Critical Health
Number 22 April 1988

AIDS in South Africa

Progressive Perspectives

CONTENTS

Due to the relatively short time that AIDS has been documented in South African society, the facts and statistics concerning this disease are being revised all the time. The information contained in this book is provided in good faith. The editorial collective of CRITICAL HEALTH does not take any responsibility for facts, statistics and advice that may in the course of time be proved incorrect.

ACKNOWLEDGEMENTS:
Thanks to Afrapix for photographs, The Graphic Equaliser for processing of photographs and MediaLink for typesetting.

CRITICAL HEALTH is published by an editorial collective, P O Box 16250, Doornfontein 2028

Editorial

AIDS has appeared in South Africa in ways which go beyond the discovery of the disease, its spread and its physical symptoms. The issue of AIDS carries with it a whole array of social and political responses, implications and policies. Research carried out recently shows that the issue of AIDS lends itself to the expression of racial prejudice: whites tend to think that it is an African disease; blacks tend to think that it is spread through white homosexual males. Indians tend to think that coloureds and blacks are more likely to get it; coloureds in turn tend to blame it on blacks. In addition, there is a strong class-based prejudice. The magazine NEWSWEEK, for instance, recently published statements by a United States research institute which predicts that AIDS could become a disease of the poor, with "a corresponding upsurge in despair and antisocial behaviour and the refusal of health workers to risk their lives by entering these areas".

To some extent, the sensationalism surrounding AIDS, its high publicity value and the resources allocated internationally to AIDS research can be seen in the light of the fact that AIDS is a disease which is not confined at present, to the lower classes- unlike cholera, TB and other diseases which have become diseases of poverty. If the current prejudices surrounding AIDS do not express this idea very strongly, they certainly espouse a victim-blaming philosophy, which stigmatises social groups already suffering from discriminatory practices.

In the wake of the panic aroused by the spread of the disease, there is an ever-increasing media coverage of AIDS; and the Department of National Health and Population Development has embarked on a national education campaign. To some extent this campaign, as well as the publications dealing with AIDS, attempt to provide information on how to prevent the spread of the disease, dispelling some of the myths surrounding AIDS . Most of the information that is publically disseminated however, addresses itself to the fears, attitudes and practices of the individual. This issue of CRITICAL HEALTH, in contrast, emphasises the need to address the threat of the spread and the trauma of AIDS in terms of the social and political conditions which engender it. To direct education and information at individuals without looking to changing attitudes leading to stigmatisation and victimisation of peole with AIDS, and conditions which break up family life and social networks (such as migrant labour, hostel accomodation, prison conditions, internal and external refugees), means to misunderstand the nature of the disease and to misdirect the efforts at combatting it.

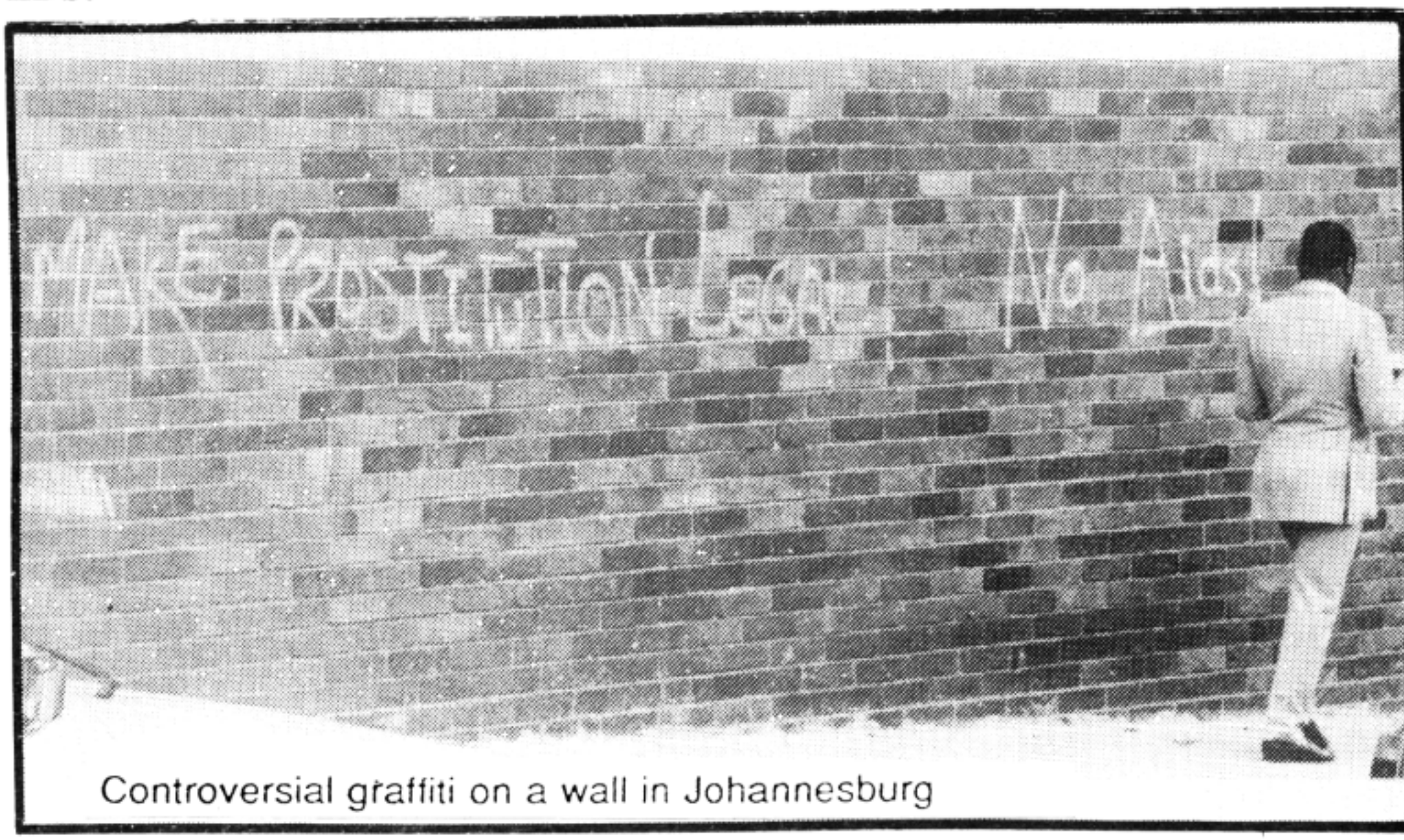
This issue of CRITICAL HEALTH aims to provide a perspective- solicited from

progressive organisations- which facilitates more appropriate and comprehensive information, action, policy-decisions and education.

The first point to stress is that AIDS and HIV infection are problems to be faced by all South Africans. Secondly, AIDS is not just a medical issue-it raises questions about the society in which it spreads. Because of working and living conditions, as well as the state's repatriation laws, migrant labourers are one of the groups of people who are facing the threat of the spread of AIDS, coupled with victimisation from employers and the state. The articles on migrant labour and AIDS in this issue of CRITICAL HEALTH point to the imperative of union and worker-involvement in education and decision-making, as well as identifying areas of research which would be essential for a successful campaign. The urgency of these issues is stressed, particularly in the face of the danger of the spread of infection to uninfected communities, the lack of compensation, and the threat of dismissal.

The current social prejudice and stigma in relation to AIDS increases the trauma an individual experiences after being diagnosed HIV poitive. The article on social and psychological perspectives points to counselling and education requirements to deal with this situation. The article on "working in the gay community" outlines possibilities for organisations giving practical support and programmes of action.

In addition to providing general basic information on AIDS and specific information for health workers, and information on existing resources, CRITICAL HEALTH supports the call from organisations represented in this issue, to develop more comprehensive, socially and politically oriented strategies for the prevention of the spread of AIDS.



Controversial graffiti on a wall in Johannesburg

WORDS RELATING TO AIDS

AIDS	Acquired Immune Deficiency Syndrome
ACQUIRED	a disease that a person can only catch from another person.
IMMUNE DEFICIENCY	a breakdown in the body's system that fights off infection
SYNDROME	collection of complaints that occur together
VIRUS	a tiny germ that cannot be cured. Many diseases, such as measles, colds and chicken pox are caused by different kinds of viruses
HIV	Human Immunodeficiency Virus. (This is the virus that can give a person AIDS.)
HIV positive	a person who is "HIV positive" has the virus in his/her blood
CARRIER	a person who has caught the HIV virus. S/he "carries" the virus in their blood. Although a "carrier" may not feel ill and will not know they have the virus unless they have a blood test, they can still pass the virus on to others
SYMPTOMS	these are the complaints that a person has when s/he is ill. For example, a runny nose is a "symptom" of flu
INCUBATION PERIOD	the time that passes between a person getting infected by the virus and first getting the symptoms of the disease
ANTIBODIES	when a person gets infected with a disease their body makes "antibodies" to fight off the disease
HETEROSEXUAL	someone who is attracted sexually to people of the opposite sex
HOMOSEXUAL (GAY)	someone who is attracted sexually to people of the same sex
LESBIAN	women who are sexually attracted to other women
STRAIGHT	a slang word referring to heterosexuals
ORAL SEX	using one's mouth to touch a partner's genitals
ANAL (rectal) SEX	the man's penis enters the anus of another man or woman
SEMEN	the fluid that comes out of the penis when a male ejaculates ("comes")
BLOOD DONATION	when someone allows his/her blood to be taken to be given to a sick person
ARTIFICIAL INSEMINATION	sperm from a man is taken out his body and placed inside a woman's body to meet her egg. This is done by a doctor and the couple do not need to have sex
HIGH RISKACTIVITIES	there are certain types of behaviour or activity that put a person in situations where they are more likely to catch the virus. These activities are called "high risk activities". For example people who have sex with many different partners are more likely to have sex with an infected person
PROMISCUOUS	this word is not easy to define. It is used when referring to people who have sex with a lot of different people. It is difficult to say how many partners or over what period of time is "a lot"
SCREENING	this is when a group of people are tested to see if they have a disease. For example, the Chamber of Mines screened mineworkers to see how many workers were infected with HIV virus

UNDERSTANDING AIDS

What is AIDS?

AIDS stands for:

ACQUIRED

a disease that a person can only catch from another person who has the disease already

IMMUNO**D**EFICIENCY

a breakdown in the body's defence system that fights off infections

SYNDROME

a collection of complaints or illnesses that can occur together.

How does one get AIDS?

For a person to develop AIDS s/he must first become infected with a virus called HIV (Human Immunodeficiency Virus). When this happens the person's defense system starts to break down after a period of time and diseases and infections develop more easily than they would normally in a person not infected with the virus. When an infected individual starts to develop one or more of these illnesses they are said to have AIDS. It takes from 4 to 8,5 years before an individual infected with the HIV virus starts to develop these illnesses. Thus there is a difference between being infected with the virus and having AIDS. People who are infected with the virus but have not yet developed AIDS do not know they are carrying the virus (unless they have had blood tests) and can pass on the virus unknowingly to other people.

How is AIDS passed on or transmitted?

The virus is not easily passed on. It is found in the blood and is transmitted through blood and semen. Although the virus has been found in urine, saliva, tears and breast milk it is unlikely to spread to others through these body fluids. In order for a person to become infected with the HIV virus it must enter the person's body through the rectum, vagina, breaks in the skin or mouth (eg cuts, grazes and sores).Once outside the body, the virus quickly dies. The virus CANNOT be passed on through the air by sneezing or coughing or through casual contact such as touching the infected person or touching things used by that person (such as knives, forks, cups, basins, toilet seats and baths).

Anybody can be infected by the virus

These are the ways that the virus is most likely to be spread:

SEXUAL CONTACT

man to man / man to woman

-The HIV virus can be spread by semen entering the vagina or rectum.

-It can also be spread when having oral sex if there are cuts or sores in the mouth.

woman to man

-Vaginal secretions of infected women can contain the HIV virus and so spread can occur by the virus entering the penis. Spread is even more likely to occur if there are sores on the penis and in or around the vagina. Other venereal diseases like syphilis can cause these sores through which the virus enter the bloodstream.

-Menstrual blood from an infected woman can also pass on the virus.

woman to woman

-There have been very few reported cases of HIV transmission in women due to lesbian sexual practice.
-Spread of the virus can occur if cuts or open sores on fingers,in and around the mouth or genital area come into contact with infected vaginal secretions or blood.

BLOOD TRANSFUSIONS

-One cannot get the disease by giving blood but people getting blood from an infected person can become infected.
-All donated blood in South Africa is now tested for the virus and if it is found the blood will not be used.

