THE POLITICAL ECONOMY OF HIV/AIDS IN THE EASTERN CAPE

RESEARCH CONFERENCE 7 - 9 MARCH 2010
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Abstract

The Eastern Cape AIDS Council (ECAC) facilitated a conference on the Political Economy of HIV/AIDS in the Eastern Cape from 7-9 of March 2010. The conference came to grips with some of the major social, economic and political aspects that drive the HIV/AIDS pandemic in the Eastern Cape. It was a catalyst for a range of strategic actions for the way forward and enhancing strategic partnerships. The conference report outlines and describes the conceptual overview regarding the political economy of HIV/AIDS and of the interrelated themes as well as the methodology and pre-conference consultations.
Executive Summary

The Eastern Cape AIDS Council (ECAC) facilitated a conference on the Political Economy of HIV/AIDS in the Eastern Cape from the 7th to 9th March 2010.

Key Questions:

What are the social, economic and political factors that influence the prevalence of HIV/AIDS in the Eastern Cape Province?
How can the knowledge of these factors be used effectively to advise the government and civil society to design relevant HIV/AIDS policies and programmes in the Eastern Cape Province?

The Conference got to grips with some of the major social, economic and political aspects that drive the HIV/AIDS pandemic in the Eastern Cape. Themes of the conference included:

- Social determinants of HIV in the Eastern Cape
- Governance and HIV/AIDS
- The effectiveness of HIV/AIDS policy and implementation
- HIV/AIDS and power relations
- Communication and HIV/AIDS
- Economy and HIV/AIDS
- Cultural practices in the context of HIV/AIDS
- HIV/AIDS – impact on socio-economic development

Leading national researchers, civil society organisations and government presented at the conference and the voices of many stakeholders were heard.

The Outcomes of the Conference Include:

- Increased knowledge and shared understanding by all stakeholders
- Refined research agenda
- Resource to advise policy and implementation
- Strengthened strategic partnerships
- Recommendations for key steps forward by various stakeholders

The conference was a catalyst for a range of strategic actions for the way forward in enhancing strategic partnerships in working together to address HIV/AIDS in the Eastern Cape.
Key recommendations were made across the interrelated themes of the conference and these are detailed in the body of this Conference Report. The deliberations and recommendations will guide the ECAC research agenda, as well as maximise its role in providing substantive policy guidance to government and co-ordination in HIV/AIDS programme implementation.

In terms of a research and knowledge management agenda the following have been prioritised:

**Table 1 - Research and Knowledge Management**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>ECAC to engage in research to ascertain the KPAs of councillors regarding HIV/AIDS and how these affect their leadership roles in the communities they serve</td>
</tr>
<tr>
<td>Social determinants of HIV in EC</td>
<td>Partner with research institutions to conduct research on social, economic and political factors related to HIV prevalence in the EC by district and sub-district</td>
</tr>
<tr>
<td></td>
<td>Review current research on effective prevention strategies</td>
</tr>
<tr>
<td>Effectiveness of HIV/AIDS policy and</td>
<td>Research should be conducted to ascertain the impact on the implementation of medical male circumcision in preventing HIV/AIDS transmission in the Province</td>
</tr>
<tr>
<td>implementation</td>
<td></td>
</tr>
<tr>
<td>Communication and HIV/AIDS</td>
<td>Collate review of research on effectiveness of communication messages and ensure that it informs programme implementation</td>
</tr>
<tr>
<td>HIV/AIDS and power relations</td>
<td>Conduct a systematic review and collate evidence for effective, pragmatic and context-specific approaches to HIV/AIDS, within the context of poverty alleviation approaches</td>
</tr>
<tr>
<td>The Economy HIV/AIDS</td>
<td>Conduct a provincial review of public-private partnerships</td>
</tr>
<tr>
<td></td>
<td>Facilitate a provincial review on the care economy i.e. financial incentives, training skills audit and training for public sector employees on community involvement</td>
</tr>
<tr>
<td>HIV/AIDS – impact on socio-economic</td>
<td>Develop content for policy briefs on the research being conducted on livelihood strategies, food security, coping mechanisms and climate change.</td>
</tr>
<tr>
<td>development</td>
<td></td>
</tr>
<tr>
<td>Cultural practices in the context of HIV/AIDS</td>
<td>Review the policy and service delivery implications of medical male circumcision as part of a comprehensive HIV prevention package</td>
</tr>
<tr>
<td></td>
<td>Review the literature on how medical male circumcision can interface with traditional circumcision practices</td>
</tr>
</tbody>
</table>

In terms of ECAC’s role as a generator of policy analysis and assistance to government and other key stakeholders the following have been prioritised:
<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Mainstream HIV/AIDS into all provincial policies and programmes</td>
</tr>
<tr>
<td>HIV/AIDS and power relations</td>
<td>Mainstream gender into all ECAC policy and programme related activities</td>
</tr>
<tr>
<td></td>
<td>ECAC should develop policy briefs for various stakeholders on HIV/AIDS and power relations in terms of various manifestations including race, gender, class, urban/rural location etc.</td>
</tr>
<tr>
<td>Social determinants of HIV in EC</td>
<td>Nutrition issues be integrated as part of HIV/AIDS treatment policies and programmes</td>
</tr>
<tr>
<td>Effectiveness of HIV/AIDS policy and implementation</td>
<td>ECAC to develop a policy brief for the government and key stakeholders in the implementation of medical male circumcision in the province as well as discuss and review the policy at large</td>
</tr>
<tr>
<td>Communication and HIV/AIDS</td>
<td>Develop an ECAC HIV/AIDS communication policy</td>
</tr>
<tr>
<td>The Economy HIV/AIDS</td>
<td>Provide content of policy briefs to government on HIV/AIDS for major policy processes, such as rural development, industrial development etc</td>
</tr>
<tr>
<td></td>
<td>Develop a policy brief on HIV/AIDS and the economy, including a greater focus being be placed on SMMEs</td>
</tr>
<tr>
<td></td>
<td>Review and update policy for dealing with HIV in the workplace</td>
</tr>
<tr>
<td>HIV/AIDS – impact on socio-economic development</td>
<td>Mainstream HIV/AIDS into provincial strategy and policy priorities as matter of urgency</td>
</tr>
<tr>
<td></td>
<td>Develop policy guidelines for government to inform funding and management of HCBs in the province</td>
</tr>
<tr>
<td>Cultural practices in the context of HIV/AIDS</td>
<td>Partner with SANAC to develop a policy and institutional framework for the regulation of traditional circumcision</td>
</tr>
</tbody>
</table>

A key governance priority recommended action is for the ECAC retreat resolutions in terms of governance, policy direction, structure and mandate to be implemented. These include the review of the vision, mission, chairing of the council meetings and constitution of sub committees.

The conference generated substantive recommendations in terms of HIV/AIDS programme implementation and the following have been identified as priority recommendations for implementation:
<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommended Action</th>
</tr>
</thead>
</table>
| **Governance**                             | OTP to broaden the scope of the implementation of a standardised workplace programme for HIV/AIDS as an element of the integrated employee wellness programme and with more emphasis on the importance of VCT and ART services  
|                                            | Co-ordinate government departments in terms of integration of HIV/AIDS into all programmes  
|                                            | Local government to be capacitated and supported on mainstreaming of HIV/AIDS in all areas of service delivery  
|                                            | OTP and ECAC to co-ordinate HIV/AIDS donor funding, support and activities in the Province directed to both government departments and civil sector formations to ensure alignment to provincial HIV/AIDS policies and priorities.                                                                                                                                                                                                                                         |
| **Social determinants of HIV in EC**       | The PSP be implemented, monitored and data from evaluation be fed back into the following planning cycle                                                                                                                                                                                                                                                                                                                                                                                                |
| **Effectiveness of HIV/AIDS policy and implementation** | ECAC to monitor how the new treatment guidelines are implemented and how information is made publicly available  
|                                            | ECAC in partnership with provincial structures including ECDOH evaluation unit to evaluate the impact of strategies towards improving the health profile of the Province (a priority for the Eastern Cape Province)                                                                                                                                                                                                                                     |
| **Communication and HIV/AIDS**             | ECAC to be an information hub and produce and collate information and resources and make it available to stakeholders  
|                                            | Promote province specific One Love campaign  
|                                            | Increase ECAC visibility and communication, both internally and externally.  
|                                            | Provide regular briefings and information to the media  
|                                            | Partner with SANAC and other national stakeholders to review training of journalists and media workers  
| **HIV/AIDS and power relations**            | Conduct internal ECAC/ECSECC seminars on nuanced analysis of poverty and power inequalities in relation to HIV/AIDS  
|                                            | ECAC should partner with the SAHRC and other partners to ensure that the rights of PLWHA or affected by HIV/AIDS, are always respected, protected and promoted  
|                                            | Strategies be developed to address issues of discrimination, stigmatisation and victimisation  
<p>|                                            | ECAC should partner with organisations addressing men and masculinity, promoting gender equality as part of addressing HIV/AIDS e.g. Brothers for Life |</p>
<table>
<thead>
<tr>
<th>Theme</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Economy HIV/AIDS</td>
<td>Review the Siyakhana Health Programme as a best practice model</td>
</tr>
<tr>
<td></td>
<td>Facilitate strategic meetings between business, labour and other key stakeholders to encourage contribution to the PSP and involvement in DACs and LACs</td>
</tr>
<tr>
<td>HIV/AIDS – impact on socio economic</td>
<td>Facilitate an internal workshop with ECAC/ECSECC staff on the impact of HIV/AIDS on work streams and programmes</td>
</tr>
<tr>
<td>development</td>
<td>All provincial priority strategies and programmes e.g. rural development, industrial development, PDGP etc should mainstream HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>ECAC should co-ordinate the activity whereby HBCs in the province are co-ordinated, registered and good governance and management principles are implemented</td>
</tr>
<tr>
<td>Cultural practices in the context of HIV/AIDS</td>
<td>Facilitate further discussions and sector workshops on how to address cultural practices and rights, in the context of HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>Revise PSP to include the role of traditional and complementary health practices</td>
</tr>
<tr>
<td></td>
<td>Ensure the greater involvement of FBOs and promote their involvement in providing healthcare services, especially in terms of HIV/AIDS</td>
</tr>
</tbody>
</table>

The key questions of the conference generated a substantive body of evidence and information in relation to the social, economic and political factors that drive HIV in the Eastern Cape, as well as how to utilise this knowledge to inform and guide government and civil society responses. One of the outcomes of the conference was the facilitation and building of working relations and partnerships - ECAC should map out the strategic opportunities for strengthening these in addressing HIV/AIDS in the province. The key conference questions have highlighted what is known and unknown about HIV/AIDS, both nationally and in the Eastern Cape. It strengthened the call for evidence that informs policy development and service implementation.

The Conference on the political economy of HIV/AIDS took place at an opportune time in terms of the enabling national HIV/AIDS policy environment, as it appears to be a priority in the new term of government, particularly with the launch of the HCT Campaign and new treatment guidelines. The conference was not simply an event and the work has really only just begun - the recommendations need to be implemented as a matter of urgency within the PSP and NSP strategic planning processes. Successful implementation of the key outcomes of the conference will require dedicated leadership at all levels and commitment from all stakeholders, as HIV/AIDS are not purely the domain of ECAC. A fundamental element in taking strategic steps forward is the greater involvement and support of organisations representing PLWHA. Strategic partnerships between ECAC and key stakeholders such as SANAC, ECDOH and organisations representing PLWHA need to be strengthened.
Acknowledgements

The Eastern Cape AIDS Council gratefully acknowledges the organisations and individuals who contributed to the development and facilitation of the conference on the political economy of HIV/AIDS, which was a significant milestone in the Eastern Cape’s response to the HIV epidemic.

In particular we want to thank the leadership and staff of the Eastern Cape AIDS Council and ECSECC for their guidance, strategic and logistic support throughout the process of working towards the conference. We would like to thank the individuals and organisations across the country that contributed to the development of the programme and/or presented at the conference. We further acknowledge the insights and experiences of those DACs and organisations representing people living with HIV/AIDS who participated in the focus groups prior to the conference.

The support before and during the conference, of organisations representing PLWHAs is sincerely appreciated, as part of implementing the GIPA principles.

The voices and active participation of all the delegates and stakeholders at conference is greatly appreciated in sharing knowledge and information and making recommendations for the strategic way forward in addressing HIV/AIDS in the Eastern Cape.
List of Abbreviations

ABET: Adult Basic Education and Training
ACHAP: African Comprehension HIV/AIDS Partnership
ACSA: Airports Company South Africa
AIDS: Acquired Immune Deficiency Syndrome
ART: Antiretroviral Treatment
ARV: Antiretroviral
ASSA: Actuarial Society of South Africa
BKCOB: Border-Kei Chamber of Business
CADRE: Centre for AIDS Development, Research and Evaluation
CAM: Complementary and Alternative Medicine
CCWPF: Community Care Worker Policy Framework
CHW: Community Health Workers
CBO: Community-based Organisation
CoGTA: Co-operative Governance and Traditional Affairs
COSATU: Confederation of South African Trade Unions
CSO: Civil Society Organisation
DAC: District AIDS Council
DoH: Department of Health
DoL: Department of Labour
ECAC: Eastern Cape AIDS Council
ECDOH: Eastern Cape Provincial Departmental Health
ECNGOC: Eastern Cape NGO Coalition
ECPA: Eastern Cape Provincial Administration
ECSECC: Eastern Cape Socio Economic Consultative Council
EXCO: Executive Council
FBO: Faith-Based Organisation
GDP: Gross Domestic Product
GIPA: Greater Involvement of People Living with HIV/AIDS
HAART: Highly Active Antiretroviral Therapy
HBC: Home-based Care
HCT: HIV Counselling and Testing
HEARD: Health Economics and HIV/AIDS Research Division
HEI: Higher Education Institution
HIV: Human immunodeficiency Virus
HPV: Human Papilloma Virus
HSRC: Human Sciences Research Council
HSV-2: Herpes Simplex Virus 2
IDASA: Institute for Democracy in South Africa
ILO: International Labour Organisation
KPA: Key Performance Area
LAC: Local AIDS Council
LED: Local Economic Development
MBSA: Mercedes Benz South Africa
MDR: Multidrug-Resistant
MANEPHA: Masihlanganeni Network of People Living with HIV/AIDS
Introduction

The Conference on the political economy of HIV/AIDS provided a groundbreaking platform to discuss the social, economic and political factors that drive HIV in the Eastern Cape and to review the current situation in terms of knowledge and intervention. It was a critical opportunity to present and share what we know in terms of research evidence as well as what we do not know and how this should inform strategic actions in addressing HIV/AIDS, both provincially and nationally. The conference was conceptualised and facilitated within the framework of the National Strategic Plan (NSP) (2007 -2011) and the Provincial Strategic Plan (PSP) (2007 -2011) and in alignment with the principle of the 3 Ones, i.e. One Authority, One Plan and One Monitoring and Evaluation system. It has generated important information and strategic issues to incorporate into the next strategic planning and implementation cycles, provincially and nationally.

A significant element of the conference was that it facilitated many voices being heard in sharing information and knowledge and discussing critical issues – these voices ranged from key national experts, PLWHA, government, and various civil society organisations and sectors such as labour and business. Of critical importance was the support and active participation of organisations representing PLWHA, both provincially and nationally.

The information and analysis that was presented at the conference will assist ECAC and partners like ECSECC to deliver on their mandate to provide information and analysis to assist the policy makers and HIV/AIDS practitioners.

The conference report outlines and describes the conceptual overview regarding the political economy of HIV/AIDS and of the interrelated themes as well as the methodology and pre-conference consultations in working towards the conference, held from 7-9 March 2010. In addition, this report presents summaries of the key presentations and discussions as well as recommendations and research gaps per theme. It concludes with suggestions for strategic steps that need to be taken in addressing the key HIV/AIDS issues in ensuring that it remains a provincial priority for all stakeholders.
Conceptual Overview

South African society continues to be ravaged by the HIV/AIDS pandemic. Despite signs that there is a steady decline in the infection rate, the country continues to have the highest number of people who are infected by HIV in the world. Compared to other developing countries and African countries in particular, South Africa is deemed to have better financial resources and infrastructure to effectively respond to the challenge that is posed by the pandemic.

Numerous researchers, writers, commentators and activists have attempted to investigate the reasons for this apparent lack of success in South Africa’s response to the pandemic. They have used various lenses to inspect the problem. Some have used medical approaches, others social, cultural, behavioural and psychological approaches. Few researchers have used economic approaches and even fewer commentators have used a political economic lens to inspect the nature and the manner in which the pandemic is manifested in South Africa.

Conference Aims

- To understand the political-economic environment and its characteristics and assess the extent that it provides fertile ground for the perpetuation of the pandemic in South African society.
- To understand the political paradigm that provides a basis and premise for the design and implementation of HIV/AIDS programmes in the country. It is a widely accepted phenomenon that the battle against the pandemic is won in areas where there is political commitment at all levels of society (government, councillors, traditional authorities, leaders of political parties). In South Africa for example, there are municipalities who declare that HIV/AIDS is an unfunded mandate for them and therefore do not prioritise it in their budgets. An analysis must be made as to what extent this political attitude influences people such as government officials, councillors, traditional authorities, civil society and ordinary members of society to take HIV/AIDS seriously or less seriously.
- To understand political incentives that go with a vigorous HIV/AIDS programme where HIV/AIDS issues occupy centre stage in the country’s development agenda. It is often argued that in countries where significant inroads have been made into the fight against HIV/AIDS, there are political incentives for politicians to be at the centre of AIDS campaigns since it affects mainly the rich and the middle class. In South Africa the pandemic affects mainly the poor and AIDS issues are often relegated to the bottom of the government’s agenda. Issues such as mainstreaming are well articulated on paper but never implemented with the vigour and urgency that the pandemic requires.
- To analyse the actors and forces (government departments, state institutions, corporate, religious, bureaucratic, and civic) who participate in the AIDS arena and the power relationships amongst and between them. Research shows that countries with a strong and active civil society have a stronger response to the pandemic. Is civil society in South Africa (especially in rural areas) empowered and funded enough to play a significant role? What is the role of
actors, business, traditional authorities, the church, and people of influence like soccer stars in the fight against the pandemic?
- To understand the relationship between service delivery or lack thereof, and the spread of the pandemic in South Africa.
- To understand the economic impact of the pandemic to specific sectors of the economy such as tourism and education and why the rate of infection is higher in certain sectors than others.

