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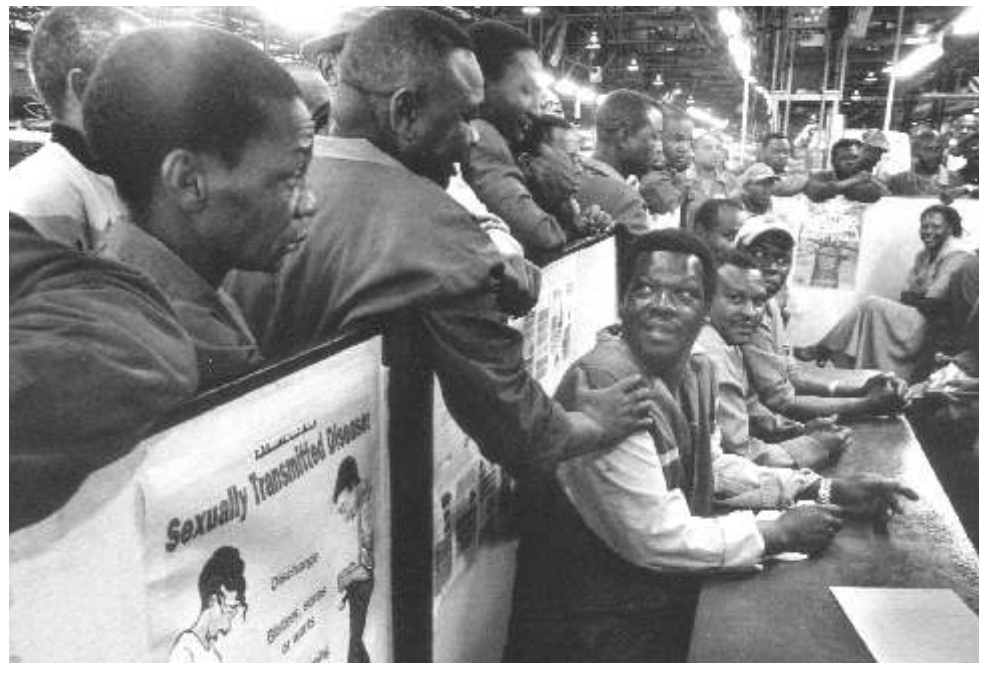
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HIV/AIDS in the workplace: How are trade unions responding?



Pic: Broken Landscapes - G. Mendel

The role of trade unions in responding to HIV/AIDS is crucial as the epidemic profoundly affects workers who often have limited space to change the factors that place them at risk of HIV/AIDS. These factors include labour migration, single sex hostels and the non-affordability of HIV/AIDS treatment.

HIV/AIDS in the workplace: How are trade unions responding?

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The role of trade unions in responding to HIV/AIDS is crucial as the epidemic profoundly affects workers who often have limited space to change the factors that place them at risk of HIV/AIDS. These factors include labour migration, single sex hostels and the non-affordability of HIV/AIDS treatment. Although COSATU has been centrally involved in collaboration with the Treatment Action Campaign (TAC) for affordable treatment, the focus has been on the national response rather than at the company level (Versteeg, 2003). Trade Unions have also held various activities such as regional workshops, information dissemination and media campaigns. The key focus of these campaigns has been the empowerment of shop stewards with HIV/AIDS information (COSATU, 2000). The effectiveness of these campaigns is not well understood in the workplace. This paper reports on a study, which assessed trade union HIV/AIDS responses and initiative in drawing up of HIV/AIDS workplace policies, involvement in prevention activities and HIV/AIDS management. It also notes the complexities of stigma and discrimination and how this limited the study.

Trade unions find themselves responding to a range of pressing issues. Clearly keeping jobs and wage negotiations are a priority against a backdrop of restructuring and retrenchments. Lower level workers are perceived to be at high risk of HIV, and retrenchments

may be an attempt to pass down the burden of HIV/AIDS to individuals and society. It is also in the process of restructuring that trade unions are weakened as they lose their members. Restructuring



Workers need HIV/AIDS Policies that protect them in the workplace
Pic: Africa Insight

as a response to globalisation thus exacerbates the causes of increased susceptibility to HIV/AIDS (Vass, 2003).

COSATU has acknowledged its weak role in responding to HIV/AIDS, as it has to grapple with issues such as, “*collective bargaining at national level competing priorities such as the labour amendments and salary increases, internal communication problems and the sensitivity and complexity of the AIDS problem*” (Versteeg, 2003, 6). This results in HIV/AIDS issues being low on the union agenda. Attempts are made by different federations to deal with HIV/AIDS but the response has been generally poor, as dealing with HIV/AIDS in a union context is not easy and is also complicated by the difficulties in communication between the unions' structures and the shop floor level workers (Stevens, 2001).

Methods

In an attempt to further understand workplace responses to HIV, a national study of workplaces was conducted in 2002.

A representative sample of 428 companies with over 50 employees, representing the manufacturing, mining, trade, transport, finance, automotive, hospitals, agriculture, construction and hotels and hospitality sectors was selected. We successfully contacted 383 workplaces and managed to interview shop stewards in 302 (79%) of these workplaces. The sample interviewed represented highly unionised workplaces, with the mean reported level of unionisation of 68.0% in their companies. Ethical approval was received from University of the Witwatersrand ethics committee, and a clear informed consent procedure was followed. The main trade union federations had been notified of this project through various meetings and workshops.

HIV/AIDS workplace policy and responsibility

Some 52.5% shop stewards reported having workplace policies on HIV/AIDS in their companies. Policies are often the first and easiest response to HIV/AIDS within a workplace. It is also an ideal place for trade unions to be involved in ensuring that the policy is consistent with the SA Code of Good Practice and upholds the principles of human rights and non-discrimination. It could also lead to the programmatic thrust of the company in having a process of dealing with HIV/AIDS in the workplace. When asked more about their involvement and employee knowledge of policy, only 28.4% of the respondents reported trade union involvement in the HIV/AIDS policy development process. More revealing is the reality of poor communication and dissemination with only 8% of shop stewards reporting that employees received a copy of the HIV/AIDS policy.

If trade unions are not involved in the HIV/AIDS policy formulation, do they feel that it is their responsibility to be involved? We believe that the greater the sense of responsibility and involvement of the trade union the more successful are the activities that the company undertakes in response to HIV/AIDS. When asked where responsibility lay for dealing with HIV/AIDS in companies, only 27.5% of shop stewards believed that trade unions were responsible for HIV/AIDS in their companies and some 17.3% of shop stewards believed that responsibility for HIV/AIDS lay as a collaboration between employees or employers in special workplace committees.

Activities and involvement

We were also keen to learn about trade union involvement in prevention activities as they could reflect engagement and participation. Table 1 below lists the prevention activities

shop stewards said that they knew someone who has died or left their companies due to HIV/AIDS related illness and 8% said AIDS was a problem in their companies; fully 21.1 % said HIV/AIDS did not affect the company at all.

Table 1. Prevention activities undertaken by workplaces

Prevention activities undertaken	Yes (n)	% (weighted by sector)
Prevention activities in the past 12 months	207	68.6%
Handed out informational materials	191	63.3%
Put up posters about HIV	191	63.3%
Educational sessions/workshops	173	57.2%
Distribution of condoms on company premises	200	66.4%
Trained employees to serve as peer educators or counsellors	95	31.5%
Provided voluntary counselling and testing	140	46.4%
Provided occupational health facilities e.g. treatment of STDs	96	31.7%

implemented in companies over the prior twelve months as reported by shop stewards.

