive to the participants and to adapt language usage accordingly. Participants must be made aware of how the sexual language they use may insult or undermine others.

A sexuality education programme needs to demonstrate precisely those qualities we hope will motivate participants in their future relationships. Qualities such as honesty, mutual respect, tolerance, commitment to our word and equality are essential. The educator needs to deal frankly and honestly with all issues that arise. It is through this approach that participants are presented with a model they can choose to adopt. Attitudes are primarily learnt by example.

Acknowledgements: PPASA staff and volunteers for stimulating debate, Buti Baloyi, Nancy Coulson, Clive Evian, Stephanie Moore and Helen Schneider for valuable feed back.

Beverly Oskowitz is involved in health promotion and related research, formerly at the Planned Parenthood Association of South Africa

Safer Sex and Gender Identity

Anne McKay

Gay, lesbian, woman, man, lover - sex is about fucking and who you fuck, and how social norms support, or raise an eyebrow at your loving, and whether your lover is male or female, and whether your loving produces children, or is supposed to produce children but you don't want to, or want to but can't. And now there is AIDS - a sexually transmitted disease that can kill you.

The experts say that avoiding HIV infection means making sure the HIV virus, carried in blood and sexual fluids, does not enter your system. This means using a condom for vaginal or anal sex, and using latex sheaths for oral sex.

But avoiding sexual fluids is not just about using 'rubbers'. It is also about how you make love. Changing the way you have sex, to having safer sex, can change how you feel about yourself as a sexual person - as a sexual man or woman.

Understanding Gender

If AIDS educators are to really address the problem of safer sex, they need to know more about gender and the practice of safer sex. For example, do women or men find it easier to practice safer sex? Is safer sex related to the particular sex roles society gives to men and women?

Men, according to socio-biologists, are programmed to 'spread their seed' as widely as possible, having many sexual partners. Men's sexuality is about having sexual conquests under their belt, being constantly sexually interested and sexually pro-active. Being masculine is traditionally associated with defending your beliefs, being independent, assertive, having a strong personality, being forceful, having leadership abilities, being willing to take risks, dominant, willing to take a stand, aggressive.

Most definitions of women, in relation to sex, describe a woman as a person who can be pregnant and have babies. She is seen as a person who is not sexually pro-active, more taken up with love than with lust. A person who waits for her lover to approach her and arouse her and make sex legitimate. A person who is nurturing, caring, concerned about connections between people. A feminist researcher found that for residents of the United States, femininity implies being affectionate, sympathetic, sensitive to the needs of others,

compassionate, eager to soothe hurt feelings, warm, tender, loving children and gentle.

Adopting Roles

But these roles do not arise directly out of one's biological make-up. People can be flexible and adopt different roles for different situations. People can be androgynous, in other words, they can behave 'like a man' (masculine) in some situations and 'like a woman' (feminine) in others. People can have sex-role identities which are different from their biological sex. Men and women can be masculine-identified, feminine-identified, androgynous or not strongly either masculine or feminine.

Therefore, in considering how gender is related to safer sex, both biological sex and sex-role identity may influence how people experience themselves and their sexual relationships.

Factors Influencing Safer Sex

Much research has been done to discover what personal and social factors influence people's ability to recognise they are at risk from HIV infection, to then decide to use safer sex, and then persuade a sexual partner to agree. This process involves several personal characteristics, such as willingness to consider being vulnerable, feelings of self-worth, communication skills, assertiveness, willingness to give up certain aspects of sexual behaviour, and

If not now, then when ...? ***From PPHCN/MRCs Roxy***

an ability to negotiate.

At first glance, the kinds of traits people would need to draw on to successfully persuade a partner to participate in safer sex, would be those personality characteristics, such as assertiveness, associated with being male. However, there are many reasons why it is not as simple as this. Men, until AIDS, have not had to think about sex as a potential danger to themselves. While there have been STDs, they could be treated with medication. This has been different for women. They have always had to think about the possibility of an unwanted pregnancy. There are other dangers about having sex that women have always had to think about, including the possibility of loss of 'reputation' and date-rape. Therefore, men may be less likely than women to think in terms of sex and risk. Another reason is the stigmatisation, in the past, of AIDS as a homosexual disease. Many men still believe this, and don't want to think of AIDS as a danger to themselves. Furthermore, the conception that being a man means having lots of sexual conquest makes safer sex unattractive to many men. Many men also express a deep-seated dislike of using condoms. They have been reported to say they do not regard safer sex as real sex, and they assume that it cannot be enjoyable.

On the other hand, social and biological factors associated with being a woman appear to be influential in determining a cautious attitude to sex. In many studies, women have given love-related reasons for having sex. This, it seems, is the only legitimate kind of female sexuality, and women may feel they have to 'legitimise' their own sexual activity by claiming love when they mean lust. Promiscuity and casual sex are not OK for women. Women are not

And if you don't like it, you can go...*From NPPHCN/MRCs Roxy*

allowed an active sex life, but are socialised into a passive, reactive, unassertive, sexuality, which responds to the desire of others. It has been argued that the discourse of sexuality for young women is that of victimisation, of fear of pregnancy and STDs, something adults warn you away from; rather than of desire. Women are encouraged to avoid the 'dangers' of sexuality.

This conception of sex has been reinforced by an anti-feminist trend. This trend warns of infertility and eternal husbandlessness for women who pursue a career, instead of traditional ways of expressing sexuality, such as marriage and motherhood. This argument is supported by some socio-biologists, who argue there is an instinctual urge in females towards finding the best possible mate and settling for purposes of child-rearing.

It has also been argued that women are socialised to have a morality which is about connection and consequences for other people, as opposed to the more 'abstract' morality men are socialised into. Therefore, thinking about the consequences of unsafe sex for others as well as for oneself is more of a 'woman' thing to do than a 'man' thing to do.

Safer Sex and Communication

It appears that the social and cultural forces acting on women may make it easier for women to accept safer sex. Certainly, traditional 'feminine' skills such as ability to communicate, and being sensitive to the needs of others is found to be related to being able to negotiate safer sex. Feelings of responsibility towards others, a traditionally feminine trait, is positively related to the use of safer sex.

The fact that heterosexual women do not necessarily act upon this more careful approach to sex may be due to having less power in a sexual relationship to impose their more cautious approach on male partners. It could be expected that the greater assertiveness found in men and masculine people would make it easier for them to insist on using safer sex. But it is not as simple as this. Assertiveness can also reinforce the use of unsafe sex methods, if the assertion is from the person who does not want to change their sexual practices.

This has certain implications for AIDS education, and for health psychology in general. AIDS education needs to include gender issues. Skills that make men and women feel competent in the masculine-dominated world of work, such as assertiveness, for example, might not be enough to assist them to negotiate the feminine/intimate issues around safer sex. Traditionally feminine skills, and the socialisation that goes with being a woman in this society, may make it easier for female or feminine people to practice safer sex.

Encouraging people to use the traditionally feminine skills of being sympathetic, sensitive to the needs of others, compassionate and gentle may give them the necessary skills to feel competent in the intimate domestic arena of sexual relationships.

It is important to remember that masculine and feminine skills are not necessarily related to being male or female. Masculinity and femininity are social constructs, and people don't have to be 'stuck' in these roles. Both men and women can develop both masculine and feminine skills. And it seems that to stay alive when AIDS is around, both men and women will need to learn to be responsible and assertive, communicative and decisive.

Mirror, mirror, on the wall ... ***Photo: Ismail Vawda***

Beyond Safer Sex

But who really finds safer sex enjoyable. (Oral sex through latex? Yugh!). All over the world, men and women have said that sex in which they enjoy 'contact with sexual fluids' does feel closer and more intimate than sex across a condom or latex sheet. Can monogamy or latex be integrated into people's sense of their sexuality? Can being careful with choice of sexual partners be integrated into the discourse of desire?

This is not an argument against safer sex. But eight years into AIDS education, it is not sufficient to promote the use of latex. There are times when a masculine-style arbitrary fuck is what any man or woman needs, and to do it safely is easy and sensible. But to survive this epidemic with our sense of our sexuality intact is going to take more than that. Unless you see your sex life as life long celibacy, marrying and taking out a no-third-party contract on your childhood sweetheart (virgin of course!) or, as an endless stream of rubberised anonymous disco-jorl fucks, there is a point at which safer sex is going to seem wearisome and bothersome. It is going to feel like safer sex doesn't express closeness and intimacy for you and the temptation to "just 'los' it! this once" is going to get harder to ignore.