**Conference Themes**

- Social determinants of HIV in the Eastern Cape
- Governance and HIV/AIDS
- The effectiveness of HIV/AIDS policy and implementation
- HIV/AIDS and power relations
- Communication and HIV/AIDS
- Economy and HIV/AIDS
- Cultural practices in the context of HIV/AIDS
- HIV/AIDS – impact on socio economic development

**Objectives**

The ultimate objective of the conference was to research and gain knowledge of the different aspects of the Political Economy of HIV/AIDS in order to assist the Eastern Cape AIDS Council to develop a better informed multi-sector response to HIV/AIDS and advise government on HIV/AIDS policy.

**Key Questions**

- What are the social, economic and political factors that influence HIV/AIDS prevalence in the Eastern Cape Province?
- How can the knowledge of these factors be used effectively to advise the government and civil society to design relevant HIV/AIDS policies and programmes in the Eastern Cape Province?

**Outcomes**

- Increased knowledge and shared understanding by all stakeholders.
- Refined research agenda.
- Resource to advise policy and implementation.
- Strengthened strategic partnerships.
- Recommendations for key steps forward by various stakeholders.
Methodology

A desktop review of key research (both provincially and nationally) was conducted, resulting in the identification of over 300 articles and reports. This activity is an ongoing one as the information is being captured in an ECAC database, which will be utilized as a growing and active knowledge base and information resource.

Conference Format

ECAC appointed key researchers to present research on specific aspects of the political economy of HIV/AIDS in the Eastern Cape Province. Given the short time frames, the current findings/reviews of existing research were presented and gaps for future empirical research were identified.

Civil society organisations from the Eastern Cape were requested to participate and present on Key Issues as per the themes of the conference.

Additionally, key national and provincial organisations, authors and structures were approached to present on specific topics related to the Political Economy of HIV/AIDS.

The ECAC chair, MEC Mabandla ECAC Working Committee, and the Council were continually briefed during the planning process as was the Director General and staff of the Office of the Premier, who gave their full support and endorsement to the conference. Civil society leadership also fully endorsed the conference and support and participation was also secured from COSATU, Eastern Cape House of Traditional Leaders, ECNGOC, NAPWA, and the provincial network of people living with HIV/AIDS, MANEPHA.

Meetings with Experts

In the process of refining the conference themes and building strategic links with key research institutions and stakeholders, meetings were held with the following organisations:

- Human Sciences Research Council (HSRC)
- Centre for AIDS Development Research and Evaluation (CADRE)
- National Department of Health
- Health Economics and AIDS Research Division (HEARD), UKZN
- SANAC
- Several ECAC stakeholders in the province

The team also participated in the Social Aspects of HIV/AIDS Research Alliance (SAHARA) conference in December 2009 and this was a very constructive opportunity to engage with critical issues, meet researchers and network with key stakeholders.
Appointment of Researchers

From the research literature as well as extensive consultation with key stakeholders, “expert” researchers were identified and invited to present and participate in the conference.

Table 4 - Key Expert Researchers

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof. Phaswana-Mafuya Prof. Seager (HSRC)</td>
<td>Social determinants of HIV in the Eastern Cape</td>
</tr>
<tr>
<td>Prof. Rachel Jewkes Medical Research Council</td>
<td>A gender analysis of social, political and economic factors in relation to HIV/AIDS</td>
</tr>
<tr>
<td>Prof. Nattrass (UCT)</td>
<td>The relationship between economic inequalities/poverty and HIV/AIDS and broader social and political factors. The key social, economic and political factors related to the access and provision of Antiretroviral Therapy</td>
</tr>
<tr>
<td>Dr. Liz Thomas (WITS)</td>
<td>Local government: an analysis of key social, economic and political factors in relation to HIV/AIDS</td>
</tr>
<tr>
<td>Dr. Kelley, Dr. Rau (CADRE)</td>
<td>An analysis of HIV/AIDS in the context of cultural and religious beliefs - what are the key social, economic and political factors?</td>
</tr>
<tr>
<td>Prof. Tim Quinlan (HEARD)</td>
<td>The social, political and economic factors within the HIV/AIDS community care economy. Overview of the impact of HIV/AIDS on socio-economic development - implications for the Eastern Cape</td>
</tr>
</tbody>
</table>

Participation

The following stakeholders participated in the conference:

- ECAC
- ECSECC
- SANAC
- Research institutions
- Government departments
- Municipalities
- District AIDS Councils
- Local AIDS Councils
- Civil society organisations
- Private sector
- Office of the Premier
- SALGA (Eastern Cape)
- NAPWA
- TAC
- Academic Institutions
- Eastern Cape House of Traditional Leaders

The participants in the conference were invited from all over South Africa but mainly from the Eastern Cape Province.
Pre-Conference consultations

The process of working towards the conference included consulting with experts and key stakeholders nationally, as a strategy to ensure a relevant and appropriate programme as well as to secure speakers’ support for this critical event, both provincially and nationally.

In addition, as part of ensuring a ‘bottom up’ approach and enhancing local support and enriching the discussions at conference, focus group discussions were facilitated with some DACs and also with NAPWA on the themes of the Conference. It represented an important approach to ensure that many voices were heard at the conference and the information from both the DACs as well as the key national researchers should be combined in providing a comprehensive picture of what the HIV/AIDS priorities are in the Eastern Cape.

A number of Key Issues and recommendations emerged from the pre-conference consultations.

Social Determinants of HIV in the Eastern Cape

Key Issues

Prominent factors emerged in all consultations, such as the poverty which drives people to engage in high-risk activities as a survival strategy (such as intergenerational sex); unemployment, gender inequalities, cultural issues, all forms of abuse, illiteracy and level of education. The Eastern Cape province also experiences an influx of migrant farm workers that start new families at their place of work without taking an HIV test, as well the increasing cross-border interactions and non disclosure of HIV status when people engage in sexual relationships. Other challenges facing the people of the province relate to poor service delivery in terms of water, sanitation, roads, transport and lack of adequate recreational facilities, coupled with a rapid collapse in family values, an increasing level of alcohol abuse and sexual indulgence as well as human trafficking. These exacerbate the spread of HIV in the province. Other factors that have led to an unprecedented increase in HIV prevalence in the province are directly linked to the way the government implements the GIPA principle, the amendment of policies to cater for the interest of pressure groups which pose as high risk populations (such as gays and lesbians) as well as the way in which government selects organisations for PLWHA to fund and work with.

Recommendations

A number of recommendations were highlighted during the sessions to ensure that some of the challenges and social issues could be addressed. There was a strong sentiment about the need to ensure that institutions take the lead in HIV/AIDS education, starting from the family, schools, churches, workplace etc as part of intensifying the campaign on HIV/AIDS and thereby contributing to the reduction in new infections, which is the goal of the National HIV/AIDS and STI Strategic Plan (2007- 2011). Participants acknowledged the presence of HIV related services in the communities provided by different stakeholders, both from government and other sectors, but their main worry was the duplication of these services, hence their intention to have all the community
based programmes mapped and regulated, to ensure effectiveness and reduce duplication and “in fighting”. Another recommendation was that PLWHA should be provided with the necessary skills to enable them to take part in HIV/AIDS interventions in the communities they reside as, part of promoting the Prevention with Positives campaign, which has been deemed a success in other countries and even communities in South Africa. There was also a strong feeling that various policies have to be revised so as to reduce the effect of social determinants of HIV/AIDS, such as the policy on the Disability Grant as well as other policies relating to confidentiality. One participant proposed that we ought to take and implement the law in one of the Asian countries which states that, “YOU CAN SELL BUT YOU CANNOT BUY – if caught buying sex, you are imprisoned”. Further to these recommendations was the need to ensure that health facilities had adequate resources for the management of PLWHA.

Governance and HIV/AIDS

Key Issues

This component sought to establish the existence of governance structures to drive the implementation of the multisectoral response to HIV/AIDS programmes at different levels. Participants highlighted the sub-optimal visibility of local AIDS councils and the lack of sound relations between ECAC and the South Africa National AIDS Council (SANAC). Some of the issues raised related to inadequate political commitment, especially at local levels, to drive the provincial HIV/AIDS agenda, as well as lack of ownership and the subsequent labelling of HIV programmes as “so and so’s thing”. The people that have been elected to take charge of local AIDS councils have been criticised as holding too many positions and in the end, not having enough time for their AIDS council activities. Further to the highlighted challenge of political commitment is the role clarification for the sectors that are outside government and also their commitment to participating in the multisectoral response. There is a gap between ECAC strategies and those of the local AIDS councils, due to lack of an integrated planning system. Local AIDS Councils also need empowerment and capacity building to be able to effectively and efficiently deliver on their mandate on the multisectoral HIV/AIDS response.

Recommendations

In as much as the participants raised their issues and concerns on governance, they also provided a few recommendations towards an effective and well governed HIV/AIDS structure in the province. There is need for role clarification between stakeholders and government departments and an integrated planning system. Another recommendation that came out strongly, targeted leadership at various levels with specific reference to their moral regeneration, to ensure that they remember their responsibilities towards the people they serve, as well as making HIV/AIDS issues part of their key performance areas. To ensure that work is done regardless of the availability of the chairperson, the position of the deputy chairpersons was proposed.
Effectiveness of HIV/AIDS Policy and Implementation

Key Issues

There are a number of policies that were developed to ensure the effective implementation of the HIV/AIDS programmes, but not all of them have been effective in terms of policy implementation. In this session, participants raised issues on specific policies that they deemed needed to be changed, as well as commenting on their shortfalls. Participants felt that the confidentiality policy was not thoroughly practiced in some instances. There are also issues around HIV testing, as people are being coerced and counselling is not done properly. Another issue pertains to the health workers not respecting the rights of patients. There is a huge concern about the interpretation and communication of policies, from the formulation to the implementation level. There is need for improved public participation in the policy making process through consultations at all levels, as people need to be aware of important HIV/AIDS policies. Other critical departments like the Department of Agriculture need to be included in the HIV/AIDS programmes, which means that policies should clearly include these departments. There should be more policies developed on prevention and treatment priorities and the disability grant should be reviewed.

Recommendations

To ensure the participation of all stakeholders and accountability, stakeholder management policy should be reviewed. The policy of accessing HIV/AIDS services by school going children should be reviewed. Areas of programme implementation that need specific attention should relate to the priority area on prevention specifically targeting the most at risk populations (MARP). There is a need to promote abstinence and delay in sexual debut among girls and boys and the Inkciyo (virginity testing) practice should be further discussed.

HIV/AIDS and Power Relations

Key Issues

There are various power relations that exist at different levels and have consequences for the spread of HIV. Issues raised related to men in power sexually exploiting young girls (intergenerational sex) and also the power relations between health care workers and PLWHA. Intellectual power has been raised with specific reference to situations were two educated people convince each other not to use condoms, although this issue needs to be debated further. There is a growing tendency in the province for households to ignore incest, especially where the perpetrator is the breadwinner. Issues of polygamy and the voice of women in such a relationship in promoting the use of condoms, especially when they are dependent on the male counterpart, were also raised. Domestic violence and child abuse have also been raised as important issues relating to HIV/AIDS and power relations.

Recommendations

The recommendations that were raised to deal with some the issues raised on HIV/AIDS and power relations, are that there is need to do proper research to ascertain the
relationship between health care workers and people who are receiving ART. There should be improved training of health care workers on HIV treatment and support to PLWHA. There should be further research on preventing the spread of HIV/AIDS without recommending the abolition of cultural practices.

**Communication and HIV/AIDS**

**Key Issues**

One key component in the fight against HIV/AIDS is ensuring appropriate communication strategies and channels for the effective education of communities. One issue of communication in the province is that most of the districts are made up of rural areas with high illiteracy rates. Another issue is the lack of human resources and vehicles to service far flung areas meaning that information on HIV/AIDS does not reach the appropriate communities. Another issue raised is that the language used in some adverts is not appropriate and lack of public consultation in the development of communication material means that some of it ends up being inappropriate. Some of the messages being communicated end up not speaking to the community, especially individuals e.g. “the it begins with you” advert. Most of the local radio stations are not utilised to convey tailor-made messages for the communities that they serve.

**Recommendations**

There is need for the communities to focus more on rural areas and use clear and understandable language for the people of that area. Peer education and involvement of people from a particular area gives them a sense of ownership and thus they will participate fully. The media should not portray HIV as a virus of choice in their adverts, but rather try to take different approaches that are aligned to HIV transmission and the changes in the strategies.

**Economy and HIV/AIDS**

**Key Issues**

The death of a breadwinner frequently results in prostitution of women and girl children as a means of survival. In some instances, unemployed graduates end up approaching older men and women for financial support and this may lead to intergenerational sex. The cost of medication and supplements needed by HIV positive people is very high and this puts the whole household in an economically disempowered position.

**Recommendations**

There is need to upscale the funding and implementation of income generating projects to ensure sustainability of households for PLWHA, as well as the general empowerment of PLWHA through supporting Local Economic Development (LED) initiatives targeting them.
Cultural Practices within the Context of HIV/AIDS

Key Issues

The Eastern Cape province has a multitude of cultural practices.

Circumcision Practices

- **Umgubho** – where girls are divided amongst the men attending the function.
- **Ukuqiniswa** – the same instrument (blade) may be used on all boys in the ritual they undergo before circumcision, to make them strong and protect them from evil spirits.
- **Umdlanga** – sometimes the single instrument used to circumcise boys is not sterilised and is used on all the boys.
- The **ingcibi** (traditional surgeon) asks the boy to swallow the foreskin to prevent **Thikoloshes** from getting hold of it.
- **Ukosula** – new initiates sleep with any woman other than their usual sexual partner (usually without a condom), to “cleanse” themselves.

Other Cultural Practices

- **Ukuthwala** – a young girl is abducted and forcibly married to an older man of an unknown HIV status.
- **Ukungenwa** – when a husband passes away, his brother or even his father takes over as a husband.
- **Ukuphutshwa** – Single women in certain religions are encouraged to marry men who claim to have dreamed about them.
- **Ukuqutyulwa** – traditional healers bite off a piece of flesh from a client under the pretext of healing them.
- **Abathandazeli** – spiritual healers pray for HIV+ clients and then tell them that they have been healed.

Polygamy and human trafficking have also been highlighted as other issues that pose a threat to the fight against HIV/AIDS.

Recommendations

There is dire need to do proper research on circumcision to avoid confusion about its application as a cultural practice. It is imperative to involve the people who are practicing it in these discussions. Traditional leaders should be involved in all cultural practices – they should disapprove of **ukosula** and **ukuthwala**. We should implement HIV/AIDS programmes in partnership with the House of Traditional Leaders, so that they do not only attend the major events. We need to involve the SAPS, especially on matters involving children and mainstream African cultural ideology and religion.
HIV/AIDS – Impact on Socio-Economic Development

Key Issues

The high absenteeism rate, due to HIV/AIDS, may lead to two people being paid for the same job (substitutes/replacements) and this impacts negatively on service delivery. There is also a heavy burden on already overstretched health services due to HIV/AIDS. There are an increased number of school dropouts due to the need for the children to take care of sick family member, meaning that they miss out on school and this poses a bleak future for them.

Recommendations

There is need to improve referral systems and links with the relevant departments – to prevent people being clinically depressed by not getting jobs after being taken off the social relief package and or disability grants.
Purpose and Objectives of the Conference

MEC Mabandla, Eastern Cape AIDS Council (ECAC) Chairperson

MEC Mabandla welcomed MEC Qwase, representatives of mayors, representatives of the ECAC, traditional leaders, members of civil society and government officials.

ECAC Mandate

- To advise the government on HIV/AIDS related policy.
- To mobilise stakeholders.
- To recommend research.

ECAC has developed a PSP for 2004-2007 and for 2007-2011, they have mobilised stakeholders – there were DACs, LACs and AIDS forums on all levels, and ECAC itself is a vibrant AIDS council.

However, there are gaps in ECAC’s work, which is why the conference was convened. By the end of the conference, two questions should be answered.

- What are the social, economic and political factors relating to the HIV/AIDS prevalence in the province?
- How can this knowledge be used to advise government and civil society in terms of HIV/AIDS?

Guests were asked to assist ECAC in advising government correctly, to enable them to devise policies that respond to the needs of the province.

HIV/AIDS impacts on the development of the province and without them (the guests), ECAC could go progress, but with maximum participation, they would be able to advise government effectively.

The main purpose of the conference was to come up with research tools and an understanding of how government should respond to HIV/AIDS throughout the province – at household, community, district and provincial levels.

HIV/AIDS are everyone’s business – not just government’s.
Keynote Address

Mr M Qwase, MEC for Education

MEC Qwase welcomed the chairperson of ECAC MEC Mabandla, members of the provincial AIDS council, distinguished guests, and ladies and gentlemen.

The strategic objective of the conference was a meeting point to discuss strategy.

HIV/AIDS is determined to remove humankind from the face of the earth if it is not stopped in its tracks. It has the ability to reverse the democratic and development gains South Africa had made and could alter the socio-economic nature of our society.

HIV/AIDS could be associated with poverty and gender inequalities and unstable socio-economic circumstances could provide fertile ground for HIV/AIDS, especially for women, children, the elderly and the disabled.

The Eastern Cape is one of the poorest provinces; HIV/AIDS could rob it of the valuable assets of economic growth, especially workers. HIV/AIDS affects teachers, nurses, the police and the private sector in terms of a decline of skills. Training takes funding and time, the decline in skills affects everyone – teachers, nurses, the police, people in the private sector, etc.

HIV/AIDS threatens people’s household security, and jeopardises community projects, as a large part of the community is either sick or taking care of those who are sick.

If the government fails, it fails the masses.

MEC Qwase hoped the conference would be more than talk, because people are dying and expect positive results. Ideally, the conference would come up with clear, implementable interventions and interrogate the policy issues of the current strategies. Attendees were urged not be afraid to ruffle feathers. The government must be advised of the weaknesses of its policies.

The ANC Manifesto committed to improving the health profile of people, the importance of looking broadly at the health profile of people was emphasised, in order to deal effectively with HIV/AIDS.