While more than two-thirds of shop stewards reported prevention interventions, the activities that were implemented were fairly passive and required fewer resources, for example, handing out pamphlets versus training of peer educators; putting up of posters versus providing an occupational health facility for the treatment of STDs. One question is how decisions are made in prioritising and which prevention activities to do? Clearly the cheaper and easier activities had been chosen over the ones known as more effective and successful but more costly.

Perceived impact of HIV/AIDS amongst employees

Employees were aware of how HIV/AIDS affected individuals but did not know, how it impacted on their workplace. Only 15.4% of the

The study suggests that shop stewards still have some way to go in recognising impacts of HIV/AIDS in their workplaces.

Stigma and discrimination in the workplace

Given the current climate and hostility around HIV/AIDS it is also crucial to deal with the stigma and discrimination in the workplace. According to Masindi *“stigma has been identified as a complex, diverse and deeply rooted phenomenon that is dynamic in different cultural settings. . . . it operates by producing and reproducing social structures of power, hierarchy, class and exclusion and by transforming differences (class, race, ethnicity, health status, sexual orientation and gender) into inequality”* (Masindi, 2003, 2). In this rapidly changing environment of retrenchments and restructuring many workers are still not aware of their human rights and are still discriminated against, illegally tested and dismissed because of their HIV status (COSATU, 2002). Masindi concurs



Organised Trade Unions can push companies to respond to HIV/AIDS by coming up with HIV/AIDS policies - Pic: Brocken Landscapes G. Mendel

with this view and argues that the most prominent form of discrimination in the workplace is in the form of termination of employment or refusal to offer employment based on employers unnecessary fears about the transmission of HIV in the workplace”

(Masindi, 2003, 6).

Stigma and discrimination emerged as a major theme in the process of fieldwork as shop stewards were reluctant to discuss about HIV/AIDS. Almost nine percent of shop stewards said HIV/AIDS was a problem in their companies. Similarly, some 91% said that stigma and discrimination was not a problem in their workplaces. This suggests that there is denial about the disease and more detailed rigorous methodologies are needed to explore this issue. The general response from shop stewards was that HIV/AIDS is a private matter, which is not discussed with fellow workers. The fieldworks was extremely difficult to perform, as shop stewards were reluctant to talk

about HIV/AIDS and were clearly not confident to discuss HIV/AIDS related issues.

Conclusion

The role of trade unions in combating HIV/AIDS in the workplace is crucial as the disease mostly affects members but the response has been limited and insufficient. There is still a climate of stigma and ignorance regarding the disease as workers don't discuss or are not well informed about the disease. Stigma and discrimination have been identified as the factors that contribute to the inadequate response to the disease, as employees are reluctant or uncomfortable to talk about it.

The study shows that the response to HIV/AIDS by trade unions is poor, with unions having to grapple with other labour issues rendering HIV/AIDS not a key labour concern. Although there have been numerous attempt to address the scourge of HIV/AIDS at federation level, information is not well communicated at shop floor level as shop stewards do not

have sufficient information regarding HIV/AIDS. Unions are not aware of the effective ways of preventing infection and are often involved in the easier and cheaper prevention methods. Trade unions need to be informed about which activities are most effective and worthwhile, so that they can inform discussion in this regard.

There is a need to provide leadership that will put HIV/AIDS at the forefront of workers rights at the negotiation table. Comprehensive and inclusive policies need to be drawn so as to establish effective ways to deal with HIV/AIDS in the workplace.

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Malawi's Ministry of Health Embarks on Behavioural Change Intervention

By Nelson Nyirenda, Malawi.

Most Malawians have heard messages on HIV/AIDS prevention. Yet, they fail to positively change their behaviour. This has resulted in the further spread of the HIV/AIDS pandemic in the country.

It is estimated that about 250 Malawians get infected with HIV everyday, the virus that causes the deadly AIDS. About one million are already living with the virus. About half a million have already

HIV and AIDS, little seems to be adopted into practice. This including the use of condoms, considered by many people as a much easier though not safest means of avoiding HIV infection.

The Ministry of Health and population, last year embarked on the development of the first ever Behavioural Change Interventions (BCI) Strategy, with a view to provide guidance to organisations on how best they could plan and

stigma free and gender balanced environment.

The strategy has been developed with guidance from the National AIDS Commission (NAC) and the Health Education Unit (HEU).

However, there are fears that the strategy, which seems well developed, could end up like many other documents on the land, that have failed to live to the expectations of the people. It is said that Malawians are good at developing guiding documents but poor at implementing the developed strategies.

According to Deputy Director for Preventive Health services in the Ministry of Health and Population, Jonathan Nkhoma, only about two percent of Malawians use condoms consistently, as means to prevent infection. About 98 percent do not.

This, according to Nkhoma, is because people are reluctant to change their sexual behaviour, either due to low knowledge on best preventive measures, cultural beliefs as well as hopelessness among some people infected with the virus.

He said, despite several interventions put in place by various organisations, including government, the HIV/AIDS epidemic has continued to rise, threatening the social and economic development of the country at all levels. HIV it affects the most productive age group of between 15 and 49.



*Edutainment is a tool that is commonly used to instigate behavioral change.
Pic: Children by choice not chance brochure*

died of HIV/AIDS related infection since the virus was first reported in the country in 1985. They have left behind hundreds of thousands of orphans.

Despite efforts by Non-governmental Organisations to sensitise people on the dangers of

implement activities aimed at facilitating positive behavioural change interventions among Malawians.

The BCI Strategy also aims to empower Malawians to develop and maintain safer sexual and reproductive health practices in a

Nkhoma however said government decided to develop the strategy to reduce further the spread of the pandemic and save about 90 percent of the population, estimated to be still HIV free.

He said there were chances that Malawians would eventually change their behaviour, once properly sensitised on required prevention measures.

"Behavioural Change is a very slow process, because people have to make up their minds and look at the advantages and disadvantages of what they would like to do. Behavioural change deals with cultural teachings, so it can not be achieved overnight," he said.

Nkhoma then called for proper co-ordination in the implementation of the strategy, noting that many interventions had failed to materialise because of poor co-ordination among partners.

In an interview, District Health Officer (DHO) for Lilongwe, Dr Alice Maida, welcomed the strategy,

describing it as a vital tool for sustainable Behavioural Change Interventions in HIV programming.

Dr Maida, while saying there had been no assessment yet on levels of Behavioural Change in the district, said the district was not spared of the ravaging pandemic.

She said, among others, the pandemic was rising in the district because of hopelessness among the infected, little knowledge on HIV transmission as well as cultural beliefs.

The DHO also said the BCI strategy was emphasising on the need to focus on youths in the implementation of interventions, which she said would facilitate sustainable behavioural change in the district.

According to BCI Technical Officer responsible for sexual and reproductive health programme in the Ministry, Ms Beth Deutsch, the

strategy also provides guidance on how best stakeholders in HIV/AIDS prevention could best involve faith leaders in implementing the strategy.

She said, many times, the faith community has operated parallel to other partners because of differences over implementation structures, especially over the use of condoms as a prevention measure.

"Our work is not to challenge their reasons, but about finding solutions to the issue," she said.

Currently, the Ministry of Health and Population and NAC are conducting briefing sessions for districts across the country.

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Opinion

HIV/AIDS-Stigma and Discrimination

by Bradford McIntyre

Individuals should not have to suffer all losses due to illness! Men, women and children are suffering with HIV/AIDS. We need to assure that these people are cared for, not discriminated against! We must provide funds for proper nutrition, housing and health care for these individuals to aid and contribute to their well-being. We need to get rid of the false perceptions and judgments. Like Doreen Millman said in Vancouver at the 1996 AIDS Conference in reference to how a 63-year-old grandmother got AIDS. She said, *"It just doesn't matter!"* Neither does an individual's race, religion or sexual orientation matter! Don't look for differences; look at how we can help one another.