Donors cannot catch the virus by donating blood

INJECTING DRUGS

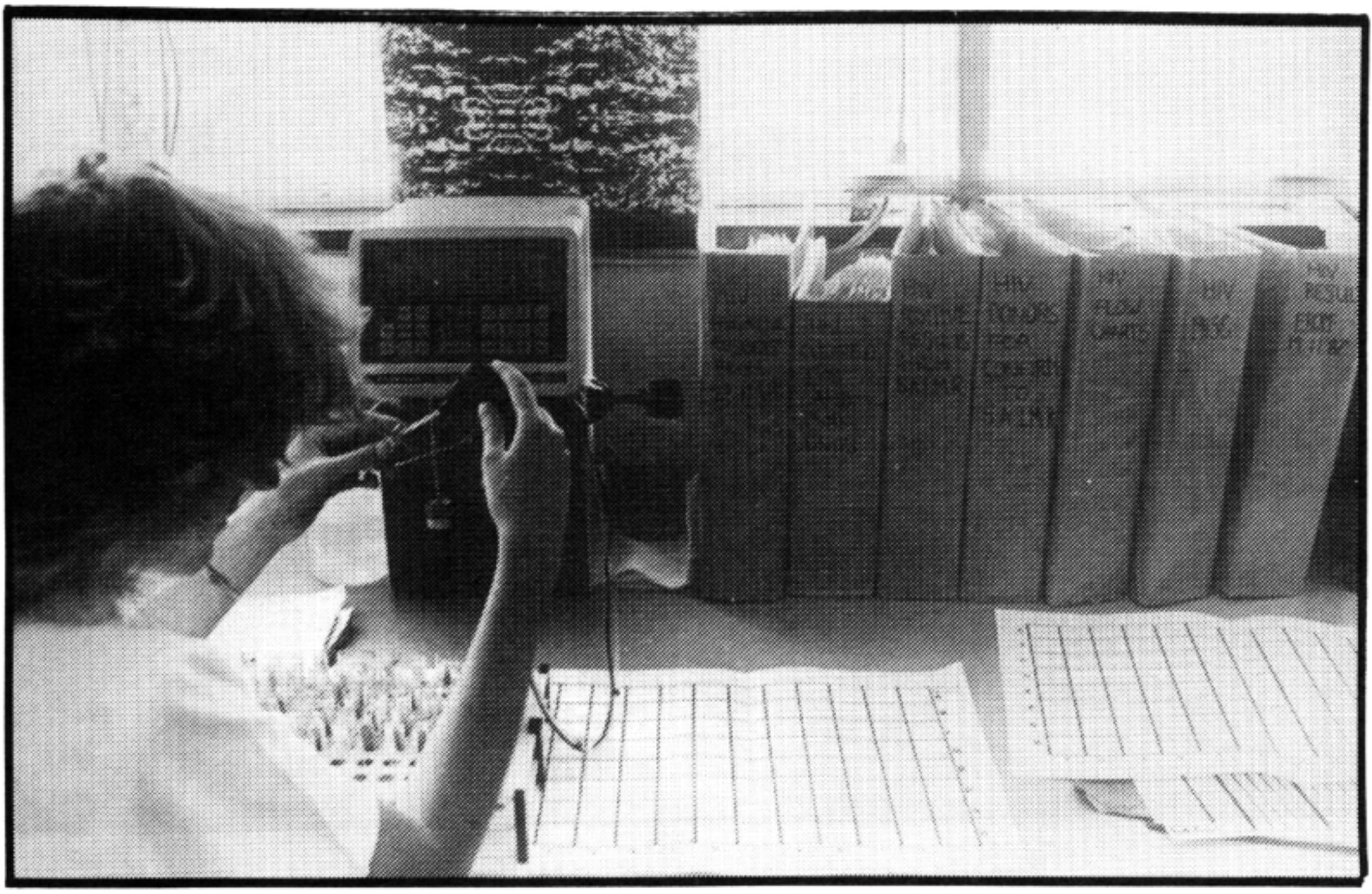
-People who inject themselves with drugs can get the virus if they share needles and syringes that have been used by a person with the virus in their blood.

PREGNANCY

-Pregnant women with the virus can pass it onto their unborn children. As regards breast feeding by HIV positive mothers, consideration should be given to the socio-economic enviroment of the mother-child pair. If alternatives to breast feeding are not safe or effective, breast feeding by the biological mother should continue. (WHO Expert Group.)

ARTIFICIAL INSEMINATION / ORGANS DONATIONS

-People who have the virus in their blood and who donate their semen or organs (livers, kidneys, hearts) can pass on the virus to the person receiving these organs or semen.



Blood samples are tested in the laboratory for the HIV virus

How can one test for the HIV virus?

When a person catches the virus the body makes very small particles in the blood stream which try to fight off the virus. These particles are called antibodies. The tests mentioned below show whether these antibodies are present in the blood. If these antibodies are found it does not necessarily mean the person has developed AIDS. It means they have been in contact with a person who has the virus and have been infected. This person is now a "carrier" of the virus and although s/he may not have AIDS and may not feel ill, s/he can still pass on the virus to other people.

If the test is positive (ie the antibodies are found) it may have severe affects on the person's psychological wellbeing. It may also result in discrimination in his/her personal and work life. For these reasons people who want to be tested are urged to receive counselling before taking this decision.

The names of these tests are:

- ELISA TEST
- WESTERN BLOT TEST
- IMMUNOFLUORESCENT ANTIBODY TEST

These tests can be wrong but this doesn't happen often. In order to be absolutely certain about positive results (results that say you have the virus) the people who test for the virus in South Africa will do two ELISA tests at different times if the first one is positive and then another one (eg the Western Blot test) to finally check that the result is positive. If the first test is negative no further tests are done and the person can be over 99% certain they are not infected with the virus. It can take up to 6 weeks after a person has caught the virus for the body to make antibodies. This means that for 6 weeks the virus may be in a person's blood stream and the tests will not show up positive. This person can still pass on the disease during these 6 weeks. This is one of the problems with the test.

It takes between 4 and 8,5 years for a person infected with the virus to develop AIDS. It is now thought that most people who become infected with the virus will eventually go on to develop AIDS.

What are the symptoms of AIDS?

All of the following complaints can occur in illnesses other than AIDS. The presence of a few of these symptoms does not mean that person has AIDS.

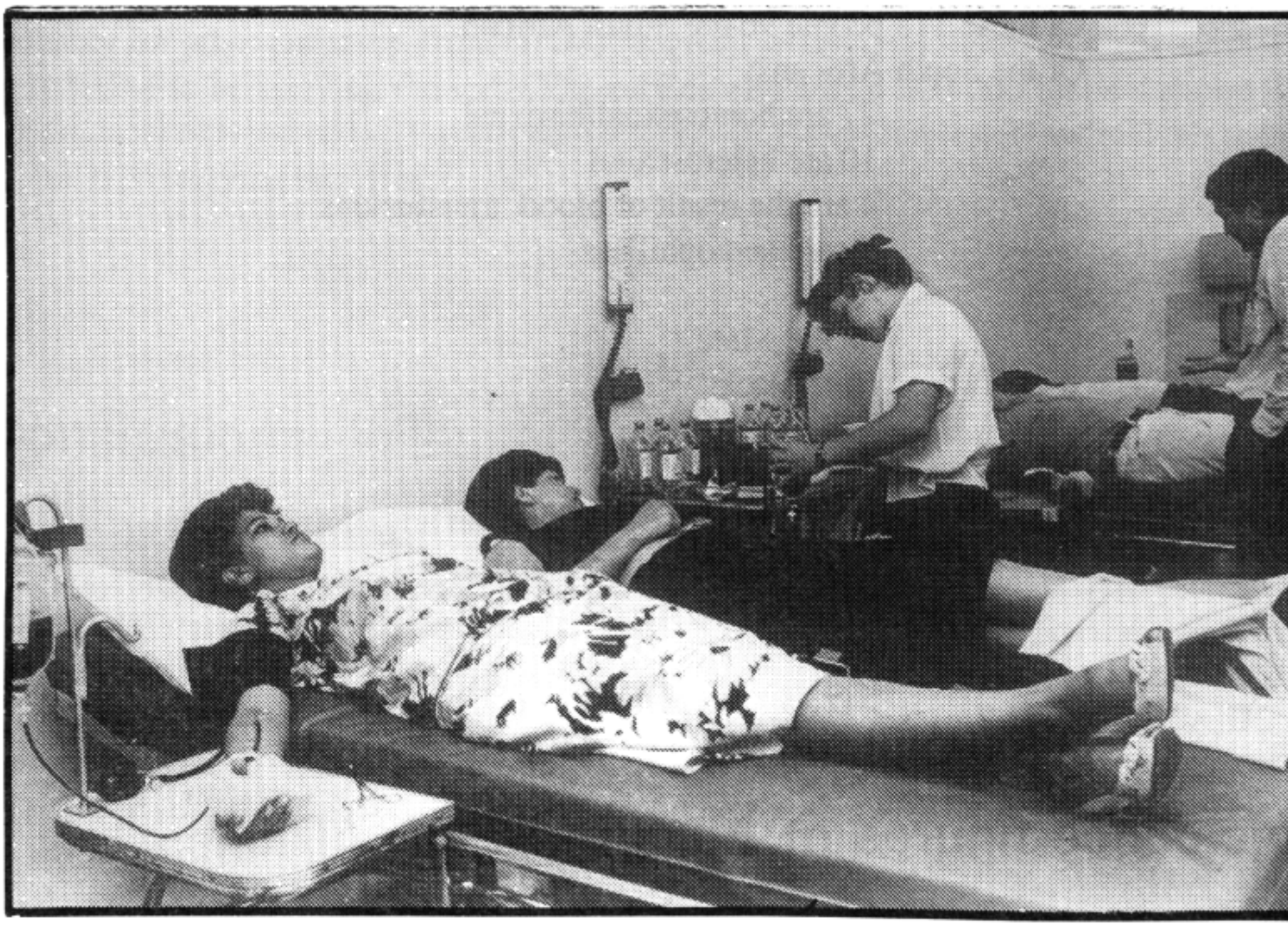
- glands in the neck and other parts of the body become swollen
- a feeling of being very tired for no obvious reason
- loss of weight more than 10% of what the person weighed before several weeks
- high temperatures and sweating at night - lasting many weeks
- diarrhoea (running stomach or watery stools) lasting longer than one week with no obvious cause (for example, drinking dirty water)
- shortness of breath and a dry cough
- skin diseases; they look like pink/purple blotches
- illnesses of the brain (infections and becoming confused)
- Kaposi's sarcoma. This is a rare type of skin cancer
- a rare kind of lung infection called Pneumocystis carinii pneumonia
- a fungal infection in the mouth and throat called Thrush (Candidiasis) that will not go away

How can we stop the disease spreading?

- Know your sexual partner; people who have sex with a lot of different people have more chance of having sex with a person who has the virus.
- Avoid any type of rough sex which causes breaks in the lining of the rectum, vagina or inside the mouth. (Anal intercourse is particuarly dangerous as the rectum is easily damaged during sex causing tears through which the virus can enter the blood-stream.)
- Use of condoms. Condoms act as a barrier. They stop the HIV virus and other venereal diseases (like syphilis, the drop, herpes) from spreading to the uninfected partner. If any creams are used to make the condom slippery (lubricants) they should be water based (eg KY jelly). Grease based lubricants (vaseline, oils) damage the condom and

will allow the virus to pass through them. The use of sperm killing creams with condoms (those containing monoxynol) have been suggested as an extra way of stopping the virus from being passed on but they cannot be used during anal sex as they may harm the rectum.

- Any kind of sex that does not involve the penis entering the vagina or rectum and any sex that does not involve passing on semen, blood, vaginal secretions or urine is of little or no risk (assuming there are no open cuts present).
- Toothbrushes, razors and other things that could get blood on them, should not be shared.



All donated blood is tested for the HIV virus

AIDS IN SOUTH AFRICA:

FACTS AND FIGURES

AIDS was first diagnosed in South Africa in 1982. From 1982 to March 1988 there have been 118 known cases of AIDS in South Africa.

Of these 118 people 96 are South African.

Of the South Africans:

77 are homosexual/bisexual
10 are heterosexual
4 are the result of blood transfusions
5 are haemophiliacs

88 are white
6 are black
1 is asian
1 is coloured

Of the 118 cases, 22 are not South African and of this group:

21 (95%) are heterosexual
17 (77%) are males
16 (73%) are "african"
5 (23%) are "white"
1 (5%) is "asian"

Incidence figures of AIDS in South Africa

For South Africa as a whole the incidence is 1,8 cases per million people per year.

South African mean doubling time

This has been calculated to be 11,4 months.In other words, in approximately one year from March 1988 (118 cases diagnosed) there will be 236 cases of Aids and by

March 1990 there will be 472 cases. (These predictions have been based on 5 years of observations and may change considerably.)

Facts about HIV infection

Based on the above figures, AIDS clearly is affecting ALL South Africans regardless of their sexual preference or racial classification. Although "white" male homosexuals at present form the main group in which AIDS has been diagnosed, it is by no means confined to this group of people and the figures of HIV infection that follow seem to indicate that many more black people are carrying the virus and may later develop AIDS itself.