The habit of not speaking openly about cause of death at funerals, and speaking only of “opportunistic diseases,” should be broken.

Everyone should commit to what President Jacob Zuma said at World AIDS Day 2009, that we “dare not fail.”

The conference would attempt to come up with a policy framework aimed at improving people’s lives. This could lead to government doing things differently, to make an impact on the lives of people infected and affected by HIV/AIDS.
The myth that South Africa does not care about HIV/AIDS should be dispelled. The National Treasury has budgeted significantly for HIV/AIDS: around R6 billion for 2010/2011, around R7 billion for 2011/2012, and around R8 billion for 2012/2013. No other country allocates so much of their budget for HIV/AIDS.

Furthermore, the Strategy from the 2001 UNAIDS International Conference on AIDS was based on South Africa’s strategy.

The impact of HIV/AIDS on fiscus is significant: the funds allocated to HIV/AIDS could conceivably have been allocated to other development issues after all. HIV/AIDS requirements reduce the allocation of funds to other initiatives.

During MEC Qwase’s visits to schools in January, it was apparent that there had been a significant increase in the number of teenage pregnancies in the province. The Mayor of the OR Tambo municipality claims that the majority of the women in the maternity ward of the hospital were around the age of 20. Many of these young mothers abandoned their babies because they were HIV positive.

The issue of voluntary testing needed to be debated.

There had also been an increase in the instances of children, and especially orphans, being abused. Caregivers at schools reported that children and orphans were frequently abused by their own siblings. Furthermore, children frequently abandon their schooling to take care of their siblings. Extended family members often do not intervene or help these orphans.

In general, there has been a noticeable disintegration of the family and community, a multitude of social ills and a general moral decay.

Perhaps the increase in teenage pregnancy was a reflection of weaknesses in the implementation of projects, including peer education. These need to be examined, to see whether they are working, and where the gaps are.

Furthermore, it needs to be determined what could be done in other areas, like the community and church, to prevent teenage pregnancies.

A platform needs to be created for young people to freely discuss issues around HIV/AIDS at churches and other places of worship. Space needs to be opened up for discussion.

In terms of statistics, the prevalence rate has slowed down, but that it has still consistently increased. The percentage of AIDS related deaths has increased. Although life expectancy has improved slightly, by two years for men, and one year for women, the average life expectancy for a South African is still only 55, which is still very low when compared to other middle-income countries.
Messages of Support

*NAPWA – Provincial Co-ordinator*

President Zuma asks us to focus on treatment, care and support. Nutrition is key – no one can take treatment on an empty stomach.

The challenges around “defaulters” need to be addressed. Although the government is trying its best, that there are still challenges including transport and access in rural areas, inadequate health facilities, and a lack of skills development. Furthermore, there is the challenge of stigma, people should be cautious in their statements. NAPWA fully supports the conference, and NAPWA hopes that government provides more resources and improves PSPs.

*MANEPHA Vuyani Sibiza*

MANEPHA supports the conference and salutes the political heads of ECAC for organising it. The conference should provide constructive deliberation, in order to shape policies. The struggle continues: Aluta continua!

*TAC – Provincial Secretary Thabang Maseko*

The TAC fully supports the conference, the people outside (the conference) rely its delegates for information. Although some of their offices had closed, this did not mark the end of the struggle. Power to the people: *Amandla Ngawethu*.

Presentation of the Provincial Strategic Plan 2007-2011

*Reverend Lulama Ntshingwa, Eastern Cape AIDS Council*

The PSP is aligned to the NSP and exists to remind stakeholders of their commitment to set targets in the form of Key Performance Areas (KPAs).

The PSP was launched in 2007 and all partners were a part of its development. It is a multisectoral framework that brings all stakeholders together so that all stakeholders can participate, because the PSP needs full participation and commitment.

The PSP is an important part of what the ECAC does, in that it directs, co-ordinates and measures its efforts. It manages the response to HIV/AIDS and minimises the impact of HIV/AIDS. The PSP is comprised of four parts including the situational analysis, an overview of the multisectoral responses to HIV/AIDS, key priority areas and operationalising the PSP.
The target organisations were the Office of the Premier, the Department of Health, the Department of Social Development, the Department of Education, local municipalities, the six district municipalities and the metro, the private sector, gender organisations and civil society organisations. The goals of the PSP are to reduce new infections, reduce illness and deaths, and provide treatment, increase care and support — especially for orphans and vulnerable children. It seeks to meet the Millennium Development Goals (MDGs), as well as the goals of the PGDP, UNGASS and the NSP.

There are six key performance areas, and four of these have been adopted from the NSP:

1. Prevention – by 2011 new infections should be reduced by 50% through testing, counselling and awareness
2. Treatment – traditional/alternative health needs to be looked at, opportunistic infections need to be dealt with, by 2011 everyone infected needs to have access to ARVs and other treatment
3. Impact mitigation – care and support for orphans and vulnerable children, social security safety nets, livelihoods and poverty, unemployment all need to be addressed
4. Promotion of human rights and legal rights
5. Management of the provincial response – organising ourselves, how we can work together, ensure strong societal components, planning, resource development, having skilled personnel, financial resources, advocacy and communications strategy, and monitoring and evaluation
6. HIV/AIDS Research – planning and implementing research, recommend appropriate research. That there should be one co-ordinating authority – namely ECAC, and one strategic plan – namely the 2007-2011 PSP, and that everyone should work within that framework. There shouldn’t be competition between stakeholders; everybody should commit themselves and their skills.

An Analysis of Social Determinants of HIV

Mr Nkululeko Nxesi – National Association of People Living with HIV/AIDS (NAPWA)

NAPWA had said as early as 2000 that HIV/AIDS is a political, not just medical issue. The issue is that we are currently applying a very narrow approach to analysing the problem of HIV/AIDS. We are the first province to see the issue clearly and to create a dialogue.

He said that HIV/AIDS is not simply a medical problem – it is a socio-economic issue, communities with socio-economic problems are more vulnerable. Women are still disempowered and cannot challenge the status quo, especially with traditional elders, and they remain the minders of the household. Women who do not stay in the home are said to be practicing a “foreign culture.” Furthermore, women are not aware of their human rights – even if they are sick, they are still expected to work, and to take care of the extended family. Women’s motivational clubs should be formed, that are in line with the culture of the Eastern Cape.

Abuse is still an issue: people keep quiet about it because they don’t want to embarrass their families, but it is a driver of HIV infection. Research should be conducted, investigating how many women are infected through abuse. Strong men’s organisations
should also be formed, as men are the drivers of HIV infections. Commercial sex occurs widely in the Eastern Cape, even within families. Culturally, people are told to keep quiet about this.

The migrant labour system is also a driver: the Eastern Cape is still a source of cheap labour for Gauteng and the Western Cape, and when people leave to work there, they often leave their children with their grandparents. Sometimes they return sick, and die, and leave grandparents to be parents, or even create child-headed households. A rural development strategy needs to be developed, and rural-urban migration should be reduced. Many poor and unemployed people are HIV positive, and these people often can’t access treatment. To these people, social grants are often a lifesaver. Treatment must be enhanced by nutrition. The number of people who are HIV positive and do not receive grants should be investigated, and the impact of this should be assessed. There has been a breakdown in the family structure in the Eastern Cape and that many children don’t know their fathers.

In terms of communication, messages (of prevention campaigns) need to be adapted to rural communities and translated into local languages by experts. The “one size fits all” philosophy behind current messages should be changed.

The conflict between local councillors and traditional leaders fighting for political space negatively affects the response to HIV/AIDS and leads to people not getting help. Local AIDS Councils are not in line with the provincial AIDS council.

Finally, the response to HIV/AIDS is being led by the elite. The masses must determine their own destiny, community leaders should be utilised. Though South Africa has the best plan of action, there are problems with implementing it, which are a problem of political changes.

**Theme: Social Determinants of HIV in the Eastern Cape**

**Social Determinants of HIV in the Eastern Cape**

*Prof Nancy Phaswana-Mafuya and Prof John Seager – Human Sciences Research Council (HSRC)*

Although there has been a decline in HIV prevalence and it seems to have stabilised, it is still unacceptably high (28% - nationally). However, since there has been a steady rise over the past 16 years, this remains encouraging.

In the Eastern Cape, the prevalence for districts varies, from 20-30%, but the figures are not very reliable, because small sample sizes were used. The prevalence for subdistricts varied even more with Sakisizwe at almost 50% and Camdeboo at 7.7% - however, once again the figures were not very reliable. The HSRC recommended that a baseline survey be done on HIV prevalence in the Eastern Cape by district and sub-district.

There has been an overall decline in children and young people (aged 16-24) with HIV. However, it is vital to remember that epidemics happen in phases. Though there has been a decline in infection within the 16-24 age group, there was an increase in the 25 and over age group.
The age of sexual debut is an important determinant, as are the existence of concurrent multiple sexual partnerships. There has been a significant increase in condom use in the Eastern Cape and the Eastern Cape’s rates were well above the national average in this regard. There has been a significant increase in people getting tested for HIV nationally.

Accurate knowledge of sexual transmission prevention in the Eastern Cape is high, at 54.5%. However, there has been a decline in the rejection of major misconceptions about sexual transmission, so it is essential not to become complacent about ignorance. In terms of stigma, 70% of people answered correctly, but it is possible that this may be due to a “social acceptability bias.”

One of the risk factors for HIV infection is hazardous alcohol use, which leads to behavioural risks and thus an increased risk of infection. Other risks include teenage pregnancy, labour-related migration, transactional liaisons, poverty, certain cultural and social norms, and infection with other STDs. There is no “magic bullet” for solving the problem of HIV/AIDS, all prevention approaches need to be used in conjunction. Behaviour is “very much part of the deal.”

Suggestions and Recommendations

- Address inadequate surveillance systems.
- More studies specifically on the social determinants of HIV.
- Gaps in knowledge of effective prevention strategies should be addressed.
- The impact of structural interventions should be explored in more detail.

Questions and Answers

**Question:** Why did Mr Nxesi say that loyalty and love is a determinant of HIV infection?

**Answer:** Abuse is still rife, and we live in a country with human rights. We need to empower women, and women also need to decide for themselves to leave abusive relationships. We also need to break the silence around abusive relationships.

**Question:** What can be done about children who are raped becoming rapists?

**Answer:** This is a research area – we should come up with interventions. Men can join groups like Brothers 4 Life. Maybe there should be an international men’s day, and men’s awards for men who are role models.

**Question:** There is stubbornness among women for a man to use a condom, because they want children so that they can get grants. What can be done about this?

**Answer:** We should kill this argument of women wanting social grants. It is not true. Men’s structures need to be established to encourage them to wear condoms. Women’s condoms are also now more user-friendly and women should use these.

**Question:** Did Prof Seager take traditional beer into account?

**Answer:** Yes, he did include traditional beer. They also use pictures for those who cannot read, and adjust quantities - e.g. 500 ml sorghum beer is the same as 1 tot of spirits. They followed WHO guidelines.
Research Recommendations

- A baseline study should be conducted on HIV prevalence in the Eastern Cape by district and sub-district.
- ECAC should partner with research institutions to conduct research on social determinants of HIV/AIDS in the Eastern Cape.
- ECAC should develop and implement a defined research and knowledge management policy.
- Research should be conducted in the Eastern Cape on the relationship between gender-based violence and HIV/AIDS.
- Research should be conducted on the number of HIV positive people who are not receiving social grants.
- ECAC should partner with key stakeholders in conducting research should be on effective prevention strategies, especially the new HCT campaign.
- Research should be conducted on the impact of structural interventions on HIV/AIDS in the Eastern Cape.

Policy and Programme Recommendations

- ECAC should ensure the involvement of DACs and LACs in the development, implementation and dissemination of research.
- The Provincial Strategic Plan should be implemented, monitored and data from the evaluation should feedback into the following planning cycle.
- ECAC should organise a provincial summit of all organisations representing PLWHA to clarity roles and responsibilities and review implementation of the GIPA principle.
- The interlinkages between gender inequality, gender-based violence and HIV/AIDS should be integrated in all HIV/AIDS programmes.
- ECAC should ensure that the Rural Development Strategy address issues of rural-urban migration in the context of HIV/AIDS.
- Issues of nutrition should be integrated as part of HIV/AIDS treatment policies and programmes.

Theme: Governance and HIV/AIDS

SANAC Mid-Term Review

*Mr Junaid Seedat – South African National AIDS Council (SANAC)*

SANAC is a hybrid structure located at the interface of government and civil society. Its mandate is to advise government on HIV, AIDS, TB and STI policy; to create and strengthen partnerships for an expanded national response; to receive and disseminate all sectoral interventions and consider challenges; and to oversee continual monitoring and evaluation of all aspects of the NSP.

The multisectoral response should be truly multisectoral and not just consist of government and friends of government; every sector should be involved to provide
an expanded response. We should ensure that the policy does filter down to advise policy, create and strengthen partnerships, receive and disseminate interventions, and oversee monitoring and evaluation.

The vision of SANAC was to have a well-co-ordinated response, that people are at the centre of the response, and that there can be an AIDS-free generation in our lifetime.

SANAC had different structures, including 19 civil society sectors, nine government departments, as well as two new sectors: the commercial sector and the lesbian and gay sector.

From November to January a mid-term review of SANAC’s activities was conducted. This demonstrates that SANAC is accountable and takes responsibility.

The review identified gaps and problems, especially in terms of effective planning, and assessed whether SANAC had progressed since 2007. It also assessed management and co-ordination structures, and monitoring and evaluation and make recommendations.

**Goals of SANAC Include the Following:**

- Prevention: reduce new infections by 50% by 2011 – the ability to measure new infections had to be standardised
- Treatment, care and support: expand by 80%, now 350 CD4 count
- Human Rights and Justice – provide support services (legal and social) for women and children being abused

We should look at the social and psychological determinants and attempt to reduce stigma and discrimination. We should make prevention number one. We should make sure the NSP is unifying, and that it is constantly monitored and evaluated – taking responsibility is very important. The response is too fragmented on national, provincial, district, and local levels. Key messages were to make prevention number one, to provide patient-centred services, to make monitoring, evaluation and research intelligent, and to provide support to the SANAC secretariat, PACs and DACs as the implementers of the NSP.

**Co-ordination and Management of the HIV/AIDS Response in the Eastern Cape**

*Ms Zolisa Xabadiya – Eastern Cape AIDS Council (ECAC)*

After the Cabinet had made a decision to adopt a multisectoral response to HIV/AIDS, ECAC was formed in 2000. ECAC receives its mandate from SANAC and was re-launched in 2004. The mandate of ECAC is to play an advisory role to government, to co-ordinate the HIV/AIDS response in the province, to facilitate and strengthen partnerships, to build the capacity of DACs and LACs, to monitor the implementation of the national and provincial HIV/AIDS plans, and to provide guidance on the implementation of the national and provincial HIV/AIDS strategic plans.

ECAC’s programming includes social mobilisation, communication, research, monitoring and evaluation, finance and administration.
Some recent achievements include the mobilisation of AIDS role players, mobilisation of financial resources, commissioning HIV/AIDS research, establishing and supporting DACs and LACs, and building sector capacity. Shortfalls of the ECAC council included no policy advice being given to government, inconsistency in representation, programmes centred on the availability of the chair, ECAC did not provide strategic leadership to society, as well as to district and local AIDS councils. A shortfall of the ECAC working committee was that there was insufficient balance in the numbers in terms of representation. A shortfall of the secretariat was that it was short-staffed, and that programming did not allow for clear monitoring on the implementation of the PSP.

In August 2009 the ECAC held a strategic retreat to reflect on the impact of the work undertaken to address its mandate since 2005. The objectives of the retreat were to reflect on the five years of the existence of the ECAC, to reflect on the representation and participation of different stakeholders and to define a strategic direction for the council and all its structures. Focus areas for the retreat were governance and policy direction, structures and mandate, and programming and co-ordination.

Key findings of the retreat included the fact that there is insufficient and inadequate provision of strategic direction by the council and its structures; that the council has not fully fulfilled its co-ordinating role; that the configuration of the ECAC secretariat was not suitable to allow ECAC to co-ordinate the PSP priorities; and that the programmes of the council are not adequately meeting the pillars of the ECAC mandate. Resolutions from the retreat in terms of governance and policy direction included the need for a new vision and mission to be developed; improvement of communication between sectors; and the development of a policy document on sector participation in the council. It was also resolved that a deputy chairperson from civil society should be appointed, and that civil society participation in the working committee should be strengthened.

Resolutions in terms of structure and mandate included that sub-committees should be encompass working groups as per the PSP priority areas and strategy and policy co-ordination; that the secretariat functions are configured according to the priority areas and that there should be more support to DACs and LACs.

Role of the Government in the Co-Ordination of HIV/AIDS

Ms Nondyebo Tyapolwane – Office of the Premier (OTP)

Improving the health profile of people in the province is one of the 8 strategic priorities. These strategies feature the Eastern Cape Provincial Administration’s Internal Employee Wellness Programme. Eastern Cape Provincial Administration has conducted an HIV baseline study which determined the cost of the impact of HIV. As mandated by the DG, and guided by the NSP 2007-2011, the Organisational and Employee Wellness Unit has to ensure the establishment of an environment that is conducive to effective service delivery.

Benefits of the Employee Wellness Programme include the improved health status of employees; increased productivity and improved service delivery; decreased stress levels and improved employee morale; improved employee relationships; reduced
staff turnover; greater work satisfaction and better performance; a safer working environment and reduced absenteeism, and “presenteeism.” It is obvious that the cost is by far outweighed by the loss that would have been incurred were this programme not implemented.

Research was conducted by the Eastern Cape Provincial Administration in 2006, namely the Combined HIV/AIDS Knowledge Attitude Behaviour and Perception and Prevalence Survey. The prevalence survey results provided baseline information for the Actuarial Impact Assessment, which provides estimates of the potential cost impact of HIV prevalence and incidence among the workforce. The study also provided indicators by which an effective Employee Wellness Program can be evaluated.

It was found that in terms of numbers, the Departments of Education and Health make up the highest and second highest proportions of the Eastern Cape Provincial Administration; whilst the Department of Safety makes up the smallest proportion followed by the Office of the Premier. In terms of medical aid membership, it was found that 15.2% were members of the Government Employees Medical Aid Scheme (GEMS), whilst 24.3% of the workforce had medical aid membership. This number was expected to increase, as it was becoming compulsory for new employees.

