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From the Editor

The mixed bag of articles in this bumper issue of AIDS Analysis Africa Online attests to how many big challenges there remain in managing HIV and AIDS in business and broader society. In this issue we tackle some tough questions: is anti-retroviral therapy working in companies?; what are the main concerns being raised around the recent antenatal HIV survey?; how is a bargaining council responding to HIV and AIDS? does being married protect people from HIV?



Together we can
beat HIV & AIDS

Whilst all of our contributors are all well-versed on the issues they tackle, I am particularly proud to introduce Nathea Nicolay who will be a permanent feature writer for AAAO going forward. Nathea is a colleague who has earned her stripes as an AIDS actuarial consultant for Metropolitan Employee Benefits. She has a reputation for tackling the 'number crunching' stuff with sensitivity and a keen sense of what the stats mean in the real world and in the lives of the people they represent. We welcome her two articles in this edition and the many future contributions that she will make.

Don't forget to visit the **AIDS Analysis Africa Online** website at www.redribbon.co.za for archived articles, statistics and reports on HIV/AIDS in sub-Saharan Africa.

Gillian

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If you would like your contact details to be added to our mailing list for notification of the latest edition of *AIDS Analysis Africa Online* or news about upcoming events, please email aidssolutions@metropolitan.co.za or call +27 21 940 5883.

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Has anti-retroviral treatment worked for companies?

By Nathea Nicolay



Employers who have been rolling out anti-retroviral treatment (ART) in the workplace are asking themselves an important question: Has anti-retroviral treatment worked for my company? Employers who are considering paying for treatment for AIDS sick workers or who have been forced to provide ART through the new prescribed minimum benefits for medical schemes, would also like to know whether the provision of treatment is cost-effective.

Five years ago consultants were crunching numbers for financial directors showing that it is cheaper to treat HIV positive employees than to allow them to die. Many of the bigger companies in South Africa went ahead with treatment whether it was financially motivated or motivated as a sustainable human resource practice. Whatever the reason for treatment in the workplace and specifically for the provision of employer-sponsored anti-retroviral treatment, it would be interesting to establish whether a nett saving has indeed been made.

By far the biggest cost saver upon the introduction of anti-retroviral treatment in the workplace is the reduction in death and disability benefits. In a recent study by Metropolitan for a Gauteng-based organisation that has introduced widescale HIV and AIDS treatment in 2001, it was calculated that an 83% saving in the cost of deaths benefits and a 72% saving in disability benefits have been incurred in 2005 alone. These figures were established through an actuarial impact assessment that compared to the cost of employee benefits under a "No Treatment" scenario to those under the current treatment scenario. Although the organisation is still experiencing AIDS deaths due to the fact that not all HIV positive employees have joined the treatment programme or have joined the programme in time, these savings far outweigh the cost of the disease management programme that was made available to employees.

In addition to the employee benefit cost, savings have also been incurred in human resource costs and medical costs. A 50% saving in training costs was visible in 2005 whereas sick leave costs have been reduced by 10%. The reason for the relatively low reduction in sick leave costs is the relatively large numbers of employees who are on anti-retroviral treatment who are assumed to take on average 12 days sick leave per annum. Those who are AIDS sick though are assumed to take up to 35 days sick leave per annum. It is therefore obviously more cost-effective to encourage HIV positive employees to join the disease management programme long before they become eligible for anti-retroviral treatment in order to prolong the onset of the final stages of the disease.

HIV and AIDS related medical costs have also reduced by 21% for 2005 alone due to an effective disease management programme. The costs associated with the treatment of opportunistic infections for an AIDS sick employee far outweigh the cost of anti-retroviral treatment.

Another interesting observation from this study is that although the take-up of AIDS sick employees at the outset of the programme (2001) was as high as 96% of those estimated to be eligible for treatment, it has reduced slowly over time. The reason for the lower take-up of AIDS sick employees on anti-retroviral treatment is that the rate of employees falling ill due to AIDS is higher than the rate of employees joining the AIDS sick programme. It is therefore important for an employer to encourage all HIV positive employees to join the disease management programme as soon as they become aware of their status.

Awareness of one's HIV positive status has been a controversial issue in the South African workplace. Voluntary counselling and testing (VCT) campaigns have shown to be only partially effective in ensuring that every employee knows their status. VCT campaigns normally have a take-up rate of around 35% - 45% which still leaves a big percentage of the workforce that are possibly ignorant of their status because they feel they are not at risk and therefore have no need to test or who may suspect that they have HIV but are too fearful to get tested. Some progressive companies in South Africa have however commenced with compulsory counselling and voluntary testing which ensures that every employee is aware of the basics of HIV and AIDS; that people understand what the test result means and their medical and lifestyle options whether they test positive or negative. The promotion of healthy living to people who test positive, at the point of early diagnosis, has ensured good health outcomes later and has contributed to their prolonged life expectancies. Compulsory counselling and voluntary testing campaigns have shown to encourage as high as 85% of a workforce to come forward and take an HIV test.