A serious commitment to avoid HIV is going to mean all the 'feminine' things about taking responsibility for sex and communication: regular HIV tests, talking partners into HIV tests, talking about sex, talking about what is pleasurable, talking about other ways of making love, talking about monogamy, talking about intimacy, talking about trust. And the 'masculine' strength of assertiveness to make this happen.

The silver lining on the black cloud of HIV, is that it opens the opportunity for people to learn more about themselves and their partners and about sex. A popular song in 1992 put it this way: "Let's talk about sex, baby, let's talk about you and me."

Anne McKay works for the Network of Independent Monitors, Durban

Demanding Sexuality Education
The COSAS National AIDS Campaign

Critical Health

The Kagiso town hall was the venue for the COSAS National AIDS Campaign launch. Thousands of scholars thronged the hall. There were guest speakers from the ANC Women's League (ANCWL), the NPPHCN National AIDS Programme, Concerned Nurses Forum, a student nurse from the Bonaseledi Nursing College, and Macmillan Boleswa AIDS Awareness Programme. The launch was decided on at a national workshop of COSAS leaders, held jointly with the National AIDS Programme (NAP) of the National Progressive Primary Health Care Network (NPPHCN). The conveners of the launch intend building an AIDS awareness campaign on the principle of community participation in health care. They recognise the lack of sexuality education in schools to prevent teen pregnancies, rape and STDs, and, as a result of limited government intervention, they see the need for a comprehensive AIDS awareness programme to be targeted at youth. COSAS national organiser, David Serekwane, demonstrated the demand of a generation, in the era of AIDS, for sexuality education, when he said to the press, "We feel as a student body, it is our duty to educate our members on the subject of AIDS, since it is not part of our curriculum."

Addressing the launch, the COSAS national projects coordinator, Albert Mahlangu urged his fellow students to take AIDS seriously. This was reinforced by the chant, "One Round, One Condom". Thandi Modise of the ANCWL stressed that AIDS was as much a threat to black people's lives as De Klerk's regime and the violence of Inkatha. Mahlangu rejected the notion of anyone dying from being educated. "We must fight for the right to know about our bodies, our health, our sexuality. We must demand sex and health education in our schools. We do not want to die of AIDS because we are ignorant", he said. COSAS, he asserted, recognised the need to involve other student, teacher and community organisations in their campaign against AIDS. COSAS needs to train peer educators to teach their fellow students about health as well as AIDS and sexuality education. It was pointed out that, not only did they have to protect themselves, but that they had a role to play in helping protect the community as well.

Condoms and Concerns

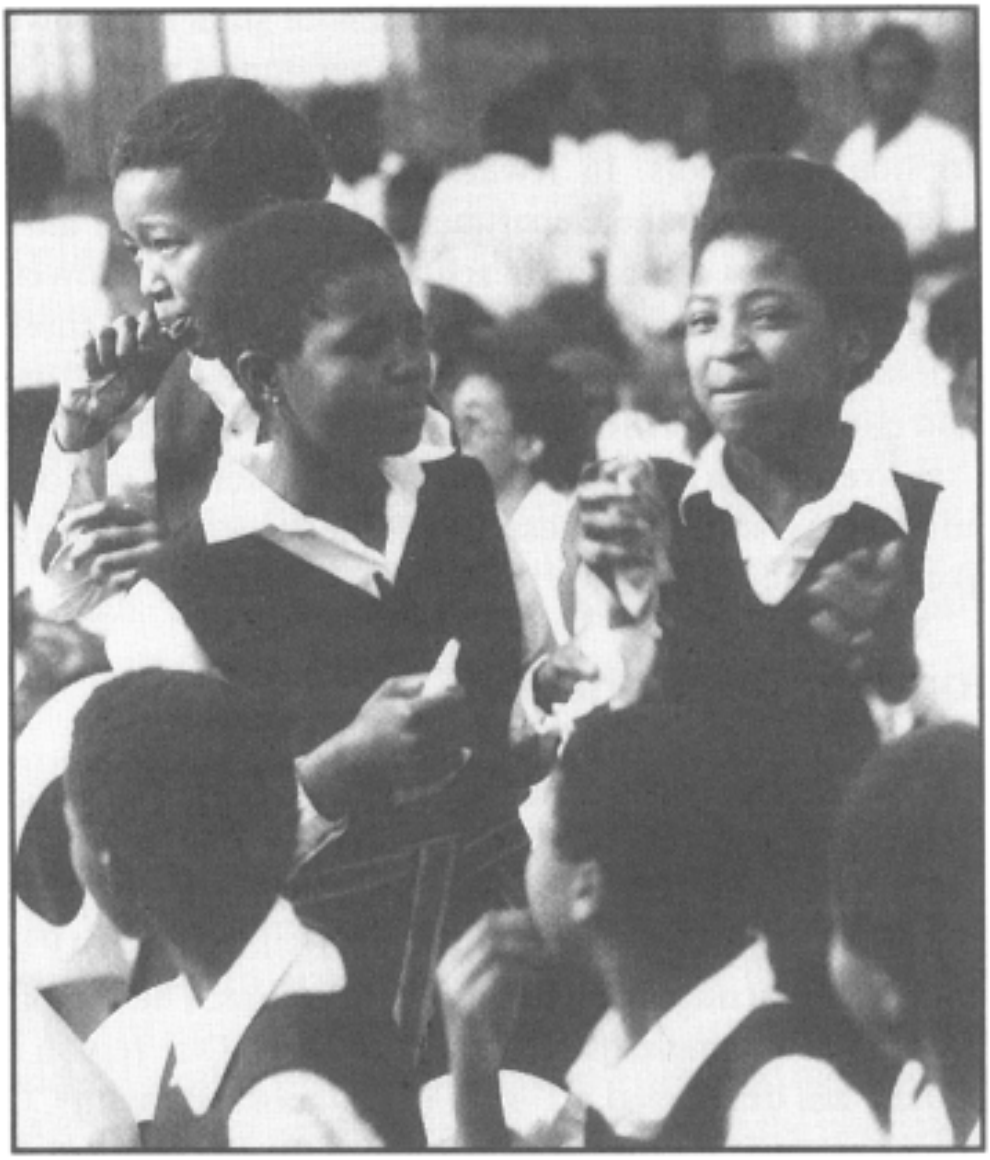
Speeches at the launch indicated a variety of approaches to education about AIDS and sexuality. There were, however, remarks which sometimes raised eyebrows. The speaker from the Bonaseledi Nursing College, in her speech directed at young girls, made a comment challenging girls to be cautious in approaching relationships: "if he tells you he loves you and therefore wants sex to show his love, he's lying!" This was applauded by a loud cheer. However, the speech was marred by comments urging teenagers that, because most of them did not know what condoms looked like, they should not ask for them. Rather, girls should do other things like sports. Children should concentrate on their academic education instead, the speaker insisted. This speech, while sensitive to confronting peer pressure to sex and encouraging youth to delay sex before completing their education, raised a number of issues. A student nurse urging young students to ignore condoms highlights the problem that, although nurses are trained health workers, they are not necessarily prepared for AIDS education. The same applies to most health professions.

Many of the speeches were made in English. It may have been better to engage youth in the vernacular, and at an accessible level. There was also a gulf between the youth and speechmakers. Standing on a podium and lecturing to students to take part in a campaign was typical of an hierarchical 'teacher teaches, students learn' classroom situation. These criticisms concern the launch, and not the overall campaign. Still, the launch did hint at issues which should be addressed in future.

Taking the Campaign Forward

COSAS recognised that youth and students could not depend on parents alone for sex education. The unquestioned, and problematic, assumption by health and education authorities that talking about sex will lead to promiscuity was challenged at the launch in a constructive way.

The campaign includes: engaging students in health education; running awareness workshops on AIDS, sexuality and teenage pregnancies; initiating national school health committees; and developing a policy on school health service. While involving students in self help, as it did with its Culture of Learning Campaign, COSAS understands that it would have to engage health organisations in this campaign. NPPHCN's NAP, as a community oriented organisation, was seen as a useful organisation to liaise with to guide sexuality



Girls have to protect themselves. ***Photo: Ismail Vawda***

and AIDS education. Another role of NAP is to develop COSAS in such a way that it can articulate its demands around sexuality and AIDS education more clearly to the relevant authorities.