In terms of the results of HIV prevalence rates by department, prevalence rates of each department were linked to their demographics; those departments with a higher proportion of female employees and that a higher proportion of younger employees and lower average salary tended to have a higher prevalence rate. To illustrate, the Department of Social Development and the Department of Provincial Treasury were compared as an example.

It was shown that Social Development has a higher proportion of women (73.2% versus 61.1%), a higher proportion of employees under age 40 (62.0% versus 40.0%), and a higher number of employees earning in the R0 – R100,000 range (39.0% versus 10.0%). She said that this might explain why Social Development is estimated to have a higher maximum prevalence rate than Treasury (22.2% versus 13.8%). In terms of medical aid benefits, it was the employees’ decision, but that GEMS membership was compulsory for new employees, which would ensure that 62% of the workforce was covered. HIV/AIDS are included under PMBs that all medical schemes adhere to.

The purpose of the Cost Impact Analysis was to assess the additional cost in providing employee benefits and the business interruption costs, as a result of HIV/AIDS being a feature of the environment. It was based on demographic projections and all benefits and business interruption costs due to HIV/AIDS. Factors considered included sick leave benefits; maternity benefits; allowances for the cost of retraining and hiring new employees in the event of death/withdrawal; and allowances for lost productivity - sick leave and death/disability. The results were used in the following ways: the results were presented to EXCO; recommendations were lifted in theIEW strategies and business plans as indicators; and the results were presented to Human Resources managers’ forum in order to be mainstreamed in departmental HR plans and departmental strategic plans.
The programme has not been mainstreamed to strategic plans, policies and Human Resource plans; there is no clear allocated budget for some departments; there are inadequate structures to deliver on the mandate; there is a lack of strategic focus and requisite skills to implement IEW guidelines and there is no standard set of monitoring and evaluation indicators.

In conclusion, the ASSA 2003 Model provides the best estimate of HIV prevalence – 18.0% (2008) for all departments combined. She said that this is expected to decrease to 7.3% by 2018 in absence of ART (due to the death rate). In terms of the Cost Impact (over the next 10 years), the most significant costs were in terms of lost productivity, including replacement rehiring costs, sick leave benefits, and family responsibility leave. This was expected to add around 6.1% (of annual payroll) to cost of operations over the next 10 years. However, additional costs can be reduced by the availability of ARTs, and that costs will fall by an average of 0.9% of annual basic payroll with the availability of ART.

It was recommended that the multi-sectoral approach be the chosen approach; broadening the scope for the implementation of a standardised workplace programme for HIV/AIDS (as an element of the Integrated Employee Wellness programme); to emphasise the importance of VCT and availability of ART; implementing a monitoring and evaluation programme using a common set of indicators; conducting a situational analysis on programme implementation for the government and municipalities that will inform the need for support (funded by SIDA); and stepping up the prevention programme through UNFPA donor support. ECPA has secured SIDA and UNFPA donor support, it has held two consultative meetings with municipalities, more sessions are due to take place in March, and that the tender for SIDA on situational analysis and implementation support will be advertised in April 2010.

**Local Government: An Analysis of Key Social, Economic and Political Factors in Relation to HIV/AIDS**

*Dr Liz Thomas – University of the Witwatersrand (WITS)*

The drivers of HIV are not only behavioural; it impacts on individuals, households and communities. Local government should address the drivers of HIV, attempt to extend the length of time and quality of life of someone who is HIV positive, and mitigate the impact of illness and death on households and communities.

The roles of local government include being a *doer* (service provider), an *enabler* (of communities’ and private sector’s role), a *facilitator* (of community participation in planning), and a *co-ordinator* (of community participation in planning). There are service delivery issues at all stages of HIV infection. In terms of drivers, there is unemployment, poverty, overcrowding in the hostels, poor living conditions, food insecurity and a lack of social cohesion. In terms of those already infected, there is a lack of service, waste removal, housing, limited access to health care, limited food and access to social grants. In terms of the implications of illness for the community, there is loss of income, further impoverishment of households, child and granny headed households, food insecurity, sex work, stigma and discrimination, household fragmentation and limited access to education.
Local governments need to know the figures of HIV prevalence of their municipality to determine how many people need ARVs and how many people are already getting ARVs. It is essential for these figures need to reach the IDPs. In terms of policy, there is little detail in the NSP on the role of local government; there is little reference to HIV/AIDS the new local government turnaround strategy COGTA. The aim of the National HIV/AIDS Framework and Task Team under COGTA is to mainstream HIV, and to roll out the HIV/AIDS handbook to all municipalities in three years. It was launched in Durban in 2009, and the Eastern Cape is one of three pilot provinces. Nelson Mandela Bay and Ukhahlamba Municipalities were selected for the project, but progress is slow.

Challenges to the handbook rollout include a lack of political leadership, a lack of provincial capacity, a lack of understanding of the developmental aspects of HIV/AIDS and a lack of capacity among HIV co-ordinators and IDP managers. HIV is seen as a non-mandated function, IDPs paying scant attention to HIV/AIDS, money for HIV programming being spent on events and t-shirts, and the response not being led by DACs and LACs. Some of the Key Issues that need to be addressed in terms of local government’s response to HIV/AIDS are leadership at all levels, commitment to and training of the DACs and LACs, the capacity of officials – national, provincial, district and local, civil society participation in DACs, LACs and IDPs, appointing an HIV focal person to drive local government’s response and moving beyond programming to mainstreaming HIV responses.

Research gaps and priorities include documenting good practice; sharing information (e.g. exchange visits); compiling and synthesising existing data; studies looking at the impact on households, high transmission areas, good interventions and vulnerable groups; mobilising leadership groups to address social and cultural barriers; studies of the drivers of the epidemic and studies of good practice in DACs and LACs.

The following recommendations were made for the national level: that the NSP needs to address the role of local government; that the next NSP should have input from local government; that local government needs to have formal links to SANAC; and more national commitment and political leadership. On a provincial and local level, the basics need to be in place – service delivery is key; that HIV needs to be seen as a developmental issue; that the specific needs of the municipality needs to be considered; that monitoring needs to be conducted and reported to provincial leadership; that training on mainstreaming needs to take place; that there needs to be financial support for local and district interventions and that HIV co-ordinators should be appointed at all municipalities.

**AIDS, Leadership and Governance: Lessons for the Eastern Cape**

*Dr Kondwani Chirambo – Institute for Democracy in South Africa (IDASA)*

A research project on local government has examined the extent to which HIV/AIDS may contribute to political fragility, particularly in terms of accountability, legitimacy and effective government.

The study concentrated on 3 895 directly elected councillors. The means by which the study tracked attrition, was by looking at the causes of by-elections. The ages of
councillors were also taken into account, and that where there is a preponderance of deaths among councillors aged 22 to 49, inferences could be drawn about the causes of such a mortality profile. The trends in death were compared to AIDS mortality in the general population, and the question was asked whether there was a correspondence in patterns.

Twelve municipalities in four provinces were chosen for interviews. The provinces included the Northern Cape, the Western Cape, KwaZulu-Natal and the Free State. The four research methodologies used for the study included statistical analysis (IEC mortality data and HIV/AIDS data), interviews (ward councillors, HIV/AIDS managers, municipal managers and IDP managers), focus group discussions (with community members) and extensive literature reviews.

Since 1993 local government has had a myriad capacity issues, and that the provision of health, water and sanitation as well as spatial land management and social services are still at the centre of a controversy. Furthermore, Afrobarometer (2006) showed that the levels of satisfaction (of local government) are lower in rural areas, that black people were the least satisfied of all races, that the number of South Africans who believe that local government is handling affairs well is on the decline, and that the four provinces without metros were the least satisfied.

Councillors were generally blamed by the public for their dissatisfaction, that councillors are seen as agents of change and development as well as local legislators and that South Africans expected their material wellbeing to be advanced by councillors.

HIV/AIDS can affect local government in many ways, including that councillors could be absent or ineffective due to illness, it may cause the death of a highly competent councillor – the results of which could be even worse in restive communities, and stigma and discrimination may prevent HIV positive councillors from performing their duties.

IEC records show that nationally, between 2001 and 2007 589 by-elections were held, and that death was the leading cause of by-elections at 48.7% (285 by-elections). The highest numbers of deaths among men were recorded in 2004 and 2005. Mortality figures peaked for women in 2003. On average, 31 male councillors died per year for seven years, compared to eight female councillors for the same period. However, there are presumably more male than female councillors in local government. The largest number of councillors to die came from the 45-49 age group and accounted for 23% of the deaths. The life expectancy of South Africans is 51. The mortality profile of South Africa shows similarities to the trends in deaths observed among councillors. If these statistics are taken as a constant from 2001 to 2007, it may be estimated that AIDS caused 70% of councillors’ deaths.

These deaths (and the resulting by-elections) incurred significant costs for the political parties – they compromised the ability of small parties to regain their seats (larger parties would be better financed), they weakened the ability parties to compete effectively. According to the IEC, a by-election, on average, costs R25 000. Therefore, it is estimated that South Africa spent R14.7 million on by-elections between 2001 and 2007. At least half that amount was spent in wards where councillors died of “undisclosed” causes. Councillors would not disclose their status; for fear that the
Disclosure could ruin their political careers. During the course of the study, only one councillor was found in the whole country who was openly HIV positive. However, community members expressed no problems with voting for an HIV positive councillor, and in fact demanded openness from leadership about its HIV status.

The deaths of councillors led to less experienced people being appointed, councillors withdrawing from their duties due to illness, ineffectiveness and lack of accountability and weak administration. “Champions” need to be identified to lead the political response to HIV, councillors need to be made HIV competent; regular medical tests should be conducted, broader institutional ownership of AIDS needs to be created, social solidarity needs to be fostered; modifications to the electoral system need to be made and public-private partnerships need to be formed.

Research Recommendations

- Documenting good practice
- Compiling and synthesising existing data
- The impact on households
- The drivers of the epidemic
- Good practice in DACs and LACs

Policy and Programme Recommendations

- SANAC mid-term review recommendations regarding governance and institutional arrangements should be reviewed and implemented where appropriate in the Eastern Cape
- ECAC resolutions from the retreat in terms of governance and policy direction should be implemented. These include a new vision and mission to be developed; improvement of the communication between sectors and development of a policy document on sector participation in the Council
- ECAC resolutions in terms of structure and mandate should be implemented e.g. sub-committees should encompass working groups as per the PSP priority areas, strategy and policy co-ordination, secretariat functions configured according to the priority areas and more support for DACs and LACs
- Office of The Premier to broaden the scope for the implementation of a standardised workplace programme for HIV/AIDS as an element of the Integrated Employee Wellness Programme with more emphasise on the importance of VCT and availability of ART
- Office of The Premier should form a stronger partnership with ECAC in the co-ordination of government programmes, especially in key departments such as Health, Social Development and Education
- ECAC to co-ordinate a provincial situational analysis on the support municipalities need in terms of integrating HIV/AIDS across their service delivery programmes
- ECAC to co-ordinate the implementation of capacity development in order to
mainstream HIV/AIDS strategies in Municipal Integrated Development Plans
- Local government needs to be trained and supported on mainstreaming of HIV/AIDS in all areas of service delivery
- Office of The Premier in partnership with ECAC should co-ordinate and implement a provincial MandE system as part of the PSP, using a common set of indicators
- Office of The Premier should co-ordinate donor activity and support more effectively
- ECAC should ensure local government level mobilisation of leadership to address social and cultural barriers in the context of HIV/AIDS
- At local government level HIV needs to be seen as a developmental issue and guided by specific needs of the municipality
- Financial support for local and district interventions should be made available and HIV co-ordinators should be appointed in all municipalities
- At local government level ‘champions’ need to be identified to lead the political response to HIV and councillors need to be made “HIV” competent
- ECAC should facilitate broader institutional ownership of AIDS as well as foster social solidarity, especially at local government level
- Modifications to the electoral system need to be made and more public-private partnerships need to be formed

Theme: The Effectiveness of HIV/AIDS Policy and Implementation

Interrogating the System: The Integration of TB and HIV/AIDS Services at TB Hospitals in the Eastern Cape

Mr Daygan Eager – Public Service Accountability Monitor (PSAM)

The South African Constitution guarantees the right to access healthcare.

A major problem is that strategic planning, which forms the foundation on which service delivery is built, in healthcare has generally not been based on data, or has been based on old data. Furthermore, strategic planning has not spoken to either need or demand. This has led to the over or under-budgeting of certain items, namely the projected R1.6 billion over expenditure for 2009/2010 due to unbudgeted items.

A highly centralised decision-making process exist within the health system. There is also a vacancy rates of 35% and up to 50% in critical posts within the health system. The integration of TB and HIV/AIDS services at TB hospitals in the Eastern Cape, which included four TB hospitals in the province, formed the basis of a study involving interviews with administrative staff, doctors and nurses.
South Africa has the second highest rate of TB in the world (after Swaziland). There is a synergistic interaction between the two infections (HIV and TB) and an estimated 73% co-infection rate. High vacancy rates exist in the hospitals that were included in the study, with only one hospital having a full-time pharmacist, and a 50% vacancy rate for doctors at the hospitals. The problem is compounded by a high staff turnover. The high turnover is due to dissatisfaction with pay, a perceived risk of working at a TB hospital and the heavy workload.

In addition, the infrastructure is generally old and insufficient, which has been compounded by the need for the isolation of Multidrug-Resistant (MDR) and Extensively Drug-Resistant (XDR) patients. This has led to the problem of infection control. Mr Eager noted that this was not necessarily a problem of budget, as the Department of Health managed to spend only 2% of its budget for infrastructure in 2007/2008. SANTA still owns most of the hospitals; the Department of Heath cannot acquire them due to bureaucracy.

Despite these problems, integration is happening, with all sites accredited or in the process of being accredited to provide ARVs. The sites do provide a comprehensive package of care and convenience for patients. Challenges do remain, especially in terms of the shortage of pharmacists, patients arriving without knowing their status, and patients arriving sicker and more difficult to treat. There are some social factors that affect treatment and adherence, including poverty, drug and alcohol abuse and a lack of education.

**NDOH Overview of Government HIV/AIDS Policy and Implementation**

*Dr Thobile Mbengashe, National Department of Health (NDOH)*

The priority of the Medium Term Strategic Framework (MTSF) is to increase the life expectancy and health of South Africans, to combat HIV, reduce TB infection and reduce maternal and child death. This Strategic Plan of the National Department of Health (DoH) for 2010/11-2012/13 is aimed at creating a well-functioning health system capable of producing improved health outcomes.

The Department of Health's key strategic priorities include overhauling the health system to improve health outcomes, changing the health service platform to provide holistic care, the training of health workers to improve quality of services and social mobilisation to increase community based care. The key policy initiatives are:

- Drug policy
- Human resources
- Decentralisation
- Task shifting
- Partnerships and co-ordination
- Supportive supervision

The Department of Health is aiming to decentralise Antiretroviral Treatment (ART) and include it under public health care; to integrate TB and HIV care; to provide
ART at antenatal care clinics; to manage HIV Prevalence; to reduce HIV incidence; to improve TB case findings; to improve TB outcomes and improve access to ART for TB and HIV patients.

HIV prevalence in the Eastern Cape is stabilising at around 28% and all districts in 2008 recorded a prevalence rate below 30%. Ukhahlamba recorded a 21.9% prevalence rate, which was the lowest. Alfred Nzo had the highest rate of 29.8%. The introduction of ART in South Africa has significantly reduced the mortality rate. Research has indicated that patients on ART had a reduced risk of both opportunistic disease and absolute risk of AIDS or death. Research has further indicated that male circumcision can significantly reduce HIV infection. In previous observational studies, male circumcision (usually soon after birth) was associated with a low risk of infection. Research showed that there was a 65%-75% reduction in relative risk of HIV infection among men who were circumcised.

There are currently over 1 million patients on ART and the target is 1.35 million. Additional health facilities will be added by 1 April 2010 and by the end of the financial period 2, 300 facilities will be able to initiate and maintain patients on ART.

**Role of the Private Health Sector in HIV/AIDS Service Delivery**

*Dr Anban Pillay, National Department of Health (NDoH)*

There is a huge gap in spending between the private and public sector medical schemes. Of all health care expenditure 14% consists of “out of pocket” payments.

In real per capita terms, government expenditure on health declined consistently from the middle of the 1990s until 2002. Expenditure only peaked in 2005. In South Africa 5.2 million people (16.6% of the population in 2009) reported that they experienced difficulties in accessing health care, including medicines. “Health care benefits are generally accrued by the rich who receive about 60% of the health care benefits,” said Pillay. This trend can be attributed to the use of private health care providers by this group. The rich also utilise highly specialised hospitals, which provide top-notch health care.

Most South Africans generally prefer to access health care for free. Seventy percent of South Africans agreed with the statement “I would join a publicly supported health insurance scheme if I could use public health services for free.” Implementation of the National Health Insurance (NHI) is thus at the top of the government’s health agenda in terms of overhauling the health care system. Government is seeking to revitalise health infrastructure, mobilise for better health for the population, accelerate implementation of the HIV/AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase its focus on TB and other communicable diseases. The government also aims to review the drug policy and strengthen research and development to this end.

There are draft proposals for legal reforms to unify the public health service, develop an accountability framework for the public and private sector and for the establishment of a leadership academy for health managers. There is a need to evaluate and strengthen the District Health System and Primary Health Care.
The need to improve human resource planning, development and management is regarded as pertinent to overhauling the health care system. There are plans to allocate resources to the reopening of nursing schools and colleges in the 2010 academic year and review the accessibility and training output of academic health complexes.

The procurement of ARVs has been highlighted as an area that government needs to urgently review. South Africa is currently overpaying for ARVs because of market dynamics, registration and poor data. New drugs are being developed and marketed at much higher prices than existing drugs, when they may only be a small improvement on the older drugs. There is thus a need to regulate drug prices in South Africa. Pharmacies normally experience long waiting times and there is poor compliance with therapy. In the private sector chronic medicines are prepared at a central depot, packed and delivered to the patient and there is a reduced possibility of drugs being out of stock.