Over 9 months the South African Blood Transfusion Service tested blood taken, probably for other purposes, from 50 000 pregnant women. Of these, 26 black mothers were found to be carrying the virus.The service also tested 800 000 blood samples of donors from November 1985 to December 1987. Of these samples, 37 individuals were found to be carrying the virus.

Conclusions

AIDS and HIV infection ARE problems amongst all people of South Africa. It is not confined to "white" male homosexuals. Transmission amongst heterosexual South Africans has occured and further transmission in this way can be expected.

Because AIDS is a disease that was discovered only recently, and national data have not yet become available, definite predictions about the spread of an HIV/AIDS epidemic cannot be made at this stage. Only a small percentage of the population has been tested and therefore the figures quoted in this article probably represent only a "tip of the iceberg" of the disease in South Africa.

AIDS: Priorities for Research into Aids and Migrant Labour

This article has been written by members of the Sociology of Work Programme based at the Sociology Department, University of the Witwatersrand. This project will be studying the spread of sexually transmitted diseases, including AIDS, amongst migrant workers.

The need for educational campaigns

The incidence of HIV positive carriers amongst Malawian miners has leapt from 4% to 10% in about 18 months. This emphasises the urgency for research and action to prevent Aids spreading amongst migrant workers.

Clearly there is an urgent need for information and educational campaigns about AIDS. This presupposes a knowledge of sexual attitudes and practices in those to whom information and education needs to be directed. However, apart from a couple of historical studies of sexuality on the gold mines, little appears to have been published - certainly little about current sexual practices of migrant workers. The following issues are important to look into.

The nature of homosexual practices in compounds

Moodie found homosexual relationships on the gold mines were strictly controlled according to social position and tended to be monogamous rather than promiscuous. For example an older supervisory worker - who was thus in a more powerful position - would take a young recruit as his "wife". The motivation behind such relationships seemed to be an expression of power as well as pleasure. The subordinate partner was

not permitted to ejaculate. Moreover, sex involved thigh contact and not anal penetration.

This suggests that the risk of the HIV virus spreading through homosexual practices in the mine compounds is small.

The migrant labour system creates conditions for the virus to spread

Contact between migrants and women in nearby townships

Studies elsewhere indicate the greater the number of sexual contacts the greater the likelihood of contracting AIDS. On the mines the workforce has steadily stabilised since the mid-seventies. Workers are spending ever longer periods on the mines and establishing greater contact with women in the the local townships. It is not known whether these liasons are casual or permanent, nor what the prevalence of prostitution is. Further questions concern the experience of women migrants living in single sex hostels, squatter camps and neighbouring farms. Some women may resort to prostitution owing to low paying jobs or unemployment. Also of critical consideration are attitudes to the use of condoms - certainly miners view them with great suspicion.

What happens to repatriated migrant workers infected with the HIV virus and/or suffering from AIDS?

The mines will be repatriating a growing number of mainly Malawian workers some of whom are terminally ill. The mines pay no compensation and little has been done to prevent the spread of the disease to workers' families and communities.

Research into the effects of the migrant labour system is needed urgently.

Underlying these questions is the fundamental issue of the migrant labour system itself. Efforts to prevent the spread of AIDS that merely concentrate on education and counselling do not recognise the social and political factors that contribute to unsafe sexual practices as these relate to the spread of the virus. The single sex migrant labour system institutionalises many factors that facilitate the spread of AIDS: long absences of men and women from their partners lead to migrants and those left at home seeking new relationships; single sex hostels create a market for prostituion; regular travel between home and work communities contribute to the efficient spread of the virus from infected communities to those free of infection. Thus research aimed at answering these questions as well as those posed above is urgently required.

Since the early eighties, urban labour markets have assumed greater permanence and the migrant labour system has become a less significant source for industrial workers. But even if the migrant labour and hostel system are dismantled in the next couple of years, current forms of social and sexual relations may take longer to break down. A century of migrant labour has moulded norms and mores of relationships, shaping attitudes to sexuality and consequent behaviour which may be conducive to unsafe sexual practices.

Clearly research is imperative to answer questions about sexual attitudes and behaviour. Preventative action must empathise with, rather than moralise against, the people it aims to reach. But no matter how well conceived and executed such action may be, the prevention of AIDS amongst migrant workers and those they relate with will depend largely on the eradication of the migrant labour system and the social behaviour it encourages.

References

T Dunbar Moodie "Migrancy and male sexuality on the South African gold mines", Journal of Southern African Studies, 14(2), January 1988;

Charles van Onselen Chibaro, Ravan Press, Johannesburg, 1980, pp 178 - 182

AIDS EDUCATION AND THE WORKER

This article has been written by members of the Industrial Health Research Group, Department of Sociology, University of Cape Town. It suggests ways in which union education on AIDS could be undertaken and outlines steps that could be taken in planning an educational programme. The group has prepared a longer booklet for union educators and is available on request.

The need for education on AIDS

AIDS has appeared in bold headlines on the covers of almost every newspaper and magazine in the country. Few subjects have been put to such dramatic use. The sensationalism of the media has meant that the real issues often remain hidden. While all this has been going on, there has been very little response from the unions. There are good reasons for this - unions have had far more urgent things to deal with. At present, consolidation and defence of organisation, at a time of repression, recession and a rapid growth in membership, are putting tremendous pressures on unions. But new developments in AIDS in South Africa demand a closer look. Other articles in this edition show that AIDS is something that needs attention and action now. AIDS can only be controlled if people change their sexual behaviour. This is a tremendous challenge. It means that AIDS education is needed urgently.

The myths that have formed around AIDS must also be cleared up.

Should unions take on AIDS education?

Public health education is not a union's normal function - it is something the government should be doing. But until recently there has been little in the way of public ed-

ucation from the state. Initially, state education was aimed at whites, but blacks are now being addressed as well. A national advertising campaign which will cost one million rand has just been launched. It is still early in this campaign to tell exactly what form it will take, but even at this stage it seems a number of issues of importance to workers have been left out. These have been outlined below.

Legal rights and principles of medical ethics

These are crucial to workers facing dismissal on the grounds of compulsory tests. This could lead to victimisation of homosexuals and people with other sexually transmitted diseases. The risk should be put in perspective; there is little chance of catching the disease from a fellow worker with AIDS.

Single-sex hostels contribute to the spread of the virus

Social aspects of AIDS

AIDS is not just a medical issue - it raises questions about the society in which it spreads. Information is often presented in a victim-blaming way. There is a commonly

Part of the State's campaign to combat AIDS: aimed at emphasising long-term relationships

held view that those who get AIDS bring it upon themselves. There is no attempt to put it in its social context. The migrant labour system provides fertile ground for the disease to grow. The disruption of peoples' family lives and sexual relationships brought on by migrant labour often leads to sex with multiple partners and prostitutes. Prostitution in turn, is often the result of poor pay and unemployment. Education from progressive organisations should point this out.

Language and media

The national media campaign directed at black audiences is different from that designed for white audiences. Programmes designed for black audiences emphasise the debilitation and death arising from AIDS in a drastic way. For whites in contrast, the campaign is `soft', with an emphasis on long-term love that should override short-sighted unsafe sexual practices. The basis for making such distinctions in the campaigns is bound to arouse mistrust and suspicion vis-a-vis the campaign on the part of black people.

Workers rights' violated

Recent actions by the government and mine management have forced unions to respond to the issue. Mine managements have begun screening mine workers for HIV antibodies in their blood, and foreign workers with positive tests will be repatriated. Legislation has been passed to allow this. This forced screening is a violation of workers' rights. Education, together with the provision of adequate medical and counselling services, are more enlightened courses of action than testing and firing. Unions, while rejecting screening, could take the initiative by starting education programmes of their own. This article will offer suggestions of the way union education on AIDS could be done. Naturally, unions will have to decide on their own programmes, depending on their capabilities and priorities.

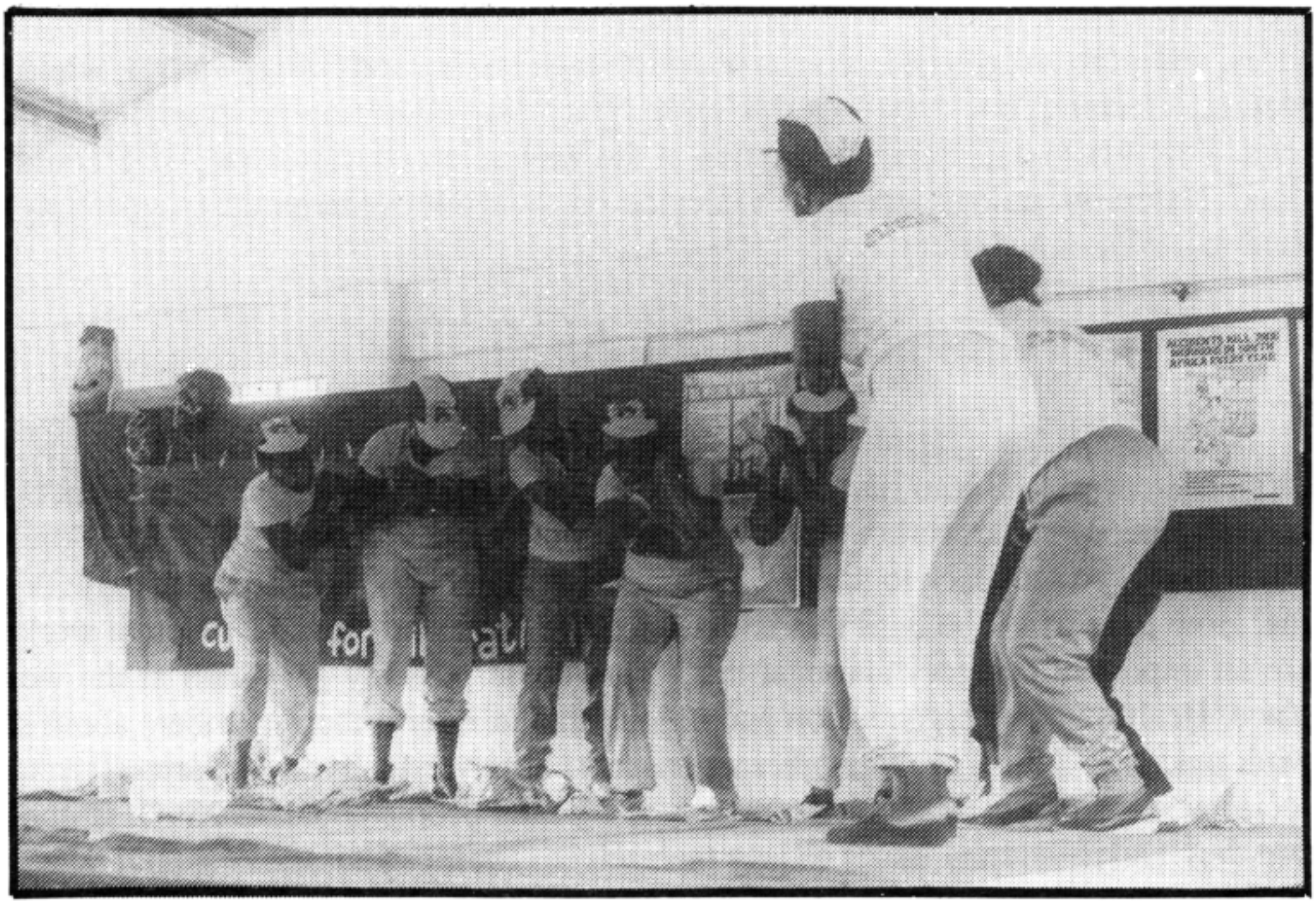
Who needs education on AIDS first?

If AIDS is to be controlled in the whole population, everyone will have to be informed eventually. But to start, we can identify groups of workers in most urgent need of information. Mine workers have already been forced to look at the issue. Foreign workers will be sent back to their own countries if found to be infected with the HIV virus. How long will it be until this is extended to "homeland citizens"? Health workers are an important category amongst those who could possibly get AIDS at the workplace. Health worker organisation and unions should inform their members about safe work practices. British health worker unions have been very active in the area. Teachers, social workers and youth workers can educate young people about AIDS - it is important they understand the issues clearly themselves. Their organisations should take this up. Managements also need to be educated about AIDS, so they do not treat workers unfairly because of their own lack of knowledge. Managements' ignorance of TB, for example led to workers on treatment being fired because bosses thought they would infect others. When they learned this was not true, many stopped this discrimination.

What information is needed?

Other articles in this edition of Critical Health give a good idea of the most important AIDS issues, but here is a summary of the type of content needed. It should be explained what AIDS is, what a germ is, what it does to the body and how people can tell if they have AIDS. There should be information about how many people have AIDS and how many are likely to get it in the future. There should be discussion of how the disease is transmitted, which will lead to discussion of how people can protect them-

selves in their sexual relationships and at work. There should be information about workers' and patients' rights. All of this should be put in the perspective of South African society, particularly the effects of the migrant labour system and the need for access to adequate care. The amount of detail and the style of presentation should be suited to the audience for which it is intended. Educators will need more information than others, so they have a thorough understanding of the subject.