The Problem of Gatekeepers

In trying to make campaigns as broad based as possible, problems of ensuring the support of important agencies arise. That is, in schools, a national campaign may have to consult education and health authorities, who would feel that their territory is being intruded upon. In addition, other NGOs and teachers unions would feel slighted if not consulted. Thus, consultation with all the relevant agencies has to be ensured. For example, drama specialists at the University of Zululand worked closely with both teachers and students in a school to develop a programme designed to carry an AIDS message through drama. The aim was

to initiate behaviour change amongst high school students. However, one of the main problems in efforts to embark on programmes at schools was that of 'gatekeepers', that is, local officials in the education system. Sexuality education is not an option at schools. In KwaZulu, permission has been gained at ministerial level from both the Department of Education and the Department of Health to embark on a campaign in schools in KwaZulu. However, this still meant getting co-operation from the gatekeepers, including, chief inspectors, local inspectors, principals, as well as, superintendents and matrons from local hospitals and clinics, authorities noted for their conservatism. A broad based campaign has to engage a lot of agencies, including formal authorities, as well as NGOs, in order to ensure its success. Hence the success of future programmes will be linked to winning over the relevant 'gatekeepers'.

Cohesion and Coordination

Commenting on a lack of cohesion in the campaign, Songzo Mjongile, COSAS president, said he hoped that NPPHCN would be able to coordinate future programmes and campaigns between the different health groups. However, an achievement of the campaign so far has been the role of the NAP involving its regions with COSAS at ongoing local level workshops. The campaign has also produced posters and pamphlets on a national level. One region of the NAP, Natal Midlands, has developed a T-shirt in collaboration with COSAS.

COSAS has made no formal contact with the Department of Education and Training (DET) regarding the campaign. However, there has been contact with the South African Democratic Teachers Union (SADTU). In the AIDS campaign, they want to develop a relationship in which neither COSAS nor SADTU is a master or pupil. To this end, COSAS and SADTU will be having a joint workshop in October. This should be a useful move forward.

A group attempting to gain access to the DET is Macmillan Boleswa, who have published a set of 18 narratives, each in a separate book for standard four to matric. They are all illustrative real life situations where HIV has made an impact on the lives of individuals and the community. Accompanying the books are teachers guides with lesson ideas *(see resource list)*. Macmillan have approached various school departments, including the House of Representatives, House of Delegates, and the DET. However, most have declined to buy the set because of inadequate funds. In the case of the Department of Education and Training, Old Mutual, the insurance conglomerate, has bought the books for standard four and five on behalf of DET schools in the Transvaal. Macmillan will be running training courses for teachers. Janet Foley, a

representative for Macmillan at the launch, said that they hoped that education departments would take the entire set. Foley maintains that it is shortsighted to only run a course for teachers of standard four and five, but at this stage it's better if children get access to some material rather than nothing at all.

COSAS and NAP invited a wide range of organisations to the launch, including political, civic and church groups. Most said they would attend, but failed to attend. As there are so many organisations who are liaising with one another, there needs to be greater coordiritation. There is a recognition that, through networking, better use is made of available resources and expertise, hinting at the need for a wider forum in which to plan programmes. The conveners of the launch also held press briefings, which most newspapers and journals did not attend. Neither did they publish the information sent to them about the launch. This reflects badly on the role of the mass print media in South Africa in its commitment to informing people about AIDS.

Sustaining the Campaign

The COSAS AIDS campaign is not the first attempt of its kind, but if it is to succeed, the various interest groups and their resources need to be drawn together. An AIDS activist pointed out that an issue that needs to be raised by COSAS is that of ensuring sustainability. Are enough support and resources being provided by other organisations in an integrated and coordinated way? Will COSAS' resources and support be developed to the point where it can be able to act independently at some stage? Given that COSAS is a student based organisation, is it planning the campaign in such a way that in two to three years, say, when current AIDS coordinators have left school, the campaign can sustain itself with fresh educators and coordinators?

This article was written by Ismail Vawda

AIDS Resource List

The following organisations are involved in AIDS work. The list is not exhaustive. It covers those organisations that responded to a letter circulated by Critical Health.

AIDS Education and Training (AET)

AET services involve:

* action planning - our consultant meets key company personnel to brainstorm and advice on issues such as selection of educators, educational media, programme planning, condom distribution, HIV testing and STD services
* workshops to train AIDS educators and counsellors (peer and professional);
* "refresher" workshops for educators and counsellors;
* training AIDS Programme Co-ordinators;
* workshops for medical staff and first aiders; and
* a standard, user friendly, educational package including a flipchart designed for illiterate groups.

Susan Hyde or Sharon White
Tel: (011) 726 1495 · Fax: (011) 904 1404

African Research and Educational Puppetry Programme (AREPP)

AREPP is an educational trust whose aim is to provide educational puppet theatre and training workshops concerning issues related to the environment and physical well being of the community.

Gary Friedman
P O Box 51022 , Raedene, Johannesburg 2124
Tel: (011) 483 1024 Fax: (011) 483 1786

AIDS Outreach

AIDS Outreach is a church-based organisation, concentrating in the following areas:

* Counselling
* Training of AIDS Counsellors
* AIDS education
* Employer/employee work policies

Grant D. Muhl
6 Paarlkop Street, Eastvale Springs · PO Box 14040, Dersley Park, 1569

AIDS Training, Information & Counselling Centres (ATICC)

The mission statement of the ATICC is to enable and equip the community, within set geographical boundaries, to deal effectively with HIV and AIDS. ATICC's goal is to provide HIV/AIDS training, information, counselling and support to the community.

We train members of the community who have been identified as role players to become educators and lay counsellors. We give input to other training programmes and educate the general public. In the area of counselling we provide pre-and-post test HIV counselling, ongoing counselling and support and counselling and outreach support services. ATICC also provides information on a personal and non-personal level, marketing, networking, research, testing and distribution of condoms.

ATIC Regional Addresses:

Bloemfontein
Dr A. Hiemstra or Daleen Raubenheimer
PO Box 3704, Bloemfontein 9300
Tel: (051) 405 8544/28 Fax: (051) 304 573

Brakpan
PO Box 15, Brakpan 1514 · cnr. Park Street and Kingsway Avenue, Brakpan 1514
Tel: (011) 741 2259 Fax: (011) 741 2262

Cape Town
Dr M Popkiss or Mrs T. van der Velde
PO Box 2815, Cape Town 8000
Tel: (021) 400 2628/3400 Fax: (021) 251 497

Durban
Vicci Tallis
PO Box 2443, Durban 4000 · 9 Old Fort Road, Durban 4000
Tel: (031) 300-3104/3020 Fax: (031) 300 3030

East London
Rose Hegner
PO Box 134, East London 5200 · 39 Cambridge, East London 5201
Tel: (0431) 342 382 or 439 743 Fax: (0431) 342 383

Empangeni
Mr van der Westhuizen or Mr Steffen
PO Box 115, Empangeni 3880 · Tel: (0351) 21131

Johannesburg Community AIDS Information and Support Centre
Clive Evian
PO Box 1477 Johannesburg 2000 · 17 Esselen Street, Hillbrow 2001
Tel: (011) 725 6719 (hotline) Fax: (011) 403 1069

Kimberley
R. van der Merwe
Private Bag X5030, Kimberly 8300 · Louis Rame Building, Stockdale no. 5 Kimbelrly 8300
Tel: (0531) 806911 Fax: (0531) 31005

Klerksdorp
P0 Box 99, Klerksdorp 2750 · cnr. Park Street and Kock Street, Klerksdorp 2750
Tel: (081) 462 2151 or 464 1371 ext 2101

Nelspruit
P. van Brakel or Hennie Peters
Nelspruit Town Council, PO Box 45, Nelspruit 1200
Tel: (01311) 592 159 Fax: (01311) 592 070

Pietermaritburg
Rose Smart
PO Box 89, Pietermaritzburg 3200 · 42 Havelock Road 3200
Tel: (0331) 942 111 or 943 101 Fax: (0331) 423245