I do not believe it is naive to think we can make the necessary changes, but rather it is

naive to think that we can continue on our current course neglecting those who suffer from poverty, illness and disease. People are judging those who are sick, disabled and poor.

At the XIV International AIDS Conference 2002, Nelson Mandela said, *"Stigma, discrimination and ostracism are the real killers."*

People living with illness are no different from anyone else, except for their disease. Prior to this, they were hard working people, contributing to society. Once sick, they are expected to do without and not have those things they had in their life before sickness! Why do we allow this?

Many people have nothing due to the lack of funding and the effort it has taken for them to survive through their illness.

People should be entitled to the right to a quality and standard of living, which promotes wellness and healing, not death and dying. There are people dying due to the stress on an already stressed and suppressed immune system. There is added stress due to a lack of funds available to support nutritional diet and good health. Proper nutrition is necessary for HIV infected individuals, as those who eat well feel better compared to those who consume a less than adequate diet. Malnutrition can compromise their ability to fight off infection. The stress that people are enduring while trying to maintain a home, food, and health is putting them at risk of continued health problems. This in turn means they are in greater need of medical attention! We should be making good nutrition a high priority in AIDS treatment!

ARV Roll out: Taking Stock of Progress, Botswana and Zimbabwe

By Neddy Matshalaga- Deputy Director Programmes (SAFAIDS)



There has been widespread campaign on access to treatment
Pic: Gender and HIV/AIDS

Most of the issues shared in this article are drawn from discussions emerging from a parallel session at the recently held Pan-African Treatment Action Movement (PATAM) on antiretroviral therapy (ART) roll out where Dr Ndwapi Ndwapi, the director of Princess Marina Hospital's ARV Programme shared experiences from the Botswana programme and a presentation by Dr Chiratidzo Ndhlovu of HIV/AIDS Quality of Care Initiative (HACOQI) (Zimbabwe) on an overview of ARV Treatment in Zimbabwe.

Background

As Africa moves towards the third decade of the AIDS pandemic, the impact of HIV and AIDS is being felt more in all facets of human livelihoods; food security,

education, labour market, economy, socio cultural networks, care of affected and infected groups.

There is a general shift in the nature of the epidemic from an HIV epidemic to an AIDS epidemic. The implications are that more people are falling sick, becoming unproductive and requiring more care and support. Unless these people access treatment to enable them to manage their HIV status, mortality rates will continue to increase thereby worsening the impact of the epidemic on society. It is against this background that access to antiretroviral therapy (ART) is now an urgent issue and concerted action is called for.

Sub-Saharan African is the worst affected with over 25 million adults

and children living with HIV and AIDS. Of the 3 million AIDS related deaths globally in 2003, over 2.2 million (adults and children) are from the sub-Saharan region. Some southern African countries have HIV prevalence rates as high as between 20 and 30 % of the population.

In 2001 the Joint United Nations on HIV/AIDS (UNAIDS), along with scientists at World Health Organisation (WHO), pledged to provide 3 million people living in developing countries with antiretroviral therapy and access to medical services by the end of 2005. This target for access to treatment is now popularly known as the WHO "3 by 5 Initiative". In Africa, only 100 000 people of the 4 400 000 are receiving treatment. This constitutes only 2% of the population that needs ARVs.

Countries in southern Africa through their national governments, sometimes with technical support from WHO, are working towards national plans of action for providing ARVs to needy groups. The national targets, most of which are planned in line with "WHO 3 by 5" initiative, are referred to as "ARV roll out" plans. Statistics shared during the PATAM conference revealed that in any given country, 10 to 20 % of people living with HIV and AIDS need ARV drugs.

The goals of ARVs are generally agreed as to delay the onset of AIDS defining illnesses; provide a high quality productive life, reduction of viral load, delay death and reconstitution of immune competence.

Botswana

Of the estimated 330 000 HIV positive people in Botswana, 110,000 of them require antiretroviral treatment. Antenatal research indicates an HIV prevalence rate of 38 %, of which 60 % are women.

The Botswana National ARV Programme commenced in January 2002. The programme started initially at four high-population clinics. The following year, the programme was rolled out to an additional eight clinics, all of which are rural. This year, an additional 19 clinics - three located in small towns, the rest in rural communities - will be incorporated into the programme. To date, nearly 16 000 people are on antiretroviral treatment (ART) and an additional 1 500 children are also on ART, so the total public number of people on treatment is nearly 17 500.

The Botswana model for ARV roll out uses the existing national health systems. There have been three major prerequisites for the national ARV roll out.

1. The existence of an enabling national policy initiative is critical. The enabling environment is characterized by a strong commitment from the government to provide ARVs.
2. Mobilization of infrastructural, human, and financial resources is key for effective implementation of the program.
3. The adoption of suitable and flexible delivery model need to be in place before the roll out.

The patient profiles for the Botswana roll out include the following; a medium CD4+ count of 57. The majority of patients are

between 30-40 years with 60 % being female and 40 % being male. There has also been a total enrolment of 1500 children.

Responses to treatment for the Botswana ARV programme can be summarized as follows:

- 85 % of the patients have improved health and productivity
- 90 % of those on treatment for at least 18 months have adhered to treatment
- 10 % of those initially enrolled for treatment were lost to non-follow up.
- overall mortality for the program was 10 % of which 3 % of the overall mortality was attributed to adverse drug reactions.

Challenges of National ARV roll out:

Infrastructure presents one of the major challenges for roll out. While most urban settings may have the necessary infrastructure, the health setting in rural areas lack adequate infrastructure. The public health system is also already overburdened.

The need for innovation on human resources has been a major challenge. Much debate revolves around the use of doctors and the possible training of other health personnel such as nurses, orderlies, and pharmacists to administer and monitor use of ARVs. Cost and sustainability remain a long-term problem for access to treatment given the current dependency on donor funding for the programme. For community education, there is need to incorporate essentials of ARV therapy in Information, Education and Communication (IEC) materials. Efforts should be

put in place to demystify ARV therapy and make it a primary health care initiative. There is also a major challenge for building capacity of current health care workers to deal with ARVs in addition to their current health care demands. A more sustainable solution could be an intervention within the health-training curriculum.

Emerging challenges for the Botswana experience include:

- stigma, which may limit the uptake of the programme
- the need to address human rights issues for appropriate legal protection
- disclosure
- labour issues
- incorporating traditional healers and religious groups and relationships with national ARV roll out programmes
- ethical dilemmas of when and how to explain therapy to a child on treatment

Zimbabwe

Zimbabwe is in the preparatory stages of the ARV roll out plan. For the Zimbabwean roll out, access to treatment plan needs to be buttressed by comprehensive packages. These include

- Voluntary Counseling and Testing (VCT)
- information education and communication (IEC)
- condom promotion and family planning
- prevention and treatment of STIs
- Prevention of Parent to Child Transmission of HIV (PPTCT)
- prevention and management of opportunistic infections (cotrimoxazole prophylaxis and fluconazole)

- universal precautions
- treatment of other HIV related conditions and complications
- provision of ARVs for post exposure prophylaxis for health workers and therapy for the general public.