**Key Issues Facing Civil Society**

*Ms Dudu Radebe, Eastern Cape NGO Coalition (ECNGOC)*

Civil society is an important pillar for a healthy democracy. NGOs and CBOs form a significant part of civil society in South Africa, performing critical tasks, as they contribute to policy making, and implementing policy at community level.

ECNGOC is a membership-based coalition of NGOs and CBOs in the Eastern Cape, which has an advocacy, capacity building, and collaboration mandate on behalf of the sector. In terms of HIV/AIDS, the role of civil society organisations is in linking HIV/AIDS to poverty alleviation strategies and other actions aimed at improving people’s quality of life. CSOs also offer psycho-spiritual support to people living with HIV/AIDS, facilitate and maintain strategic partnerships, contribute to and participate in policy formation relating to HIV/AIDS, and advocate for socio-economic rights relating to HIV/AIDS.

Key roles are played by ECNGOC in implementing HIV/AIDS policies and programmes. First of all, it has a right-based approach, which focuses on the inadequate implementation of human rights, particularly social and economic rights which results in inappropriate implementation, monitoring and evaluation mechanisms. This approach continues to advocate for the recognition of the human rights of those infected and affected by HIV/AIDS.

As part of the rights-based approach, ECNGOC promotes political will and action to achieve certain specified objectives of the national AIDS strategy; aims to break the silence around HIV/AIDS; implements programmes to eradicate stigma and discrimination and provides effective programmes to prevent, treat, care for, and mitigate the impact of HIV/AIDS.

In addition, ECNGOC mobilises and makes available resources for civil society organisations involved in prevention and care; identifies and ensures that the most vulnerable populations (including caregivers) receive priority attention and seeks to address gender inequality and aims to bring about poverty alleviation and reduction (which is integrated with prevention, treatment, care and impact mitigation).
The rights-based approach coincides conveniently with the governance partnerships and holistic understanding. Furthermore, ECNGOC is a partner in service delivery. This is collaborative and is particularly evident at the local level, especially through home-based care programmes. Civil society assists AIDS councils where they do exist, and helps establish them where they don’t.

ECNGOC is able to advocate a holistic approach to HIV/AIDS and rights issues. It implements and complements government interventions and supplements the skills and expertise within government, thereby “amplifying” the human resources available to address HIV/AIDS.

ECNGOC is also a lobbying agent, and offers a critical reflection on inadequate service delivery by government. It advocates for new forms of government that are free from corruption, patronage and cronynism. In the context of HIV/AIDS, the issues dominating the public are related to treatment and care, including post-exposure prophylaxis, antiretroviral treatment and a protective and enabling legal environment.

In terms of participation in policymaking, ECNGOC’s role fluctuates between collaboration, partnership, rubberstamping and antagonism. ECNGOC advocates for conducive policies and legal environments and attempts to get government, via parliament, to adopt their mandate. Based on their experiences of local realities, NGOs and CBOs are able to offer policy makers relevant and realistic information.

ECNGOC’s success includes the alignment of its plans with the framework of the National and Provincial AIDS Strategies, and that ECNGOC build the capacity of its members and enhances the voice of its members on the PAC, DACs and LACs.

The challenges faced by ECNGOC are not having sufficient resources to build the capacity of its members, the partnership between civil society and AIDS councils being ineffective, is a lack of commitment to strategic plans, uncertainty over whether AIDS councils should be politically lead or lead by civil society, an ineffective flow of information from DACs to LACs and LACs to communities and a lack of integration between the DAC and LAC plans.

**Research Recommendations**

- Research should be conducted to monitor the implementation of medical male circumcision as part of HIV prevention in the Eastern Cape
- ECAC should co-ordinate more research in the Eastern Cape on the effectiveness of government policy implementation, especially in light of policy changes
Policy and Programme Recommendations

- ECAC should ensure that the National and Provincial HIV/AIDS Strategic Plans are based on relevant and up-to-date data to prevent over/under spending.
- The new treatment guidelines that are being implemented in April 2010, including initiating TB/HIV patients, pregnant women and infants earlier into treatment, should be costed and made publicly available to all relevant stakeholders.
- ECAC should partner with the ECDOH to evaluate and strengthen the District Health System and Primary Health Care, including the need to improve human resource planning, development and management.
- ECAC should facilitate strategic meetings with the ECDOH to discuss health systems issues such as high vacancy rates, high staff turnover as well as the need for improved infrastructure in the context of HIV/AIDS.
- ECAC in partnership with SANAC and other key stakeholders should discuss and review the medical male circumcision national policies.
- ECAC should develop a policy brief for government and other key stakeholders on the implementation of medical male circumcision in the Eastern Cape.
- ECAC should partner with ECDOH and other provincial stakeholders to review the procurement of ARVs.
- ECAC in partnership with key stakeholders should monitor ART roll out in the Eastern Cape.
- ECAC should ensure that partnerships between civil society and AIDS councils should become more effective.
- At DAC and LAC the involvement and participation of PLWHAs, HBCs and CSOs should be enhanced.
- ECAC to facilitate strategic discussions which seek clarity as to who should lead AIDS councils i.e. should be politically lead or lead by civil society.
- ECAC should ensure that information flow and integrated planning between DACs, LACs and communities is improved.

Theme: Communications and HIV/AIDS


Antoinette Ntuli, Soul City

The Onelove campaign works against Multiple Concurrent Partners (MCP). The term ‘concurrent sexual partnerships’ is used to define a situation where partnerships overlap in time, either where two or more partnerships continue over the same time period, or where one partnership begins before the other terminates.

This campaign against MCPs was started in response to the numerous academic
and opinion articles confirming MCPs as a driver of the AIDS epidemic in Southern Africa. At a SADC Think Tank meeting in Maseru, Lesotho, in May 2006 multiple and concurrent partnerships by men and women with consistently low condom use in the context of low levels of male circumcision, were identified as key drivers of the HIV pandemic in Southern Africa. The Onelove campaign primarily uses mass media and social mobilisation to communicate its message and stimulate social and behavioural change. The Soul City series, which is the main tool of the campaign, comprises of a TV and radio drama, educational booklets, magazines and posters. It aims to get people talking about the trend of having more than one sexual partner at a time.

The overall goal is to change this behaviour, which is a factor in the transmission of HIV in the region. The Onelove campaign also seeks to decrease new HIV/AIDS infections by 10%, by 2011 in line with the National HIV/AIDS and STI Strategic Plan for South Africa; to kick start key debates that South Africa needs to have if the HIV/AIDS epidemic is to be turned around; and to empower communities to take positive organised action to prevent and reduce the incidence of HIV/AIDS.

- Key messages that the campaign aims to drive home:
  - Having many partners in the same period of time increases one’s risk of getting infected with HIV, and often puts loved ones at risk.
  - Encouraging the concept of enjoyable sex within monogamous relationships and that it can be fulfilling for both partners
  - That both men and women can control their sexual desires and that having secret sex is not protecting your loved ones but may in fact harm them.
  - The importance of HIV testing and knowing one’s status.
  - Encourage consistent and proper use of condoms.
  - Transactional and intergenerational sex is very risky, due to the big differences in power in the relationship; which result in unsafe sex
  - Having sex when you are drunk puts you at risk of having unsafe sex and multiple sexual partners.

The Soul City qualitative research project focused on ordinary men and women. The research generally revealed that MCPs are a common practice. MCPs are generally influenced by sexual dissatisfaction and a lack of communication in relationships; emotional and physical dissatisfaction; culture and social norms; money and material possessions; alcohol or drunken behaviour; stereotypes, for example that men cannot control their sexual desire; male domination and abuse; HIV/AIDS risk and fatalism.

Important lessons have been learnt from the Onelove campaign. The ‘splash’ of mass media has led to a large number of people recognising the campaign. Making the campaign fun and non-judgmental was important as was appealing to young people. The campaign touched people in a personal way and highlighted the need for counselling and support in forming good loving relationships. There was also a positive response to encouraging honest and open discussions about sex. There is a need for a province-specific campaign in the Eastern Cape. The campaign should be structured in such a way that it involves health and social development and targets the youth.
HIV/AIDS – The Role of the Media

Ms. Ntando Makhubu, Daily Dispatch

In the absence of a vaccine, information is vital in preventing the further spread of the virus. Education and awareness is the only preventative tool we have and prevention begins with information. The media, which conveys information and influences public opinion, must be at the core of the campaign to help people make informed choices and that the media’s reporting has an enormous effect in terms of how HIV/AIDS is viewed and as a consequence, an enormous effect in terms of stigma and discrimination. HIV/AIDS stories have of late taken the back pages, meaning that the media are not prioritising these stories. Journalists should thus find interesting and creative ways to write HIV/AIDS stories in order to maintain public interest. In creating an efficacious awareness about HIV/AIDS, the messages need to be informative, educational as well as entertaining.

The media can raise awareness levels and can bring about sustainable behaviour change thereby reducing vulnerability to the virus. Media can only be effective if journalists have access to accurate information and are given the time and capacity to do further research.

Accuracy is essential when writing HIV/AIDS stories and journalists should always double check the validity of the information. The challenge with regards to accuracy is that at times advertisers influence the news agenda and the advertisements themselves can carry inaccurate information about HIV/AIDS related issues. The media is urged to be cautious while reporting on HIV/AIDS as the affected person bears a strong social stigma.

Journalists trying to provide better coverage on HIV/AIDS are grappling with complex ethical issues of how best to treat the issue. The media becoming increasingly commercialised has compounded this and these types of pressures have led to the media being more prone to sensationalism and chasing an easy story. This compromises the quality of coverage given to HIV/AIDS stories.

The media should avoid using scientific facts indiscriminately and inappropriately using quotes. It is always important for the media to make information on HIV/AIDS as clear and concise as possible as this is crucial in the fight against the epidemic. The media needs to be extra cautious while reporting and there is an urgent need for the media to change the way it reports on HIV/AIDS.

The Influence of Language of Communication on the Effectiveness of HIV/AIDS Messages among Young South Africans

Ms Elizabeth Lubinga, University of Limpopo

Effective communication is crucial to behaviour change. Contrary to previous research, the National Communication survey of 2009 highlighted that there are high levels of general HIV/AIDS awareness in South Africa. There are low levels of specific accurate knowledge about HIV/AIDS among South Africans especially 15-24 year old women.
It is important to ask ourselves whether HIV/AIDS messages are best communicated in first languages to first language speakers. Diverse literature on HIV/AIDS has suggested that messages presented in first languages to African language speakers tend to have much more of an impact, are better understood and can lead to possible behavioural change. In 2006, Lovelife launched their “HIV - Face It” campaign. For the first time, a number of messages were not only presented in English, but in all of the official South African languages. Ms Lubinga and Mr Jensen from Radboud University thus conducted research to find out to what extent the language of presentation of the Lovelife HIV/AIDS messages affected the reception of the messages among South African youth. The research employed structured interviews in English, Sepedi and Tshivenda about posters and radio advertisements on HIV/AIDS. The posters and radio advertisements were in three languages; English, Northern Sotho (Sepedi) and Tshivenda. Lubinga highlighted that all participants were fluent (mostly mother tongue) speakers of either Tshivenda or Sepedi.

The participants were 64 grade 8-11 secondary school learners, randomly selected from four different rural and peri-rural schools in Limpopo province and 12-17 years of age. The researcher (not a first language speaker) worked together with research assistants who were first language speakers of Tshivenda and Sepedi. The researcher conducted the interviews in English and the research assistants conducted interviews in Tshivenda and Sepedi. The research materials included four Lovelife messages presented to each learner. Again, each learner was presented with four posters or four radio advertisements (two in English, two in Tshivenda or two in Sepedi). The researcher and two independent assessors assessed the answers to the open question - learners were asked what they perceived to be the most important message of the poster or radio advertisement.

Actual comprehension of the messages was low in all languages and the language of communication did not have a statistically significant effect on comprehension of any of the messages. The study did not support the argument that messages presented in first languages would be better received by South African youth. While many campaign message producers are producing messages in all official South African languages, there is a need to test the effectiveness of these messages. A bottom-up approach would be recommended, in which targeted audiences participate in the construction of potentially effective messages.

More Public and Less Experts - How Citizens can be Involved in HIV/AIDS Communication

Ms Ayanda Roji, IDASA

Citizens have been generally neglected in the construction of HIV/AIDS messages. Celebrities, political actors and generally high-ranking stakeholders dominate these messages.

We need to shift from the current status quo and include citizens in HIV/AIDS communication. Spaces and environments need to be created which will facilitate
the involvement of citizens in HIV/AIDS communication processes. In approaching HIV/AIDS communication, it is imperative to have debates around the role of government, citizens and journalists in influencing the HIV/AIDS discourse.

The John Hopkins Health and Education Programme evaluation found that the interaction between exposure to AIDS communication programmes and local social capital was statistically significant. This means that much more work is needed to actively involve citizens in defining HIV/AIDS problems as they experience it in their communities and proposing solutions that are locally appropriate.

There are questions to be asked as to why the (Eurocentric) United Nations human development index only takes into account unemployment, poverty and food shortages in Africa, while leaving out HIV/AIDS. The disconnect between the conversation about HIV/AIDS as conducted by the funders, aid agencies and health activists and the conversation as conducted by citizens is a cause for concern. Providing journalists and communicators with information about HIV/AIDS governance and making a case for citizen involvement will not necessarily translate into the mobilisation of “citizen energy” and lead to the type of social connectedness and cohesion which communication programmes strive for as described in the Johns Hopkins report. The role of journalists and government communicators in this process is to provide quality information that allows the deliberative process to continue beyond the story itself. Journalists need to move beyond the printing moment. The media should not to be reduced to channels for UNAIDS, USAID and Bill and Melinda Gates to talk to and on behalf of citizens to Departments of Health and AIDS Councils and Presidents.

Building a habit of participative and informed political discussion between government and citizens and between citizens and citizens in the fight against the HIV/AIDS scourge is absolutely vital.

The Role of Community Media in Covering HIV/AIDS

Mr Phumzile Ngcatshe, EC Communication Forum

Small independent publications in the Eastern Cape mostly serve disadvantaged communities in small towns and rural areas.

The majority of small community newspapers in the Eastern Cape are not doing enough in terms of covering and delivering dependable and relevant information on HIV/AIDS. These small community publications have not yet established a strong and valuable working relationship with relevant HIV/AIDS organisations. The Highway Africa conference, a gathering of African journalists and media practitioners in Grahamstown held a seminar, where the media was accused of neglecting stories on HIV/AIDS. The media was also accused of covering HIV/AIDS in a manner portraying an unmanageable disease as well as portraying people who are HIV positive or have AIDS as victims. Such stories fail to reach the interest of readers and are considered rather boring. The workshop thus encouraged journalists to tackle stories relating to HIV/AIDS from a different angle by putting the human story at the core instead of the disease.

Community newspapers have attempted to forge working relationships with relevant HIV/AIDS organisations. Attempts to forge a working relationship with ECSECC and the
Eastern Cape AIDS Council (ECAC) failed. ECAC is the perfect partner for community media in sharing information and knowledge so that small media organisations are better equipped to report to the people especially in rural areas.

There are difficulties in obtaining HIV/AIDS related information from nurses and doctors and keeping contact with infected members of the society are some of the challenges faced.

The role community media can play in communicating the right messages, giving space for debate and engaging with the readers is crucial, but it becomes a mammoth task when there is no support. NAPWA, ECAC, ECSECC and other organisations need to recognise and reach out to the small media and make an effort to work with them.

**Research Recommendations**

- ECAC in partnership with key stakeholders should conduct research on the effectiveness of communication messages, especially HIV prevention messages
- ECAC should ensure that HIV prevention messages are informed by research and best practice and adapted for rural audiences

**Policy and Programme Recommendations**

- ECAC to initiate a province-specific Onelove campaign for the Eastern Cape
- ECAC in partnership with key stakeholders to develop and implement a provincial HIV/AIDS communication policy
- The communication policy should ensure the use of a bottom-up approach in formulating HIV/AIDS messages in which targeted audiences participate in the construction of potentially effective messages
- The communication policy should ensure active involvement of citizens in defining HIV/AIDS issues as they experience these in their communities and in proposing solutions that are locally appropriate
- ECAC visibility and communication should be increased, working closely with community and mainstream media to inform and mobilise communities
- ECAC should co-ordinate the training of journalists and the media on Key Issues in relation to HIV/AIDS reporting
- Journalists to put the human story at the core in stead of the disease, interact with communities, and not just government when reporting on HIV/AIDS
- ECAC to develop strategies to ensure participative and informed political discussion between government and citizens and between citizens and citizens
- ECAC to work closely with media and journalists in communicating key HIV/AIDS messages
- ECAC, ECSECC and NAPWA to work more closely and provide more information to media, especially community media to ensure their messages reach everyone, including rural areas
Theme: HIV/AIDS and Power Relations

AIDS, Sex and Poverty

Prof Nicoli Nattrass – UCT

Research refutes the common perception that poor people are more likely to contract the HIV virus and AIDS.

While poverty may increase vulnerability in some circumstances, there is no single relationship between poverty and HIV. Rather, contextual factors in Africa have a far larger impact than economic drivers.

Common arguments posited for the correlation between poverty and the spread of HIV/AIDS are:

- **Biological**: People living in poverty are likely to be malnourished and/or infected with worms, TB, and malaria. It is also more probable that they are burdened with untreated sexually transmitted infections. As STIs cause skin lesions and malnutrition weakens mucosal and skin integrity, people living in poverty have more possible entry points for the HIV/AIDS infection.
- **Behaviour**: Poor people are less likely to have access to condoms and/or information regarding HIV/AIDS. Poor women are also less likely to have the power to shape their sexual relations.

There is, however, very little evidence to support these claims.

Rather, the evidence points to regional factors having a greater influence on the spread of HIV/AIDS. Specifically, the middle-income countries of Southern Africa (Namibia, Botswana and South Africa) illustrate this finding.