Pietersburg
Mr Herbi Smith
PO Box 111, Pietersburg 0700 · 16 Palm Centre, 23 Grobler Street, Pietersburg 0699
Tel: (01521) 914 962 Fax: (01521) 914 744

Port Elizabeth
Dr F. E. Carstens or Dr du Plessis
PO Box 293, Port Elizabeth 6000

Pretoria
Dr Conradie or Ms Reggie Stighling
PO Box 234, Pretoria 0001 · K1202, 1st floor Munitoria 0001
Queenstown
Ms M. Schelver
Private Bag X7111, Queenstown 5320
Vanderbijlpark
Dr Louw or Dr van der Walt
Vanderbijlpark Town Council, P O Box 3, Vanderbijlpark 1900
Tel: (016) 31 2820 Fax: (016) 33 5410
Witbank
Hennie Venter or Johan Hattingh
Health Services, Witbank City Council, P O Box 3, Witbank 1035 · President Avenue 1035
Tel: (0135) 906 911 or 906 204 (direct line) Fax: (0135) 906 207

Baragwanath Maternity Hospital HIV Clinic

This clinic provides AIDS information, counselling, HIV testing and medical care for HIV positive pregnant women and their infants. The clinic also provides a supportive environment in which women can discuss their concerns and problems in group sessions. These sessions involve women in discussing methods of self-care and approaches to informing their friends and relatives. The clinic also strives to educate women about various topics connected to HIV-infection. Township AIDS Project puts on a video or a slide tape show on prevention and care, every morning.
Dr James McIntyre (Obstetrics) or Dr Glenda Grey (Paediatrics)
Dept. of Obstetrics and Gynaecology, Baragwanath Hospital, PO Bertsham 2013
Tel: (011) 938 1534 Fax: (0111) 938 1534

Community AIDS Information and Support Centre (CAISC)

Aims of the organisation include:
* information and education on HIV and AIDS;
* HIV testing and pre and post test counselling of people relating to HIV and AIDS;
* telephone information line (725 6710);
* media production (AIDS poster, leaflets, etc).

Services are available to all residents of Johannesburg, private sector health care workers, NGO and community groups working in AIDS and related fields, local authorities and state structures.
Details of current programmes:
* Talks, lectures and workshops on HIV and AIDS
* Theatre-acting troupe doing popular theatre on AIDS prevention ·
* AIDS awareness using mass media and Johannesburg buses
* Counselling for HIV tests (counselling by appointment)
* Treatment of sexually transmitted diseases
* Production of posters and pamphlets on HIV and AIDS

PO Box 1477, Johannesburg 2000 · 17 Esselen Street, Hillbrow 2001
Tel: (011) 725 6710 (hotline) Fax: (011) 403 1069

Friends for Life

Friends for Life is a non-governmental, non-discriminatry, non-profit, voluntary organisation. We offer emotional, practical and moral support to people affected by and living with HIV and

AIDS. We have trainee volunteers who offer home and hospital visits, household chores, shopping or just being a friend. We also provide food parcels when necessary.
PO Box 17165, Hillbrow 2038
Tel. (011) 922 4000 (code SM13)

Funlab: Nick Aidsbuster

Aidsbuster's aim is to stimulate popular action conducive to victory over AIDS facilitated through marketing Aidsbuster products and services.
PO Box 17222, Hillbrow 2038
Tel: (011) 725 2381 Fax: (011) 725 2381

Jenni Gillies and Associates: Consultants in Workplace Wellness

A) Development of Strategies to manage AIDS and HIV at the workplace

* Policy Development
* Education at all levels in the organisation to create a climate which will assist the company to manage this disease at the workplace. This includes: management presentation; education sessions for all levels; workshops for managers on handling AIDS and HIV at the workplace; attitude change workshops

B) Development and implementation of employee assistance programmes as an effective management tool to enhance performance

* Administration systems to measure performance improvements
* Training of EAP co-ordinators
* Training of managers and supervisors

10 Tenth Avenue, Parktown North, Johannesburg 2193
Tel: (011) 7884271 Fax: (011) 7884271

HIVES: HIV Education and Support Group (East Rand)

This non-government organisation was initiated in 1991 in Brakpan. There are now Springs, Heidleberg and Tsakane groups as well. There is close networking with Life Line (ER), Hospice (ER), Compassionate Friends (ER), AIDS Outreach, FER Hospital, Pholosong Hospital, St Francis Hospice, Brakpan, Springs and Heidleberg health departments.
Aims and Objectives:
To facilitate the education of the public and to support those affected and infected by HIV by

* initiating and undertaking educational programmes;
* upholding the dignity and rights of persons with AIDS or HIV and their partners, families and caregivers by abiding by the AIDS and HIV Charter.

There are about 15 trained counsellors. Some have had Life Line training as well. The group has been instrumental in the training of nurses in the above-mentioned health departments and hospitals and hospices, and was a major factor in the establishment of an ATIC on the East Rand.
Patricia Sills (011) 741 2261 or H Grove (011) 741 2259
c/o Health Department, Town Council of Brakpan, P O Box 15, Brakpan 1540

HIVES Counselling and Support
Hettie (011) 741 2263 (mornings), Selest (Geluksdal), Maria & Lydia (Tsakane) 738 1003, Jenny 818 5068
AIDS Outreach
Grant (011) 816 1296

LifeLine
(24 Hours Service) (011) 54 0088
Hospice (ER)
Petra (011) 422 1530/2

Human Sciences Research Council (HSRC): Focus Group Health Care

The HSRC's mission is to conduct and promote research with a view to finding workable solutions for human problems, in order to help establish a just and sound society.
We aim at:

* improving health in Southern Africa through research and consultation;
* researching all aspects of health care; and
* ensuring community participation in research.

Living in Hope

Aims:

* to offer effective education in the form of one-day courses to companies throughout the country, highlighting for their employees the dangers and repercussions involved in the spreading of HIV and emphasising the cost-effectiveness and value to companies of maintaining the health of employees who are HIV positive;
* to provide a self help organisation for people with a positive diagnosis of HIV and those who are affected by HIV infection;
* to inform people of the advantages of early intervention of an holistically based health care approach, in conjunction with allopathic health treatment and monitoring, which treats HIV as a chronic, manageable condition;
* to establish a community-based monthly newsletter which will provide information for people affected by HIV infection, irrespective of gender, race, social status or sexual orientation, as a means of combating the isolation and anxiety often encountered by individuals with HIV

Vincent Veal
9 South Street, Bellevue East, Johannesburg 2198
Tel: (011) 487 1607 Fax: (011) 648 5310

Macmillan Boleswa

A set of 18 narratives for standard four to matric have been published. They all illustrate real life situations where HIV has made an impact on the lives of individuals and the community. Accompanying the books are teachers' guides with lesson ideas. In order to prepare teachers for sexuality education in the classroom, Macmillan Boleswa runs three day seminars for groups of teachers. Seminars cover STDs, AIDS prevention, prejudice, with particular reference to sexuality, living positively, issues of adolescence, essential life skills, networking and involving parents.
PO Box 32484, Braamfontein 2017
Tel: (011) 339 2935 Fax: (011) 403 1627

The Planned Parenthood Association of Southern Africa (PPASA)

The PPASA is an independent organisation which strives to bring the principles of planned parenthood, reproductive health and responsible sexuality, primarily to the youth and young adults of South Africa, so that as individuals they are empowered to make informed choices about these matters.

We will achieve this by involving and challenging the media, government and other

policy and opinion makers to ensure that comprehensive reproductive health services and education are provided for all. We will also work with, challenge and empower individuals, groups and communities to address these issues themselves and to this end we will involve ourselves primarily with training others. We will initiate and facilitate model programmes and provide information, training and research.

We are also committed to the training and development of staff so that they can fulfil their professional role within the organisation. We recognise and will promote the inextricable links between the world's population, the environment and the allocation of natural resources. so that all can work together towards achieving a balance between human numbers, human needs and the natural environment. We are committed to adapting to the needs of a changing South Africa.