An actuarial impact assessment can also provide an indication of further savings should a higher percentage of people join the disease management programme. These savings are in addition to the current and future expected savings that a company has incurred as a result of the current percentage of HIV positive employees on the disease management programme. For instance the Gauteng-based organisation can increase the savings on HIV related training costs to 87% from 50% and the HIV related medical costs to 39% from 21% in 2005 should as many as 85% of the AIDS sick employees join the disease management programme. This comparison between the “No Treatment”, “Status Quo” and “Effective Treatment” scenarios is a very useful tool to measure the relative likely success of a company’s HIV and AIDS intervention programme over time. Estimated HIV positive employees, AIDS sick employees and employees on treatment are projected into the future for each scenario, thereby creating a clear picture of what the employer can expect. Linking these figures to the various HIV and AIDS related costs, projections can also be made for future employee benefits, human resource and medical costs related to HIV and AIDS.

Analysing the savings of HIV and AIDS related costs for different companies throughout South Africa, Metropolitan has observed a wide range of workforce epidemics. For some companies that are mostly based in the Western Cape for instance, the bulk of the HIV and AIDS related savings are still to be made in the future due to the fact that the epidemic is lagging behind that of other provinces that are already seeing widespread sickness and death. For companies in Gauteng, the bulk of the savings have already been made, provided that treatment was in place,



due to the relatively mature epidemic in this province. Companies in Gauteng who have not introduced workplace treatment programmes can however still save on employee benefits, human resources and medical costs, should they decide to make treatment available. It should be noted though that these companies would already have incurred huge HIV and AIDS related costs as a result of increases in group life assurance premiums and sick leave. Companies that have not noted these costs, would either have experienced an increased staff turnover, or their employees would have a higher average salary and different profile than those in industries where HIV prevalence is relatively high. It is discouraging to note that companies operating in the province in South Africa where the HIV and AIDS epidemic has had the biggest impact, namely KwaZulu Natal, have been the least pro-active in introducing HIV and AIDS disease management programmes.

Some companies still hold the naïve view that a levelling off in their death claims under group life insurance is an indication of the success of their workplace health programmes despite their death rates being twice as high than other companies in related industries. Firstly a levelling off of deaths is expected in a mature epidemic when the rate of deaths and the rate of new infections converge. In the initial stages of an epidemic, the rate of new infections is higher than the rate of deaths thereby resulting in an exponential growth in numbers of HIV positive people. As the death rate increases, the infection rate decreases until the two are more or less equal, resulting in a levelling off of the numbers of HIV positive individuals. Secondly, an HIV and AIDS workplace programme can only be labelled as successful if the numbers of deaths reduce immediately and visibly upon the introduction of treatment.

Many companies in South Africa are small and medium-sized enterprises that cannot afford to provide medical scheme benefits or a disease management service to their employees. These companies can however offer voluntary counselling and testing as well as a clear HIV and AIDS policy and a comprehensive education programme to their employees. Local government clinics should be able to provide anti-retroviral treatment free of charge, but the reality is that many of these clinics do not yet have the infrastructure in place to provide testing and treatment. Companies can meet HIV positive employees halfway by funding the testing and assisting them in obtaining treatment from government.

For those bigger companies who have been running an HIV and AIDS treatment programme for the past few years, the answer is clear, anti-retroviral treatment is cost effective. Savings in HIV and AIDS related employee benefits; human resources and medical costs have far outweighed the cost of treatment.

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The BCCCI HIV/AIDS Project: Pioneering the way forward for a Bargaining Council approach to mitigating the impact of HIV and AIDS at an industry level.

by Genieve Lemmon

Subsequent to the signing of a memorandum of understanding on the 21st of July 2004, the Services SETA, SABCOHA (South African Business Coalition on HIV and AIDS) and the BCCCI (Bargaining Council for the Contract Cleaning industry in KZN), have actively engaged in implementing a comprehensive and integrated HIV/AIDS strategy for the Contract Cleaning Industry in Kwa-Zulu Natal. Currently this initiative is the first of its kind within Bargaining Councils and has provided a platform and learning opportunity not only for other Bargaining Councils but for especially vulnerable communities and industries as well.



