

Historical Trends in the HIV/AIDS Training of Health Care Workers in the Western Cape, South Africa, 1990-2003

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Introduction

South Africa has one of the largest and most rapidly expanding HIV/AIDS epidemics in the world.¹ Health care workers² play a crucial role in the prevention and treatment of HIV/AIDS, and their training is vital to the management of the epidemic. Training organisations have, over time, become a central component of any HIV/AIDS strategy. They are at the forefront of much of the innovative action research in the field, yet not much of this experience is documented.³ Thus, training organisations are significant new sources of information, opening up fresh historiographical questions. It is useful both to understand the shifting trends in training content and methodology, and to examine the underlying historical factors contributing to these shifts. This study examines this fissure in the current literature.

This paper begins with a literature review and an overview of how the historical analysis was conducted. The key findings are then presented in terms of the shifts observed in training content and methodology. These shifts are then analysed according to the primary contributing historical factors.

Literature Review

The output of biomedical HIV/AIDS research is considerable and well established. There is a noticeable lack of social scientific research,⁴ particularly in Africa.⁵ As early as 1991, in Africa, it was noted that HIV/AIDS policies and programmes should reflect a balanced biomedical and social effort.⁶ In 1998, it was argued that HIV/AIDS is not simply a health problem and that the underlying economic, social, and political factors of the epidemic need

¹ UNAIDS-WHO, 'AIDS Epidemic Update' (December 2003).

² In this study, *health care workers* refers to professional and student doctors, nurses, psychologists, social workers, and counsellors involved in HIV/AIDS prevention, treatment, support, and care. Trainers and staff in HIV/AIDS non-profit, community, and faith-based organisations are also included. Finally, because of their central role in providing HIV/AIDS prevention, care, and support, home-base carers, community health workers, traditional healers and peer HIV/AIDS counsellors and educators were also included. There have been calls to broaden the definition of HIV/AIDS health care workers, in order to make it more inclusive of all the various people involved with HIV/AIDS treatment and care. See, for example, WHO, 'The World Health Report', (2004). <<http://www.who.int.who/2004/en>> (Accessed: 10 January 2005).

³ Peter Delius and Liz Walker, 'AIDS in Context', *African Studies*, 61/1 (July 2002), 5-12.

⁴ *Ibid.*, 5.

⁵ See Philippe Denis' introductory chapter.

⁶ E. Maxine Ankrah, 'AIDS and the Social Side of Health', *Social Science and Medicine*, 32/9 (1991), 967-980.

to be addressed.¹ Barnett and Whiteside (2002) explored the role of HIV/AIDS in the context of globalisation and development.² The complexities of HIV transmission and the failure of interventions have been traced to local economies, increasing poverty, migration, gender, war, and cultural politics.³

Since the mid-1990s, there has been increasing historical research and involvement in the field. Examples of historical HIV/AIDS research in Africa include investigations of migrancy,⁴ labour,⁵ sexual relations and transmission,⁶ sex workers,⁷ manhood,⁸ attitudes and behaviour,⁹ and historiography.¹⁰ Important contributions to the history of the epidemic come from researchers like Grmek,¹¹ Hooper,¹² and biomedical scientists like Korber,¹³ Bailes,¹⁴ and Gao.¹⁵ In 2006, Iliffe made an important contribution to the history of HIV/AIDS in Africa.¹⁶ In South Africa, there have been historical contributions by Grundlingh, Fassin, Schneider, Denis, and Phillips.

Examples of greater involvement from historians include, first, the “AIDS in Context: Explaining the Social, Cultural and Historical Roots of the Epidemic in Southern Africa” conference (Johannesburg, 4 - 7 April 2001).¹⁷ The goal of this conference was to examine the specific interaction of historical, social, political and cultural factors that have formed the nature of the HIV/AIDS epidemic. Second, the *African Journal of AIDS Research* (AJAR)¹⁸ was launched in 2002. The AJAR’s goal is to contribute to the understanding of the social

¹ Charles Becker, Jean-Pierre Dozon, Christine Obbo, and Moriba Touré, *Vivre et penser le sida en Afrique (Experiencing and Understanding AIDS in Africa)* (Paris: Codesria, Karthala, & IRD, 1998)

² Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century: Disease and Globalisation* (Basingstoke: Palgrave Macmillan, 2002).

³ Ezekiel Kalipeni, Susan Craddock, Joseph Oppong, and Jayati Ghosh, *HIV and AIDS in Africa: Beyond Epidemiology* (Oxford: Blackwell Publishing, 2003).

⁴ S. Horowitz, ‘Migrancy and HIV/AIDS: A Historical Perspective’, 103-123, in P. Setel, M. Lewis, and M. Lyons, (eds.), *Histories of Sexually Transmitted Diseases in Nineteenth- and Twentieth-Century South Africa* (Cape Town: Greenwood Press, 1999).

⁵ Ackson M. Kanduza, ‘HIV/AIDS and Labour in Swaziland. Paper’, Biennial Conference of the South African Historical Society, University of the Free State, 29 June - 1 July 2003.

⁶ A. Larson, ‘Social Context of Human Immunodeficiency Virus Transmission in Africa: Historical and Cultural Bases of East and Central African Sexual Relations’, *Review of Infectious Diseases*, 11/5 (September - October 1989), 716-731.

⁷ Marjolein Gysels, Robert Pool, and Betty Nnalusiba, ‘Women Who Sell Sex in a Ugandan Trading Town: Life Histories, Survival Strategies, and Risk’, *Social Science and Medicine*, 54 (2002), 179-192.

⁸ Philip Setel, ‘AIDS as a Paradox of Manhood and Development in Kilimanjaro, Tanzania’, *Social Science and Medicine*, 43/8 (October 1996), 1169-1178.