National Office:
Mr Tsietsi Maleho, Mrs Gail Brittain, Mr A. Wilson
PO Box 8687, Johannesburg 2000 · cnr Smit and Biccard Street, Braamfontein 2001
Tel: (011) 339 1361/2 Fax: (011) 339 2205

Branch offices

Cape Town
Mrs A van Esch
Unit 8A, The Waverley, Dane Street, Mowbray 7700
Tel: (021) 448 7312 Fax: (021) 448 7320

Durban
Mrs P Kozik
PO Box 49471, Qualbert 4078 · 320 West Street, Durban
Tel: (031) 305 2588 Fax (031) 307 3500

Johannesburg
Ms T. Ndondo (Acting)
3rd Floor, Marlborough House, 60 Eloff Street, Johannesburg 2001
Tel: (011) 331 2695/6/7 Fax: (011) 331 7777

Port Elizabeth
Mrs E. Lindoor
39 Fettes Road, North End, Port Elizabeth 6001
Tel: (041) 34 3003 Fax: (041) 34 3319

Lenasia
Mrs J. Suleman
JISS Centre, P O Box 344, Lenasia 1820
Tel: (011) 852 3502 Fax: (011) 852 3502

National AIDS Research Programme of the Medical Research Council

The Programme will conduct research and disseminate relevant information with the purpose of helping to reduce the transmission of HIV infection and contain and reduce the impact of HIV illness. This would involve:

* understanding of the epidemiology of HIV/AIDS and the vulnerability of individuals and society to HIV infection;
* assessment of HIV prevention strategies and programmes;
* assessment of the social, political and economic impact of HIV infection among individuals and society, including health and welfare services and the informal and formal sectors; and
* evaluations of medical, psycho-social and welfare programmes for HIV infected and

affected individuals.

Branches:

Western Cape
Ms Cathy Mathews
P O Box 19070, Tygerburg 7505
Tel: (021) 938 0453 Fax: (021) 938 0342

Natal
Mrs Quarraisha Abdool Karim
P O Box 17120, Congella, 4013
Tel: (031) 25 1481 Fax: (031) 25 8840

Transvaal
Dr Malcolm Steinberg
P O Box 1038, Johannesburg 2000
Tel: (011) 725 6551/2 Fax: (011) 725 3009

National Progressive Primary Health Care Network (NPPHCN) National AIDS Programme (NAP)

Objectives:

* to raise awareness of AIDS and develop prevention programmes
* to improve the AIDS component of primary health care services
* to encourage and pressure government to provide good quality health services and curative care for people with AIDS, as well as to supply condoms
* to develop community support structures for people with AIDS

9 Floor, Cavendish Chambers, 183-185 Jeppe Street, Johannesburg 2001
Tel: (011) 337 7126 Fax: (011) 337 9206

Soweto Eldorado Lenasia AIDS Forum (SELEF)

Networking, planning and advocacy organisation for all NGOs and health services working in HIV/AIDS in the south west Johannesburg area.
Dr James McIntyre
c/o Dept. of Obstetrics and Gynaecology, Baragwanath Hospital, PO Bertsham 2013
Tel: (011) 938 1534

Support for AIDS Families and Orphans (SAFO)

This organisation, based in Soweto, offers psychological and practical support to women, children and families affected by HIV/AIDS. SAFO provides bereavement and death counselling in the absence of the extended family. SAFO also assists the most disadvantaged women become self sufficient, for instance, by encouraging and helping them set up vegetable gardens.
Claire Fleming Tel: (011) 6789908

Township AIDS Project (TAP)

TAP is a community based organisation involved in AIDS awareness, research, legal assistance, training of counsellors and in pre and post-test counselling. A member of TAP is involved in the antinatal HIV-clinic at Baragwanath Hospital and has a special interest in women and HIV/AIDS.
Ipelegeng Community Centre, Crossroads, White City Jabavu. Tel: (011) 982 1016

Some Books To Read

Critical Health has received a number of publications on HIV/AIDS from publishers and friends. This is not a comprehensive reading list, and some of the books may, as yet, not be available in South Africa. The books listed here provide a range of approaches to dealing with the problem of HIV, from the entertaining educational Roxy Comic to other literary, sociological and more clinical pieces.

Women, AIDS and Activism
Marion, Banzhaf (et al) (eds) .
ActUp/New York women AIDS Book Group, 1990
A comprehensive and progressive book about women and the Aids epidemic. It contains an informative discussion of safer sex and sexuality, HIV testing, treatment and drug trials, public policy and activism. It also looks at issues specific to lesbians, heterosexuals, bisexuals, sex workers, intravenous drug users, teenagers, mothers and women in prisons.

Women and HIV/AIDS: an International Resource Book
Marge Berer (ed).
Pandora Press, London, 1993
More than a resource book. This book gives personal accounts from women with HIV, and deals with topics such as safer sex, women's reproductive health, sexuality and sexuality education, gender relations and other issues of relevance to women, such as motherhood and HIV/AIDS. A comprehensive appendix, providing a list of organisations involved in HIV/AIDS work worldwide.

Primary AIDS Care
Dr Clive Evian.
Jacana, Johannesburg, 1993
Evian's book provides a comprehensive guide to primary health care personnel including nurses and doctors, with a step by step approach to the symptomatic care of people with AIDS. The book has an accessible page layout and gives a clear explanation of the stages in the transmission of HIV. Evian has produced a volume which may also be of great value to the families and friends of HIV positive people, not only in their domestic involvement in caring for their kin, but also in their engagement with health personnel. This publication also provides a countrywide resource list of organisations involved in education, care and treatment of HIV positive people.

We miss you all: AIDS in the family
Noerine Kaleeba.
Women and AIDS Support Network 4 (WASN), Harare, 1991
A moving personal account by Ugandan, Noerine Kaleeba, who experiences the death of her husband from AIDS. She records the challenge she took up, in defiance of her community's prejudice, to become involved with HIV positive people in setting up an AIDS counselling and care programme.

The Hidden Cost of AIDS: the challenge of HIV to development
Panos.
The Panos Institute, London, 1992

Panos examines the economic, demographic and social implications of AIDS throughout Africa, where the AIDS epidemic is most acute.

Triple Jeopardy: Women and AIDS
Panos.
The Panos Institute, London, 1990
Here, Panos explores the implications of the HIV epidemic for women, their children and their families. Women in dozens of countries describe how AIDS is disrupting families and communities, and highlight the steps which women are taking to protect themselves and those close to them.

Women, AIDS and Communities: a guide for action
Gerry Pearlberg.
Women's Action Alliance and Scarecrow Press, 1991
This book aims to encourage service providers and advocates at women's centres and other organisations to become involved in providing AIDS related services, information and education for women. It provides an overview of the information, resources and support necessary to begin such a service.

A Shallow Pool of Time: an HIV positive woman grapples with the AIDS epidemic
Fran Peavey.
New Society Publishers, 1990
A deeply moving description of Fran Peavey's experiences of isolation, rejection, anxiety, fear, sadness, anger, prejudice and social hysteria as result of her HIV status. By telling her story with openness, she diffuses the politics of AIDS by showing how the AIDS epidemic has an effect on everyone.

Roxy Comic
National Progressive Primary Health Care Network (NPPHCN) and
Medical Research Council (MRC)
AIDS prevention education for youth, done in an entertaining way, sensitive to a complex culture of sexuality among black South African youth, gay and straight. A useful addition to personal collections of Mills and Boons or photo romances. 'Roxy' should be on every school library shelf, and on every teacher's desk.

Positive Women: voices of women living with AIDS
Andrea Rudd and Darien Taylor (eds).
Second Story Press, Toronto, 1992
An anthology of personal experiences including poetry, private notes and diary entries, sketches, public addresses and recorded conversations of women across the globe. This book captures a range of experiences and the creative ways in which women cope with HIV. A beautiful and informative reading.

Section D

GENERAL SECTION

Negotiated Health Schemes
An Appropriate Option For the Unions?

Yogan Pillay

There is widespread agreement that the health system of South Africa is in crisis. The crisis has many dimensions. These include the crumbling public sector which is overburdened and underfunded; the significant increase in the cost of health care, especially to those dependent on the private sector; the policy of the state to unilaterally privatise public sector health facilities and the state's insistence that the medical aid schemes become the main source of financing for health services; and the emphasis on expensive, high technology curative care and the parallel neglect of primary health care services.