The intention of all parties is to strengthen the capacity of the contract cleaning industry in Durban, in respect of programmes aimed at mitigating the impact of HIV/AIDS, improving the use of resources, and increasing productivity.

Key underlying principles which have contributed to the various stakeholders reaching this common vision have been:

- inclusivity, reciprocity, mutual respect and equity in achieving the goals established by the partnership;
- promotion of learning and the use, or development of local skills, expertise and products;
- leveraging of individual parties particular skills and capacity to enhance development in the private sector in South Africa;

Key areas which were identified for co-operation in the initial first six month phase of the project are:

- Policy development and review;
- Assessment and benchmarking;
- Employee Awareness
- Capacity building and training;
- Employee assistance programs;
- Treatment and evaluation.

As a means to meeting the requirements of all parties, international best practice guidelines, as well as guidelines from the Services SETA EAP Programmes and SABCOHA toolkit were used through a consultative process to develop a recommended industry policy document.

The age old adage you can't manage what you can't measure lead to a comprehensive assessing and benchmarking investigation into the status of HIV/AIDS within the contract cleaning industry in KZN. Results of the Sero-Prevalence and KAP surveys conducted thus far have rendered a devastating picture.

When including all three company sites, a total of 85 (33%) of the 256 employees who participated in the study were found to be HIV positive. Therefore, the finding from this study that one in three employees is HIV infected ranks this industry as one of the highest risk work environments yet described in South Africa

Some of the important issues that the report highlights are the following:

- The majority of employees knew the basics about HIV and how it is or is not transmitted. However, the levels of knowledge are superficial which is demonstrated by the fact that only about two thirds of employees knew that a mother could transmit HIV to her child
- There is also a hard-core 20% of employees who do not believe that HIV causes AIDS.
- Condom use remains inconsistent among contract cleaning employees and even when engaging in sex with an irregular partner, less than half used a condom during the last sexual encounter.
- The fact that almost a third of respondents believe that they can recognise someone with HIV is of concern because such people show a lack of knowledge about the illness and may also not protect themselves adequately if they believe that they can tell if someone is infected

- A significant proportion of employees still have conservative attitudes towards women's rights.

The report confirms the suspicions that the council has had with regards to the extent of infection within the contract cleaning industry. While these results are not in and of themselves a full picture they do give some indication as to the severity of the problem. The statistics reported certainly are grave cause for concern and highlight the need to embark on a full cost impact analysis within the industry, which is to be done as part of the second phase of the project. On a more positive note the uptake of VCT during this process was extremely high, in the large company 95% of those who participated in the sero-prevalence survey chose to participate in VCT as well.

The findings of the report add validity to the activities in which the BCCCI Project has already engaged and supports the continuation of the project. To date over 130 AIDS ambassadors have been trained to train and educate their peers on the basics of HIV and AIDS. In addition to this the AIDS Ambassadors serve as a referral and networking mechanism for the 2 EAP centres which have been set up to provide VCT, lifestyle management and counseling. Feedback from both participants on the training as well as from the training facilitators has indicated an extremely positive response to the training and 100% of participants who have attended have indicated their willingness to engage in further education and training. While grassroots level training is important, it cannot exist in isolation and in order to further capacity build organisations the council has over the past 5 months employed a master trainer on a full time basis to provide ongoing support and management training. The management training component of the programme has been both managerially supported and co-funded by InWEnt Capacity Building International, Germany. The master trainer has run 5 training courses to date and feedback on both quality and relevance has been exceptional.

The funding for the project has been extended through SABCOHA for a further six months and as part of the second phase of the project the master trainer will be auditing and evaluating the implementation of best practice principles and workplace programmes.

Given the successes of the project, discussions have begun with the Department of Health, to initiate a pilot condom distribution project, using the contract cleaning industry as the distribution agent. Again such a pilot would be the first of its kind and is certain to produce useful and value adding insights and services.

While the project is a work in progress, the learnings with regards to implementation at an industry level as well as within such a fragmented and vulnerable sector have been of huge importance. It has been the privilege of the project to share these learnings at the National Association for Bargaining Councils AGM in August of last year, as well as with the Food and Bev SETA last October and it is the intention to continue to build a working model which can be applicable across all bargaining councils.

Genieve Lemmon is the Project Manager for the Bargaining Council for the Contract Cleaning Industry. As a qualified psychologist, over the last four years, she has specialised in HIV/AIDS strategic visioning and project roll-out at an industry level working in particular with bargaining councils within the cleaning, manufacturing and engineering industries as well as the garment industry in Lesotho.