⁹ L. Grundlingh, ‘Early Responses, Attitudes and Behaviour Regarding HIV/AIDS in South Africa, 1983-1988’, *Journal for Contemporary History*, 26/1 (2001), 86-103.

¹⁰ S. Ellis, ‘Writing Histories of Contemporary Africa’, *Journal of African History*, 43/11 (2002).

¹¹ M. D. Grmek, “Le concept de maladie émergente.” *Hist Phil Life Sci*, 15 (1993): 281-296, M. D. Grmek, “Some Unorthodox Views and Selection Hypothesis of the Origin of the AIDS Viruses.” *Journal of the History of Medicine*, 50 (1995): 253-273, and M. D. Grmek, *Histoire du Sida. Début et origine d’une pandémie actuelle* (Paris: Payot, 1989). Trans. R. C. Maulitz and J. Duffin, *History of AIDS. Emergence and Origin of a Modern Pandemic* (Princeton: Princeton University Press, 1990).

¹² Hooper, E. *Slim: A Reporter’s Own Story of AIDS in East Africa*. London: The Bodley Head, 1990, and Hooper, E. *The River: A Journey to the Source of HIV and AIDS* (New York: Little, Brown, 1999).

¹³ B. Korber et al., “Timing the Ancestor of the HIV-1 Pandemic Strains,” *Science*, 288, no. 5472 (2000): 1789-1796.

¹⁴ E. Bailes et al., “Hybrid Origin of SIV in Chimpanzees,” *Science*, 300, no. 5626 (2003): 1713.

¹⁵ F. Gao et al., “Origin of HIV-1 in the Chimpanzee Pan Troglodytes Troglodytes,” *Nature*, 397 (1999): 436-441.

¹⁶ J. Iliffe, *The African AIDS Epidemic: A History* (Oxford: James Curry, 2006).

¹⁷ Peter Delius and Liz Walker, ‘AIDS in Context’, *African Studies*, 61/1 (July 2002), 5-12.

¹⁸ See *African Journal of AIDS Research*, <<http://www.inasp.org.uk/ajol/journals/ajar/index>>

dimensions of HIV/AIDS in the African context. The contributions to this journal are interdisciplinary, including contributions in the field of history.

While there are a growing number of international HIV/AIDS training guidelines,¹ there are noticeably few historical analyses of training. When training has been addressed, it has been part of historical analyses of HIV/AIDS issues like education,² awareness,³ and counselling.⁴ Training organisations find it difficult to provide an historical critique of what training has worked and why it has worked. These organisations often need to respond to external demands from clients and health care services without having the necessary time to evaluate and reflect on best practices. This has resulted in ahistorical and decontextualised planning and assessment of training programs. This study examines the relevant historical factors in training organisations.

Method

An historical analysis of key HIV/AIDS training organisations⁵ in the Western Cape, South Africa was conducted, covering the period 1989-2003. The organisations studied specialise in the HIV/AIDS training of health care workers and peer counsellors. While the goals of the training organisations vary, they all prepare health care workers to work in HIV/AIDS prevention, care, and support. The trainees are drawn from the provincial health care department, as well as non-profit, faith-based, community-based, university, and corporate organisations. The acquired training skills are utilised, essentially, with patients in the primary health care system.

Information was gathered from HIV/AIDS training organisations by analysing training material, interviewing training managers, trainers, counsellors, and supervisors, collecting feedback from course participants, conducting site visits, analysing ongoing evaluation of programs, and analysing personal experience as a trainer for various organisations. This information was then analysed for significant historical trends in training content and methodology.

Results

The analysis showed that there have been major shifts in both training content and methodology over the last 14 years. Placed on a timeline, the shifts accord with four periods:

¹ For example, see organisations like UNAIDS <<http://www.unaids.org>>, CDC <<http://www.cdc.gov>>, International Training and Education Center on HIV <<http://www.go2intech.com>>, Center for AIDS Research <<http://www.sph.emory.edu>>, WHO <<http://www.w3.whosea.org>>, World Bank <<http://www.worldbank.org>>, The Synergy Project <<http://www.synergyaids.com>>, IntraHealth International <<http://www.intah.org>>.

² Louis Grundlingh, 'Neither Health nor Education? An Historical Analysis of HIV/AIDS Education in South Africa, 1980s-1990s', unpublished paper, RAU University (24 May 2002).

³ M Hunter, 'The Ambiguity of HIV 'Awareness' and the Power Behind Forgetting: Historicizing and Spatializing Inequality in Mandeni, Kwa-Zulu Natal', conference paper, AIDS in Context Conference, University of the Witwatersrand, 4-7 April 2001.

⁴ School of Psychology, 'Evaluation of HIV/AIDS Counselling in South Africa', University of Natal, Pietermaritzburg, November 1999.

⁵ These organisations are: Aids Training, Information, and Counselling Centre (ATICC) (it has trained the majority of health care workers in the province); Lifeline/Childline HIV/AIDS Program; Department of Health – Western Cape; Somerset Hospital – HIV/AIDS Unit; Red Cross Society; Student Health Services (University of Cape Town); Final Year Medical Student HIV/AIDS Training, Department of Medicine (University of Cape Town); Department of Psychology (University of Cape Town); Philipi Trust HIV/AIDS Training; FAMSA; Helderberg HIV/AIDS Program; Leadership South HIV/AIDS Program; Irving & Johnstone Pty.; and the Rape Crisis Centre.

- (1) 1990-1994, The Early Days,
- (2) 1995-1998, The Growing Epidemic,
- (3) 1998 onwards, The Questioning of Orthodoxy,
- (4) 1999-2003, The Generalised Epidemic.