The State Should Provide

The trade union movement has responded to the health care crisis by demanding that the state reverse its policy of privatisation and insisting that it is the state's duty to provide health care benefits to all those in need. I conducted interviews with the Southern Natal branch secretaries of five unions affiliated to COSATU. Four of the respondents agreed on the need for a national health service (NHS) and one argued that it should be the state's responsibility to provide health services to those who cannot afford private health care fees. Four of the unionists thought that the state should provide free health care to the working class while one felt that the state should charge a reasonable fee. All the respondents agreed that health care should be treated as a basic right available on the basis of need rather than the ability to pay. There was also agreement that unions need to be involved in the shaping of national and regional health policy.

These responses are in line with the historical position of trade unions in many parts of the world. Navarro has argued that trade unions are one of the driving forces behind the struggle for universal entitlement to health care, based on need rather than the ability to pay. Trade unions in many industrialised countries have been particularly successful in this regard. In South Africa, however, the trade union movement still has to convert its demands into concrete gains. Moreover, the unions still have to crystallise their views on a

future health system. From the interviews, it became apparent that most unions are still in the process of debating the nature of the national health policy that will serve the interests of their membership.

Workers' Immediate Health Needs

It is, nonetheless, also true that trade unions have to meet the immediate material needs of their members. South African workers have begun to demand affordable and accessible care in the form of membership to medical schemes. Within the South African Commercial and Catering Workers' Union (SACCAWU), it has been recognised that the demands of their membership must be linked to the needs of the broader working class, including the unorganised and the unemployed. At the same time, it has also been argued that "it is difficult to reject medical aid because workers need proper health care now".

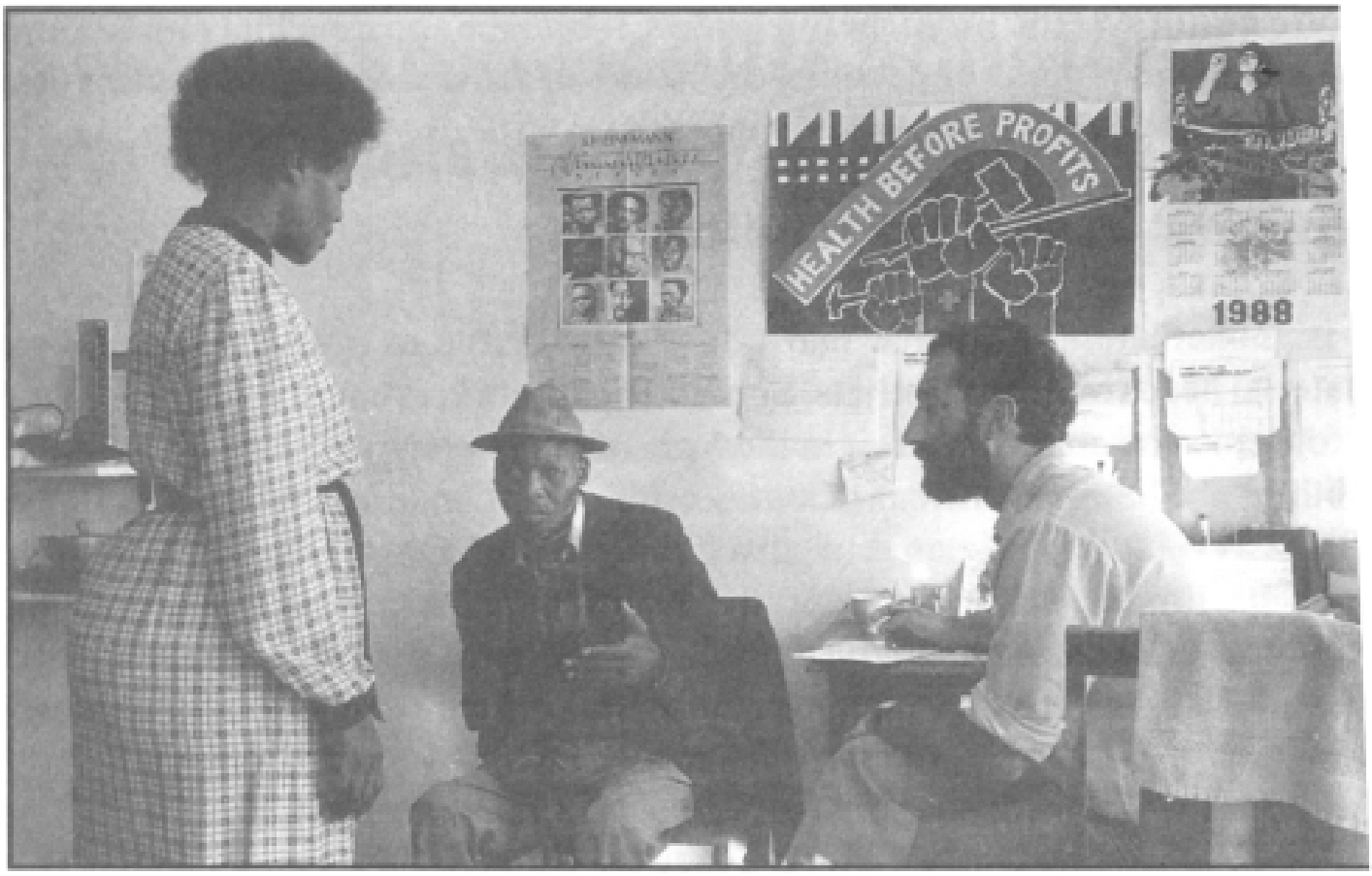
In 1989, a National Union of Metalworkers of South Africa (NUMSA) research group proposed an alternative to the medical aid scheme system. This proposal was similar to that of the Centre for Health Policy researchers, Broomberg, de Beer and Price. The key features of the proposal were the following. Health schemes would contract the services of health care providers and thus eliminate the fee-for-service aspect, thereby reducing costs. Members of these schemes would have more control over services than they would have in typical medical aid or benefit schemes. The schemes would be established in such a way as to easily incorporate them into a future national health service.

More recently, the National Union of Mineworkers (NUM) appears to have been investigating schemes that have similar features to that proposed by NUMSA and Broomberg, de Beer and Price. The type of service envisaged is one similar to the staff health maintenance organisation (staff-HMO), that is, a primary health level clinic run by health providers who are paid by a salary.

Staff-HMOs - Dividing the Working Class?

It may be argued that the NUMSA and NUM initiatives are imaginative and constitute a positive contribution to the demands of their members. The advantages of the proposed HMO system are to be found in its key features. It provides a mechanism that can potentially deliver affordable, accessible health services in a way in which members have control over both the financing and delivery mechanisms. This is surely more than workers are getting at present.

However, the suggestion that the unions should negotiate for staff-



FAWU ran a clinic in the Western Cape. ***Photo: Medico***

HMOs to meet the needs of their members is not without its problems. It can be argued that the creation of in-house HMOs by the unions would violate the principle of universality. In fact, four of the Southern Natal unionists interviewed argued against HMOs. In the words of one respondent, such a response by the union would create a 'union aristocracy' or elite segment of the working class, thus dividing the working class.

Current trends suggest that only a small percentage of the working class will have access to union initiated HMOs. At present, only 6,5% of the total African population are members of medical schemes, and only a portion of this number are workers. The formal employment sector is shrinking while the ranks of the unemployed and the informal sector are growing rapidly. Employers may currently be willing to subsidise health care benefits, but this is one of the first casualties in firms that are struggling financially. The majority of the working class will thus be increasingly reliant on a collapsing state sector.

This argument may be countered by the suggestion that staff-HMOs may incorporate mechanisms that include the possibility for non-members to obtain care as fee-for-service patients. However, this suggestion may only be viable in communities in which HMO members are in the majority, or if certain limits are placed on the services available to non-members. Otherwise, the HMO will

be viewed as a service that supplements the public sector facilities and will soon be overloaded. There is a real danger that union initiated HMOs will provide a further opportunity for the state to decrease its commitment to providing public health care facilities.

Possible Resistance to an NHS

The suggestion that the salary model HMOs that 'belong' to organised workers could become the foundation of a future national health service is also problematic. Proponents of this proposal do not envisage any resistance from workers to incorporation into a national health service. But workers may become comfortable with their own facilities and be reluctant to share these with the rest of the population. There is every reason to expect such resistance given the experiences of other countries. The American trade union federation, the AFL-CIO, has, over the years, won significant access to health care resources for its members, by way of medical aid schemes. It has since been resistant to the creation of a national health insurance system.