Cultural workers can help to educate people about AIDS

How are people going to react to this information?

People are not empty pots into which you can pour information. Everyone has deeply held attitudes to sex. AIDS education could elicit strong reactions. The cultures, values, beliefs and languages of working class South Africans are very different from those of Europeans and Americans and this must be taken into account in planning an education programme. It is not enough simply to apply foreign methods in South Africa. These factors are unlikely to be taken into account adequately in the government educa-

tion drive, even if commercial advertising companies with their research methods are used. Unions and mass-based organisations should be consulted. This appears not to have been done and will probably not be done in the future. Nobody wants to be told how to conduct his/her sex life. Realistic alternatives should be sought through discussion. Condoms appear to be the central focus of state and Chamber of Mines education. But their use is likely to be resisted. The ability to reproduce is seen by many as a crucial index of femininity and virility. A woman who has not had children may have difficulty getting married and may be reluctant to persuade her partner to make use of condoms. Condoms are also costly for people with no money to spare. It is unclear whether greater availability of free condoms will be part of the anti-AIDS campaign. Even if condoms are supplied free of charge, it will not help much without explanation of how to use them and discussion of how they could affect peoples' sexual practices. Few men will like the idea of sex without penetration.

There is also the danger of dividing people: homosexuals, prostitutes and even foreign workers could become scapegoats for peoples' fears. All of these factors should be taken into account in the initial planning of a campaign. Research should also be done into the way people understand and react to the teaching. These are very real problems, but they are not a reason to avoid the issue. They should rather be considered as a challenge. Education could break down these barriers if they are confronted sensitively.

Who can do this teaching and how?

Unions clearly have priorities in the education they provide. They need to teach about union organisation so their officials and members can function effectively. They must also provide political education. In the field of health education, disease and accidents at work often take priority, as they are something unions can organise around to bring about changes. Diseases like TB and gastroenteritis are important to workers who see them in themselves, their comrades and their communities. AIDS is a unique disease and it needs an original response. Also, AIDS education need not replace, but could complement education and action on other health issues. We can get ideas from the ways unions in other countries have dealt with AIDS. British unions appear to have relied largely on newsletters, circulars and booklets to inform their officials and members. A pamphlet to American health workers deals mainly with a joint union/management development of an infectious disease control programme. A circular from Australian unions' Occupational Health and Safety Unit gives unions' guidelines on how to act on the issue: recommendations on education, the inclusion of clauses on action around AIDS at work in health and safety agreements, workers' rights and union policy on discrimination are discussed. Of course there are major differences between these countries and South Afica and these must be taken into account in interpreting these examples. Print-

ed media are one way of getting the message across. Articles could be put in branch, union and federation newspapers and newsletters. Magazines and newspapers of the alternative press reach many workers - these could be used. Unions could put out simple pamphlets for their membership. They could also send circulars to their branches giving basic information. Progressive health workers and groups providing services to unions could be used to prepare media where unions do not have the time or resources to make their own. The Industiral Health Research Group has prepared a longer booklet to be used by union educators. Teaching by mouth is far more important than printed matter to those who cannot read. For the literate, talks, discussions and demonstrations are a useful complement to written material. AIDS education could be fitted into union programmes of seminars and workshops. A single session on AIDS - possibly linked to other sexually transmitted diseases and TB - could be part of a regional workshop, an education day or a health and safety day. It could also be included in the training of officials or shop stewards. The general membership could be reached through their shop stewards. Mass education through meetings of the general membership is one possibility. Union educators - officials and members - could give the input and outside health workers could be invited to help. Plays and videos could provide a powerful form of input. Their usefulness is limited by the time, skill and money they need. At present Wits Medical School is experimenting with the use of a drama group for education on health issues, including AIDS. Their experience could help other organisations wanting to use this medium.

Conclusion

The threat of AIDS is a difficult issue to respond to. It would be easy to say it is not a priority and leave it at that. This was the initial response in Western countries; since then AIDS has spread rapidly and become a major problem. AIDS is likely to spread at an ever-increasing rate in South Africa. The harsh or inadequate measures taken by the state and employers are a challenge to workers. Unions could regain the initiative by acting on the issue.

Industrial Health Research Group
Department of Sociology
University of Cape Town

Interviews with unions

The Workplace Information Group (WIG) conducted interviews with a number of unions to find out whether AIDS was seen as an important issue to raise in the union movement. They spoke to representatives from PPWAWU (Print, Paper, Wood and Allied Workers Union), CAWU (Construction and Allied Workers Union), CWIU (Chemical Workers Industrial Union), H&RWU (Hotel and Restaurant Workers Union), NUMSA (National Union of Metalworkers of South Africa) and T&GWU (Transport and General Workers Union). All of them said the issue of AIDS had not been raised in their union yet but were all interested in receiving more information about the disease.

LEGISLATION AND THE CHAMBER OF MINES' SURVEY

In 1986 the Chamber of Mines carried out a survey on 512 000 male migrant mine workers to determine how many of these people were infected with the HIV (AIDS) virus. Only miners on gold and platinum mines were chosen. 330 000 blood specimens were taken from this group and of these, 29 961 specimens were tested for the virus. The National Union of Mineworkers was not consulted on this decision and no informed consent was obtained from the miners themselves. Confidentiality was however, ensured at the time.

Out of 3165 Malawians tested, 119 (3,76%) were infected with the HIV virus. Of 2063 Botswana workers tested, 7 (0,34%) were infected. Of 1885 Swaziland workers tested, 1 (0,05%) were infected. Of 2152 workers from Mocambique, 2 (0,9%) were infected. Of 2246 workers from Lesotho tested, 2 (0,9%) were infected. 0,4% of South African migrants tested were found to be infected.

AIDS: NUM PRESS RELEASE

After the Chamber of Mines had completed the above study, the state demanded the names of the infected miners. The doctors who took the blood from the miners refused to hand over these names. The state has taken legal action to obtain this information. Had the study been anonymous, this situation could not have arisen. These events show the importance of conducting future ethical studies anonymously. The following statement was released by the National Union of Mineworkers in response to the survey and legislation outlined above.

The NUM views with alarm the government's announced intention to repatriate mineworkers who are carriers of AIDS. This intention opens up many avenues of controversy.

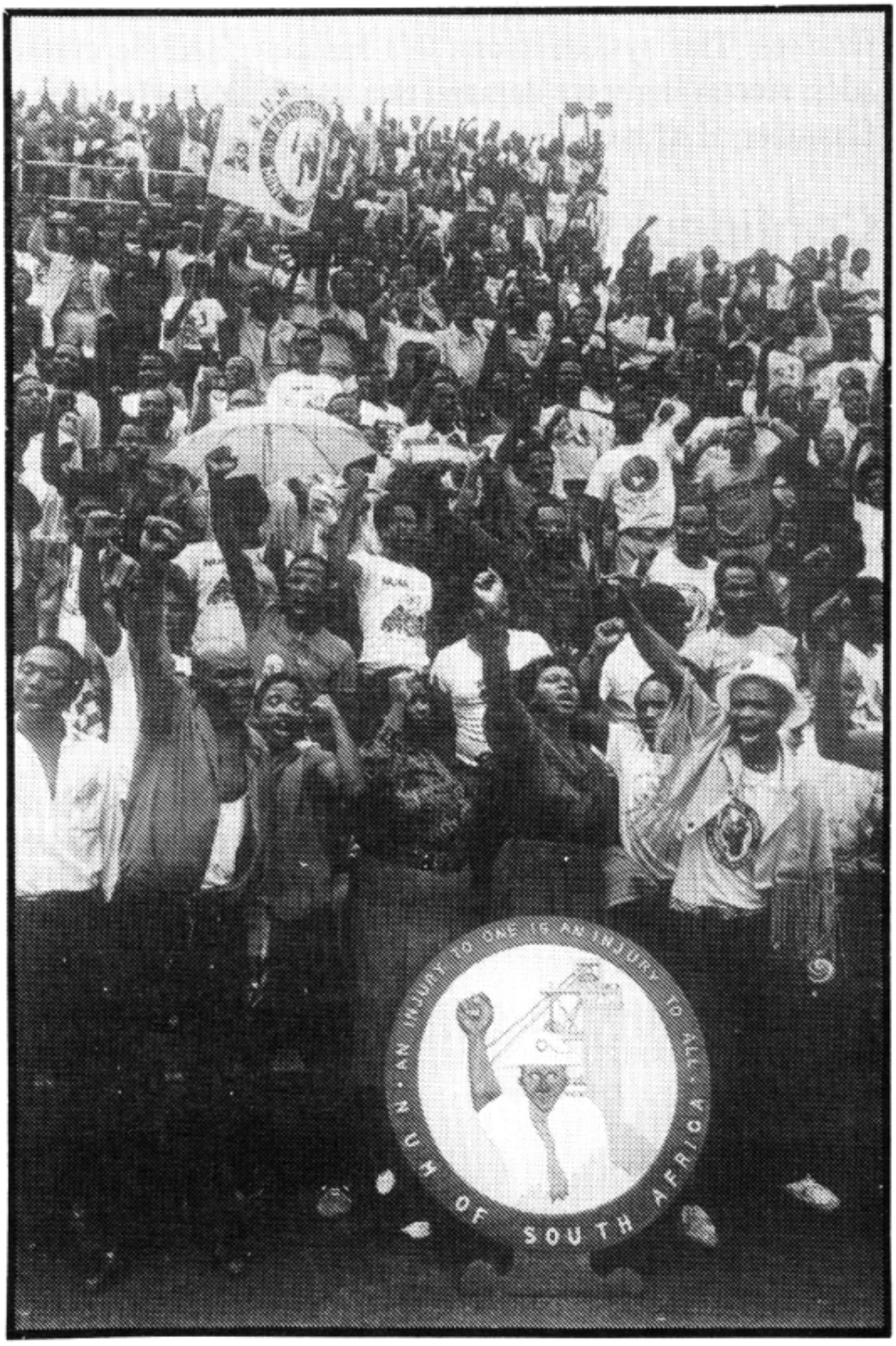
Infectivity.

If these carriers are properly counselled on sexual activity, they represent no danger to anyone else. AIDS is not infective in the same way TB, measles or other viruses are. We challenge the Ministries of Health to produce any medical evidence to the contrary.

Fitness for work.

As carriers, these workers are all 100% fit for work. No one knows how many of them will in future develop the full-blown AIDS disease but at the moment they suffer no physical impairment at all.

Spread on the mines.



NUM rally, 1987

To our knowledge there is no evidence of spread of AIDS on the mines. The statistical incidence of the disease among mineworkers is the same as the reported incidence in the countries of origin.

Compensation.

If spread on the mines was to occur, the NUM would lay the blame squarely on the

migrant labour system and the concomitants of single sex hostels and the break-up of families. This system is one that has benefited the mining industry financially for decades. Accordingly we demand that any AIDS sufferer be adequately compensated by the Chamber of Mines.

Confidentiality.

To our knowledge, no mineworker has had explained to him the new consequences of a positive blood test for AIDS. As far as the workers were concerned, the blood test was a confidential matter between themselves and their doctor. Any doctor who performs this test without explaining the implications to his/her patient is guilty of a breach of ethics if the patient is subsequently victimized through the results of the test. The NUM will demand disciplinary action from the appropriate body if any doctor is found to have acted unethically.

Scapegoats.

The problem of AIDS is wider than the mines. We suspect the minister is attempting to create the public image that the government is doing something about AIDS by targeting foreignborn mineworkers. We regard this as bully-boy tactics of the crudest kind.

The legality if this move.

We maintain that the minister is exceeding his authority. The NUM demands that the minister provide us with the names of those to be repatriated. We will then challenge this ruling in court.

Future action

High-handed bureaucratic rulings of this nature can only obscure the extent of AIDS on the mine. Our members would be entitled to ask why they should have these tests if the only results are possible repatriation; loss of a job without compensation; and the knowledge of a possible fatal outcome. The NUM itself might have to consider advising workers to refuse to be tested in the future.

AIDS : PSYCHOLOGICAL AND SOCIAL PERSPECTIVES

This article addresses the importance of counselling people with AIDS or HIV infection and the need for developing support groups. The AIDS pandemic has given rise to many responses ranging from fear, panic, irrational judgements, stigmatisation and condemnation to concern, organisation and social and political motivation. Reactions of fear and stigmatisation have tended to manifest themselves in the individual suffering from AIDS as severe psychological trauma. As both a mental health and social welfare issue, AIDS presents a special problem to progressive health care practitioners. Against this scenario, the adequacy of official reactions to AIDS, and hence of the existing social welfare structures, are once again brought sharply into relief.

Crisis for society

AIDS-related deaths, suicides and the practice of "gay-bashing" by self-appointed AIDS vigilantes represent the extremes of the social dimension of this crisis. The public's reaction reflects large-scale ignorance which needs to be countered by an extensive educational programme aimed at preventing further spread of the disease and undoing the prejudiced ideas held about AIDS. In South Africa, where prejudice constitutes a psychological "pillar" of apartheid, the inappropriate management of AIDS could easily lead to AIDS becoming divisive, with further justification for unfair practices and policies.