Once these basic shifts were established, the predominant themes of each time period were then analysed. The themes were organised into shifts in *content* and *methodology*. A brief description of these shifts is provided before discussing the contributing factors.

Shifts in contents

First, in terms of the shifts in *content*, each period was characterised by the following:

(1) 1990-1994

In this initial period organisations provided basic HIV/AIDS information, awareness, and skills. Also, these organisations found themselves in an advocacy role, highlighting the importance of the growing epidemic and the subsequent human rights issues. Training during this period was difficult and often frustrating because of government, public, and professional disbelief and inaction. Many trainees felt that they were forced by their managers to attend training courses.

(2) 1995-1998

The number of reported HIV-positive persons began to increase significantly. This was largely due to the fact that the government had implemented the primary health care model, and patients who were previously limited to a few specialist clinics now attended community clinics. Training was now in demand, and organisations began to focus on high incidence prevention, treatment, and care input. Trainees reported that they felt overwhelmed by the increasing number of patients and the lack of resources within the healthcare system. This period was experienced as a time of accelerated skill acquisition and crisis management.

(3) 1998 onwards

The infamous “Does HIV Cause AIDS” debate that was resurrected by President Thabo Mbeki and his advisors not only had an interesting effect on the belief structures of the South African and the international health community, but also on training organisations. Training managers and directors of NGOs stated that content was compromised during this period in that there was regression to many of the training issues of earlier years. Trainers had to return to the dissemination of the basic HIV/AIDS information of the early 1990s. Many health care workers had to be once again convinced of the scale and impact of the epidemic. Training organisations played an important advocacy role during this period in that they continued to provide facts and treatment options while the epidemic grew amidst confused public health messages.

(4) 1999-2003

Trainees reported that they once again began to feel overwhelmed by the numbers of HIV-positive persons attending clinics and hospitals, and the increasing demands being made on health care workers and the health system. The last phase is characterised by program and

intervention specific HIV/AIDS input. It was now rare to encounter participants who did not believe in HIV/AIDS and its massive impact on their community and the country at large. Many participants received specialised and advanced training in the areas of treatment and counselling. Health care workers reported more agency in the prevention and management of the disease.

Shifts in methodology

Second, in terms of shifts in *methodology*, a more predictable observation was made. Over the 14 years it was shown that there was a shift from traditional teaching methodology to more adult-based learning methodology. With this shift came the move towards methodology that was more culture-, gender-, and language-sensitive. There were particular issues that were the focus of each period:

(1) 1990-1994

During this period training methodology was largely a continuation of the traditional and didactic training methods that were evident in previous regional training of health care workers. It was held that there was specific information to give, and it was given in the traditional classroom manner of trainers teaching concepts, and trainees taking notes.

(2) 1995-1998

The increase in the reported number of HIV-positive persons attending clinics resulted in more local examples. The traditional training methods were proving cumbersome and unsuccessful because trainees now had more experience and were more vocal about this experience. Thus, trainees were given the opportunity to share more of their increasing experiences and skills. Training organisations began to describe their work as facilitation rather than teaching or training.

(3) 1998 onwards

Despite the advances in methodology that the previous period witnessed, this period saw a split in methodology. For those trainees who became confused by the government's reluctance to state that HIV caused AIDS, a return to more traditional methodology was witnessed. For those trainees who continued to work with high numbers of HIV-positive persons, there were continued advances towards more adult-based learning. Trainers complained that it was difficult facilitating courses when both positions were being expressed within the same group. This resulted in trainers having to work in two methodologies simultaneously when providing input on one topic.

(4) 1999-2003

This last period was characterised by a return to the principles of adult-based learning. The demand for innovative responses in a resource-limited environment led to more problem-, experience-, and peer-based learning. There was also a focus on training in rural areas and the utilisation of local skill bases in the provision of training. This led to the successful implementation of community-based train-the-trainer programs and capacity development

initiatives. This was a period of challenging new training demands and innovative methodological solutions.

Discussion

Once the main shifts in content and methodology and the four periods had been established, the contributing historical factors were grouped. Some of these factors can be generalised across the four time periods, while others are time- or event-specific.

Epidemiology

In South Africa, the collection of HIV/AIDS statistics is controversial. Since 1991, the annual National HIV Survey of Women Attending Antenatal Clinics has provided data in terms of national, provincial, and age group percentages. These figures have been questioned by various international and local sources. For example, in 2002, the Nelson Mandela Foundation/ HSRC Study on HIV/AIDS argued that the antenatal survey is not nationally representative of HIV prevalence.¹ In 2003, WHO/UNAIDS claimed that the antenatal surveys represent a significant underestimation.² The government attacked the former study with its higher prevalence rates as being alarmist, and commended the second study because it gave cause for hope with its lower figures.³

This diversity of opinion created confusion for the South African public, and it made it difficult for training organisations to present accurate national and regional statistics.⁴ Most organisations chose to present the results from the antenatal survey, despite its flaws, because this data was continuous from 1991 onwards. Even though statistics are regularly updated in training courses, many health care workers continued to question their validity and reliability based on their own lack of, or very close, association with HIV/AIDS. The former experience resulted in an underestimation, while the latter experience resulted in an overestimation of HIV prevalence. The resulting views had a profound influence on whether or not the presented statistics were seen as accurate, and how trainees responded to the rest of the training. It was common for trainers to present examples of trainees who have argued about the statistics, typically presented at the beginning of a course, and then to either leave the training or ignore further training input.