Esping-Andersen agrees that it is possible that organised workers may be reluctant to share health resources with other segments of the working class, despite their current claims to the contrary. He argues that, while unions see their own organisations as "embryos of an alternative world of solidarity and justice, as a microcosm of the socialist haven to come, ... these micro-socialist societies often became problematic class ghettos that divided rather than united workers, (as) membership was typically restricted to the strongest strata of the working class, and the weakest, who needed protection the most, were most likely outside".

The Southern Natal unionists also raised practical difficulties with the staff-HMO proposal. In some of the packages that are currently being negotiated, provision is made for employers to continue covering retrenched workers for 13 weeks after retrenchment. But how, for example, will the staff-HMOs counter the loss of income as a result of reduced employer contributions in the wake of massive retrenchments? Given that state facilities will shrink further if more private facilities are created, who will provide health care benefits for retrenched workers once the 13 weeks of coverage has expired? The need for adequate benefits for those conditions which incur high costs, for example AIDS, also presents a problem, as each staff-HMO will only be able to spreadthe risk across its relatively small number of members.

Guaranteeing the Rights of the Working Class

The unions have a difficult task: how do they respond to the need of their members for access to health care resources and, at the same time, fight for equitable access to health care for the entire working class? One solution appears to be the creation of staff HMOs which may be open to some members of the public. However, this option presents many problems, as we have argued above. Another possibility is that unions use their bargaining powers to, on the one hand, demand that employers, either individually or collectively, fund public health care facilities and, on the other hand, pressurise the state to increase the health budget and guarantee access to health care for all South Africans.

It might be argued that the second option does not meet the immediate needs of the organised working class and that unions have a responsibility to meet the needs of their membership. In addition, there is a possibility employers may not be willing to co-operate in securing better health care facilities for all. Given these arguments, it might be suggested that unions should embark on the creation of staff HMOs and simultaneously demand that the state provides adequate public facilities.

The last mentioned option is a dangerous one. Any attempt to obtain better facilities for one segment of the working class is ill timed, at a critical period of transformation. Buying into employer-sponsored health insurance, of any kind, will strengthen the hand of capital and weaken that of the working class. Access to health care is a right and unions should demand that the state guarantees this right. It is now, more than ever, that the organised working class has to consider the needs of, and act on behalf of, the working class. This is particularly important in South Africa, given that a significant segment of the working class is unemployed or under-employed and thus relatively powerless.

Yogan Pillay works for the Department of Psychology
at the University of Durban-Westville

Transforming Social Welfare
A Radical Approach

Ann Ntebe

This article aims to emphasise the importance of having a relevant and acceptable social welfare model, which allows social workers to engage in effective and appropriate professional intervention. A model of this sort will contribute to meeting the challenges facing the South African social work fraternity.

The following should not be seen in isolation, but rather as a contribution to the lengthy discussions on social welfare issues that have taken place at various social work conferences and meetings in and outside South Africa since 1987. The dissatisfactions expressed and the search for constructive alternative proposals are clear indications that social workers, especially those within the progressive fraternity, are in search of a unitary, non-racist, democratic welfare system.

The State Withdraws

The South African welfare system is based on a residual welfare model and operates within a context which has been shaped by decades of apartheid rule. The residual model is based on the assumption that people have the ability to govern themselves, to handle their rights and responsibilities maturely. In essence, it assumes they can take care of their own welfare needs. Thus the state and private welfare machinery will only start helping once people's ability to care for themselves becomes dysfunctional.

State policy documents, such as the October 1990 proposals by the Department of National Health and Population Development, further increase the burden that people and their communities will have to bear. The department is insisting that, "individuals, families and communities be primarily responsible for the financing of welfare services needed for their effective social functioning; government's contribution to welfare provision be reduced, and the burden be shifted to the private sector; and welfare structures be privatised."

Privatisation in social welfare means curtailed state responsibility for welfare services and increased expectations on the business sector to play a major role in the provision of finances for essential services. The government

is putting pressure on welfare organisations to limit their staff intake, thus forcing more social workers to go into private practice. This affects the quality and intensity of services delivered. Welfare organisations are forced to rely on volunteers and have to charge fees for services in order to generate income.

Inadequate, Inappropriate Services

According to the South African Council for Social Work, the statutory body which controls the profession, there are only 7 769 registered social workers rendering services through state and private welfare and community organisations to a population of over 37 million. As a result, one social worker often has to cope with a caseload of 100 families per month in addition to having to do community outreach work. An added concern is that these families are mostly affected by problems such as lack of housing, eviction, unemployment, public violence and associated trauma, poverty, alcohol and drug abuse and physical and sexual abuse. Patel refers to social work relating to these problems as "finding private solutions for public issues".

The consequence of such policies on an economically stressed population is increased political instability and continued social inequality. In addition, state welfare departments have been established on racial lines: the House of Representatives for 'coloured' people; the House of Delegates for Indians; and various regional services councils and local area committees for African people. Valuable, scarce resources are thus spent on a duplicated, fragmented, racially based, bureaucratic structure.

Racial differentiation has strongly entrenched inequalities between welfare beneficiaries, violating a fundamental principle of social justice and human rights, namely equal access to resources. Note, for example, the different pensions that were paid to pensioners of different races. Moreover, welfare assistance is regarded as a privilege rather than a needy citizen's right, thus the added humiliation of a means test in order to qualify for help. The state rationale is that South Africa is not a welfare state.

Dismantling the Old Order

It is my opinion that social workers and the social work fraternity as a whole have to fight tirelessly at drastically changing social welfare practice, theory and policy in order to contribute to South Africa's social transformation. In addition, goals set by the social welfare fraternity can only be achieved if the ruling structures of the country develop the political will to uproot poverty and

Not even Whites can depend on a safety net from the state.
Photo: Photo Workshop

promote healthy living and working conditions for all citizens.

Social workers in progressive structures have already initiated the dismantling process. Historic social work conferences were held in May 1989, April 1990 and June 1991, which involved organisations such as the Social Workers' Forum (Cape Town), South African Black Social Workers (SABSWA), Concerned Social Workers (CSW), the Welfare Policy Committee (Durban) and the Society for Social Workers (Witwatersrand). These organisations have resolved to promote a unitary, non-racial, non-sexist, democratic welfare system and to actively encourage the consumers of social welfare services to participate in decision making. They have agreed to make conscious efforts to dismantle the old welfare order and lay the blocks for the new, one which promotes human rights and acts as a mechanism through which wealth can be redistributed.

In addition, social workers have resolved to become agents of change in the struggle towards social justice and transformation. Social workers, at agencies such as the Child Welfare Society in Natal and Johannesburg and the Cape Mental Health Society in Cape Town, have started to address issues of paramount concern in the apartheid welfare system. In their own organisations, they have begun to desegregate management structures which have tradition

ally been dominated by white, middle class experts. They are starting to tackle racial inequalities in service delivery through strategic planning of future services. Social workers are now also beginning to address the need to use languages appropriate to the people they serve, indigenous to the South African scenario.

In the process of transformation, social workers face many challenges. Resolutions at conferences cannot easily be implemented if there is resistance from agencies and communities which have fallen victim to the 'welfare syndrome'. Social workers will need find ways of meeting these challenges and will, moreover, have to examine their own commitment to this process of change. Paulo Freire commented that social workers, as helping professionals, confronted with a changing environment with varying needs and demands, can never be neutral. This point was echoed by Jay Naidoo of COSATU, who said that social workers must never cease to expose the ways in which "exploitation and oppression create victims".

Radical Change, Not Modification

The challenge to the progressive social welfare fraternity is radical transformation of the residual, fragmented, discriminatory, expensive and individual oriented welfare policy to a unitary, non-racial, democratic and humane one. If the social welfare fraternity is serious about contributing to radical social transformation in South Africa, rather than modifying the system, then it needs to pursue a radical approach.

Radical social work locates the source of welfare problems in the socio-economic system. If breadwinners are unemployed because of widespread retrenchments and, as a result, do not have money to adequately support their families, and if this leads to snowballing problems, then the source of the problems lies within the market mechanisms rather than individual deviant behaviour. According to Louw, in his propositions for an appropriate social welfare model, "Social welfare needs to be interpreted broadly, and not just serving the casualties of society. Welfare should be interpreted as embracing human need in the form of food, shelter, employment, health, education and social security."