The regional nature of the spread of HIV/AIDS could be attributed to several tentative factors:

- **Sexual norms and practices**: While there is little evidence to support the notion of a risky African sexual culture, long-term concurrent sexual relations are more common in Africa than in other parts of the world. Concurrency drives the spread HIV/AIDS to a much larger degree than the number of sexual partners.
- **Untreated herpes simplex virus 2**: HSV-2 is more widespread in Africa than the rest of the world and is known to heighten the risk of contracting HIV/AIDS. The evidence to support this hypothesis, however, is lacking.
- **Genetic differences**: There are speculative claims, somewhat backed by evidence, that people of African descent are more vulnerable to HIV infection. This may be due to the absence of two chemokine receptors, known to facilitate HIV infection, in a percentage of people, more likely to be European. This is speculatively attributed to the Black Death.

There is no direct evidence of a systemic relationship between poverty and HIV, although malnutrition and economic vulnerability may well increase the risk of HIV contraction in some contexts.
Thus, while poverty-alleviation programmes are valuable in themselves, they are not likely to be effective in combating the spread of HIV/AIDS. Evidence suggests that efforts would be more effective if they are concentrated in pragmatic, context-specific approaches.

**Gender and Sexuality: Implications for HIV Prevention**

*Prof Rachel Jewkes (presented by Tanya Jacobs)*

There is a strong correlation between gender based violence and HIV infection. Abused women, for instance, are 55% more likely to contract the virus. Men who are violent towards women also have a higher chance of becoming infected.

Sexual practices are a direct result of gender identities. The full interplay between genders, therefore, needs to be understood to change sexual behaviour and thereby decrease infections.

There is compelling evidence from cross-sectional research that both abused women and men that have used violence are more likely to have HIV. Women with low relationship power equity, further, had a 50% higher HIV incidence (after adjusting for other risk factors). Those who had experienced more than one episode of intimate partner violence also had a 50% higher chance of contracting the HI virus.

Calculations show that 13.9% of HIV infections in young women could be prevented if no women experienced most severe gender inequity in relationships and 11.9% of HIV infections in young women could be prevented if no women experienced intimate partner violence.

While many people assume that rape is main link between gender violence and HIV. However, there are enough statistics regarding rape, HIV prevalence, transmission risk, etc. to know that it’s very unlikely that more than 1 in a 1000 (0.1%) new HIV infections in women is due to rape.

Preventing these is critically important, but it is not rape that is the key nexus of the problems of HIV and gender-based violence.

For instance, research has shown that rural Eastern Cape women between the ages of 15 and 26 years who experience partner violence have more risky sex. Men who are violent towards their female partners in EC and KZN also have more risky sex.

Theories that describe gender and its associations can go some way to explaining these correlations.

In society today, the dominant view of what it means to “be a man” is generally associated with the subordination and oppression of women. This view is a dominant cultural model of idealised manhood, and whilst this encompasses elements of fantasy, it is important as a frame used by individual men against which to judge their ‘success’ as men. With regard to femininity, there are more diverse conceptions of what it means to “be a woman”, but a dominant one is “emphasised femininity”, characterised by compliance with women’s subordination and an orientation towards accommodating the interests and desires of men.
In urban areas and among the relatively more advantaged classes another dominant viewpoint is prevalent: “Modern Girl” femininity. A modern girl resists conservatism and incorporates elements of empowerment to varying degrees. There is, however, still an emphasis on success viewed in terms of desirability to men, often framed in terms of sexual agency and acknowledgement of women’s sexual desire and power.

Thus, compliance with forms of acquiescent femininity is rewarded, not just by men, but also by other women. It is important to see hegemonic masculinity, as well as acquiescent femininities, as having deep cultural roots and thus models of behaviour that may be hard for individuals to critique and exercise real choices around.

If we view sexual practices as rooted in and flowing from gender identities, we then need to address our attention to changing these, rather than the individual behaviours. In real terms this means focusing attention on building more gender equitable and caring masculinities, and less acquiescent femininities. Indications of the value of this are seen in the results of the Stepping Stones RCT evaluation. Stepping Stones is a gender transformative programme for HIV prevention that aims to improve sexual health through building stronger, more gender-equitable relationships. It has been used in the Eastern Cape since and has led to a 33% reduction in new genital herpes infections in young men and women over 2 years.

There is thus strong evidence linking violence and gender inequity in relationships to HIV risk. Sexual practices need to be seen as flowing from gender identities, and this provides a frame for understanding why men and women behave in the way that they do. It follows that only when we understand this, will we be able to change sexual behaviours and thereby reduce the risk of HIV infection.

**Stigma and Discrimination**

*Aubrey Mdazana – SAHRC*

The ways in which discrimination against people with HIV negates efforts to stop the spread of the disease. Discrimination enables people to blame the pandemic on other people and, in so doing, neglect to take responsibility for themselves.

While effective prevention depends on people being tested, discrimination makes it less likely that they will. To stop discrimination, societal leaders at all levels must take responsibility and promote awareness through legal, cultural and social means.

The stigma attached to HIV seriously hinders prevention efforts, and makes HIV-positive people wary to seek care and support for fear of being discriminated against. Some of the factors which contribute to HIV/AIDS-related discrimination are as follows:

- HIV/AIDS is a life-threatening disease
- People are scared of contracting HIV
- HIV/AIDS is associated with behaviour that is already stigmatised in many societies
- People living with HIV or AIDS are often thought of as being responsible for becoming infected
Religious or moral beliefs lead some people to believe that having HIV or AIDS is the result of “bad” behaviour (such as promiscuity or deviant sex) that serves to be punished.

With reference to the national legislation, the Promotion of Equality and Prevention of Unfair Discrimination Act (Equality Act) has been enacted primarily to deal with instances of unfair discrimination. While the Equality Clause and the Equality Act does not mention HIV/AIDS explicitly, it also prohibits discrimination based on “other” grounds that may not be specifically listed, but that are used to unfairly discriminate – such as HIV infection.

The Equality Clause and the Equality Act can protect people living with HIV or AIDS in a number of ways:

- HIV/AIDS may be interpreted as a disability
- HIV/AIDS may be added to new laws as a separate listed ground for non-discrimination
- HIV/AIDS may be treated as an ‘other ground’

People with HIV face many kinds of discrimination:

- Many people are refused employment or membership to employee benefit schemes
- Insurance companies refuse to offer life insurance to people with HIV and banks often refuse bonds
- Many people are refused proper health care and equal membership of medical aid schemes
- Children and students with HIV, or of parents with HIV, are victimised at schools.
- Many people are tested for HIV in our hospitals without giving informed consent, or are told about their HIV status without being counselled
- Breaches of confidentiality and privacy happen almost every day (e.g. disclosing someone’s HIV status without their consent). Under the Constitution and laws such as the Employment Equity Act, many of these actions are unlawful and can be challenged

Discrimination, stigmatisation and victimisation help the spread of HIV. Discrimination has made it easy for people to blame others without protecting themselves. Instead of campaigns that educate everyone in our society, people like to believe that HIV infection happens to gay people, sex workers and ‘people who sleep around’. Many people think that if you are not gay or a sex worker, you are safe. This is not true. Effective HIV prevention and treatment depends on people wanting to have an HIV test – and finding out if they are infected with HIV. But for as long as people with HIV continue to face discrimination, people will be afraid to volunteer for an HIV test. Similarly, if people with HIV or AIDS continue to be discriminated against with the lack of access to treatments that can help to keep them well, they will see no purpose in having an HIV test.
Using the law is one way to fight discrimination and to make sure that HIV prevention is successful. So, where discrimination does take place, especially when it is by major bodies such as hospitals or public and private sector employers, it is important to do everything we can to stop it.

The solution to the HIV/AIDS pandemics is not as simple as having every person undergo a HIV test and disclose status. The AIDS pandemic is highly complex and requires deep-rooted and long-term societal changes, such as gender equality, freedom of expression, and an end to poverty and hate.

Another area that deserves attention is the issue of cultural practices, which contribute to the proliferation of HIV, and consequently results in stigmatisation and discrimination of the victims. Reference here should be made to the practice of *ukuthwala* where allegations have surfaced to the effect that young girls are targeted under the notion that having sexual intercourse with virgins helps to cure AIDS.

The other dimension that needs closer scrutiny in an effort to deal with discrimination is the message carried by the campaigns that stress HIV prevention on ABC or variants of that such as delayed sexual debut, reducing the number of partners, etc. There are various shortcomings to this approach such as providing little information that present basic HIV definition, transmission and prevention information in a way that is inclusive, easily understandable and non-discriminatory. Another misconception created is that if people ‘save’ themselves for marriage, and get through the risky teenage years, then sex will be safe. Another discriminatory notion is the lack of information relevant to people, who chose not to engage in heterosexual sexual activity – campaigns generally focus on ‘taking your relationship to the next level’ and depict heterosexual couples. This bias towards heterosexuality impacts on the ability of a person to access relevant information, and hence, the extent to which a person is in the position to make fully informed choices around sex and health issues.

It could be argued that what is missing is creating a context in which messages can be heard, and a context in which accessing information is just that; accessing factual information, rather than being subjected to messages pushing a specific agenda. It could also be argued that the context, in which this could happen, would be a context in which the fundamental human rights of equality, non-discrimination, dignity and freedom of choice are respected and protected.

The Commission, in partnership with the government, willing civil society organisations and NGOs will continue to ensure that the rights of people living with or affected by HIV/AIDS are always respected, protected and promoted.
The Political Economy of HIV/AIDS – A Male Perspective

Desmond Lesejane – Sonke Gender Justice

Gender, race, ethnicity and class relations fuel the HIV/AIDS pandemic. HIV/AIDS are more than a health issue, but rather form part of a gender, economy and HIV complex. It is both fuelling and being fuelled by inequalities across gender, race, ethnicity, class and age. Policies that respond to HIV/AIDS, like the rules and regulations of any society, follow dominant discourses, and thereby fuel the power relations that encourage the spread of the virus.

Gender is a particularly important construction that affects people’s power, both social and economic, within society. Through the unbalanced power distribution between male and female genders, men are able to deprive women of their bodily integrity, eliminating their ability to consent to sex or even negotiate safer or more satisfying sex. This contributes to the spread and impact of HIV/AIDS.

However, the impact of the rights of women and other social concerns like rural livelihoods, impoverishment and child welfare are not reflected in planning and programming for the pandemic. Treatment strategies, for instance, continue to be delinked from other necessary support needs, such as food and transport. The budget allocated to government programmes and departments are choices made by government committees and sanctioned by the public through their silence. This make the inadequate budget for the health system and the relatively new Ministry of Women, Youth, Children and People with Disabilities, which remains without an office, senior management and a clear programme of action ten months into the term, inexcusable.

It is also important to engage men in the struggle against HIV/AIDS by appreciating their agency, using their reality, de-stigmatising their engagements and involving them in activities.

Power, the threat of violence, deprives women of bodily integrity by eliminating their ability to consent to sex, negotiation of safer and satisfying sex, and determining the number and spacing of children. This also causes the spread and impact of HIV/AIDS. The link between concerns about rural livelihoods, impoverishment, the rights of women, and child welfare and HIV/AIDS continue to escape the attention of planning and programming for the pandemic.

A further policy gap can be found in the National Strategic Plan, which does not address the reality of strangers and guests in our country. This leaves open the impact of cross border migration on the pandemic.

There is a need to “upscale” activism to include budgets for relevant programmes, the empowerment of women in real terms and equitable relations between the public and private sector. Preventative programmes, further, must appreciate the agency of men, use their realities and destigmatising their engagement.
Research Recommendations:

- A review of literature on the interrelationship between poverty and HIV/AIDS should be conducted. More research is needed on malnutrition and economic vulnerability and risk of HIV contraction.
- ECAC should conduct a systematic review of evidence for effective, pragmatic and context-specific approaches to HIV/AIDS, within the context of poverty alleviation approaches.

Policy and Programme Recommendations:

- ECAC should develop policy briefs for various government departments on HIV/AIDS and power relations in terms of various manifestations in terms of race, gender, class, urban/rural location etc.
- ECAC should facilitate seminars and discussions with various stakeholders on the interrelationship between various experiences of poverty and underdevelopment and HIV/AIDS, given the range of views that currently exist.
- All provincial policies and programmes should integrate HIV/AIDS as both fuelling and being fuelled by inequalities across gender, race, ethnicity, class and age.
- Gender identities which give rise to and inform sexual behaviour should also be addressed in HIV/AIDS programmes, rather than only individual behaviours.
- HIV prevention policies and programmes should focus attention on building more gender equitable and caring masculinities, and less acquiescent femininities.
- ECAC should facilitate the engagement of men in HIV/AIDS prevention programmes by appreciating their agency, using their reality, de-stigmatising their engagements and involving them in activities.
- ECAC should partner with organisations such as Sonke Gender Justice, whose exemplary work focuses on addressing men and masculinity, promoting gender equality as part addressing HIV/AIDS.
- ECAC should partner with the SAHRC and other partners to ensure that the rights of PLWHA or affected by HIV/AIDS, are always respected, protected and promoted.
- ECAC in partnership with other key stakeholders should ensure that strategies are being developed to address issues of discrimination, stigmatisation and victimisation.
**Theme: Economy and HIV/AIDS**

**Key Note Address: The Political Economy of Antiretrovirals in Developing Countries**

*Prof. Nicoli Nattrass – University of Cape Town*

Despite unprecedented international mobilisation to support universal provision of highly active antiretroviral therapy, national governments continue to play the key role in determining access to treatment.

South Africa has not performed well in terms of rolling out antiretroviral treatment even though it has the largest number of HIV positive people in the world. The past government’s policies on HIV/AIDS are to blame for this lacklustre performance. Countries like Brazil and Thailand have adopted exemplary policies on antiretroviral treatment. Both countries (Brazil and Thailand) have supported HIV prevention and AIDS treatment and that these countries have also developed the capacity to produce easily accessible drugs.

A range of extra market forces has over the past decade, profoundly affected Antiretroviral (ARV) prices. These include pressure from AIDS activists and non-governmental organisations (NGOs) on pharmaceutical companies to reduce prices; popular protest against, and lobbying within, the World Trade Organisation (WTO) for a more flexible approach to protecting intellectual property on essential medicines; successful international and domestic protests against the USA’s promotion of the economic interests of pharmaceutical companies in its trade policy; and international initiatives to facilitate bulk discounts on ARVs for poor countries.

These interventions, together with the growth of generic pharmaceutical manufacturing capacity in developing countries, have facilitated the marked reduction in ARV prices from about US$10 000 to US$350 per patient per year from the early 2000s. Price reductions for ARV programmes in South Africa were achieved largely through pressure by activists on pharmaceutical companies and by the importation of Indian generics by NGOs rather than through government action.

About 2.5 million people are now estimated to be on Highly Active Antiretroviral Therapy (HAART) in developing and transitional countries. However, less than a third of those needing HAART actually receive it, and there is wide variation globally in coverage. This can be attributed to practical factors such as the scale of the HIV epidemic, the distribution of HAART patients between urban and rural areas, country-level economic and institutional capacity to roll out HAART and the availability of support from external funding sources such as the Global Fund and the US President’s Emergency Plan for AIDS Relief (PEPFAR).

Cross-country econometric analysis suggests that these factors account for about half of the variation in HAART coverage. The remaining difference can be attributed to country-specific policies and characteristics including political will on the part of national governments to roll out HAART. Thailand and Brazil, both well-known for their proactive leadership on AIDS, achieve far higher levels of HAART coverage than
predicted given their economic, demographic and institutional characteristics whereas South Africa, which is infamous for its suspicious stance towards ARVs, has a far lower HAART coverage than it should, given its characteristics.

The South African government should support local pharmaceuticals. Although South Africa also has a domestic pharmaceutical industry, no assistance has ever been provided to producers of generic ARVs. Instead, the industry has been harmed by long delays involved in negotiating voluntary licenses and obtaining the necessary approval from the Medicines Control Council for generic formulations. Rather than assist generic producers, the government awarded tenders to the producers of branded drugs, and placed restrictions on the generic producers (such as limiting the co-packaging of pills).

The ‘bizarre’ approach to ARVs by the South African government has been attributed to AIDS denialism at the highest levels. Some have argued that the government was deliberately trying to save money for other development purposes given that a HAART rollout (reaching 80% of those who need it) was estimated to require 12% of the health budget. This view is erroneous because such direct cost calculations do not take into account the cost savings that occur elsewhere in the health sector as a consequence of HAART related declines in the number of AIDS cases.

By restoring AIDS-sick people to health, HAART can help reduce costs incurred in those parts of the health sector involved in treating AIDS-related opportunistic infections. Such cost-savings, however, could erode over time as HAART patients become resistant to their treatment and ‘sicken and die’. Whether a HAART rollout is cost effective over the longer term depends crucially on whether it helps reduce the number of new HIV infections (and thereby the number of future AIDS cases) or not.

A HAART rollout has the potential to reduce the number of new HIV infections because people are less infectious when they have their viral loads suppressed by HAART, and because the availability of treatment encourages more people to be tested and counselled. In essence, the balance of evidence suggests that putting people on HAART will not only extend their lives, but will probably also result in fewer new HIV infections overall. Fewer AIDS cases would take pressure off the government health budget.

Although individual leaders might demonstrate different aptitudes and commitment, ultimately they all respond to political incentives: the greater the pressure from civil society, NGOs and activists, the more likely it is that leaders will prioritise a HAART rollout.

**HIV and the Labour Market – Policy Implications of the Eastern Cape**

*Mr Mkhawuleli Maleki, COSATU*

COSATU has noted that HIV prevalence is different from province to province. KwaZulu-Natal had the highest HIV prevalence rate of 15.8% in 2008. The Eastern Cape had a 9% prevalence rate.
Most of those who are infected by the virus are of the working population and this in itself is a cause for concern. COSATU has taken the initiative to educate the working population and employers on HIV/AIDS related issues. Provinces need to intensify their efforts on the training on management of HIV and TB.

However, organisational support is also needed. Fighting HIV cannot just be left for the provincial government, we need workplace organisational support that will ensure equitable access to employment and employment schemes to people infected and affected by HIV/AIDS and TB.

Governance and institutional development partnerships with the Department of Social Development and the Department of Finance are important in facilitating programmes that ensure access to poverty alleviation, including economic growth and development as well as responsiveness to Millennium Development Goals. ECAC’s multisectoral approach is an effective response to challenges presented by HIV/AIDS, but there is more to be done for these efforts to have a profound impact.

Some employers still have a negative attitude towards HIV/AIDS. He said that it is still an uphill struggle to have a workplace policy at a number of workplaces. The absence of a clear-cut policy encourages stigmatisation, discrimination and the exclusion of infected employees from training and promotion.