Crisis for the individual

"I don't know how to live my life anymore ... if I am going to die then I'd want to use the time differently. I don't know if it's right to kiss my lover anymore. Maybe the worst part is not knowing ... waiting for the other shoe to drop is just hell."

(Conversation between a psychologist and a patient diagnosed as HIV positive.)

For some people, being diagnosed as seropositive (HIV positive) leads to serious practical and emotional consequences. On a practical level it may mean loss of employment, rejection by a partner, family and friends; exclusion from established social networks and even total ostracisation. It may also mean exclusion from life insurance policies or medical aid schemes and difficulties in obtaining adequate medical care, presuming such care is available and affordable. On an emotional level a person's reaction immediately after diagnosis is often one of initial denial, extreme shock, severe anxiety and despair. Chronic depression and feelings of guilt may develop rapidly. The trauma of a breakdown in relationships and wider social ostracisation - together with the miseries of impaired daily and social functioning as the person's condition worsens all contribute to the person's emotional reactions.

Counselling and issues in counselling

From the above brief introduction it is clear that what might broadly be described as "AIDS counselling" will follow two paths ... education, on both a social and individual level, and individual, supportive counselling.

Education

Education is vital for two reasons - the first is to prevent further spread of the HIV (Human Immunodeficiency Virus). A recent article in the Morbidity and Mortality Weekly Report (vol 17 no 5-2) points out that the virus is transmitted almost exclusively by behaviour which can be modified by people, for example ways of relating sexually with others. It follows that an educational programme aimed at influencing relevant behaviour will help prevent further infection. This is not to suggest that a person who is infected is responsible for that, rather it acknowledges that people have it in their power, within limits, to protect themselves. The second reason is that there is no cure at present and so spread of the disease can only be controlled by educating people on preventative measures.

Thus any educational programme will need to aim at:

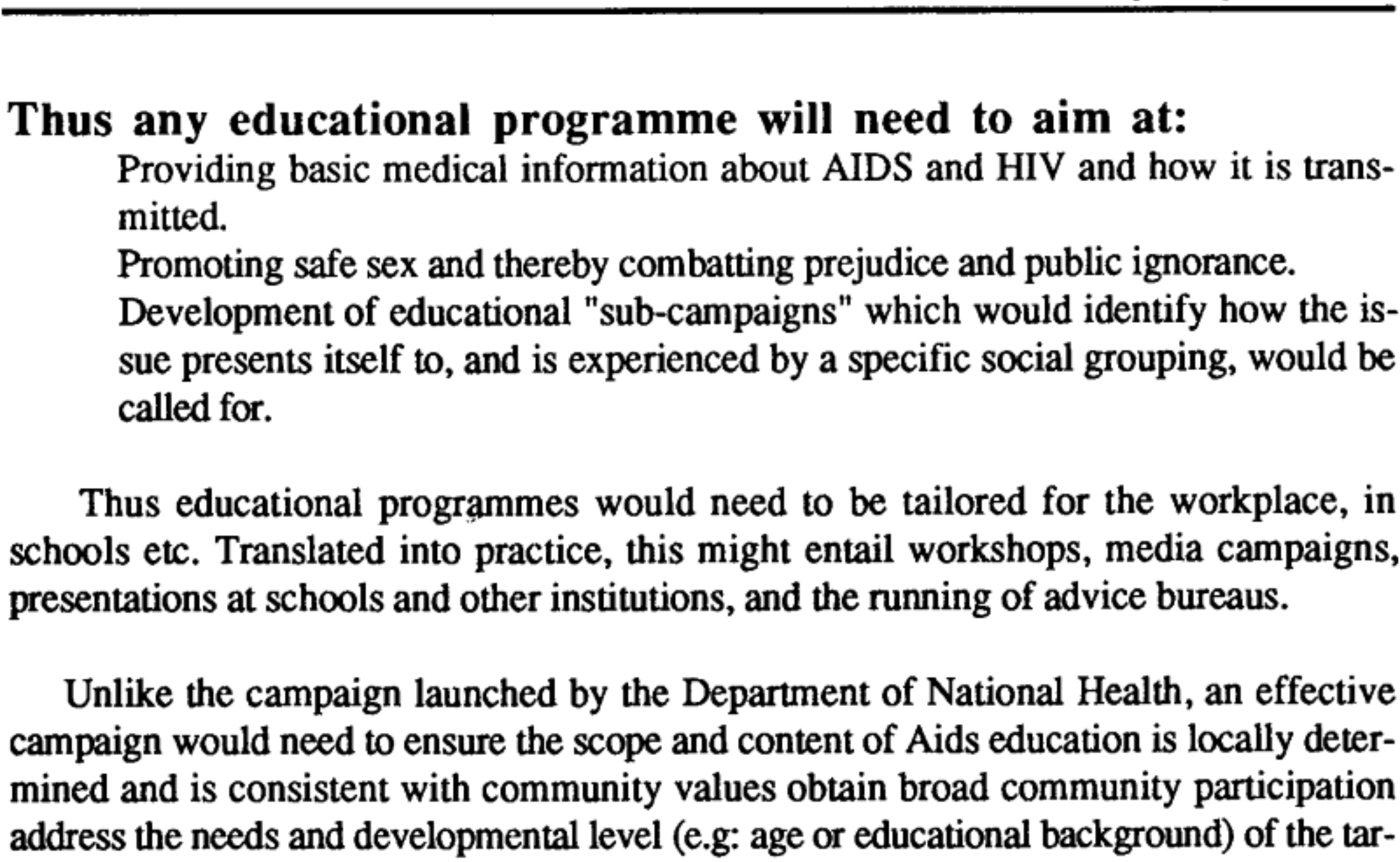
Providing basic medical information about AIDS and HIV and how it is transmitted.

Promoting safe sex and thereby combatting prejudice and public ignorance.

Development of educational "sub-campaigns" which would identify how the issue presents itself to, and is experienced by a specific social grouping, would be called for.

Thus educational programmes would need to be tailored for the workplace, in schools etc. Translated into practice, this might entail workshops, media campaigns, presentations at schools and other institutions, and the running of advice bureaus.

Unlike the campaign launched by the Department of National Health, an effective campaign would need to ensure the scope and content of Aids education is locally determined and is consistent with community values obtain broad community participation address the needs and developmental level (e.g: age or educational background) of the target audience In order for people to understand AIDS education, they must have basic education about sex, medical terminology and drug abuse.



Media should aim at education rather than creating panic

Counselling

Counselling would be offered to a person infected with the HIV virus or who has what is called "full blown AIDS". Counselling would also be offered to the person's partner and/or family where needed or requested. The aim would be to manage the psychological problems arising from knowledge and fear of HIV infection and to provide support together with an educational programme which would take into account the infected person's life history and lifestyle.

Points of intervention

There are various points at which the counselling could take place: before an HIV test; after the test where the person continues with high risk activities although the diagnosis remains negative; where the diagnosis is seropositive. Pre-test counselling includes taking a sexual history, assessing likely risk, and providing information and advice about AIDS and the test itself. Of crucial importance is preparing the person for the possibility of a positive result.

In the case of a negative result further advice will be necessary in terms of protection from infection, along with advice for regular testing. Counselling to help the person cope with being in a group involved in high risk activities with the resultant uncertainty and anxiety will also be necessary; consent and confidentiality must be met at all times.

A person with the symptoms of AIDS, or who is diagnosed as HIV positive and begins to develop symptoms of AIDS, presents special counselling problems requiring a specific programme of crisis intervention. The life threat, miseries of sickness, physical and mental degeneration, isolation from society and emotional and mental anguish, material support, and self- help support groups require immediate attention. Linking with other services becomes very important. These may be located in the hospital or community, for example gay support groups, drug dependency agencies, social services, church support groups. Effective management immediately after a positive test result begins with the establishment of a life line. The counsellor will have to respond to the questions and practical problems which tend to be raised almost immediately - "whom do I tell?", "what do I say?".

Access to medical treatment, future sexual options, financial and legal management are issues that have to be faced. The patient or counsellor should not try to guess how long it will take before the person dies as this will contribute to depression and undermine the motivation and compliance required in counselling and treatment respectively. Thereafter begins the often long, slow and painful counselling directed at helping the person cope with death and dying.

Towards a service approach

AIDS exposes a patient to an array of diseases of indeterminate duration which may be incapacitating or fatal. This, coupled with the nature of the AIDS patient's emotional reactions, renders a pure crisis intervention model inadequate. Unlike other crises, AIDS is not self-limiting. It is not a crisis that is limited by time with reduced coping and problem solving capacity. With the progressive physical deterioration the person's total defensive and coping strategies are tested. There is a dual uncertainty - what illness or specific health crisis is next; and when does death become a reality? Confusion and emotional shock may occur and this, together with the use of drug therapy for pain, may make counselling difficult. Problems in counselling also arise when attempting to balance support in overcoming the immediate crisis of an opportunistic disease and preparing the patient for death. The first requires hope, the second leads to hopelessness. This conflict will most likely remain an issue until both counsellor and patient acknowledge "cues of death recognition". At this point a clear and appropriate response which helps the patient plan for the adventof death, is required.

Another issue which may arise in counselling concerns gay AIDS patients. If the patient has maintained what is called an "in-closet" life style (not allowing people to know that they are gay), then being diagnosed as having AIDS will most likely force the patient into "coming out". Here ostracisation is often double-edged; the patient is ostracised for "being" gay, and for having AIDS. This can result in increased guilt and anxiety. In this situation additional, supportive counselling is needed; especially since patients may have been denied support systems that they might have been able to utilise had they not been gay.

The above serves to outline issues in counselling AIDS patients. Not all issues have been identified or addressed, such as the case of women who have AIDS and are pregnant, or women who give birth to infected infants. Educating and counselling around AIDS in South Africa will have to recognise the economic and political structures which contribute to most social and personal problems; and of the endemic lack of resources in the hospital and community along with fragmented health care services.

Betty Livingstone
OASSSA (Organisation for Appropriate Social Services in South Africa) member

WORKING IN THE GAY COMMUNITY

This article has been written by a member of the gay community. He is a member of a progressive gay organisation called "The Congress of Pink Democrats" as well as the Johannesburg AIDS Action Group. It addresses the problems that AIDS presents to this community. Measures being taken to fight the disease are outlined as well as steps being taken to support those who have it.

Myths about AIDS

Gay people have realised the threat of AIDS much earlier than straight (heterosexual) people. This is not to say that AIDS is the gay plague which the media have helped to generate and which heterosexual society has been quick to accept. This myth is just part of society's choice to deny the impact of the disease. The terror behind the denial links itself to a moral issue which represents a return to Victorian values in the spheres of medicine and health education.

This makes one wonder whether we have learnt anything since the cholera epidemic in the 1830's. At the time of this epidemic, doctors realised that cholera was more prevalent in poor urban areas with the lack of drainage and fresh water. But they said cholera was due to moral depravation. This is what heterosexual society, with its mass backing of institutions, from government to the church, is doing to AIDS. The blame for the disease is being directed at the morality of high risk groups instead of directing it at the particular sexual activities of these groups which puts them in a high risk category.

Support for people with AIDS

It is against this reaction that the gay community has been forced to work together to support the increasing numbers of dying and ill people. Few diseases produce as many losses for those afflicted loss of physical strength, mental ability, ability to work, self-sufficiency, social roles, income and savings, housing and the emotional support of family and friends. These losses are accentuated by social oppression and stigmatisation of people with AIDS. These people therefore have to rely all the more on social welfare and medical institutions.

Services offered in South Africa

Although the South African gay population is far behind its counterpart in San Francisco, we have begun to address the needs of the crisis in terms of some services to people with AIDS. These include the provision of continuous care from information and educational programmes, to screening, counselling, out/in patient, hospice and chore worker services.

Models followed in the United States

Generally the American hospitals have followed one of two models in treating people with AIDS. Some have set aside specialised units designed to meet the unusual needs of people with AIDS while others have found it more useful to follow the "scatter bed" method where patients with AIDS are integrated into the general hospital population. If the patient is gay, the primary health team includes a peer group counsellor, a trained volunteer from a gay organisation, who helps to reduce the alienation and isolation which invariably accompanies an AIDS diagnosis, as well as a doctor, nurse, psychiatrist and social worker.

People infected with the HIV virus often face discrimination socially and at work

AIDS in South Africa

AIDS was first diagnosed in South Africa in 1982. Initially relatively few cases were reported and therefore little was done to co-ordinate support services. It was only in 1986 and 1987 that an influx of persons diagnosed as HIV positive, as having an HIV related illness, or with AIDS, presented themselves at the existing gay counselling services. In Cape Town, where there is the most well-established gay counselling service, the number increased in this period from 16 to 44. This was possibly one of the most important events in getting the AIDS Action Group and the counselling group together. For the first time it was no longer uncommon for gay Capetonians to have first-hand knowledge of someone affected by AIDS. This experience has proved crucial in motivating preventative strategies and care requirements for those concerned. Often people with AIDS are loathe to approach the gay support groups or to identify themselves with them. This can be overcome by raising the profile of these groups, gaining credibility in terms of counselling and confidentiality and maintaining consistency with their visibility and activities.