One training organisation reported that it was more useful to present the statistics in a low-key manner and rely on participants' personal and work experience to discuss incidence and changing trends in the epidemic.⁵ In this way, the official statistics simply backed up or challenged experience. The same organisation claimed that in the last few years it was more useful to use the UNAIDS/WHO Classification of Epidemic States⁶ when dealing with statistics. This classification system uses three states to describe an epidemic, i.e. low, concentrated and generalised. Low refers to an HIV infection that has not spread to a significant degree in any sub-population despite its presence over a period of time.

¹ Press Briefing, 'Nelson Mandela/HSRC Study on HIV/AIDS', 2002. <<http://www.cadre.org.za/publications>> (Accessed: 7 March 2004).

² WHO-UNAIDS, 'Reconciling Antenatal Clinic-Based Surveillance and Population-Based Survey Estimates of HIV Prevalence in Sub-Saharan Africa', (August 2003).

³ Department of Health, South Africa, 'Government Statement on the Nelson Mandela/HSRC Study on HIV/AIDS', 5 December 2002. <<http://www.doh.gov.za/docs/pr/2002/pr1205>> (Accessed: 27 February 2004).

⁴ Trainers, ATICC, Focus Group, April 2003, Cape Town.

⁵ Trainers, ATICC, Focus Group, April 2003, Cape Town.

⁶ WHO-UNAIDS, 'Improved Methods and Assumptions for Estimation of the HIV/AIDS Epidemic and its Impact: Recommendations of the UNAIDS Reference Group on Estimates, Modelling and Projections, (2002).

Concentrated refers to an HIV infection that has spread rapidly and widely in a particular sub-population but is not established in the general population. Generalised refers to the state when HIV is firmly established in the population as a whole.

Participants responded more positively to the concept of classifiable states rather than fixed numbers.¹ Presenting statistics continued to be problematic in terms of reliability, validity, availability, and government support thereof. This was especially true when working with participants from low-incidence areas. However, most health care workers today are working in high-incidence areas and the reality of AIDS in their daily work is enough to convince them of the enormity of the epidemic.

Social factors

Linked to the issue of statistics are the issues of social and occupational contact of health care professionals with HIV-positive persons. In the early 1990s, very few health care workers had worked with, or knew anyone personally, who was HIV-positive. By the mid-1990s, most health care workers had worked with HIV-positive persons and some had personal experience with an HIV-positive family member or friend. By 2000, all health care workers had been contact with HIV-positive persons professionally, and many more had personal experience. This shift in focus had important implications for the quality of course participation and attitudes towards HIV-positive persons.

Organisations argued that the principle here is simple and predictable: Greater personal or professional contact with HIV-positive persons results in more constructive involvement in training courses. All organisations claimed that social factors were more important than trainees' education in assessing the quality of course participation; in fact higher education often served as a hindrance to constructive participation. For example, this was found when training nurses and doctors with fixed ways of approaching disease prevention and treatment.

Social exposure to HIV-positive persons became important in the choice of content and methodology. Up to 1995, trainers experienced many difficult course participants who had not been exposed to HIV-positive persons and would bring very unhelpful, moralistic views into the training room. For example, participants claiming that HIV-positive persons should be isolated like in Cuba; HIV-positive persons were being punished by God because of their promiscuity (a very popular word in training courses in the early days); HIV-positive persons do not deserve treatment; HIV is not a threat to anyone in a relationship or marriage. By 1995, exposure tempered some of these attitudes. By 2000, the complexities of issues like poverty, migrant labour, post-apartheid family structures, unemployment, and the sexual patterns between older men and younger women were well established, and, to a large extent, accepted.

While the growing epidemic, time, and exposure helped organisations deal with this issue, trainers also found that changing the training methodology helped to expose participants to the complex realities of HIV/AIDS. Some of their initiatives included: (i) bringing in HIV-positive persons from similar backgrounds to talk to course participants, (ii) identifying mothers, fathers, siblings, spouses who felt comfortable talking about the loss of an HIV-positive person, (iii) requiring participants to have some professional HIV/AIDS experience as a training entry requirement, and (iv) including practical training, under professional supervision, with HIV-positive persons as part of the course.

A final point highlights the impact of high incidence areas on the visibility and exposure to HIV-positive persons. Even though it is well known that HIV/AIDS is not

¹ Trainers, ATICC, Focus Group, April 2003, Cape Town.

limited to any economic group, it did accelerate in certain high incidence areas in the Western Cape. By the end of the 1990s, areas like Khayelitsha, Guguletu, Mitchell's Plain, Nyanga, and Helderberg had been identified as high incidence areas. The reasons for the acceleration in these areas are linked to economic and social factors like unemployment and migrancy. Health care workers living and working in these areas brought relevant experience to training courses, and have often remained ahead of participants from low-incidence with lower social and professional exposure.

A pertinent related issue, especially before 1995, was the fear, and increasing number of reports, of occupational exposure to HIV. It was a topic that was often raised by concerned health care workers, and some training organisations assisted in establishing and communicating guidelines for HIV post-exposure prophylaxis and the management of potentially exposed health care workers. This issue continued to raise apprehension, but by the end of the 1990s health care workers were no longer as concerned because of the establishment of acceptable occupational prevention, exposure, and management guidelines.