After the 10th National Congress, COSATU resolved to work with the Treatment Action Campaign, the South African National AIDS Council, business and the rest of civil society for a month of action at workplaces and in communities. This initiative will be in support of HIV prevention and treatment and will coincide with World AIDS day. Mr Maleki said that during the month of November each year COSATU will embark on the following programmes:

- The distribution of 1,5 million pamphlets through affiliates
- Training of shop stewards to be home-based caregivers and counsellors
- The distribution of condoms and femidoms
- A campaign to collect and distribute food parcels to households headed by children, and orphanages
- Participate effectively in the 16 days of activism against women and children abuse

COSATU has resolved to do the following:

- Support systems at workplaces and strengthen the practical side of the education and treatment components of the campaign
- Set a target of 100 000 workers a month to be covered by union workplace communication on HIV/AIDS
- Train 4 000 peer educators
- Continue campaigning for free care and treatment for people living with HIV/AIDS
- To campaign vigorously for people to go for voluntary counselling and testing

The Department of Health must protect society from unfounded claims of cures for HIV/AIDS. COSATU is dedicated in the fight against HIV/AIDS in the workplace and the society at large.
Business Sector: Role of HIV/AIDS

Brad Mears – South African Business Coalition on HIV/AIDS (SABCOHA)

There should be no divergence between business and labour’s response to HIV/AIDS. Business and labour should be having an open and honest dialogue on the issue.

The role of SABCOHA was to mobilise business in South Africa to take affective action in the workplace in terms of HIV, STIs and TB. SABCOHA was in the process of ‘provincialising’ and setting up provincial structures. It is often believed that, the grassroots response to HIV was the most effective response.

SABCOHA’s four areas of delivery are co-ordination, policy/lobbying/advocating, monitoring/evaluation and empowering businesses.

Within the business sector, there is a multiplicity of views on what the role of business should be in fighting HIV. SABCOHA tries to run initiatives other sectors can’t, and gave as examples supporting peer educators and advocating for more responsive policy on behalf on business.

Public-private partnerships should be the order of the day, to help the government extend its mandate. SABCOHA is involved in drawing up the NSP as well as in the restructure of SANAC.

There is still a high level of cynicism if HIV programmes do not have strategies, budgets and timeframes attached.

Businesses should contribute to the PSP, and sit on provincial, district and local AIDS Councils. They should use the 54 indicators in the PSP to see whether business is contributing to the PSP.

SABCOHA now has provincial offices in the Western Cape and Northern Cape, and that more provincial offices will be opened as resources become available.

The Supply Chain Initiative is implemented in medium-sized businesses. This is because it was found that medium-sized businesses did not have a high sensitivity to the impact of HIV/AIDS because labour is easily replaced. The programme includes sensitisation, referral systems for HIV positive workers, and training for peer educators.

Furthermore, SABCOHA places particular importance on operating in the informal sector, especially in terms of the needs of micro enterprises in terms of training. SABCOHA also distributed condoms in toilets, and works with ACSA, tertiary institutions and gambling institutions in this regard. SABCOHA also supports 100 000 peer educators.

Businesses should contribute to the PSP and strengthen district and provincial AIDS Councils. They should assist in extending the mandate of the Department of Health, especially in the form of public-private partnerships. With the expertise and capacity
of the business sector, they are really in a position to help the government to achieve their goals, especially private hospitals, medical AIDS, etc.

SMMEs, which are a vulnerable sector, partner with government. Sectorally, the trucking and agriculture sectors are important sectors to focus on in terms of HIV/AIDS, both are difficult to reach and need to be capacitated and co-ordinated in terms of their HIV/AIDS response.

Blockages to the effort of SABCOHA included the fact that the upcoming ACT campaign is unclear, especially in demonstrating how a meaningful partnership could be formed around testing, treatment and care after testing, and how to communicate this to stakeholders in the private sector. Secondly, the health insurance policy was also not very clear.

The Care Economy and Interventions to Support Home-Based Care

Mr Andrew Gibbs – Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal (UKZN)

Home-based care (HBC) is central to dealing with the overwhelming burden of HIV/AIDS, and is supported by the South African government. The government actively promotes home-based care, as the health system simply is not able to provide enough care, and that it also encourages the Primary Health Care (PHC) system, as well as Community Health Workers (CHW) programmes.

Donors also support HBC. HBC is often seen as a kind of volunteerism, caring for each other.

The impacts of HBC include that it can entrench gender inequalities, has huge financial costs, as well as huge opportunity costs (e.g. preventing a girl from going to school because she has to care for someone with HIV or AIDS). Furthermore, whilst a lack of education could be a result, a lack of education is also a determinant of HIV/AIDS.

How can we improve the positives of HBC, and how can it be made to support gender empowerment and agency?

Simply providing supplies, like food and support, is good, but does not address the underlying issues. In order to improve the positives and support gender empowerment and agency, the underlying issues need to be addressed.

A study was conducted in Entabeni in rural KwaZulu-Natal where the HIV prevalence is 35%. Entabeni is 30 km from the nearest town, and authority comes from both the local chief and the local municipality. The study had three approaches: to provide support for carers, to create a supportive context for carers, and to build external support (government/NGOs) for carers.

The project included both a practical (providing food, medical kits, etc.) intervention, and a strategic (empowerment) intervention. The practical intervention led to an
increased scale and quality of care, and the strategic intervention led to increased confidence of the carers, but not to empowerment.

In terms of CHWs a few incentives might motivate them, including the introduction of a stipend and the creation of a group image. These measures should be sustainable, especially the stipend. Community support for CHWs is varied: churches were very supportive, but men saw it as women’s work, and young people were not inclined to it, as they saw no future in the rural areas.

In terms of building external support, the study found that the PHC nurse had no skills in community support, and served a large area, that the social worker from the Department of Social Development was keen but overworked and faced a large backlog in her work, that the Municipality was overworked, and that NGOs were very supportive but did not always have the funding.

Financial incentives are needed for care giving in order to eliminate inequalities - something that is touched on in the Community Care Worker Policy Framework (CCWPF). Strong public sector support for HBC is needed, from more than the Department of Social Development and the Department of Health alone. This too is clear in the CCWPF. Furthermore, training is needed for public sector employees on supporting community participation, and that it needs to be more socially oriented than medically oriented.

**Siyakhana Health Trust: Best Practice Work-Based Programme**

*Dr Clifford Panter – Siyakhana Health Trust*

Those who are economically active feel the largest burden of HIV/AIDS. It was further noted that HIV/AIDS is a critical risk management issue for business. SMMEs make a large contribution to the GDP. Siyakhana deals with organised business, especially SMMEs, response to HIV and TB, and encourages partnerships.

The aim of the programme is to strengthen PHC in the public and private sector. The choice of workers who do not have medical aid is to keep their job or seek treatment. During the pilot phase in 2006/2007, 6 700 employees and 26 000 dependents were involved. In 2008-2010 15 000 employees were involved. The programme involves developing HIV workplace policy and workplace training for managers, champions, employees and peer educators. Furthermore, it encompasses compulsory counselling, and voluntary testing for employees, which creates a fair amount of peer pressure. Free health care is also provided to HIV positive employees. The programme has a network of private GPs and provides call centre support to GPs. Furthermore, the programme also provides for patient literacy training workshops for HIV positive employees who are about to embark on lifetime treatment. The programme conducts quality of care audits, and does capacity building at PHC services. Furthermore, the programme also provides for the training of PHC nurses and doctors. It also makes use of retired nurses. The programme regularly conducts monitoring and evaluation of its activities. Since the inception of the programme, there has been more than 100% increase in testing, and 315 people were on treatment after the pilot phase. More than 3 000 people have been tested.
The second phase will focus on scaling up and will concentrate on “true” SMMEs. In a programme like Siyakhana, leadership is a key ingredient. SMME owners are keen to participate when there is good information and support available, and employees are eager to get tested, but confidence building is still needed. Denial is still the most significant barrier to treatment. In the future, Siyakhana would like to implement the programme wherever the Border-Kei Chamber of Business (BKCOB) has an office.

**An Analysis of the Automotive Industry Response**

*Mr Libhongo Ntlokonkulu – Eastern Cape Socio-Economic Consultative Council (ECSECC)*

The automotive industry is the third largest sector in the country in terms of its contribution to the GDP. In terms of HIV/AIDS, Mercedes Benz South Africa (MBSA) is one of the first companies in the automotive sector to respond, and launched its programme in 1996. ARVs were made available to employees on the company medical aid. In terms of business in general, responses have been concentrated in the mining sector, which is generally considered to be a risky sector in terms of HIV/AIDS. KwaZulu-Natal, Gauteng and the Western Cape had more mature responses to HIV/AIDS than the Eastern Cape.

Business responses to HIV/AIDS should be holistic, partnerships are very important – once again, MBSA can be used as an example, as MBSA formed a partnership with the local government and a German aid organisation. MBSA saw a 56% drop in HIV/AIDS related deaths within three years of the programme, and saw a significant increase in the number of employees going for voluntary testing and counselling (VCT). The International Labour Organisation’s (ILO) Code of Practice, the Department of Labour (DoL) Code of Good Practice, COSATU’s Campaign Against HIV/AIDS, the Employment Equity Act, the Labour Relations Act and PIDS provide enabling policy, but all the provisions made by the enabling policy are voluntary.

Botswana and Merck-Gates was cited as a good example of a public-private partnership. Together, they established the African Comprehension HIV/AIDS Partnership (ACHAP).

Shell Companies of Nigeria collaborated with various NGOs to tackle HIV/AIDS in the Niger Delta. These companies are not mere financers of community projects. Companies in the automotive sector should adopt the strategic plan of the AIDS Council and become involved in peripheral areas. HIV/AIDS destroys human capital; the biggest issue for business in terms of HIV/AIDS is the loss of skills.
Research Recommendations

- ECAC should conduct a review of public-private partnerships and should encourage it to help the government extend its mandate, where appropriate
- ECAC should review The Siyakhana Health Programme best practice model and support should be rolled out across the Eastern Cape, where relevant
- ECAC in partnership with key stakeholders should conduct research and develop HIV/AIDS policies on key sectors of the economy such as automotive and agriculture

Policy and Programme Recommendations

- ECAC in partnership with SANAC should provide policy advice to government on how to provide assistance to local producers of generic ARVs
- ECAC should support government to improve the process of applying for voluntary licenses and obtaining the necessary approval from the Medicines Control Council for local producers of generic ARVs
- ECAC should facilitate workshops and discussions on how best to support increased advocacy from civil society, NGOs and activists for the prioritisation of HAART
- ECAC should co-ordinate training and awareness raising to address HIV/AIDS denialism among politicians and leaders
- ECAC should support the development of a policy for dealing with HIV in the workplace
- ECAC should develop a policy brief on HIV/AIDS and the economy, including a greater focus being be placed on SMMEs
- ECAC should facilitate strategic meetings between business, labour and other key stakeholders to encourage contribution to the PSP and involvement in DACs and LACs
- ECAC should provide policy advice to government on how it should communicate its HCT campaign and health insurance policy more clearly to business
- ECAC in partnership with key stakeholders should facilitate a provincial review and summit on HBC to address issues such as financial incentives, care economy and training for public sector employees on community involvement
- ECAC should develop policy guidelines for business on corporate social investment in HIV/AIDS
Theme: Cultural Practices in the Context of HIV/AIDS

Nkosi/Prince Zolile Burns Ncamashe – Eastern Cape House of Traditional Leaders (ECHOTL)

Our thoughts are oppressed, and we are not doing very well in protecting our culture. We must go back to basics in maintaining our standards. Our province must ensure that medicine is available to our rural communities and our planning must include food security programmes to build a viable human environment for the next generation.

In going back to basics, we have to adopt the girls’ inspection custom, ‘ukuhlola’, with a view to prevent rather than to cure this pandemic. This begins at birth where we identify a child as a boy or a girl - we must continue until the adolescent stages, because these are cost effective ways with which we can achieve zero infections. People should not be victims. Our education is eurocentric and needs a major overhaul, in which traditional leaders have a huge role to play. Within the next 50 years, our grand daughters should bow their heads when passing our graves and respect us because we protected our dignity and theirs.

The Science of Male Circumcision

Prof H Rees – Reproductive Health and HIV Research Unit (RHRU), University of the Witwatersrand (WITS)

For every one person on treatment (for HIV/AIDS) there are three new infections - South Africa has the worst case of the HIV epidemic in the world. Areas with the least circumcision practised also have the highest HIV prevalence rates. Globally, only 30% of men were circumcised.

There are several medical advantages to male circumcision: men who are circumcised have fewer ulcers, are less likely to get STIs, and are less likely to contract Human Papilloma Virus (HPV). There are also advantages for the female partners of circumcised men: they are less likely to get cancer of the cervix.

Prospective studies (studies that look to the future) showed that circumcised men were protected by 50% from HIV. The Randomised Control Trial, in Orange Farm, (one of the communities in which the trial took place), a 61% protection from HIV was shown among circumcised men. This did have a biological/physiological basis, in that the inner mucosal layer of the foreskin did in fact have a vulnerability to the HIV virus.

After receiving information about the medical benefits of male circumcision, 65% of men polled in Orange Farm indicated that they would like to be circumcised, while 69% of women indicated that they would like their partner to be circumcised. Many men thought that they were circumcised when in fact they were not. If even a part of the foreskin remained, they were still at higher risk.

The United Nations (UN) has released a guide for male circumcision scale-up. The majority of men in South Africa are not circumcised – there are still 3 million uncircumcised men in South Africa. Male circumcision is not a solution in itself, but
needs to become a part of a comprehensive package in addressing HIV/AIDS and it should be voluntary. Clear community messages should be formulated, including messages for women – as mothers and partners. 1 April, a male circumcision programme will be rolled out in KwaZulu-Natal.

**Experiences in Interventions toward Safe Traditional Circumcision**

*Dr E M Chabula-Nxiweni*

The presentation focused on the Xhosa ritual of male circumcision. New epidemiological research demonstrates that circumcised men carry a lower risk of contracting HIV than uncircumcised men. Male circumcision is thus a cultural issue that is complexly linked to public health.

In the Xhosa culture, male circumcision illustrates the transition from boyhood *(ubukwenkwe)* to manhood *(ubudoda)*. Circumcision is an example of permanent bodily alteration, which signifies membership to a particular group; however, ritual circumcision becomes a health issue when certain problems or factors arise. Some surgeons still operate under the influence of liquor, which compromises the whole circumcision process.

There is a lack of formal training for practitioners, especially in relation to the surgical procedure and the management and aftercare of wounds. Anyone can aspire to be a practitioner and this can result in poorly performed surgical procedures. The commercialisation of the process has also diminished the sense of responsibility and dedication previously attached to performing the ritual.

There is general inexperience and a lack of adequate wound aftercare with the assistants *(amakhankatha)* often absent for extended periods. Medical complications occur very often during the aftercare period of the initiate. A traditional attendant *(ikhankatha)* is ascribed to each initiate, and is responsible for taking care of the wound. Ischaemia (starvation of blood supply) and/or infection from the tight thong bandage wrapped around the wound, leads to penile sepsis and gangrene, with subsequent loss of penile tissue. Infection can spread throughout the body. Septicaemia is the cause of most deaths from circumcision.

Some of the initiates are STD carriers or have chronic underlying conditions. This is dangerous as traditionally an *assegai* is used in the surgical process. These surgical apparatus may be blunt or reused. This practice has been implicated in the spread of blood-borne infections, such as Tetanus, Hepatitis B and STDs, including HIV/AIDS. There is thus a need to improve on traditional circumcision rites as well as other cultural practices which result in deaths in our communities from time to time.

The establishment of policies and statutory bodies to regulate traditional circumcision rituals would be vital in reducing the number of deaths from circumcision as well as the spread of blood-borne diseases. The national, provincial, regional and local authorities must establish structures or incorporate in their relevant structures and or committees the question of traditional circumcision rites as part of the implementation of their health and cultural objectives, which form part of social development.
Training circumcision surgeons in health care should be actively promoted; there should be a review of the instruments used in circumcision rituals; commission research on other alternative instruments; pre medical examinations should be executed on all boys prior to initiation and registration of trained and experienced circumcision surgeons onto an accredited Circumcision Rites Association at local, sub-regional, regional, provincial and national levels must be prioritised.

Discussions and workshops must take place at national, provincial, regional and local levels in the health structures of public, private and social sectors of our society to address the question of developing and supplementing the traditional methods associated with circumcision rites. These discussions or workshops must take into account the diversity of our cultures in South Africa.

**Religious Assets and the Challenges of Engaging Them in HIV Responses**

*Dr Kevin Kelly – Centre for AIDS Development, Research and Evaluation (CADRE), Rhodes University*

Civil Society Organisations (CSOs) have grown since they became involved in HIV/AIDS research. Faith-Based Organisations (FBOs) are significant in providing services; an example is the Catholic Church in South Africa. In 1952, the Catholic Church had 50 hospitals. The Catholic Church has by now lost most of these, but it still has clinics, home-based care, hospices, etc.

The Catholic Church started to provide ARTs in 2003, and provides ARTs as effectively as any other organisation. In addition, they now provide ARTs to foreigners living in South Africa, thus filling in the gaps left by the government. In addition to the Catholic Church, there are many other FBOs who also provide services to people with HIV/AIDS, including the Anglican Church, the YMCA, Masangane, the Lutheran Church, the Methodist Church and Evangelical Churches. Some of the challenges to FBOs providing services include that they are often dismissed and even despised by scientists and public health officials, that some FBOs create rather than mitigate stigma surrounding HIV/AIDS, that church bodies are not represented in government and that different churches do not collaborate well with each other. FBOs could be leveraged for greater value, but many researchers and policy makers have “religious blindness.” Between 30% and 70% of all medical infrastructures in Sub-Saharan Africa are held by religious organisations.