The need for a positive approach

To learn to live with the reality of AIDS, a positive approach needs to be encouraged. The need for education, specifically education based on caring and understanding and not the type of "terror campaign" currently seen on South African television screens and in the media generally is very important. Education includes the recognition that certain life-style changes are necessary modifying behaviour relating to sexual practices, diet, rest and physical fitness. Ways in which the gay community has come together to counter the problem have been diverse. Major centres in South Africa have set up, or are in the process of setting up, counselling services with the specific aim of educating the population and assisting people with AIDS and people who are carrying the HIV virus in their blood.

Programmes of action

One of the first programmes of action to be put into operation is referral systems. These are made through private doctors, hospitals, blood transfusion services, welfare organisations and frequently clients themselves. However, partly due to the nature of the

disease and largely due to fear or a dislike of homosexuality in the medical profession, the system of referrals has had many complications. In South Africa 66.1% of AIDS patients is gay or bisexual; therefore a failure on the part of the doctor or therapist to deal with these negative feelings must seriously impair professional relationships with AIDS patients. It is also the duty of the government to explain to the gay community the need for safe sex procedures. It is possible that the government feels it cannot perform this duty, as homosexual activity is outlawed in South Africa. This situation shows how important it is to decriminalise homosexuality as part of a national strategy to contain the spread of AIDS. Because of the stigma attached to homosexuality, people with AIDS in many cases, have not come to terms with their own sexual preferences until they are tested positive. Even then it is often a difficult and painful process. The referrals are made to a team of professional therapists or counsellors and are treated in the strictest confidence. Any leak of confidentiality is likely to lose the organisation many clients who fear they may become known to the general community as HIV positive and this of course decreases the credibility of the counsellors. Once the emergency period is over, usually after 3 to 6 weekly 45 minute appointments after diagnosis stage, the person can choose to join one of various support groups.

Support groups

The HIV positive support team

This team is made up of people who themselves are HIV positive. Where appropriate and at the discretion of the counsellor, HIV positive persons are referred to a member of the team for shared experience. This is usually helpful during the first days and weeks following diagnosis of HIV positive status.

The HIV positive support group

This is not a therapy group. It has been formed for persons who are positive to get together purely on a social basis.

The AIDS service group

Members of this group befriend and assist people with AIDS or persons with AIDS related complex (ARC) with shopping, transport, banking, chores and outings. Not

only does the befriender help with practical daily needs, but is also a companion who makes a long term contract with the person who has AIDS along the lines: "I will help you until you die."

The AIDS action group

This group monitors research, liases with health care providers in the interests of the clients and undertakes the "Safer Sex Campaign". The latter campaign is undertaken by means of public addresses, the showing of relevant videos and the publication and distribution of information pamphlets at gay commercial venues around the cities. This preventative strategy has largely been conducted by the Cape Town group (called "6010" to which the AIDS Action Group is affiliated) and a few doctors. A survey of people frequenting gay social insititutions in the city has revealed that an excess of 80% know about AIDS, its mode of infection and the preventative safe sex practices required. New statistics suggest that the education campaign is successful.

Other Groups

There are also various other groups such as parent and spouse support teams and pre-test counselling dealing with issues such as the taking of a test and facing problems that could occur if the result is positive practically it may mean difficulties with employment and insurance).

Conclusion

The AIDS epidemic poses many problems. The answer is not celibacy but safe sex and a caring approach. The level of caring and insight that AIDS is generating must benefit the community ultimately, without displacing the devastation that dying means to any individual.

AIDS AND HEALTH WORKERS

All hospitals and clinics should have general rules for preventing the spread of infections. If followed, these rules are sufficient to protect the careful health worker from becoming infected with the HIV virus. In this way, the caring for these patients need not and should not be compromised.

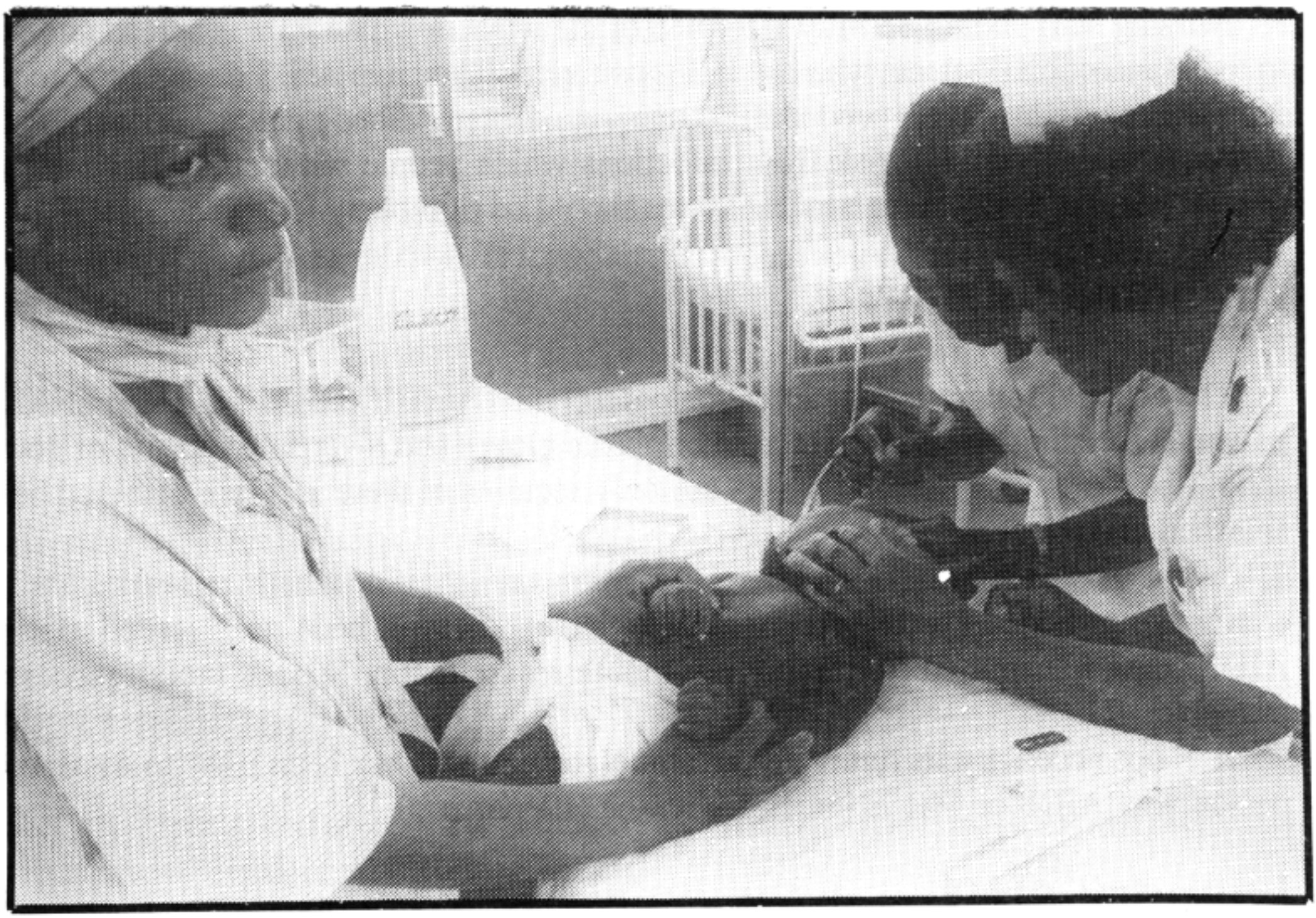
However, in many hospitals in South Africa there are shortages of resources which lead to problems in the control of diseases. The health worker should check to see if the hospital rules regarding infection are working adequately and if they are not, should challenge the hospital authorities on the question of infection control. It should be noted however, that even when there are policies for infection control, it may be extremely difficult to practice safe procedures when working under pressures of overcrowding and staff shortages.

Measures for general protection

Infection control rules should entail:

- the disposal of needles and syringes in a properly constructed container which should be clearly marked "SHARP", "SYRINGES". These should not be put into plastic bags.
- the sterilization before use, of all non-disposable medical instruments, needles and syringes
- the use of rubber gloves when cleaning up spillage of blood and other body fluids and when disposing of contaminated materials
- the disinfection of contaminated surfaces in a 1:10 solution of household bleach to water is sufficient
- washing of hands with soap and water after any contact with contaminated material

- washing of hands before smoking, eating and drinking
- covering existing cuts and grazes with waterproof dressings
- care when taking specimens from infected patients. Avoid pricking oneself with infected needles or allowing contaminated blood or body fluids to come into contact with grazes or open wounds
- Blood specimens should only be taken by trained and experienced staff.
- Gloves, aprons and gowns should be worn when taking specimens from an infected patient. A mask should be worn if there is a risk from splashing.
- Contaminated surfaces and the outside of specimen containers should be closed, labelled and sealed in plastic bags. If a health worker has sustained a needle prick injury the blood should be allowed to flow freely. Wash the area of the wound liberally with soap and water. The incident should be reported to the supervisor and the health worker must make sure the accident is recorded.



If routine infection control measures are followed, health workers have little risk of being infected at the workplace

Guidelines for health workers caring for an AIDS or HIV infected patient

All the general measures mentioned above apply to each of the groups that follow. All of these groups have the right to be informed of AIDS or HIV infected patients that they may be caring for.

Nursing staff

Nursing staff should be fully informed of the ways in which HIV is spread and how to avoid infection. Patients who are HIV positive or who have AIDS do not require isolation. They do however, need skilfull nursing and sympathetic caring. Because AIDS patients are especially at risk from infections which people without AIDS can resist, normal hospital infection control measures should be rigorously followed.

Ambulance staff

They should follow routine infection control measures. If the HIV infected or AIDS patient is bleeding or incontinent, rubber/plastic gloves and disposable aprons or gowns should be worn. Goggles and masks are only required if there is a risk of blood being splashed into the eyes.

When giving mouth-to-mouth resuscitation one should, where possible, use the equipment provided for that purpose. There have, however, been no recorded cases of AIDS being transmitted from mouth-to-mouth resuscitation. Special mouth pieces are available.

It is not necessary to fumigate the ambulance after it has been used to transport a person with AIDS or who is infected with the HIV virus.

Laundry staff

Occasionally needles and other contaminated waste is found amongst the linen sent for laundry. Laundry staff should watch for this hazard and other staff should take care when bagging clothes and linen for laundering.

Washable clothes and linen that are stained with blood or semen or any other body fluids should be washed in a well maintained washing machine on the hot cycle, or boiled before hand washing. Heavily contaminated linen should arrive in a specially marked bag and should be handled wearing gloves and an apron which should be disposed of in a labelled plastic bag.

Non washable items should dry cleaned.

Hospital porters

Protective clothing is only necessary if patients are bleeding or incontinent. In such cases disposable gloves, aprons and gowns should be worn.

All specimen containers should be carried in specially designed racks or boxes. Porters are advised not to handle specimens which are broken, leaking or unlabelled.

Specimens known to be infected should be sealed in plastic bags and should be labelled.

If a specimen is dropped and broken, this must be reported to the relevant supervisor. No attempt should be made to clean up spillage unless the cleaner has been taught the correct procedure.

When removing waste sacks one should watch for sharp objects that may be carelessly mixed with other rubbish. If found the incident should be reported to the supervisor.

Non classified workers

Mopping up waste and blood and body fluids should be done with gloves and aprons and using a bleach solution.

Sorting out soiled linen and medical instruments should be done wearing gloves and aprons.

Post mortem staff

Only experienced anatomical pathology technicians should assist in post mortems of patients with AIDS or with HIV infection.

Disposable gloves and aprons should be worn when transporting all bodies to the mortuary or post mortem room.

If patients have died of AIDS or hepatitis B, the body should be enclosed in a plastic bag to prevent the spread of infectious material.

CONCLUSION

- Health workers should be given a working knowledge of the cause, signs and symptoms, ways of spread and ways to prevent the spread of the HIV infection and AIDS.