Political factors

The impact of government response on knowledge, attitudes, and prevention strategies is profound. Centralist leadership is key to mobilising state organisations, foreign aid, and significant non-state involvement.¹ South Africa has many examples from the last decade that illustrate the role of political figures and policy in aiding or confusing public understanding. The National Party government was slow to respond to HIV/AIDS. In 1994, the democratic government inherited a rapidly worsening epidemic. The ANC government immediately acknowledged the problem but, for various reasons, was slow to address HIV/AIDS in any significant way.² Various government scandals ensued, which have continued to the present.³

Training organisations reported that participants in the first few years of training claimed that the government's lack of HIV/AIDS coverage confirmed certain trainees' perception that the problem was not important enough for consideration. The growing epidemic and the number of HIV-positive persons reporting at clinics started shifting these perceptions. In 1999, when President Mbeki invited the dissidents to debate the HIV-AIDS link in South Africa, many people became confused after having begun to accept the realities of HIV/AIDS. There were numerous training examples of direct challenges from participants in response to accepted and well-utilised material. Many participants no longer believed the trainers. This was particularly evident in the training of content such as virology, epidemiology, statistics, and treatment strategies. There were also many reports from health care workers who stated that patients were openly declaring that they were no longer going to use condoms because even in the unlikely event of contracting HIV, they would not develop

¹ James Putzel, 'The Politics of Action on AIDS: A Case Study of Uganda', *Public Administration and Development*, 24 (2004), 19-30.

² Kyle D. Kauffman, 'Why is South Africa the HIV Capital of the World?', in Kyle D. Kauffman and David L. Lindauer (eds.), *AIDS and South Africa: The Social Expression of the Disease* (New York: Palgrave Macmillan, 2004), 28.

³ For example, (1) In 1995, there was Sarafina II, the AIDS musical and the accusations of financial mismanagement, (2) In 1997, then-deputy president Mbeki, and Dr Zuma (then-Health Minister), enthusiastically endorsed the toxic drug Virodene. There was a call from government to abolish the Medicines Control Council because it had criticised the government's role and management of this issue, (3) The government's alliance with the dissident view that "HIV Does Not Cause Aids," (4) In 1999, Mbeki claimed that providing AZT was irresponsible because of its alleged toxicity, (5) In 2001, Mbeki used 1995 statistics to argue for lower prevalence rates in the country, and (6) In 2003, Mbeki denied that he knows anyone affected by the disease.

AIDS.¹ Health care workers and NGOs claimed that the President's stance had a long-lasting negative impact on clinic attendance, treatment, and the safer sex campaign.

An interesting example that illustrates the power of positive government messages comes from HIV/AIDS counsellors in Khayelitsha.² Since 1994, a group of HIV counsellors walked home from the day clinic along a certain route that brought them into contact with the same group of teenagers. Often they would stop to talk to the teenagers, which was a good opportunity for sex education. The teenagers invariably told them that there was no such thing as AIDS, and hence they did not have to practise safer sex. Over the years the banter continued, and there was no change in what the teenagers believed. Then, in October 1998, then-deputy president Mbeki's delivered the government's HIV Address to the Nation. Then-president Nelson Mandela was scheduled to give this address and at the last moment this was changed and Mbeki delivered the address on behalf of President Mandela. The message of this address was: "The danger is real ... [and] we can only win against HIV/AIDS if we join hands to save the nation."³ A few days after the address the counsellors were walking home and were stopped by the visibly agitated teenagers. They said, "You were right, Ma, Aids does exist – Thabo Mbeki said so!"

This is not to imply that President Mbeki is solely responsible for the deleterious effects reported; as any historian knows, individual actions are the result of complex historical factors. The factors behind President Mbeki's actions are interesting and multifarious, but beyond the scope of this paper. The overwhelming nature of the disease, the fact that it is predominantly sexual in transmission, and the inconsistent public health messages, resulted in a confusion that required strong HIV/AIDS leadership; something with which South Africa is still grappling.

Cultural factors

One of the major challenges facing training organisations is the incorporation of relevant cultural factors into their content and methodology. During the initial phase of the epidemic, it was common to hear trainees echoing what the larger community was saying, that is, HIV/AIDS, if it does exist, exists only in other cultural or religious groups. This is the familiar "Not Us-Them" response. There were also many conspiratorial, amusing, and alarming HIV/AIDS genesis theories that were related to this response. For example, "It is a white, apartheid disease," "It is a black freedom fighter disease," "It is an American disease brought in oranges," and "P.W. Botha (the second-to-last apartheid leader of South Africa) manufactured this in a laboratory because he was forced out of political power." Another paper awaits a detailed historical analysis of these HIV/AIDS genesis theories in Southern Africa over the last twenty years.

Dealing with these attitudes in training courses proved difficult given the power of conviction with which some trainees supported these views. Certain views were harmless, but others endangered public health. The most striking example comes from a traditional sexual practise, "dry sex." This refers to the practice where men insist that their female sexual partners "dry" their vaginas before having sexual intercourse.⁴ Women use things like soap, wool, coffee grind, tea bags, household detergents, scouring agents, antiseptics, and

¹ Leadership South HIV/AIDS Counsellors, private communication, December 1999, Cape Town.

² Lifeline HIV/AIDS Counsellors, Khayelitsha HIV/AIDS Project, private communication, June 2000, Cape Town.

³ Thabo Mbeki, 'Partnership Against Aids Declaration', (9 October 1998). <<http://www.gov.za/issues/hiv/aidsdeclaration98>> (Accessed: 17 April 2004).

⁴ PATH (Program for Appropriate Technology in Health), 'Vaginal Douching: Unnecessary and Potentially Harmful?', *Outlook*, 15/4 (December 1997), 6-7.

herbal remedies.¹ This is done for three main reasons: (i) certain men enjoy “tight” sex which means sex where there is more friction, despite the obvious discomfort to the woman, (ii) based on some traditional associations of vaginal fluid with being “unclean,” and a barrier to fertility,² certain men want dry sex in order to ensure “cleanliness,” and (iii) certain men believe that if a woman is “wet” it means that she has just had sex with another man and is thus being unfaithful.