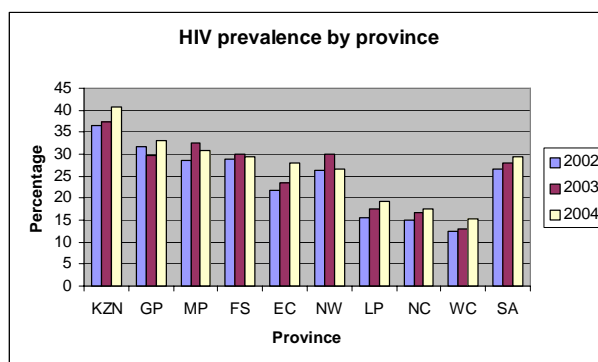
National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2004: a commentary

By Nathea Nicolay and Arlene Georgeson

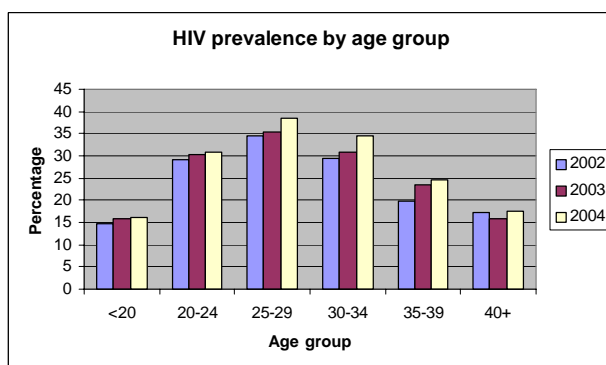
The HIV prevalence (percentage HIV positive) amongst pregnant women attending antenatal clinics has increased to 29.5% in 2004 from 27.9% in 2003, and 26.5% in 2002. These statistics were reflected in the new antenatal sero-prevalence survey for 2004 which was released on 8 July 2005. The results of this survey are based on antenatal blood samples that were taken from pregnant women attending public antenatal clinics. The Department of Health has been conducting the surveys since 1990.



The prevalence by province shows that there has been a statistically significant increase in prevalence in KwaZulu-Natal (36.5% 2002, 37.5% 2003, 40.7% 2004), Gauteng (31.6% 2002, 29.6% 2003, 33.1% 2004) and the Eastern Cape (21.7% 2002, 23.6% 2003, 28.0% 2004). This means that for these three provinces the 2004 HIV prevalence fell outside the upper level of the HIV estimate of 2003. The HIV prevalence rate is normally given as a midpoint within a confidence interval or uncertainty band with a lower and upper limit.



Other provinces that have shown an increase in prevalence include Limpopo, Northern Cape and Western Cape. Gauteng has not shown a consistent increase over the three year period and the Limpopo, Northern and Western Cape increases are not statistically significant. Provinces that have shown a decrease include Mpumalanga, Free State and North West, however these can also not be considered statistically significant and can be as a result of bias of the specific sample.



As can be seen from the above graph, the age group 25-29 is currently the highest risk group in pregnant females (38.5%). There has also been a significant increase in prevalence in the age group 30-34 (34.4%).

Comments on the Survey:

- The National HIV antenatal sero-prevalence survey is one of the most important sources of data for the modelling of national HIV and AIDS statistics. Both the Doyle model and the ASSA2002 AIDS and demographic model use these HIV prevalence figures to estimate population HIV prevalence. These models allow for the bias in the survey data as a result of the fact that all women tested were sexually active (they were pregnant) and they attended public antenatal clinics.
- The publication of the 2004 survey results have been met with widespread controversy due to the fact that the Department of Health used the data to estimate the total number of HIV positive individuals in South Africa at 6.29 million.

- We do not agree with the estimated numbers of individuals in the general population as stated in the report. We consider the **antenatal HIV prevalence** study as scientifically sound and reliable, but do not however agree with the assumptions used in the modelling of the HIV prevalence in the **general population**. The reasons for this are as follows:
 - The report basically stated that the HIV prevalence rate in ALL women aged 15 to 49 year old is the same as the HIV prevalence in pregnant women attending antenatal clinics. This assumption is clearly unreasonable because not all women in this age group are sexually active and not all women attend public antenatal clinics.
 - The estimate by the Department of Health of people living with HIV (around 6.29 million) is much higher than that of the ASSA2002 model (5.2 million). The latter is more reliable as it uses mortality statistics from Statistics SA to refine the numbers.
 - The estimate from the Department of Health is higher than both those of Statistics SA (4.5 million) and Dr Olive Shisana (5.6 million) from the HSRC.