Like Botswana, Zimbabwe has identified prerequisites for a comprehensive package for access to treatment to include;

- training of health workers in HIV management, reduction of dependency on doctors to manage AIDS
- delegation of some aspects of HIV/AIDS care to non doctors and non health professions
- strengthening of basic infrastructure which include laboratories and counseling space
- mobilization of financial resources to support the programme
- increasing community participation and involvement in AIDS care
- more attention to reduction of stigma and discrimination

Target Clientele

While actual statistics are debated, it is estimated that between 300 000 and 500 000 of the 1,8 million positive people need antiretrovirals. In line with the WHO 3 by 5 Initiative, the Zimbabwe government has set targets for providing ARV to AIDS patients. Zimbabwe targets providing 260 000 patients with ARVs by 2005. At least 800 of the first 4 000 patients to be treated will be HIV-positive children. The Zimbabwe roll out will start from urban hospital centers. Lessons learnt will be addressed to make roll out a success in rural areas.

Progress to Date

Clinics for the treatment of opportunistic infections (IOs) have since been set up at two major hospitals of Harare-Gomo and Mpilo central hospitals. ART teams led by experienced physicians have been formed. Health staff has received training on opportunistic infections, rapid HIV testing and ART (locally and internationally). For laboratory support, two labs have been upgraded with assistance from Centre for Disease Control. The upgrade will extend to other laboratories at district and provincial level. The National Medical Reference Laboratory at Harare hospital is now equipped to perform CD4 counts, viral loads and resistance testing. The Bulawayo laboratory currently can do CD4 counts and it is hoped that in the near future it will perform similar tests to the Harare laboratory. The two sites have been assessed and are ready to initiate ART. Authority has been granted for the Ministry of Health and Child Welfare to procure ARV drugs using the special formal tendering process to kick-start the programme.

Conclusion

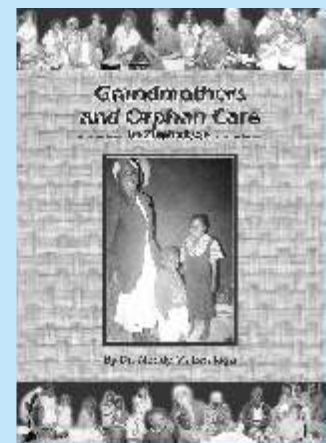
The main challenge of national governments is how to rationalize and operationalise national health policies and health delivery systems in order to urgently address demands for ART. As a result of high mortality rates due to AIDS and the mounting demand for therapy, there is pressure by AIDS activists, on national governments to act as urgently as possible. Civil society generally views their national governments as not giving high priority to providing ART. The urgency for addressing issues

of treatment will call for more multi-sectoral collaboration involving a wide range of stakeholders who may include governments, civil society, academic institutions, funding partners, and individuals experts.

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Upcoming SAfAIDS Publications



Grandmothers and Orphan Care in Zimbabwe
By Dr. Neddy Matshalaga

Research on HIV/AIDS Counselling

By Kimberly Richards

A Summary of a Mixed Method Study on HIV/AIDS Counselling in Zimbabwe

A Summary of a Mixed Method Study on HIV/AIDS Counselling in Zimbabwe.

A mixed method research study was carried out in order to explore the status of HIV/AIDS counselling in Zimbabwe. The study used both a five part mailed (electronic mail) questionnaire and telephone interviews to gain an understanding of Zimbabwean counsellors' attitudes and knowledge around HIV/AIDS, to identify counsellors emotions when providing HIV/AIDS counselling, and to gather insight into the professional experiences and perceptions of HIV/AIDS counsellors in Zimbabwe.

The counsellors were 30 to 59 years old, four of the participants were male and four were female. Half the participants were in jobs where they exclusively counselled HIV/AIDS clients and the other half of the participants had jobs that were not specific to counselling HIV/AIDS clients, but they had clients with HIV/AIDS. All of the participants worked in public settings. The participants of the study represented the four main "racial" groups in Zimbabwe (Black, White, Coloured, Asian-Indian). Additionally, counsellors represented rural, high-density, town, and city settings.

Counsellors knowledge of HIV/AIDS

The survey results indicated that the counsellors were very



Counselling is an important component in the overall health of people affected and infected with HIV - Pic: Gender and HIV/AIDS

knowledgeable about HIV/AIDS in the Western context. In regard to the interview, the counsellors indicated that they were also knowledgeable in the local context about HIV/AIDS. The counsellors recognized that culture, gender issues, unemployment, the economic crisis, housing, political instability, HIV/AIDS education, and the availability and affordability of HIV/AIDS therapies were all issues that impacted on the HIV/AIDS epidemic and that had to be addressed in conjunction in order help stem the epidemic. The counsellors were able to identify that HIV/AIDS was a complex problem that required a multisectoral solutions approach. The areas that the counsellors were least knowledgeable were in regard to how easily HIV is transmitted through bites, French (deep) kissing, oral sex, and through the sharing of toothbrushes.

Counsellors beliefs around the origin of HIV/AIDS

In regard to the counsellor beliefs around the origin of HIV/AIDS, Six counsellors specified that they believed HIV caused AIDS, one counsellor indicated she did not know if HIV caused AIDS, and another counsellor thought HIV did not cause AIDS. With the exception of one counsellor, all the counsellors thought that HIV/AIDS was not caused by cosmological forces. Around the issue of HIV/AIDS originating in Africa, four of the counsellors did not believe HIV originated in Africa, one counsellor did believe HIV/AIDS originated in Africa, and three counsellors were not sure what to believe about the origin of HIV/AIDS. In response to how to HIV/AIDS come to Zimbabwe, the counsellors agreed that it came to Zimbabwe from an outside source. The counsellors agreed it

was more important to try to manage the epidemic than be concerned with the origin of HIV/AIDS.

Counsellors attitudes toward HIV/AIDS and clients with HIV/AIDS

With the exception of one counsellor, the counsellors in this study indicated on the questionnaire and during the interview process that they had positive attitudes toward people with HIV/AIDS. All of the counsellors believed that counsellors in general in Zimbabwe had positive attitudes towards people with HIV/AIDS.

Counsellors emotional Experiences when counselling HIV/AIDS clients

All of the counsellors were aware that they experienced particular emotions/feelings while counselling HIV/AIDS clients. These feelings were both positive and negative. The feelings in some cases were directed at the client, at other times at the counsellors themselves, or at the environment (political, social, cultural, and economic contexts). Specifically, the positive feeling that were reported by one or more of the counsellors were hopeful, positive attitude, uplifted, useful/helpful, and having feelings of admiration for the client. The negative feelings that were reported by one or more of the counsellors were over-identification, conflict, anger, fear, sadness, helpless, inadequacy, anxiety, overwhelmed, hopeless, apprehensive, frustration, horror, distress, unsure, irritation, ambivalence, shock, remorse, tiring, and trying. Though the counsellors reported experiencing more negative emotions than positive ones, many of the negative emotions the Zimbabwean

counsellors had were not directed at the clients. In regard to their personal fears of HIV/AIDS, three counsellors expressed fear about HIV/AIDS, but this fear was not in relation to being afraid of acquiring HIV from their clients, but rather their own personal worries. Two counsellors had fears in relation to the impact of HIV in Zimbabwe in general. Two counsellors did not express any personal fears about HIV/AIDS.

Of concern is that though most of the counsellors in this study have much experience with HIV/AIDS clients and have a number of hours of training in HIV/AIDS counselling, the counsellors reported either on the survey and/or during the interview process they experienced feelings of inadequacy, helplessness, and to some degree anxiety when counselling HIV/AIDS clients.

Difficult aspects of the HIV/AIDS counselling process

In regard to what aspects of the HIV/AIDS counselling process the counsellors found most difficult, the findings suggested that the early stage of the counselling process is the most difficult part for the counsellors. Other areas of difficulty are the later stages of the counselling process, having a couple with discordant HIV results,

and counselling HIV clients that wish to have children. Of interest is that with the exception of one counsellor, the counsellors were comfortable discussing issues of human sexuality with their clients and all of the counsellors reported that they were comfortable discussing issues of human sexuality cross-culturally.