While health care workers in Southern Africa were aware of this practice, they were not aware of its long history, prevalence,³ and role in HIV transmission.⁴ Researchers warned that dry sex could promote HIV-1 in that dry sex promoted lesions by damaging vaginal mucosa. Women who practise dry sex have been found to have vaginal inflammation resembling a chemical burn or allergic reaction.⁵ Moreover, it was unlikely that men who were insisting on dry sex would use a condom,⁶ a fact that had important implications for the condom distribution and safer sex campaigns.

Trainers reported that the topic of dry sex initially met with a stony silence from participants, particularly black women. After many unsuccessful attempts to discuss this, trainers decided to change their methodology. Rather than simply provide information, they attempted more group discussion without feedback, identifying older black women who were willing to discuss the issue, utilising the skills of older black women and men who were prepared to speak out against the practise, and using focus groups to gain access to the issue. These attempts proved successful in that participants started opening up about the issue. This led to more detailed and interesting discussions, which allowed participants to develop their own ideas and strategies about dealing with dry sex in day hospitals and clinics.⁷ Many older female and a few male health care workers included a discussion of dry sex in their pre- and post-test HIV/AIDS, and STI (sexually transmitted infections) counselling and education. Numerous examples of successful education and behaviour change interventions were reported in both female and male patients.⁸

This issue is by no means over, and Southern Africa needs to deal with the wider economic, gender, power, and legal issues in order to change this practice, and significant related issues like gender-based violence. It is important to note that some training organisations have been proactive and innovative in beginning to help health care workers understand and manage these problems.

¹ Sydney J. Lachman, *A Knowledge Base of Heterosexual HIV/AIDS as a Global Problem in the 21st Century: a Guide for Medical Practitioners and Health Care Workers* (Houghton, South Africa: Pharmaceutical Society of South Africa, 1999); S. Ray, N. Gumbo, and M. Mbizvo, ‘Local Voices: What Some Harare Men Say About Preparation for Sex’, *Reproductive Health Matters*, 7 (May 1996), 34-45.

² L. van der Poll, ‘Formulating an Appropriate Legal Response to Dry Sex and Virginity Testing Within the Discourse on Sexuality and Human Rights in Africa’, conference paper, IASSCS International Conference: Sex and Secrecy, University of the Witwatersrand, South Africa, 22-25 June 2003.

³ M.E. Beksinka, H.V. Rees, I. Kleinshmidt, and J. McIntyre, ‘The Practice and Prevalence of Dry Sex Among Men and Women in South Africa: A Risk Factor for Sexually Transmitted Infections?’, *Sexually Transmitted Infections*, 75/3 (1999), 178-180.

⁴ A. Baleta, ‘Concern Voiced Over “Dry Sex” Practices in South Africa’, *Lancet*, 352/9136 (1998), 1292.

⁵ K. Kun, ‘Vaginal Drying Agents and HIV Transmission’, *International Family Planning Perspectives*, 24 /2 (1998), 93-94.

⁶ D. Civic and D. Wilson, ‘Dry Sex in Zimbabwe and Implications for Condom Use’, *Social Science and Medicine*, 42/1 (1996), 91-98.

⁷ Health Care Workers, Community Clinics, Interview, May 2001, Cape Town.

⁸ Lifeline HIV/AIDS Counsellors, Khayelitsha HIV/AIDS Project, private communication, September 1999, Cape Town.

Teaching ethics

Teaching ethics was one of the most complex and challenging tasks for HIV/AIDS training organisations.¹ HIV/AIDS raises unique ethical deliberations, which encompass the four principles of medical ethics, patient autonomy, beneficence, non-maleficence, and social justice.² Organisations begun dealing with these issues in 1989 and by the end of 2003 some of these issues were still unresolved. The problems lay in the presentation of specific issues like confidentiality, partner notification, and employment laws.

Many health care workers reported problems with what they perceived as the clash between protecting the patient's confidentiality and protecting partners at risk, as well as family, community members, and employers. This unresolved debate is well known in HIV/AIDS circles, and yet training organisations were not prepared for the resulting difficulties when presenting this content. Organisations attempted to implement changes in both content and methodology, but without much success. Trainers argued that it seemed that there will always be those participants who accept the HIV/AIDS laws and those who do not. The reasons for this are complex. One, in a culturally and geographically diverse country like South Africa, there are often different traditional markers for the same ethical problem. That is, some rural groups are more community-oriented, while other urban groups are more individual-oriented. In looking at partner notification, for example, the former favour community or group human rights (the partner, the family and the community), the latter favour individual human rights (the patient). Two, one organisation also works on the belief that teaching HIV/AIDS ethics requires patience because, given the extensive history of human rights abuse in South Africa, participants are naturally going to be more sensitive to abuses on both sides of the debate, that is to both communities and individuals.

The teaching of ethics raised human resources problems.³ Few trainers wanted to present this content because of what was considered troublesome content and challenging delivery. As a result external trainers were sometimes brought in and subsequently there was no professional development of the organisation's trainers in this particular field.

There were some positive reports about the teaching of ethics. First, trainers reported that some health care workers only truly grapple with this issue when they make their first ethical mistake. This is obviously not ideal because of the legal implications for the health care worker, but support, supervision, and advice structures were set up by some training organisations to assist the health care workers. Second, other health care workers were frightened into action by the legal implications of not following the law. This is also not the best reason for implementing policy, but it did seem to work. Third, organisations accessed resource material that health care workers could buy and keep on hand in order to guide good practise.⁴ Fourth, organisations encouraged programs like couple HIV counselling in which the issues of confidentiality and partner notification were explored. While there were problems with these programs, like the unwillingness of patients (particularly men) to present with their partners, some organisations trained counsellors who were successful in dealing with the ethical issues with the couple sitting together in the counselling room. Fifth, organisations made significant training contributions to areas like HIV/AIDS and employment, and HIV/AIDS and women.