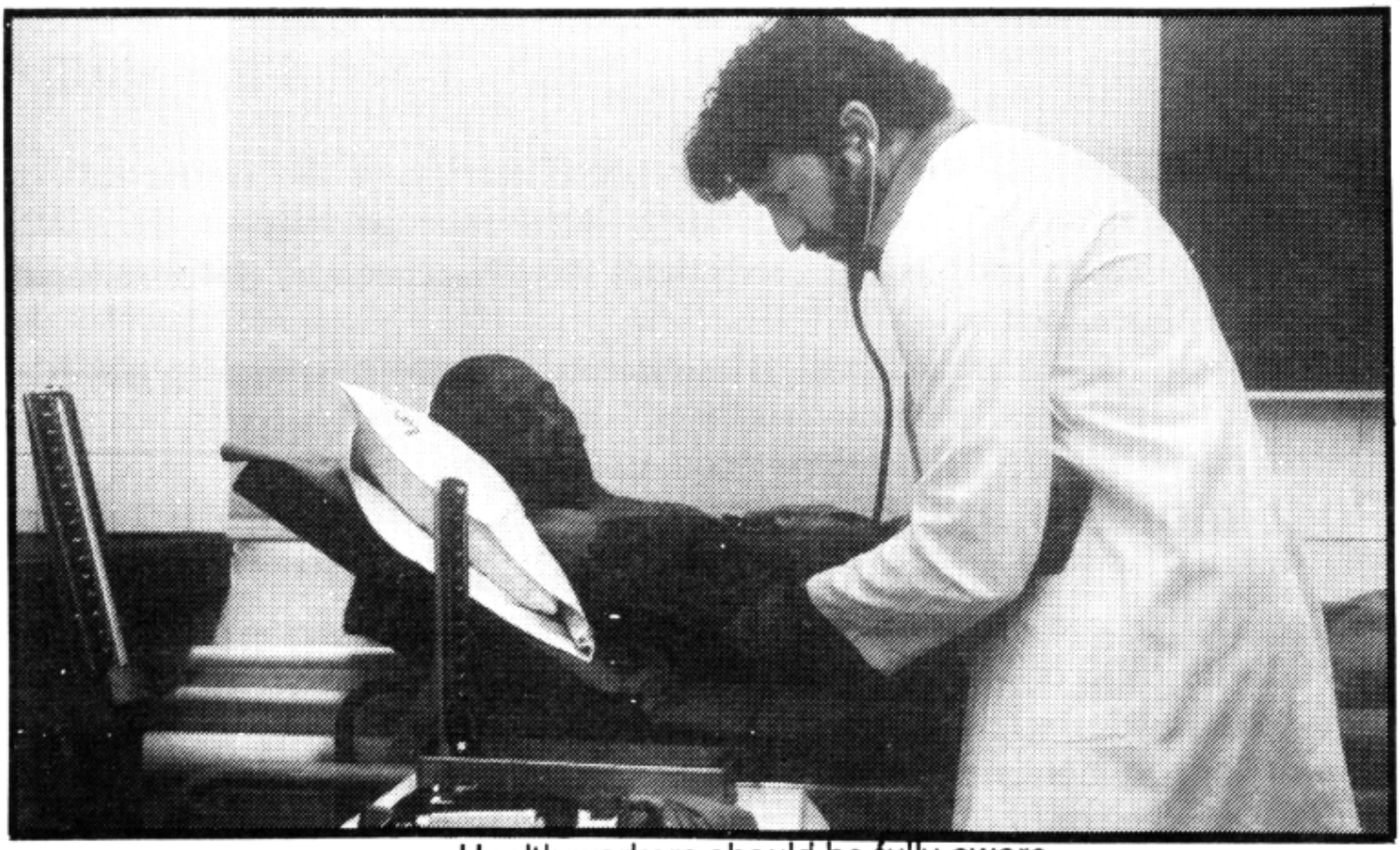
- It is important for all health workers be informed of patients with HIV infection or AIDS whom they are caring for.

- Supervisors should be informed of all accidents involving needle prick injuries and blood and body fluid spillage. The supervisor must keep records of all of these accidents. If these do not exist or are not being followed, health workers should insist from the hospital authorities that they be implimented.

- The virus is NOT easily transmitted and if the guidelines mentioned in this article are adhered to, the chances of health workers catching the virus through their work is minimal.

- This implies that there is NO NEED for health workers to discriminate against HIV infected or AIDS patients.

Health Workers' Association
Johannesburg



Health workers should be fully aware
of the ways HIV virus is spread

RECOMMENDATIONS

The following recommendations are the result of discussions with various people concerned with the need for the implementation of a clear policy on AIDS. The policy that is finally adopted and the way in which it is implemented requires careful consideration and a broad consensus. This article is not intended to be conclusive. It is presented here for debate.

Screening recommendations

Compulsory pre-marital screening is not advisable as very few people in this group would be expected to carry the virus. There is a strong case for compulsory screening in blood, semen and live organ donors provided these donors have given consent and have received counselling. Strict confidentiality should be maintained. The same applies for compulsory screening in patients on "kidney machines" and people staffing these units.

Women involved in promiscuous sexual behaviour (eg prostitutes) who are thinking of having babies or who are in the early stages of pregnancy should be strongly advised to have a test . This advice should include counselling and the choice of terminating the pregnancy if the test shows HIV antibodies in the blood.

HIV testing in prisons should be done only for the purposes of diagnosis, ethical epidemiological studies or on demand. The primary policy for prevention of HIV transmission amongst prisoners should centre around education, counselling, the provision of condoms and the prevention of prison rape.

If screening is used by life insurance companies to deny cover, alternate schemes must be offered by the state. Procedures to ensure strict confidentiality must be instituted.

Voluntary testing programmes as opposed to compulsory screening should be developed and should be specifically designed for and targeted at those people involved in high risk activities. People who have had contact with infected individuals in ways that are likely to have resulted in transfer of the virus should be offered testing, counselling and education.

Health workers

Infection control policies to prevent transmission of infectious diseases should be practiced routinely when handling all potentially infected patients and health workers infected with HIV should be adequately compensated and their HIV status must remain confidential. All health care workers should accept a moral obligation to examine, treat and care for HIV infected patients provided appropriate infection control measures exist and are being practised. Education of health care workers about AIDS, HIV and the risk of infection should be given top priority. This education should aim at breaking down prejudiced responses towards infected individuals.

Children

As HIV infection is not yet widespread in the "under 5" population in South Africa, the results of further research should be awaited before deciding on a policy for the immunisation of symptomatic HIV positive children. Centrally stored breast milk is sometimes collected from nursing mothers to feed other babies. This practice should only be used where the mothers donating the milk are known not to carry the HIV virus.

Education campaigns

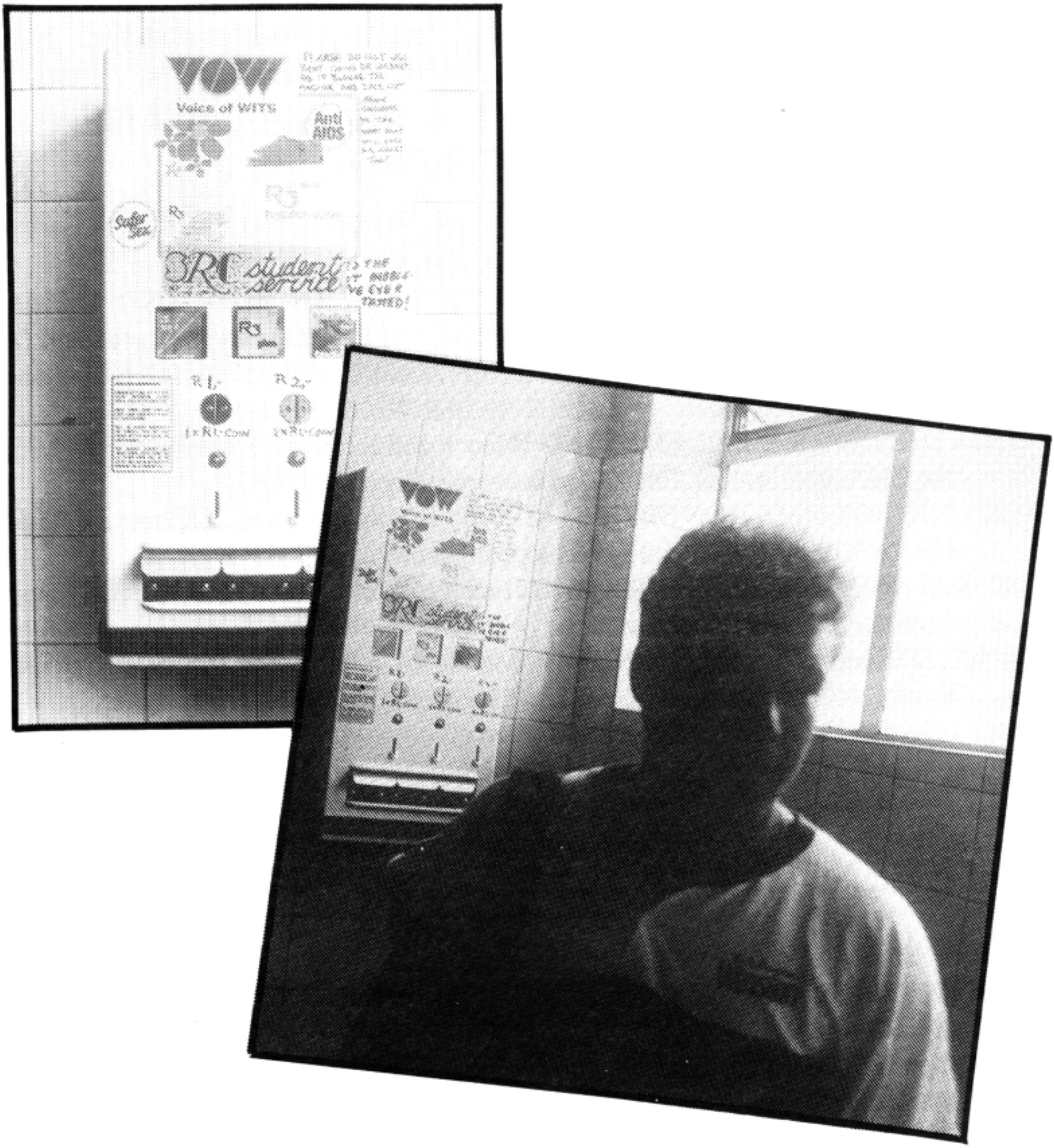
Before any education campaign is undertaken, a variety of experts should be asked for advice. These should include in particular, persons who are aware of cross-cultural and specific group needs. The education campaign should be conducted openly and should include basic sexual information.

All the facts that are made available to the authorities should be presented to the population at large in an understandable way.

Condoms and spermicides should be made generally and freely available. Any laws and circumstances (especially those which break up family life such as migrant labour) should be changed.

Responsibility

The state, in consultation with members of the broader community, should accept responsibility for control of HIV infection and AIDS. The people responsible for the state's programme as well as the way in which it will be funded, should be made known. The education strategy and framework within which it is to be developed and implimented must be clarified as a matter of urgency. An appropriate group for this



Condom machines have been installed at the University of the Witwatersrand

purpose must be set up immediately. This group should pursue a policy of complete openess at all stages.

Research into the psychological and social issues relating to AIDS and HIV infection should be given high priority. This should involve research into ways in which people's behaviour can be altered to prevent the spread of the disease. Adequate funding must be set aside for this purpose.

A LIST OF BOOKS ABOUT AIDS WHICH ARE AVAILABLE IN SOUTH AFRICA

AVOIDING AIDS. WHAT EVERY SOUTH AFRICAN MAN AND WOMAN SHOULD KNOW ABOUT PREVENTING INFECTION. By V Leroux and Dr F Spracklen. Available for R4.95 at the CNA and Campus Book Shop, Johannesburg

AIDS--THE DEADLY EPIDEMIC By G Hanock and E Carim. Available for R11.95 at the CNA and Campus Bookshop, Johannesburg

TEENAGE INFORMATION SERIES--AIDS By A Kilpatrick and D Kilpatrick Available for R13.50 at Campus Bookshop, Johannesburg

WOMEN AND THE AIDS CRISIS By D Richardson. Available for R19.98 at Campus Bookshop, Johannesburg

PANIC. THE STORY OF AIDS By R McKie. Available for R9.95 at Exclusive Books, Johannesburg SEX, DRUGS AND AIDS By O Wachter. Available for R9.95 at Exclusive Books, Johannesburg

REFERENCE ARTICLES

World Health Organisation. Acquired Immunodeficiency Syndrome (AIDS). Provisional WHO clinical case definition for AIDS. Wkly Epidem Rec 1986; 61: 72-73

ABC of AIDS SERIES. Br Med J 1987.

Department of National Health and Population Development. AIDS: the 1979- Pandemic, with special reference to S.A. Epidemiological Comments 1987; Vol 14 April, 1-61

Grose R. AIDS: Proposals for action. The global epidemic and the crisis in Africa. War on Want. May 1987: 39

American Medical Association. Prevention and control of Acquired Immunodeficiency Syndrome. An interim report. JAMA 1987; 258: 2097-2103

The attitudes and information contained in the above books do not necessarily reflect the views of the editorial collective.

BOOK REVIEW

AVOIDING AIDS. What every South African man and woman should know about preventing infection.

Anubis Press, Cape town, 1987. R4.95 Available at C.N.A.