This necessitates a reconsideration of both the theory and practice of the dominant psycho-social, pathological and rehabilitative approach to social work. We need to assess whether the intrapsychic casework method of solving problems should be dominant, or whether we should pursue collective solutions to problems, in direct consultation with those affected.

The radical approach needs to permeate the daily work of social workers on the ground in order to be effective. Social workers need to be radical in their approach as opposed to reformist. They have to critically analyse the reality of their working system and then plan appropriate intervention strategies that promote the redistribution of power and resources according to the rights of the consumers of welfare.

They need to ensure that knowledge is shared and that critical discussion takes place in the communities in which they work. They have to play the roles of enabler, facilitator and advocate, with the view to empowering the communities. Through the strategy of empowerment, people are encouraged to take charge of issues that affect their social well-being. Social workers must not only make people and communities aware of unsatisfactory social conditions that negatively affect them, but must strongly motivate them to take action in order to bring about positive change to their prevailing situation. They should encourage communities to come up with their own solutions and to take collective action on this basis. Social workers also need to network with all helping professional and indigenous workers in the communities, so as to share creative ideas and ensure the development of a mutually consistent approach.

The Need for Organisational Unity

I believe that the radical approach outlined above is a constructive and viable alternative to the residual welfare model. However, radical transformation will only take place if all the key players are prepared to work at change consistently and relentlessly. Much is expected of social workers as agents of change in their places of work. In addition, social workers have to align themselves and join forces with social worker organisations, as well as other professional and community social service groups whose common goal is social justice.

Radical social work highlights many issues of concern in the South African social welfare system. A pertinent issue is that of the lack of unity amongst social worker organisations. This is obviously a reflection of life in broader society, but we need to move forward. Social workers have to acknowledge their differences and make progress towards establishing a national forum or association of social workers in South Africa. Many painful, but hopeful, days lie ahead in our move towards unity, democracy and social justice.

Ann Ntebe is an assistant lecturer in the School of Social Work at UCT. She is also the chairperson of the Social Workers' Forum in CapeTown.

NEXT EDITION

Putting the Health and Welfare of Children First

Under apartheid, children have always been vulnerable to various problems of ill health and abuse. Today, these problems are intensifying. Government policy makes poor households bare the brunt of the social and economic crisis, which in turn has a severe impact on children. These children are vulnerable to AIDS, crime, drought, disability and negligence, illiteracy, poverty, political turmoil, starvation and various forms of abuse from parents, the state and white racists.

**** What are the priorities for child health and welfare in rural areas?***

**** How do we prevent children from starving?***

**** Are there alternatives to imprisonment for children involved in crime?***

**** How do we involve communities in protecting children from violence and sexual abuse?***

**** What is the best approach to early childhood education?***

The next edition of Critical Health looks at the social problems of children in South Africa in the 1990s, and creative ways of addessing them.

SUBSCRIBE to CRITICAL HEALTH!

Critical Health is an independent quarterly journal dealing with health and politics in South Africa. It has been published for the last 14 years and has been contributing to debates on progressive aspects of health and health care. *Critical Health* reflects the concerns and issues currently facing those seeking alternatives in South Africa.

Critical Health aims to:

- provide ideas for roles that health workers can play in promoting a healthy society;
- show that good health is a basic right;
- provide a forum for debate for the discussion of health related issues;
- provide insight into the political nature of health.

SUBSCRIPTION RATES:

Please tick the rate category:

SOUTH AFRICA & NAMIBIA:

- ❒ Students, workers - R15.00
- ❒ Salaried individuals - R30.00
- ❒ Organisations - R50.00
- ❒ Business corporations, government bodies, university libraries - R80.00

SOUTHERN AFRICA:

- ❒ Students, workers - R25.00
- ❒ Salaried individuals - R40.00
- ❒ Organisations - R65.00
- ❒ Business corporations, government bodies, university libraries - R95.00

AFRICA, UK & EUROPE, MIDDLE EAST, SOUTH AMERICA

- ❒ Individuals - R70.00
- ❒ Organisations - R115.00

ASIA, NORTH AMERICA, AUSTRALASIA

- ❒ Individuals - R80.00
- ❒ Organisations - R130.00

IMPORTANT NOTE TO FOREIGN SUBSCRIBERS: could all payments which are not made in South African Rands be made by international postal order. All payments by cheque in a foreign currency should include an additional R20.00.

✉

Critical Health
PO Box 16250
Doornfontein
2028 South Africa

☎

(011) 484 3078
(011) 484 3557 (fax)

Please start off my subscription with no. .....
Please renew my subscription, starting with no.....
Name: .....
Address:.....
..... Postal Code:.....
Occupation:..... Tel. no. .....

ORDER BACK ISSUES NOW!

Please tick the issues you want:

- ☐ no. 7 - A Tribute to Neil Aggett
- ☐ no. 11 - Health Services: international edition
- ☐ no. 14 - Health care: who can afford it?
- ☐ no. 15 - Health Worker Organization
- ☐ no. 19 - Privatisation: health at a price
- ☐ no. 25 - SA medical education: ivory tower or community based?
- ☐ no. 26 - Detention and hunger strikes
- ☐ no. 27 - Health Workers Organize!
- ☐ no. 28 - Health in the cities
- ☐ no. 29 - 10 years in the health struggle
- ☐ no. 30 - Health before profit! Organizing for health & safety #1
- ☐ no. 31/32 - Health and Welfare in transition - the Maputo Conference, April '90
- ☐ no. 33 - Health before profit! Organizing for health & safety #2
- ☐ no. 34 - Women and health
- ☐ no. 35 - National Health Service
- ☐ no. 36/37 - People's health and social services - first joint national conference, July '91
- ☐ no. 38 - Focus on welfare
- ☐ no. 39 - Health Workers #1: Exposing conditions and debating roles
- ☐ no. 40 - Health Workers #2: Accountability & Training
- ☐ no. 41 - Healing new wounds: Violence and health
- ☐ no. 42 - Policy in Transition: NPPHCN/SAHSSO Health Policy Conference, Dec. '92
- ☐ no. 43 - Drugs: what's behind their prescription?

PRICE PER EDITION (including postage):

South Africa & Namibia: R5.00 Student/worker/unemployed: R3.00
Rest of Southern Africa: R7.00 Student/worker/unemployed: R4.00
UK, Europe, North Africa, Middle East, South America: R12.00
North America, Asia, Australasia: R15.00

IMPORTANT NOTE TO FOREIGN SUBSCRIBERS: please make payments which are not in South African Rands by international postal order. All payments by cheque in a foreign currency should include an additional R10.

✉

Critical Health
PO Box 16250,
Doornfontein 2028
South Africa

☎

(011) 484 3078
(011) 484 3557 (fax)

Name: .....
Address: .....
.....
Postal Code: .....

CONTRIBUTE

Critical Health aims to reflect the views and debates amongst health and welfare workers and organisations interested in developing an appropriate health and welfare service for South Africa.

We request you, our readers, to send us articles or book reviews on new developments and debates in health and welfare, for inclusion in the journal. We also encourage responses to contributions with which you do not entirely agree. Make Critical Health your journal and take the opportunity to engage in public debate with other health and welfare workers.

Critical Health's readership includes doctors, nurses, social workers, psychologists, non-professional and voluntary workers. Please ensure that your articles are accessible to as wide a readership as possible. Where the use of certain technical or academic concepts is unavoidable, these should always be clearly explained.

Articles should be concise and should not exceed 2000 words. Responses to articles and book reviews should not be more than 1 200 words. References and bibliographies are not required.

We also welcome any pictures (preferably black and white) and graphics which could be used to illustrate your contribution.

an article, response, or book review

Compassion, Care & Condoms ...

Inside:

SPECIAL PHOTO ESSAY:
Living with Dignity - the Sacred Heart Hospice

Plus

☞ **How poverty, migrant labour and homeslessness influences the spread of AIDS**

☞ **Safer sex - an honest approach**

☞ **What the government fails to do with its money**

☞ **Women living with HIV - a group encounter**

☞ **Trade Unions taking up the challenge**

☞ **Towards a radical welfare approach**

...Fighting AIDS