¹ Trainers, ATICC, Focus Group, February 2001, Cape Town.

² Satish Bhagwanjee, David Muckart, Prakash Jeena, and Prushini Moodley, 'Commentary: Why Did We Not Seek Informed Consent Before Testing Patients for HIV', *British Medical Journal*, 314 (12 April 1997), 1082.

³ Manager, ATICC, Private Communication, January 2001, Cape Town.

⁴ For example, AIDS Law Project, *HIV/AIDS and the Law* (Johannesburg: University of the Witwatersrand, 1997).

Finally, various organisations played an important role in the HIV/AIDS training of ethics. For example, in May 1997, the AIDS Law Project and Lawyers for Human Rights published *HIV/AIDS and the Law*.¹ This publication provided important information for health care workers: for example, checklists and recommendations for health care workers, with respect to partner notification. One group that played an important role in providing strong ethical messages was the Treatment Action Campaign (TAC). The TAC was launched on 10 December 1998. Its objectives were to "campaign for greater access to treatment for all South Africans, by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments."² Health care workers were aware of, and supported the TAC. Trainers reported that, from 1999 onwards, participants increasingly asked questions about the TAC and its objectives, and used the TAC as a reference point for ethical guidelines, treatment and policy development.

Changing perception of training organisations

Training organisations initially saw themselves as providing basic HIV/AIDS information and combating denial. Within two or three years, their advocacy and skills development roles came to the fore. By the mid- to late-1990s, training organisations began promoting and providing training for specific prevention and treatment strategies. For example, the Prevention of Mother-to-Child Transmission (PMTCT) program (1998), the Voluntary Counselling and Testing (VCT) program (2000), and the roll out of the antiretroviral (ARV) program (2003).³

Trainers stated that expectations and demands from government, health sectors, and the public have increased from about 1998.⁴ Training organisations were now expected to be actively involved in a wide range of issues. For example, they needed to be involved in, or at least be aware of, issues like multisectoral HIV/AIDS responses with its focus on capacity/human resources development, care and support, children, conflict, education, democracy and governance, and economic development and microfinance.⁵ This increase in involvement led to staff specialisation, a high rate of reworking and turnover of material, and ongoing discussions about the presentation of material.

Recruitment, training, and capacity development of trainers

Many of the first trainers claimed that they ended up in HIV/AIDS training by default or because it sounded interesting.⁶ Almost all of these trainers entered the field in the late 1980s or early 1990s with no HIV/AIDS experience; some had training experience in health or human resources. These trainers were trailblazers, writing training material and developing courses from scratch. They had very few resources and almost no comparative training courses.⁷

Trainers reported that strong leadership, that is, training managers and directors, played a vital role in providing strategic direction, not only to the training organisations, but

¹ The AIDS Law Project and Lawyers for Human Rights, *HIV/AIDS and the Law* (Johannesburg: University of the Witwatersrand, 1997).

² 'About TAC', <<http://www.tac.org.za>> (Accessed: 2 August 2004).

³ Certain training organisations have been very successful at positioning themselves at the heart of these initiatives by ensuring that they are part of all strategic program development, training, and assessment.

⁴ Trainers, Various Organisations, Focus Groups, January 2000-June 2000, Cape Town.

⁵ UNAIDS, 'Multisectoral Responses to HIV/AIDS: A Compendium of Promising Practices from Africa. USAID-PVO Steering Committee on Multisectoral Approaches to HIV/AIDS', (April 2003).

⁶ Trainers, ATICC, Interview, December 1996, Cape Town.

⁷ It is important to note that the same process was happening independently in other HIV/AIDS sites in South Africa, for example, Kwa-Zulu Natal and Gauteng.

also to those attending the training courses. These strategic directions influenced training content and methodology and ultimately changed prevention and treatment practises.¹

After five or so years of staff stability, there was a sudden turnover of staff, a pattern that has continued to this day. One manager described the early days as pioneering days when people stayed in their jobs because they felt a commitment to fighting the epidemic.² The reasons for staff leaving after five years were that many felt that the field was becoming too complicated and politicised; there were too many players; there were no clear career development paths; and working with HIV/AIDS was too exhausting and overwhelming.

Some directors and managers were sensitive to these reasons for trainers leaving the field, and they made changes to ensure staff continuity. These changes included the establishment of: (1) career path development, (2) greater diversity in job descriptions, (3) increased networking and involvement in external task groups and committees, (4) management training, (5) advanced skills development, (6) coaching, (7) caring for the carer through interventions like staff support groups focussing on psycho-social and occupational stress, and (8) regular strategic planning. From an organisational development point of view, these organisations were coming of age. They were no longer small, limited organisations but growing and increasingly complex organisations. This growth suited some staff but not others. Since the late 1990s, most training organisations have specialised in various areas of HIV/AIDS like counselling, programme management, and treatment. By 2003, most organisations were employing at least double the number of trainers than they were in the early 1990s.

The final point deals with the recruitment of trainers. Since the mid-1990s, there has been a huge response to any advertised post for an HIV/AIDS trainer. Most organisations realised the importance of offering first language training, and thus made an effort to recruit suitable Xhosa, Afrikaans and English trainers. This made a huge difference to both the content and methodology employed by organisations. They now have parallel courses in three languages, and the content and methodology might all be slightly different from each other depending on the target training group. This resulted in more complex and interesting training, as attested to by training assessments and trainee feedback. Trainees have requested more first language training from trainers drawn from their own, or similar, communities.