**Integrating Indigenous Knowledge in the Multi-Sectoral HIV/AIDS Response: Opportunities and Challenges**

*Prof Nceba Gqaleni – University of KwaZulu-Natal (UKZN)*

The Comprehensive Plan, before the NSP, spoke to indigenous knowledge, but the NSP did not address indigenous knowledge sufficiently. Indigenous knowledge was defined as “community knowledge and innovation systems which have grown within African local communities, incorporating learning from experience over generations and also gained from other sources and fully internalised within local ways of thinking and doing.” National principles for integrating indigenous knowledge, include nation building (affirming the previously oppressed), the idea of an African renaissance, and
quoting the words of former president Nelson Mandela: “never, never, never again in this land will any person oppress another person”, to show that traditional medicine, which had up until 1994 been banned, should be integrated. Furthermore, indigenous knowledge is a component of a larger, rich heritage; it is a part of people's spirituality and a part of the philosophy of ubuntu. It is useful to understand that traditional healing happens within a totality of an experience of a cosmology that has specific elements – both objective and subjective elements, which those who believe in it understand to be exactly that.

The ANC's National Health Plan for South Africa makes provision for traditional healing, the document states: “People have the right of access to traditional practitioners as part of their cultural heritage and belief system.” The first World Health Organisation (WHO) Congress on Traditional Medicine in 2008, during which the Beijing Declaration was adopted, promotes the safe and effective use of traditional medicine, and calls on member states to take steps to integrate traditional medicine (TM) as well as complementary and alternative medicine (CAM) into national health systems. He said that, according to the WHO, 80% of people consult some traditional/alternative healers. Whilst South Africa recognises TM and CAM, it is not fully integrated, and it may not be accessible at all levels of healthcare, it may not be covered by health insurance, official education in TM and CAM may not be available at university level, and the regulation of TM and CAM may only be only partial or lacking.

Traditional healers should be recognised and respected as highly qualified experts who understand and assist patients and people in an African cultural and traditional way practice African traditional medicine. Traditional medicine is in one way or another, our primary source of healing, and we have home grown natural herbs like ‘umhlonyane’, which is widely used for flu and cough when boiled. We also need to integrate ‘ukuhlola’ as a measure to curb HIV infection. Traditional Healers HIV Prevention Programme joins biomedical and traditional medicine in preventing HIV. Currently, the programme, which runs in three districts in KwaZulu-Natal and started in 2005, works with 1200 traditional healers, and integrates Adult Basic Education and Training (ABET).

Within the programme, traditional healers are encouraged to refer patients for VCT, treatment, etc. A nurse has been appointed to liaise with all clinics in the three districts to capture the number of people who have been referred to the clinics by traditional healers. The media has been used extensively, and prevention messages from the traditional healers are broadcast via public service announcements (PSAs), MMS, radio stations, and will be aired during the World Cup on SABC channels. The programme also makes use of ambassadors, including Ihhashi Eminhlope, Macbeth Sibaya, Busi Mhlongo, Robert Marawa, Zulu Boy and Sello Maake kaNcube, who will take the programmes to communities. Community events and dialogues have also been held during which screening and VCT services have been offered. The scientific study of certain local plants used by traditional healers in treating HIV-induced ailments, like Sutherlandia, is part of the TICIPS (International Centre for Indigenous Phytotherapy Studies). It was shown to benefit HIV-infected adults with early disease. Traditional healers promote good values and they support people in adhering to their treatment. The Eastern Cape should embark on similar projects focusing on involving traditional health practitioners, promote medical male circumcision, and revise the PSP to consider the role of traditional healers.
Research Recommendations

- ECAC should co-ordinate research on how to address HIV/AIDS within the various cultural, religious and beliefs and practices in the Eastern Cape
- ECAC in partnership with key stakeholders should conduct studies to see how medical male circumcision can interface with traditional circumcision practices
- ECAC in partnership with SANAC and other key stakeholders should review the policy and service delivery implications of medical male circumcision, as part of a comprehensive HIV prevention package
- ECAC should review and provide feedback on the SANAC male circumcision communication strategy as informed by the provincial realities

Policy and Programme Recommendations

- ECAC should facilitate further discussions and sector workshops on how to address cultural practices and rights, the context of HIV/AIDS
- ECAC should ensure that appropriate messages are communicated to various sectors of the Eastern Cape communities, including young men, older men, girls, women parents etc
- ECAC in partnership with government and other key stakeholders should develop a policy and institutional framework for the regulation of traditional circumcision
- ECAC should facilitate the formal training for the practitioners of traditional circumcision
- ECAC should ensure the greater involvement of FBOs and promote their involvement providing healthcare services, especially in terms of HIV/AIDS
- ECAC in partnership with the ECDOH and other key stakeholders should encourage traditional medicine and complementary and alternative medicine to be fully integrated into the healthcare system
- The PSP should be revised to consider the role of traditional healers in the response to HIV/AIDS

Theme: HIV/AIDS – Impact on Socio-Economic Development

Linkages Between Human Vulnerability and the Environment

Dr Kevin Kelly – Rhodes University

“Ecosystem services” are defined as services offered to humans by their environment. This includes weather, soil, water and climate. While these services are seldom thought of in discussions around the impact of HIV/AIDS, they are essential in understanding impoverished people’s ability to cope with the virus.
Poor people face a multitude of stressors, all of which have different effects on households, with the result that some households become trapped in a downward spiral as one shock after another erodes assets and savings and affects food security. Climate change, land degradation, decreased soil productivity and poor water quality makes it difficult for HIV impacted households to cope. Natural resources, further act like a safety net to protect households when their resources and assets are eroded by the impact of HIV/AIDS.

Research findings support this hypothesis, indicating that:

- A disproportionate amount of people enter the trade in natural resources (for example the sale of traditional craft products like mats and brooms) due to the “loss of husband’s income”, which is linked to HIV/AIDS.
- Children who are classed as highly vulnerable make significantly more use of wild protein sources, for example wild mammals, birds, reptiles and insects.
- Vulnerable children are more likely to commercialise wild foods.
- Other research in Limpopo indicates that households will use natural resources and “ecosystem services” following the death of an adult.

According to research in Botswana, the mean daily consumption of water in a household affected by HIV/AIDS rises from 30 to between 67 and 165 litres per day. When the water supply is interrupted, then, these households depend on naturally occurring water. The use of dam or river water, however, makes AIDS patients more vulnerable to opportunistic infections.

An interrupted water supply also affects AIDS patients in other ways. For instance, an inability to bath or wash clothes increases discomfort and presents unhygienic conditions. Family care givers, further, are often accused of not looking after the patient properly and face social sanctions.

To explore this and related subjects further, a research project has been commissioned by the International Development Research Centre entitled “Vulnerability, Coping and Adaptation within the Context of Climate Change and HIV/AIDS in South Africa”.

This research project aims to:

- Assess the strategies employed by rural households to cope with HIV/AIDS and climate change
- Investigate the effects of climate variability and HIV/AIDS on household assets and how this impacts on vulnerability and adaptability
- Assess the ways climate change and HIV/AIDS interact to constrain the ability of people to reach livelihood goals
- Assess the drivers and determinants of food security and the changing roles of wild foods and agriculture in the context of HIV/AIDS and climate change
What’s Good and Wrong with South Africa’s Response to HIV/AIDS

*A broad overview of the political, economic and social currents that influence South Africa’s progress in the struggle against HIV/AIDS was framed in terms of two questions. The first is, “What is South Africa doing right in the fight against HIV/AIDS?” And the second, “What are we doing wrong?”*

**What is South Africa Doing Right in the Fight Against HIV/AIDS?**

Firstly, South Africa has one of the largest public ART programmes and perhaps the largest Prevention of Mother to Child Transmission programme in the world. There has also been a significant expansion of the ART programme in the last four years.

In both the public and private sector, there has been a positive change in mindset with regard to the fight against HIV/AIDS. Interventions and prevention programmes are being refined to include the principles of comprehensive care and a continuum of care.

The South African government has, in the last year, revived the National AIDS Council. There is a new DOH strategy, backed by the World Health Organisation and Treasury has increased funding for HIV/AIDS interventions.

The South African response can rightly be termed “multi sectoral”. All sectors are working together more and more in the struggle against HIV/AIDS.

**What is South Africa doing wrong in the fight against HIV/AIDS?**

There is good reason to be sceptical of the statistics that appear to indicate an increase in the number of people receiving ART treatment. The sharp increase between 2007 and 2008, for instance, is unlikely to be accurate, given that the Free State completely stopped treatment from October/November to January.

The statistics, such as they are, further lack essential indicators, like the health state upon recruitment, defined as CD4 count levels, the number still on treatment after a time period and attrition rates by default or death. South Africa does not have reliable data beyond HIV prevalence estimates with which to assess the efficacy of the ART programme. This is due to the absence of a sound baseline of information on HIV incidence and treatment. South Africa further, recently made recourse to devise a new strategy to guide national efforts. A strategy, however, is a precursor to a plan. The strategy’s efficacy will be measure by whether it leads to a national plan with measurable objectives.

**Experiences of HIV/AIDS Home-Based Care in the Eastern Cape**

*Kizito Nsanzya - Promotion of Rural and Urban Livelihoods Programme (RULIV)*

RULIV recently completed a mapping of home-based care (HBC) in the Eastern Cape; the results of this exercise were a response to the lack of data with regard to HBC in the Eastern Cape.
This lack of data resulted in:

- Unco-ordinated and insufficient support to HBCs
- Inadequate planning information
- Services provided by HBCs are varied in quality and extent
- Unco-ordinated community responses to HIV/AIDS
- Location and characteristics of HBC insufficiently established
- Inadequate accessible record of community responses to HIV/AIDS
- HIV/AIDS mitigation and prevention programmes utilising outdated and inappropriate information

RULIV aimed to create maps of the location, distribution and accessibility of health services. They would further analyse and understand the settlement characteristics that promote or impede the provision of service and effectiveness of healthcare interventions.

This would enable the province to assess whether the supply of services in a given neighbourhood or community is adequate and appropriate for the target population, examine the extent to which health services are equitably distributed and identify ways to achieve a more equitable distribution.

RULIV findings may be summarised thus:
Most HBCs view themselves as NGOs and developmental organisations. Almost 65% of them, however, are not registered. They mostly offer preventative and educational services. Those that provide specialised services normally have retired healthcare professionals in their employ. HBCs in the province generally lack proper implementation of good governance and management principles. This lack in proper administration is an obstacle to receiving grant funding.

HBCs mostly offer services to the community in which they are based. There are few organisations that cater services to sex workers and traditional healers. Only 20% of HBCs offer voluntary testing and counselling services. Of the HBC’s surveyed, 74% refer patients to other organisations for these services. A large proportion, however, is willing to receive training in this regard.

With regard to people providing the actual services offered by HBCs, 19% are retired nurses and 24% are volunteers. With regard to condom delivery, HBCs find door-to-door delivery most effective, perhaps because of the increased privacy this delivery method offers. The mapping exercise has shown that the availability of spatially referenced information about the location of HIV/AIDS mitigation initiatives is a crucial part of the knowledge base necessary for effectively addressing the pandemic. Spatial locations of HBC, as well as the systematic analysis of proximity, accessibility, connectivity and density are of importance if the deployment of limited resources and backup service is to be effective. A provincial role-out of the HBC mapping therefore is urgently sought if we as a province have to emerge victorious in the battle against HIV/AIDS.
Provincial Policy Priorities in the Eastern Cape – Where is HIV/AIDS?

Siv Helen Hesjedal – ECSECC

Four key provincial policies and the emphasis they place on HIV/AIDS:

- Provincial Growth and Development Plan (2004-2014)
- Provincial Strategic Framework (2009-2014)
- Industrial Strategy (work in progress)
- Rural Development Strategy (final draft)

The Provincial Growth and Development Plan is the province’s overall development plan for 2008-2014. It is expected that all other provincial plans will be aligned to the PGDP.

The PGDP fares best of the four policies with regard to the attention it pays to the strategic importance of the HIV/AIDS pandemic. It forms part of the plan’s strategic framework, targets and programmes.

The plan articulates clearly the ways in which the pandemic is likely to affect its goals, objectives and targets, especially in terms of the labour market, life expectancy and the future cost to society. The Provincial Strategic Framework translates the electoral mandate into a government programme for the 2009-2014 electoral period. It is, therefore, the Eastern Cape articulation of the Medium Term Strategic Framework.

While the PSP identifies HIV/AIDS as a developmental challenge, it does not mention how the pandemic will affect the framework’s goals, objectives and targets.

The Industrial Strategy outlines the strategy towards growth in selected industrial sectors in the province. The focus of the strategy is to diversify the economy and retain and create jobs. It encompasses the manufacturing and service industry.

The Industrial Strategy makes no mention of HIV/AIDS.

The Rural Development Strategy articulates the vision, principles and goals for rural development in the Eastern Cape. It mentions HIV/AIDS as a key issue in social and human development. As a consequence, it does not mention how the pandemic will affect the strategy’s goals, objectives and targets, but rather deals with it as part of human and social development.

This brief analysis of policy in the Eastern Cape shows that high-level policy development is not benefiting from learning and practice. Poor information management systems do not enable easy flow of analysed information. High-level policy layer is sometimes isolated from practice. Experiences are not documented and the quality of monitoring and evaluation information is lacking. The establishment of institutional mechanisms, further, lead to issues being taken for granted and viewed as the sole responsibility of the AIDS Council.
The Eastern Cape AIDS Council, thus, should not just articulate programmes, but also have high level impact in other policy priorities, for example rural development, industrial development, job creation, health and education. ECAC should have the capacity to be part of policy and strategy development teams to ensure that AIDS is addressed. ECAC, further, should give policy briefs on HIV/AIDS for major policy processes. These could be done each year as priorities are outlined or before this process to contribute to setting priorities. This can be done in partnership with HEI/research institutions.

**Research Recommendations**

ECAC in partnership with key research institutions should conduct research on:

- The strategies employed by rural households to cope with HIV/AIDS and climate change
- Effects of climate variability and HIV/AIDS on household assets and how this impacts on vulnerability and adaptability
- The ways climate change and HIV/AIDS interact to constrain the ability of people to reach livelihood goals
- The drivers and determinants of food security and the changing roles of wild foods and agriculture in the context of HIV/AIDS and climate change
- ECAC in partnership with key research institutions should develop papers and information tools on the importance of addressing HIV and AIDS as a fundamental component of development in the province as well as nationally
Policy and Programme Recommendations

- ECAC should ensure that HBCs in the province are co-ordinated, registered and good governance and management principles are implemented
- ECAC should develop policy guidelines for government to inform funding and management of HCBs in the province
- ECAC should partner with key stakeholders in the provincial role-out of HBC mapping in terms of the systematic analysis of proximity, accessibility, connectivity, density and deployment in the context of limited resources
- ECAC in partnership with ECESCC should have high level impact in other policy priorities, for example rural development, industrial development, job creation, health and education
- ECAC in partnership with ECSECC should ensure that HIV/AIDS is mainstreamed into provincial policy priorities as a matter of urgency
- ECAC should be capacitated in terms of policy and strategy development teams to ensure that HIV/AIDS is addressed across provincial policy and service delivery priorities
- ECAC in partnership with ECSECC should provide policy briefs to government on HIV/AIDS for major policy processes, such as rural development, industrial development etc
Conclusion

The key questions of the conference generated a substantive body of evidence and information in relation to the social, economic and political factors that drive HIV in the Eastern Cape as well as how to utilise this knowledge to inform and guide government and civil society responses. A key message from the conference is that HIV/AIDS is deeply rooted in the social, economic and political fabric of our province and it is at this level where HIV/AIDS also needs to be addressed in order to conference deliberations is the inextricable link between concerns about rural livelihoods, impoverishment, gender equality, child welfare and HIV/AIDS, which should be integrated into all work in the Eastern Cape. HIV/AIDS is not just a health issue, but also a development priority for the province.

The Conference on the Political Economy of HIV/AIDS has been a catalyst in defining key areas for research and guiding intervention by ECAC and other key stakeholders for the next few years. Leading national researchers, civil society organisations and government presented at the Conference and the voices of many stakeholders were heard in the sharing of knowledge and spaces to discuss and debate. It provided many answers to questions in relation to the themes, but also reiterated the need for ongoing discussions and debates on critical issues amongst stakeholders. For example, issues relating to cultural practices and rights in the context of HIV/AIDS need to be debated thoroughly within the AIDS Council before a provincial position is arrived at. What is also evident from the Conference is that there is a wide range of understandings of what the complex interrelationship between the social, political and economic drivers and impact of HIV/AIDS in South Africa are, for example views expressed in the pre-conference consultations vary somewhat from those expressed by key researchers. There is therefore a clear need for ECAC to lead dialogues and discussions across the sectors on key HIV related matters in the province and ensure participation from district and local level.

One of the outcomes of the conference was the facilitation and building of working relations and partnerships and ECAC should map out the strategic opportunities for strengthening these in addressing HIV/AIDS in the province. The conference questions have highlighted what we know as well as what we do not know about HIV/AIDS, both nationally and in the Eastern Cape and strengthened the call for evidence that inform policy development and service implementation. The health systems challenges of fragmentation and capacity limitations of government and civil society need to be allocated sufficient human and financial resources and must be supported by a strong MandE system.
Strategic Way Forward

The recommendations and research priorities identified in the conference have provided a significant and important challenge for ECAC and its key stakeholders. What is evident from the Conference is that we need to work with the entrenched social, economic, cultural and political factors in the Eastern Cape and nationally if we want to be effective in addressing the continuum of HIV/AIDS challenges.

The conference was not just an event and the work has really only begun - the recommendations need to be implemented as a matter of urgency within the PSP and NSP strategic planning processes. Successful implementation of the key outcomes of the conference will need dedicated leadership at all levels and commitment from all stakeholders as HIV/AIDS is not just the domain of ECAC. A fundamental element in taking strategic steps forward is the greater involvement and support of organisations representing PLWHA. Strategic partnerships between ECAC and key stakeholders such as SANAC, ECDOH and organisations representing PLWHA need to be strengthened. What was evident prior to and during the conference is the need to clarify exactly what the role and function of ECAC is and implement the retreat resolutions in terms of governance, management and institutional arrangements to make it a more effective and efficient leader in the province. The reconfigured ECAC and its secretariat will require the appropriate technical and financial support and strengthening to drive the strategic way forward as recommended by the conference. This report will give rise to a plan of action detailing and mapping out activities for implementing recommendations with timeframes, benchmarks and resource requirements and this will be done in consultation with ECAC structures and key stakeholders.