Counsellors' professional experiences/perceptions about HIV/AIDS counselling

The findings suggest that most counsellors in Zimbabwe have only a few weeks of training for this very demanding job. The findings revealed too that these counsellors thought that support, and supervision of counsellors was Zimbabwe is limited. Zimbabwean HIV/AIDS counsellors appear to be under extreme stress from their jobs as counsellors on the professional, psychological, and economic levels. Despite this stress, the counsellors in this study found meaning in providing HIV/AIDS counselling to their clients. This sense of meaning and fulfilment may help HIV/AIDS counsellors deal with the stress of their jobs.

The role of the HIV/AIDS counsellor in Zimbabwe appears to be complex, difficult, and tiring. The data suggest that the

Call for Assistance

Farai Mahaso, the only son of the late prominent Zimbabwean AIDS activist, Auxillia Chimusoro has been offered a place at Leeds Metropolitan University in United Kingdom to study for a Msc in Public Health (Health Promotion) for one and half years. The programme is starting in September 2004. Upon completion of the course Mahaso intends to return to Zimbabwe to use his knowledge and skills in the fight against HIV/AIDS following in the steps of his mother Auxillia.

Mahaso is appealing for £11 875 towards fees for the duration of the one and half years. Those interested in assisting can contact:

SAfAIDS or

Farai Mahaso, fmahaso83hotmail.com, Tel: +263-23 895 740

counsellor has many roles to play such as, educator; resource person; nutritionist; prepares the client and family for the death, burial, and bereavement process; and also attends to the psychological needs of the client and family.

Counsellors in Zimbabwe may be themselves experiencing multiple losses from HIV/AIDS and could also be HIV positive as well. The picture the findings paint is that working as an HIV/AIDS counsellor in Zimbabwe is not only extremely demanding psychologically on the counsellors, but also demanding in terms of developing both a knowledge base and counselling skills to meet all the needs of the client. Moreover, the data indicated that counsellors may be lowly paid, not taken seriously as professionals, and are not recognized as professionals.

Trustworthiness of the Study

In order to establish the trustworthiness of the study the researcher continuously examined her experience as a researcher as the research progressed. Additionally, triangulation, external audits, thick descriptions, member checks, examining researcher's biases, shifting conditions, and negative case analysis were used to establish trustworthiness (Creswell, 1998; Lincoln & Guba, 1985).

Limitations

Though the study may have a degree of trustworthiness, there are potential limitations of the study that need to be considered. Though external auditors and triangulation may help provide some generalizability to the study, there were only eight counsellors/participants in the study and the use of snowball and convenience sampling may limit generalisability as. Generalizability may also be limited in that the

indigenous counsellors in the study were from the Shona ethnic group.

Another issue to take into account is that all of the participants in this study except one were educated beyond high school. They also all had qualifications in counselling and training in HIV/AIDS counselling. Most counsellors in Zimbabwe are neither as educated nor as well trained. If one were to survey and interview para-professional counsellors, the results of the study may be different. Another potential limitation may be the counsellors in this study would a times talk about counsellors and counselling in general in Zimbabwe when they

Counsellors need to be provided with supervision and support systems to help them cope with for example grief, bereavement, fear, and anger

may have only the remotest professional, economic, and social connections with other counsellors in Zimbabwe.

Culture may also present another potential limitation on the study. Various cultural norms may impact on the study. However, triangulation and external auditing did help verify the responses of all the counsellors.

Conclusions

The information presented above is a summary of the results of a mixed method study that took place over a two year period. The counsellors in this study were in general very knowledgeable about

HIV/AIDS, had positive attitude towards people with HIV/AIDS, and believed that the AIDS epidemic in Zimbabwe could be contained. Though these counsellors are well trained, they reported that most counsellors in Zimbabwe are not. They also relayed that most counsellors do not have adequate support and supervision. Most of the counsellors in the study reported they also received little in support, supervision, or ongoing training. Counsellors need to be provided with supervision and support systems to help them cope with for example grief, bereavement, fear, and anger. Though the counsellors in this study have faith in the work of paraprofessional counsellors, they identified that they are under trained and lacked supervision and support. It appears that Voluntary Counselling and Testing (VCT) counsellors in Zimbabwe may also be acting as community counsellors, that is individuals, come to them for counselling unrelated to HIV/AIDS counselling, for which the counsellor is not trained for. As such those counsellors need additional training, support and supervision to manage their role as community counsellors.

The counsellors in this study experienced a number of feelings both positive and negative when counselling HIV/AIDS clients. Most of the feelings reported were negative. These negative feelings are for the most part not directed toward the client. Counsellors in Zimbabwe could benefit from supervision and support groups to help them understand and cope with their feelings.

The findings of this study appear to have a good degree of trustworthiness. Both Creswell (1998) and Lincoln and Guba's (1985) criteria for establishing trustworthiness.



HIV Prevention Efforts Failing Women and Girls

Existing HIV prevention and protection efforts are failing to stem infections among women and girls because they do not take into account such issues as gender relations and sexual behaviour, according to the United Nations AIDS programme.

"All too often, HIV prevention is failing women and girls," said Dr Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS). Dr Piot was speaking at the launch of the Global Coalition on Women and AIDS, a UNAIDS-initiated group of leading women and men committed to mitigating the impact of AIDS on women and girls worldwide.

"Because of their lack of social and economic power, many women and girls are unable to negotiate relationships based on abstinence, faithfulness and use of condoms. It is precisely to address these inequalities and reduce women's vulnerability to HIV that the Global Coalition on Women and AIDS has been created."

Women are particularly vulnerable to HIV, with about half of all HIV infections worldwide occurring among women. This vulnerability is primarily due to inadequate knowledge about AIDS, insufficient access to HIV prevention services, inability to negotiate safer sex, and a lack of female-controlled HIV prevention methods, such as microbicides.

Women and girls are often powerless to abstain from sex or to insist on condom use. They may be coerced into unprotected sex or run the risk of being infected by husbands in societies where it is common or accepted for men to

have more than one partner. Women are also biologically more vulnerable to infection; male-to-female HIV transmission is estimated to be twice as likely than female-to-male. In some of the regions worst-affected by AIDS, more than half of girls aged 15 to 19 have either never heard about AIDS or have at least one major misconception about how HIV is transmitted.

While condoms have been proven effective in HIV prevention, their correct and consistent use rests with the male partner, making it more difficult for women to negotiate safer sex. In fact, most sexually transmitted HIV infections in females occur either inside marriage or in relationships women believe to be monogamous. *"The typical woman who gets infected with HIV has only one partner - her husband or steady boyfriend,"* said Oscar-winning actress Emma Thompson, an ambassador for ActionAid International. *"Regardless of their relationship status women desperately need new HIV prevention tools that they can control."*

A study in Zambia found that only 11% of women interviewed believed that a woman had the right to ask her husband to use a condom - even if he had proven himself to be unfaithful and was HIV-positive. Studies in the US suggest that many women infected by male partners were unaware the men had had multiple sex partners, sex with other men or that they injected drugs. Violence, too, increases the danger of HIV infection among women. In certain places - Cameroon, the Caribbean, Peru, and South Africa - between 20%-48% of girls aged 10-25 reported that their first sexual encounter was forced. Fear of violence not only prevents women from accessing HIV/AIDS information, it prevents them from getting tested, disclosing their HIV status and receiving treatment and counselling, even when they know they have been infected. This is primarily due to the stigma and discrimination associated with HIV and AIDS. *"When women are infected with HIV they often face physical and emotional violence. As a result, they can be abandoned by their families and*



*Women and girls are still facing the brunt of HIV/AIDS
Pic: Zimbabwe women voices*

ostracised by their communities," said Ludfine Anyango, a woman living with HIV and National HIV/AIDS Coordinator of ActionAid Kenya.