"Avoiding Aids" is a booklet written for a South African readership. It is relatively cheap (R4.95) and is available from C.N.A. bookshops, which puts it within reach of a broad section of people. It provides general information, data and statistics on the extent of the spread of the disease in South Africa. In addition, the booklet outlines some of the policy decisions of the Department of National Health and the South African Blood Transfusion Services. It gives information on donating and receiving blood as well as advice on testing with addresses of local doctors and services who do testing. It outlines non-sexual high risk activities and provides a chapter focusing on various sexual practices, which are well described and explained.

The style of writing suggests that the booklet is geared towards literate, matric-level readership. It contains no illustrations, is written in small print and doesn't explain complicated terms (apart from those pertaining to various sexual practices). The booklet to a large extent avoids evaluative judgements, giving detailed description and information. It does attempt to avoid some of the myths surrounding AIDS. However, in talking about the origin and spread of the disease, the booklet singles out male homosexuals, people from certain African countries, intravenous drug users, prostitutes and promiscuous practices. This attitude - expressed in an indirect way - leads to misunderstanding of the disease, and to stigmatisation of groups who already experience discrimination in our society. Such stigmatization will not bring about a change in attitudes, values, practices and social condi tions needed for preventing the spread of AIDS.

While the booklet talks about "high risk activities" rather than "high risk groups", there are certain instances of strong moralistic overtones, for example, in the section dealing with intravenous drug use. While such use of drugs cannot be officially con-

doned, the free issuing of sterile needles at certain publisized outlets would be more effective in combatting the spread of AIDS. This has been the approach adopted by countries where the use of intravenous drugs forms a major route of spread.

Current official responses to AIDS present similar contradictions. If education and information are identified as priority areas, how can teenagers be provided with relevant AIDS information if sex education in the schools is prohibited? How can workers in danger of contracting the virus be targetted for education if they are faced with repatriation, dismissal or victimisation? How can this very booklet aimed at educating the public about AIDS be sold in a sealed wrapper with a label saying "Due to the explicit sexual information contained in this book, the publisher has been advised to seal all copies"? These are issues the book does not mention. Nor does the booklet mention the social and political circumstances which lead to high risk practices. For example, unemployment and poverty compelling women into prostitution as a form of self-employment; migrant labour with its disruption of family life facilitating casual sexual encounters; life in institutions such as prisons and single-sex hostels encouraging homosexual practices.

A serious omission in the booklet is the lack of information and advice on counselling and support groups. While one section of the booklet deals specifically with testing, there is no mention of pre-and post test counselling. If education is to be the main focus of the campaign, counselling should be given priority over testing. The procedure of notifying the person concerned of a test result, as outlined in the book, is contradicted by organisations and health workers dealing with people who are carrying the virus or who have AIDS. They stipulate that test results should not under any circumstances be given over the telephone. These omissions suggest that the authors would have been well- advised to consult with organisations concerned with AIDS and AIDS patients and to incorporate the services they offer, their experience and advice.

The booklet provides useful but limited information. It claims to address itself to "every South African man and woman". The information is superficially geared to local conditions, as can be seen from the sections dealing with "Rugby and Boxing", "Mos quitoes and Bedbugs" and "Ritual Scarification". Yet the booklet fails to address the social, economic and political realities facing the majority of South Africans. In addition to individual precautions, any serious attempt to prevent the spread of AIDS in South Africa must address the social and political conditions which provide the fertile ground for the spread of the disease.

Addresses of AIDS Information & Advice groups

HIV CLINIC, Johannesburg Hospital
(011) 488-4911
Jubilee St
Parktown

GASA 6010 Counselling
Service, Cape Town
(Gay Association of S A)
(021) 21 5420

GAB Counselling Services
(Gay Advice Bureau)
(011) 643-2311
(031) 22-1788

AIDS TRAINING & INFORM-
ATION CENTRE
(011) 725-0511

CENTRE FOR APPLIED LEGAL
STUDIES
(for legal advice)
(011) 716-5678

AIDS ACTION GROUP
(for information and education
only)
(011) 403 3600
(021) 21 5420

AIDSLINE
DEPARTMENT OF NATIONAL
HEALTH AND POPULATION
DEVELOPMENT

Southern Transvaal:
(011) 836 2232
Pretoria:
(021) 325 5100
Western Cape:
(021) 97 8151
Natal:
(031) 305 6071
Eastern Cape:
(041) 22541
O F S:
(051) 472194
Northern Cape:
(0531) 29524
Northern Transvaal:
(01521) 6541

IHRG (Industrial Health
Research Group)
Department of Sociology
UCT
Private Bag
Rondebosch 7700
(021) 650 3508
(021) 650 3720

Some people requiring a test for the Aids virus, are offering to donate blood. It is suggested that you contact a counselling service or information centre before you take this decision.

Editorial Collective.

Update on the Baragwanath Hospital crisis

Recently a number of doctors from Baragwanath Hospital spoke out against the conditions at this hospital. They have been victimised by the Transvaal Provincial Administration as a result of this. Although a forthcoming issue of Critical Health will be dealing with the general crisis in hospital services, this article has been included here to express solidarity with these doctors.

Letter to the SAMJ

On September 5 1987, a letter was published in the South African Medical Journal (SAMJ) signed by 101 doctors in the Medicine Department at Baragwanath Hospital. The letter mentioned gross overcrowding in the Department, shortages of hospital beds re sulting in patients sleeping on the floor, toilet facilities that are far short of acceptable standards and that nurses have to struggle to attend to over-whelming numbers of patients. The letter was critical of the attitude of the adminis tration to this "inhumane" state of affairs. The signatories appealed to the rest of the medical profession through the letter in the SAMJ in the hope that enough response would be evoked "at least on humanitarian grounds, to bring about urgent relief to an appalling situation that is rapidly approaching a major crisis."

The history of the complaints

This letter had been preceded by voluminous correspondence stretching back about fifteen years, between the Medicine Department and the Transvaal Provincial Administration. The grossly deficient facilities in the department as well as the imminent collapse of the over-burdened department had been frequently pointed out.

Court action

In November 1987 it became apparent that six doctors who had applied for posts at the hospitals, and who had been recommended for these posts by Heads of Department at the hospital, were being turned down on the grounds that they had been signatories to the letter of September 5 1987 in the SAMJ. On December 10 1987 an urgent application was brought before a Rand Supreme Court judge by those affected. The judge found the decision that the doctors were unsuitable for employment in the Department of Hospital Services could not be made unless the doctors were given a hearing by the Administration. It was found further that the Department had acted unfairly. The Department of

Health Services was granted leave to appeal against costs being awarded to the doctors. The appeal has been set down for four months time.

The hearings

Hearings were held on December 12 1987, at which the doctors were legally represented. Extensive oral and written submissions were made on their behalf. Prof L Schamroth, Professor of Medi cine and recently retired Head of the Department of Medicine at Baragwanath Hospital, gave evidence in support of the doctors. This was uncontested by the Administration. On December 12 1987, two days before the appointments were due to take affect, the doctors were informed by telex that they had again been found unsuitable for their posts.

Interviews

During the following weeks, most of the other signatories to the September 5 1987 letter were interviewed by members of the Administration. They were questioned about the statements they had made in the letter. All those doctors who had applied for new posts in 1988 were interviewed first. The remainder fell into the category of "temporary employees of the province." It emerged during these interviews and subsequent events, that doctors who had applied for new posts would be denied these posts unless they submitted an unconditional apology for the September 5 1987 letter to the SAMJ. Further, they were asked to withdraw certain statements and to correct those that the Administration regarded as "inaccurate". It became clear that doctors currently in "temporary" posts would be threatened with disciplinary action in terms of their "service contract" if they failed to meet the above requirements. Of the 51 "temporary doctors" questioned and threatened with dismissal (or non-appointment), 44 have signed the prepared "apology".

Permanent staff

The last group of signatories to be dealt with by the Administration were those in "permanent" posts. On January 25 1988 all these doctors, including heads of units and the acting head of the medicine department, received letters from the Administration detailing the objections the Adminstration had to the SAMJ letter of 5 September 1987. The Adminstration's letter included the following paragraph: "We are sure that you would agree in retros pect that the incorrect statements and unacceptable language should be withdrawn by you. I shall be pleased to receive your reply on or before 12 February 1988." Those of the "temporary" staff who had not yet submitted "acceptable apologies" received letters similar to those received by "permanent staff" which contained the following threat: "Should this (an acceptable apology) not be forthcoming, further steps against you in terms of your service contract will be considered."

Reply from the permanent staff

After obtaining an extension of the deadline by the Administration, 23 of the permanent staff submitted a joint letter of reply on February 19 1988. In the letter the signatories noted the Adminstration's objections to their letter to the SAMJ on September 5 1988. They stated that these were not relevant to the conditions under which their patients in the Medicine Department at Baragwanath Hospital were being treated. They expressed again their concern at the overcrowding and deficient facilities present in the Department. They noted their willingness to contribute to solutions to these problems. The letter concluded that the dispute with the Administration could not be resolved while several doctors were denied the posts for which they had been recommended and others re mained under the threat of disciplinary action. A reaction by the Administration to this reply is awaited.

Court action

Five doctors have been denied posts for failing to submit "acceptable apologies". Three of these have instituted legal proceedings against the Administration. Their applications, due to be brought before the Rand Supreme Court, will constitute a Supreme Court review of the hearings granted them by the Admi nistration. Three further doctors, currently in temporary posts, have not submitted "acceptable apologies" and therefore are still under threat of disciplinary action.

Overcrowding in Baragwanath Hospital results in many patients having to sleep on the floor

SUPPORT FOR IVAN TOMS

On March 3 1988 Dr Ivan Toms was sentenced to 630 days imprisonment. (The maximum sentence asked for by the state.) His "crime" was to refuse to serve a one month camp in the SADF. Ivan graduated as a doctor from UCT in 1976. From there he reluctantly went into the army. Although his religious, moral and political convictions told him the SADF was being used to defend apartheid, the alternatives of leaving the country, living in hiding, or even spending time in jail were too harsh to consider. Ivan's experiences in the operational area and on the Angolan border made him feel that "...the Namibian people....do not want the SADF in their country; international law says that South Africa has no right to be there....". Since 1984, SADF troops have been used to "control" the black townships and to suppress resistance to apartheid. Ivan saw their violence while working as a doctor for 6 years in the Crossroad community. These events lead Ivan to say " I am committed to South Africa and I believe that the truly patriotic action for me is to go to prison rather than deny my faith and my beliefs."

At present the law provides for community service only to conscripts who are both religious and pacifist. They are forced to do 6 years of service in a government institution. In sentencing a person like Ivan to prison, we are losing for a while, an individual with valuable skills who is committed to working for communities and not for private gain. The editorial collective of CRITICAL HEALTH expresses its solidarity with Ivan Toms, as a health worker and as a committed South African, and supports his call for constructive alternative service to be the same length as military service and for this option to be available to ALL conscripts (not only religious/pacifists) in non-government organisations.

How much are you contributing to a changing South Africa?

HOW ABOUT R1·12 PER WEEK FOR STARTERS.

Isn't that a small price to pay for a more realistic perspective on South Africa?

Simply peruse the subscription details below and complete this coupon.

And put your money where your mouth is.

Subscriptions	6 months	12 months
Home deliveries in Johannesburg, Pretoria, Cape Town, Durban, P.E. & Grahamstown.	R32	R59
Postal deliveries in South Africa, the homelands and Namibia.	R32	R59
Airmail to Zimbabwe	R36	R70
Airmail to Botswana, Swaziland, Lesotho, Zambia, and Mozambique	R70	R132
Airmail to United Kingdom	R100	R188
Airmail to U.S.A., Europe, Australia and elsewhere overseas	R120	R225

☐ I enclose my 6-month / 12-month subscription of R _____

Name: _____

Address: _____

_____

_____

Code: _____ Telephone: _____

Post to: The Weekly Mail, P.O. Box 260425, Excom, 2023, South Africa.
FW

The paper for a changing South Africa.

HUNT LASCARIS TBWA 87050/69

SUBSCRIBE!

CRITICAL HEALTH is a quarterly publication dealing with health and politics in South Africa.

CRITICAL HEALTH aims to:

* **present a critique of health in South Africa**
* **provide ideas for the roles that health workers can play in promoting a healthy society**
* **show that good health is a basic right**
* **provide a forum for the discussion of health-related issues**
* **provide insight into the political nature of health**

Annual subscription rates:

LOCAL:	
Students, workers	**R5.00**
Salaried Individuals	**R10.00**
Organisations	**R30.00**

Donor subscriptions:	**R20.00**	**R30.00**	**R50.00**

OVERSEAS:	
Individuals	**UK 8.00 pounds**
	US 12.00 dollars
Organisations	**UK 15.00 pounds**
	US 20.00 dollars

NAME: .....

ADDRESS: .....

.....

..... **postal code** .....

Enclosed please find R ..... for my annual subscription.
Send to: Critical Health, P.O. Box 16250, Doornfontein, Johannesburg, 2028.