Before moving on to the conclusion, an observation regarding a community acceptance model shall be made. Having completed an analysis of factors contributing to the shifts in content and methodology, it was noted that there is a useful model that helps explain community and individual responses to HIV/AIDS being spread as multiple epidemics. This is the Business Exchange on AIDS and Development (BEAD) Group's Sequence of Changing Behaviour Model.³ This model argues that communities go through four stages – Invisible Epidemic, Awareness, Acceptance, and Behaviour Change – in changing their behaviour in response to HIV/AIDS.

First, *Invisible Epidemic* – In this phase, the community is not interacting significantly with the epidemic, and, for the most part, refuses to accept that HIV/AIDS exists. This phase is characterised by many conspiracy theories of why those in power want us to believe in a fictitious disease. Psychologically, this predictable and adaptive denial is usually associated

¹ In 1995, the AIDS, Training, Information, and Counselling Centre (ATICC) agreed to take on 4 of the 5 Provincial Key HIV/AIDS Strategies. ATICC managed the following strategies: Syndromic Management of STIs, Media/Condom Distribution, Lifeskills, and Counselling. ATICC made changes to their training content and methodology in order to incorporate these strategies into their courses. This initiative was successful in orienting health care workers to the key provincial strategies.

² Manager, ATICC, Interview, June 1995, Cape Town.

³ Barbara J. Heinzen, 'The Business Exchange on AIDS and Development (BEAD)', *AIDS Analysis Africa* (Southern Africa Edition), 5-6 (April/May 1995), 4-5.

with shock. That is, an individual or community will cope with the news of something negative by initially acting as if they have not heard about it. This is normal in that it provides the person or community time in which to filter and make sense of the shocking news. The problem arises when this denial becomes habitual and continues indefinitely. This can result in sudden upward trends in HIV transmission because the individual or community is practising unsafe sex. If one does not believe in the existence of a disease, why take precautions? The underlying assumption of this phase is “There is no problem.”

Second, *Awareness* – The community accepts that HIV/AIDS might exist, but they argue that it only exists in other communities, despite friends becoming ill and dying. These other communities are usually of different cultures, religions, or socio-economic groups. Implicit in this view is that the community in question deserves the presence of HIV/AIDS because of its difference. This phase, like the first phase of denial, contributes to increased transmission because of unsafe sex. The underlying assumption of this phase is “There is a small problem, and it exists in other communities.”

Third, *Acceptance* – The community now takes another step towards individual behaviour change by beginning to accept that HIV/AIDS is a problem. Acceptance and care in the community become more prominent. This phase, like the first two, sees no significant change in sexual behaviour, and transmission of HIV continues. The underlying assumption of this phase is “The problem exists, but not for anyone close to me”.

Fourth, *Behaviour Change* – The community is finally pushed to complete acceptance of personal risk factors and individual behaviour change. That is, the community can understand that anyone who is sexually active is at risk, despite what the person believes about the quality of trust in the relationship. For example, trainers reported that many participants, especially in the first few years of training, reacted strongly to the suggestion that persons in a marriage or a long-term relationship are, theoretically, at risk to HIV/AIDS. Trainers argued that some participants found it difficult to fully accept that there might be a past, present, and future risk of HIV transmission in any relationship. According to this model, this kind of response would place the participant in phase 3 (acceptance) rather than phase 4 (behaviour change). The underlying assumption of this phase is “HIV/AIDS is a serious problem, and anyone who is sexually active is potentially at risk.”

This model argues that very few communities get to phase 4 (behaviour change); at best, some individuals within communities might reach this phase. This conclusion, as disturbing as it is in terms of transmission rates, is backed up by what safer sex campaigners have referred to as the ceiling of those practising safe sex. That is, not every sexually active person will continuously practice safer sex. This model can assist training organisations understand the participants’ and patients’ acceptance of HIV/AIDS.

Conclusion

The historical analysis of HIV/AIDS training highlighted the significant shifts in content and methodology in the last fourteen years, and the factors contributing to these shifts. It also illustrates the complex interaction between the various contributing factors that influence the success of training programs. On a more fundamental level, this study shows the important role played by training organisations in the preparation and development of health care workers in the fight against HIV/AIDS.

Such analyses have important implications for practice and research. The high prevalence rates of HIV/AIDS in Southern Africa forced training organisations to work as quickly and efficiently as possible in delivering training to health care workers. Most training organisations have managed to establish innovative and practical training courses, and the history of how this was achieved can be used to assist organisations in other parts of the world

in designing, delivering, evaluating, and managing training. The findings of this study are useful in guiding future HIV/AIDS training, as well as the importance of historical methodology to HIV/AIDS research. Various areas of HIV/AIDS research await the attention of historians.

The relationship between the HIV/AIDS training organisations and the provincial government is complex and unexplored. Further research is needed to investigate the sustainability of training organisations without the consistent support of central government. Related to this issue is the lack of historical research on the interaction between policy formation and training organisations. There are variations in how different health care workers are trained and interact with HIV/AIDS management. Further research is needed to examine the roles and experiences of specific professions working in HIV/AIDS, e.g. the current research being conducted on South African physicians treating people with AIDS.¹ Also, it would be useful to conduct historical research of the experiences of those largely silent persons like home-based carers and mothers of AIDS orphans.

This study is limited in that one region in South Africa was analysed, and thus the results are not representative of the whole country. There are regions with significantly higher prevalence rates, e.g. Kwa-Zulu Natal, which might show different shifts and contributing factors. Similar comparative historical analyses would be interesting if conducted in other Sub-Saharan countries with high incidence rates, e.g. Botswana and Swaziland, as well as in countries elsewhere in Africa and the rest of the world with low, concentrated, and generalised epidemics.

¹ For example, the current research being conducted by Ron Bayer and Gerald Oppenheimer; authors of *AIDS Doctors: Voices of the Epidemic: Voices from the Epidemic* (New York: Oxford University Press, 2000).