Women's vulnerability to HIV and AIDS is further exacerbated by unequal property and inheritance rights. In many countries men usually own property - women only have rights through marriage. This radically reduces their economic security and can lead to women enduring abusive relationships or resorting to sex for economic survival. Women whose male partners die of AIDS are often left homeless as the property rights are passed on to relatives instead.

"It is crucial that HIV prevention programmes involve both women and men to effectively address gender inequality and reduce women's vulnerability to HIV," said Mary Robinson, former President of Ireland and Executive Director of the Ethical Globalization Initiative.

"Women's rights must be fully respected and protected if we want a realistic chance at reversing the spread of AIDS."

Another promising HIV prevention option for women lies in microbicide research. Formulated as a gel, film, sponge, lubricant or time-released suppository, a successful microbicide could help protect women and couples who cannot or do not use condoms against HIV. Researchers at the London

School for Hygiene and Tropical Medicine estimate that a microbicide could prevent more than 2.5 million new HIV infections in only three years, even if it is 60% effective. To date, microbicide research is severely under funded. Of the US\$775 million needed to test existing products in the pipeline, only US\$343 million is available.

The Global Coalition on Women and AIDS aims to be a highly-visible group of men and women, including activists, government representatives, community workers and celebrities, that seek to stimulate concrete action on the ground to improve the daily lives of women and girls.

Its efforts will focus on preventing new HIV infections among women and girls, promoting equal access to HIV care and treatment, accelerating microbicides research, protecting women's property and inheritance rights and reducing violence against women.

Women comprise about half of all people living with HIV/AIDS. In Sub-Saharan Africa, 58 percent of those living with HIV were women as of end 2003 and young women aged 15 to 24 were 2.5 times more likely to be infected than young men.

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information about UNAIDS, please visit our website, www.unaids.org

Source: Global Coalition Press Release, 2 February 2004

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My concern and disappointment is directed at the lack of consideration given to the present situation of poverty, poor nutrition, inadequate sanitation and housing for people living with HIV. These issues are of the utmost importance to individuals who are trying to maintain their health and living. The present situation is driving people below poverty, affecting their health and forcing them to live in standards no one would want to experience! People, who have worked and contributed to society, should not be subjected to living in inadequate conditions due to health and inability to work when diagnosed with a life threatening disease!

A call for action is necessary. The present situation dictates that these are vital necessities for people living with HIV/AIDS throughout the world! Since many people infected with HIV have neither the health nor energy to work towards creating awareness and change, it is my intention to speak through my experience

for those whom I hope will benefit. Ignoring the importance of meeting these needs will bring an ever-increasing cost to our health care systems and us worldwide. A simple exercise in these directions and implementation would have an enormous impact on the fight against AIDS!

We are all here together, connected. Nothing is happening to just one of us, but affecting ALL of us! Illness and poverty can strike any one of us, at any time! What is happening affects us all. We can no longer look at others or view other places in the world where people are sick and dying and continue to neglect caring for them, without recognizing how it affects society. We have the means to provide all that is necessary, but we will have to work together to correct the global imbalance. The richer countries have a moral responsibility to help out poorer countries.

We have been warned by science that we are faced with an ever-increasing battle -- the battle against the bug! Every country is at

risk of every disease... We cannot continue to allow millions to suffer and millions to die and expect we will not be affected.

We have to make the necessary changes and care for one another. If HIV and AIDS have not brought this realisation, then surely West Nile, SARS, Mad Cow, Monkey Pox and Ebola are convincing enough! ...We would do well to pay attention and learn from the enormous poverty, illness and deaths worldwide caused by HIV/AIDS.

At the XIV International AIDS Conference in 2002, Nelson Mandela in his closing speech said, "*AIDS is a war against humanity.*"

There is no doubt this situation is going to have an enormous effect on all our lives. When will our eyes be opened to what is going on all around us?

*by Bradford McIntyre
Vancouver, B.C. Canada
www.PositivelyPositive.ca*

UNAIDS in Angola



group into an expanded technical forum including participation of technical focal points from the different sectors.

The UN Theme Group is currently engaged in discussions to outline a joint UN work plan to support the implementation of the national strategic plan. Currently, the UN joint strategy is harmonized with the ongoing elaboration of the UN Development Assistance Framework for Angola, and based on the UN Declaration

of Commitment on HIV/AIDS made at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS)

Since 2001, the Theme Group has supported the following projects through UNAIDS' Programme Acceleration Funds (PAF):

- Inter-provincial training for the decentralized implementation of strategies.
- Capacity building for national NGOs.
- Government-led participatory process to draw up the National Strategic Plan on STI/HIV/AIDS 2003-2008.
- Decentralization of the National Strategic Plan.
- Sentinel surveillance reinforcement.
- Capacity building of the National AIDS Council to put in place a management and monitoring and evaluation system.

- Support to a programme on the prevention of mother-to-child transmission of HIV.
- International education and communication activities and campaigns.

Additional UN joint and collaborative initiatives funded from other sources include:

- Mainstreaming of HIV/AIDS in national institutions to reduce the impact on human development.
- Integration of sexual and HIV/AIDS education in the school curricula.
- Peer education involving youth in HIV/AIDS programmes.
- Reproductive health support programme, surveillance and laboratory capacity building greater involvement of people living with HIV/AIDS.

In Angola UNAIDS works through the UN Theme Group on HIV/AIDS, which consists of the UN Country Team (cosponsors and non-cosponsors of UNAIDS), with the UNAIDS Country Coordinator's office serving as its secretariat.

Additionally, an Expanded Theme Group serves as a nationwide information-sharing forum on HIV/AIDS attended by the government, bilateral donors, civil society, people living with HIV/AIDS and the UN system. As part of the evolution of the national response to AIDS, this forum is shifting from UN stewardship to a government-led body.

There is also a Technical Working Group on HIV/AIDS, chaired by the UNAIDS Country Coordinator and composed of UN focal points and the National AIDS Control Programme. Discussions are ongoing about the transformation of this working

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Treatment Literacy is Crucial in Southern Africa

By Tsitsi Singizi



The issue of treatment literacy was discussed at length at the just ended PATAM conference

Treatment literacy

“Are anti-retroviral drugs a cure for AIDS?” “What about the side effects we hear about?” These questions asked repeatedly at the recently held, Pan African Treatment Access Movement (PATAM) Conference, highlight a huge information gap that exists in communities, organisations, families and People living with HIV/AIDS (PLWHAs) with regard to the issue of treatment of HIV/AIDS.

Embarking on a vigorous treatment literacy campaign in southern Africa is crucial as this empowers the general public with the knowledge about HIV/AIDS and how to treat it. In Zimbabwe, most of the rural populace, where 70% of the people reside, have never heard about antiretroviral (ARVs) drugs. They do not know their purpose, if and where they can access the life prolonging drugs. For them an HIV diagnosis is equal to a death sentence.

The ignorance is not isolated. Where the little information on ARVs is available, it is not clear and is often shrouded in fear of the perceived danger of using these “powerful and toxic drugs.” In Swaziland the debate on side effects and the confusing signals it is sending has resulted in PLWHAs being reluctant to start anti-retroviral therapy. The need for information on the area of HIV/AIDS treatment cannot be emphasized.

Speaking to *SAfAIDS News* at the PATAM Conference, *Sipho Mthathi* the national coordinator on treatment literacy from the South African based, Treatment Action Campaign (TAC) concurred that there was need for treatment literacy in the region.

“Treatment literacy means creating awareness in people on issues that impinge on access to treatment, as it is in the region we haven't even begun. Southern Africa is

the epicenter of the AIDS epidemic yet very little has been done in this area.”

Mthathi said that literacy campaigns had to take a two-pronged approach of advocacy and information dissemination. She explained that the advocacy usually feeds into the awareness creating campaigns and vice-versa.

The issue of treatment is a fairly new area in Southern Africa. Most countries are still advocating for access to treatment and very few organisations and governments have taken up the initiative to educate and mobilize communities in this area. Yet the AIDS pandemic present enormous opportunities for public health to educate PLWHAs. People living with HIV/AIDS, are often passive recipients of whatever professionals decided to tell and give them. Treatment literacy gives them the chance to say “no we won't accept this,” and “we want this.”

In the short term treatment literacy can ensure that demands for access to treatment, specifically ARVs and drugs for opportunistic infections can be made from an informed position.

Although they are not a cure, ARVs inhibit replication of HIV, the virus that causes AIDS, and boost the immune system's ability to fight infections. In all countries where ARVs have become widely available to people living with HIV/AIDS since 1996, they have led to a dramatic reduction of HIV-related illness and death. ARVs have saved hundreds of thousands of lives in Europe and the United States.

Treatment literacy can focus on options available, how ARVs work and side effects. However, Mthathi strongly feels that in the long term

literacy should focus on social circumstances that affect people and make them vulnerable to HIV/AIDS, human rights, various health issues and the psycho-social issues in relation to treatment.

She said, “*There are many issues that are characteristics of treatment literacy. These are the social issues, gender dimensions, stigma and discrimination and nutrition.*”

Mthathi added that there was

still a lot of work to be done on all fronts, if the issue of treatment was to be fully understood by communities.

“*PATAM still needs to work. There is still a lot to be done.*”

PATAM is a social movement comprised of individuals and organisations dedicated to mobilising communities, political leaders and all sectors of society to ensure access to antiretroviral

(ARV) treatment, as a fundamental part of comprehensive care for all people with HIV and AIDS in Africa.

In southern Africa most people living HIV are likely to die of AIDS because antiretroviral medicines and adequate treatment of opportunistic infections are often out of reach. AIDS is the leading cause of death in sub-Saharan Africa.

Antiretroviral Treatment Feasible in Africa



Dr Françoise Louise

In 1999 *Medicins Sans Frontières*, launched the first ever campaign for Access to Essential Medicines of neglected disease, including HIV/AIDS, with the money they had won for winning a Nobel Peace Prize. Five years after, the initiative has grown and has spread to Africa. Tsitsi Singizi from SAFAIDS caught up with Dr Françoise Louise, Technical Advisor of the MSF Regional HIV project at the just ended Pan-African Treatment Access Movement (PATAM) held in Zimbabwe from the 3rd to the 5th of March 2004

Q: How many projects are *Medicins Sans Frontières* (MSF) currently working on in Africa and how many of these are in resource poor settings?

A: Currently we are engaged in many programmes. In Southern Africa we have programmes in Mozambique, South Africa and Zimbabwe. In South Africa we are running two programmes, one of them is in a township in Cape Town and the other is in a rural setting in Eastern Cape both are resource poor settings. We have two treatment cities in Mozambique, one is in Tete province and the other is in Lichinga. We have just started three projects in Zimbabwe. We also have projects elsewhere in Africa in countries like Benin, Burkina Faso, Cameroon, Guinea, Kenya, and Rwanda. In most instances these cities are in resource poor settings.

Q: How long have these programmes been running?

A: Some have been running for over 4 years like in Cameroon and those are obviously at an advanced stage. In South Africa we have been running for the past two years and we have seen a tremendous change in the past year. Some like the projects in Zimbabwe, are just starting.

Q: What has been your experience in all these projects?

A: The experiences are varied and depend on the location and the human resources and support in that particular area. However, it has proven to be feasible to provide treatment in Africa.

Q: The issue of perceived inability of people living with HIV/AIDS in Africa to adhere to treatment regimens has caused global concern. What is your comment on that?

A: Actually studies have proven that people in Africa tend to do better than elsewhere. This can be attributed to the fact there is a lot of support. There are innovative methods to assure adherence schedules. Counsellors, nurses and family members offer support.

Q: What are the challenges MSF has encountered in implementing its programmes

A: In a number of programmes we are still working within the hospitals and this has made it difficult for some of our clients who will be based far from these centres. We hope to decentralise to smaller clinics in the rural areas and the townships like the one in Cape Town, which is running from a township clinic.

Q: Is it feasible to provide antiretroviral therapy in Southern Africa?

A: It is very feasible. As long as there is the political will, human resources and funds, treatment programmes are implementable. It is actually a sin not to implement treatment in the region. I am not saying it is simple but it can be done. MSF cites have proved that it can be done. Treatment projects have so far been running very well.

Q: Where does the success of your programmes lie?

A: I think the MSF HIV project's major success has been because of five important areas:

- We successfully managed to integrate the ministries of health in all the countries we have worked. This integration of government structures and support from other existing infrastructures has helped.
- Our services are very client-

centered. In most instances we work with the grassroots and this has yielded good results.

- In all our projects we have managed to train the health workers we will be working with.
- The availability of the medicines and laboratory facilities are also instrumental in making sure that everything runs smoothly.
- Building capacity of NGOs, CBOs and governments is crucial to achieve our goals.

Gender Inequalities and HIV/AIDS

SAfAIDS Correspondent

On World AIDS Day in 1998, a brave South African woman Gugu Dhlamini announced her HIV-positive status. Soon after, she was stoned to death by a group of young men in her community.

Women are disproportionately affected by HIV/AIDS. Biology and gender inequality conspire to drive the spread of the disease and forces women to bear the brunt of the social and economic costs, according to a UNIFEM briefing paper.

Dhlamini's murder was made possible by societal norms that discriminate and rob women of power, and fail to protect the rights of men and particularly women living with HIV/AIDS.

Although few women were among those infected in the early years of the epidemic, by the end of 2000, 55 % of HIV infected adults in sub-Saharan Africa were women.

UNIFEM points out that for teenage girls in some of Africa's hardest hit regions, the reality is even bleaker. They are infected at a rate five or six times higher than teenage boys.

"The fact that HIV/AIDS poses a greater threat for women and girls, their lives and their futures, is now undisputed." a UNIFEM publication of 2001, *Turning the tide*, reports.

"This change reflects the fast growing understanding that gender equality and power imbalances between women and men in every society heighten women's vulnerability to infection and leaves them with heavier burdens when HIV/AIDS enters the households and communities," the report further asserts.

Gender roles make it hard for women to protect themselves. In a study carried out in Zambia, less than 25 % of the women interviewed believed that a married woman could refuse to have sex with her husband, even if she knew he had been unfaithful and was infected. Only 11% thought that a woman could ask her husband to use a condom. A UNAIDS survey found that women who fall sick from any cause are less likely than men to be admitted to a hospital or to have access to family resources. Poverty further disadvantages women in terms of HIV/AIDS infection and in circumstances of conflict, the combined impact is devastating.

"In spite of the now universally recognised cause and effect relationship between women's low social status and HIV transmission, concrete solutions are absent from international resolutions and national strategic plans that address HIV/AIDS."

Almost 20 years into the

pandemic, it is not enough to acknowledge its deadly gender dimensions. *"Policy makers and society at large must find ways to share power and autonomy with women,"* a UNAIDS report notes. Colleen Lowe Morna, executive director of Gender Links, South Africa said women and girls are still not yet receiving education and training on HIV/AIDS prevention because of discriminatory and stereotyped gender roles and norms.

"In many societies there are cultural dictates for women to play a passive role in sexual interactions, and strong social pressures for women and girls to remain ignorant about sexual matters," Lowe Morna said.

"Consequently, there is a frequent need to provide education about issues relating to sexuality to girls and women and they may be hesitant to pursue the information themselves."

"Social norms requiring that women be virgins when they marry mean that girls may be especially afraid to ask for information about sexual matters, as the impression created could mean that they are sexually active," Lowe Morna said.

Article 10 of the Convention on the Elimination of All forms of Discrimination against Women CEDAW provides that states must take all appropriate measures to 'eliminate discrimination against

women in education' and also specifically in relation to their 'access to the educational information that will help ensure the health and well being of families', including advice on family planning. In its 'General Recommendation on the Convention's article on health, the CEDAW Committee has recommended that States ensure the 'removal of all barriers to women's access to health education and

information in the area of sexual and reproductive health', and allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS. The General Recommendation on HIV/AIDS also directs State parties to increase their efforts to disseminate information to 'increase public awareness of the risk of HIV

infection and AIDS, especially in women and children'.

Even though many governments have signed conventions, such as CEDAW, pledging their commitment and support in the AIDS fight it is saddening to note that the gender dimensions of the pandemic are still absent from most HIV/AIDS interventions and unless this is done we will continue to fight a losing battle.

Donor Commitment on Access to treatment

By Tsitsi Singizi

One of the first things that one was struck with at the just ended Pan-African Treatment Action Movement (PATAM) conference was the conspicuous silence of the donor community. There seems to be an enormous paralysis of both local and international donors; an uncertainty and hesitancy to fully back and support the campaign on access to treatment bringing to fore questions about their commitment to the cause.

The conference, a first of its kind in the country, was hosted by the Pan-African Treatment Access Movement (PATAM), the Treatment Action Campaign (TAC), Zimbabwe Activists on HIV and AIDS (ZAHA), Southern Africa HIV/AIDS Information Dissemination Service (SAfAIDS) and HIVOS, and was focusing on scaling up Access to Treatment in southern Africa.

Addressing journalists at the beginning of the conference, Ndumiso Mpofu from HIVOS, the donor agency co-hosting the conference said the meeting provided a forum to review some of the challenges faced in the roll-out of ARVs, but admitted that the issue of treatment had not received

adequate support from donors.

"The issue of access to treatment has not been receiving adequate support. This to a large extent can be blamed on us the donor organisations. Some donors say they are not yet involved in the curative side of AIDS. Yet access to treatment is part of the social justice, which we claim to seek."

Although they are not a cure, ARVs inhibit replication of HIV, the virus that causes AIDS, and boost the immune system's ability to fight infections. In all countries where ARVs have become widely available to people living with HIV/AIDS since 1996, they have led to a dramatic reduction of HIV-related illness and death. ARVs have saved hundreds of thousands of lives in Europe and the United States

While donor agencies have been supportive in the areas of prevention and counselling, most have been slow to respond to the issue of access treatment. Excuses have been brewed to defend this donor position. Lack of evidence that scaling up is feasible in resource poor communities, the expense, lack of self-sufficiency on the part of the recipients are some of major reasons that have been cited as deterrents to the donor support.

Sipho Mthathi from the Treatment Action Campaign admits that donor support has been inadequate.

"Donor support has been difficult to come by, it is only after the donors found out that AIDS related deaths were threatening their donor investment that they started to seriously consider the issue of treatment. But this is not only about donors, it is also about governments."

The conference, which was hosted in the backdrop of the World Health Organisation (WHO) 3 by 5 initiative, which aims at providing antiretroviral treatment to three million people by 2005, will also focus on the mobilisation of governments in southern Africa to scale up access to treatment.

Billed to officially launch the conference, the Zimbabwe's Ministry of Health reneged on its task and was also not represented for the rest of the conference. In southern Africa only Botswana is providing antiretrovirals through its public health system

Treatment activists feel that the reluctance shown by both governments and the donor community to provide access to life-saving anti-retroviral treatment is a moral, political and economic oversight, which threatens the entire quest of sustainable development.

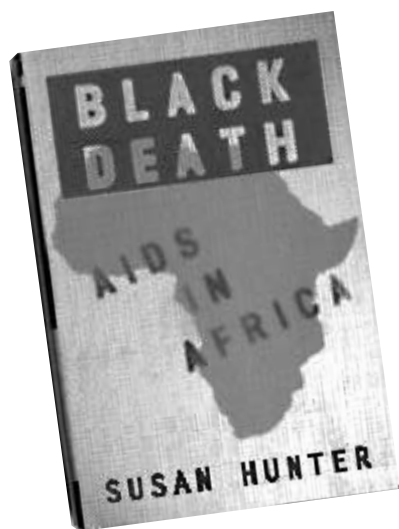
Publication review

Black Death: AIDS in Africa

November 2003

Author: Susan Hunter

Reviewed by: Tsitsi Singizi- SAfAIDS



"Black Death: AIDS in Africa is an alarming, disconcerting, angry title."

Labeled as stigmatising and racist, the title has drawn a lot of controversy, yet this title and the book sum up the harsh reality wreaked by the HIV/AIDS in Africa. AIDS is indeed the leading cause of death in sub-Saharan Africa.

Africa is home to 80% of the 40 million people in the world currently infected with HIV/AIDS and this is no accident. Highlighting various antecedents, Susan Hunter chronicles the suffering, poverty and the triumphs of the African people.

The publication is premised on two critical aspects, the scientific evolution of man and disease and the history of exploitation of Africa and its social

and political implications in relation to the AIDS pandemic.

In the first three chapters the author states her argument by placing the HIV/AIDS pandemic in a historical context. The first chapter introduces her four main characters, Charles Darwin and the Ugandans, Molly, Paulina and Robina. While the second chapter is on *AIDS and the World*, the third explores *Africa political and economic development*. It is from these initial chapters that the publication anchors its argument from.

The author uses Charles Darwin life and ideas to parallel developments in public health, medical science and responses to the epidemic. The book explores how Darwin's ideas were used to justify the oppression of those thought to be inferior. This led to unequal power relations, slavery, colonialism in Africa and subsequently the cycle of deprecation and deprivation. Addressing existing unequal power relations, poverty, under-developed economies and lack of political will from the west is a start, argues the author.

Chapter 5 focuses on *Internal Dynamics of epidemics* in which an important observation on responses to an epidemic is made through a quote from one Cristofano Ceffini, who was a Health Officer in Italy in 1630.

He said *"One learns at the cost of human life what happens when one receives from God the scourge of an epidemic without*

having light or experience wherewith to guide one's conduct in so exacting a task."

Hunter paints a vivid picture of the African experiences in trying to respond to HIV/AIDS through her three *"heroines"*, Molly, Paulina and Robina. The three women are at the heart of the pandemic in Uganda. They are shaping responses in their communities.

Faced with the AIDS epidemic, Molly, Paulina and Robina are forced to deal with unprecedented levels of orphans. They mobilise communities to help those infected and affected by HIV and AIDS. Taking care of the orphans, offering palliative care to people living with HIV/AIDS becomes a part of their lives as they struggle to mitigate the devastating impact of AIDS in their community.

Chapters 6,7 and 8 focus on Disease and Evolution and to cap the previous chapters, chapter 8 includes a component on epidemic management. In her summary conclusion the author articulates how HIV/AIDS threatens the well-being of the entire human species in at least five ways. The book will be useful for policy makers at the highest levels, programme managers, planners and professionals in health and human development.

Black Death: AIDS in Africa is a refreshing read, which offers a very different perspective in dealing with the AIDS pandemic in Africa.

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