- Metropolitan is currently using the ASSA2002 AIDS and demographic model to estimate the level of the HIV epidemic in South Africa and our 2005 mid-year estimates are as follows:
 - Total HIV positive women in South Africa: 2.8 million
 - Total HIV positive men in South Africa: 2.4 million
 - Total HIV positive individuals in South Africa: 5.2 million
 - Accumulated AIDS deaths in South Africa to middle of 2005: 1.5 million
 - AIDS related deaths in 2005 alone: between 356 000
 - Estimated AIDS sick individuals (in final stages of the disease): 590 000
 - Estimated HIV prevalence rate for total population (including elderly and children): 11%
 - Estimated HIV prevalence rate for working age population (ages 20 to 64): 19%
 - Current life expectancy at birth:
 - Males: 48 (as opposed to 57 in 1985)
 - Females: 52 (as opposed to 65 in 1985)

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HIV and marriage

By Shamola Pramjeeth

Many organisations around the world, including some governments, encourage abstinence before marriage as a means to stopping the spread of HIV. But where marriage was once considered a “safe haven” from contracting sexually transmitted diseases, and the use of condoms was superfluous, AIDS has changed the social landscape considerably. Studies and media reports indicate that there is an increase in HIV amongst married people.



Professor P. Denis at the University of KwaZulu-Natal notes that maintaining abstinence and being faithful to one's partner will help prevent HIV/AIDS⁸. However, abstinence especially amongst young men, and even women, has proven difficult to uphold. The high teenage pregnancy and HIV prevalence rates among the youth in South Africa indicate that abstinence has not been brought on board as a lifestyle choice amongst many young people.

Kofi Annan, UN Secretary-General says that it is a norm in developing countries for women to be married by the age of 20, yet they have higher HIV infection rates than unmarried, sexually active women⁸. Marriage is a major risk to women with low levels of education as a high number of HIV positive women were infected by their husbands who were their only sexual partners⁷.

According to a study by the HSRC, Dr. Olive Shisana notes that 92% of married women upheld abstinence or monogamy when their husbands were absent, but the majority of the men admitted to extramarital relations, thereby increasing the risk of HIV transmission to their spouses³. However, one needs to ask, can women always uphold abstinence in a marriage? Would this not lead to possible abuse as a result of suspicion of infidelity?

Studies often portray men as the “perpetrators” engaging in extramarital relationship, but women often engage in this behaviour. It is important to note upfront that there are not many studies on women increasing the spread of HIV, which unintentionally may render this review biased towards men.

Dr. Shisana indicates that marriage does not necessarily decrease the risk of contracting HIV. In her study, HIV prevalence amongst married people was 10.5% compared with 15.7% for unmarried people in South Africa. The study indicates that the relationship between marital status and HIV is influenced by socio-economic status, and the risk depends on various demographic factors and sexual behavioural practices.³

The UNFPA State of the World Population Report for 2004 revealed that in Tanzania the rate of infection amongst sexually active unmarried women was lower than that of young married women, while in Cambodia the rate of new infections among married women had increased from 11% to 46%, which was higher than that of prostitutes. Similar findings were found in Jamaica, where more housewives (169) than prostitutes (159) were found to be ill⁷.

According to the National Council for Women's Organizations, up to 80% of women who were infected while in long-term stable relationships, became infected through their partners who had sex outside the relationship or through intravenous drug use⁹.

Dr. Solomon, a pioneer in HIV/AIDS in India, says that 22% of HIV cases in India were of housewives with a single partner¹. However, Prof Mark Lurie has found that the direction of spread of the epidemic is not only from returning migrant men to their rural partners, but also from women to their migrant partners⁶, thus affirming that married women are also spreading HIV in their marriages.

Previously HIV was high amongst the uneducated, rural poor – rural married couples who got infected as a result of migration by the men to the cities, and the polygamy, and extramarital relationships condoned in some cultures, which ensued. This is not the case anymore. Educated, middle to high-income married couples (from all race groups) are equally at risk as they have enough money to “buy the HIV risk” as indicated by the rising curve of income and risk, says Dr. Olive Shisana. She goes on to say that men with money can buy sex and also have transactional sex i.e. they become “sugar daddies”².

Some of the reasons for the rise of HIV in marriage are premarital or extramarital sex amongst women and men, poverty, lack of education and resources, sexual mixing patterns, lack of condom use and HIV testing in marriages, financial dependence of women, socio-cultural norms that demand submissiveness from women in sexual matters, polygamy, fear of abuse and cultures that expect women to subordinate their needs to that of their husbands.

A Zambian study revealed that less than 25% of women felt they could refuse sex to their partner even if he had been unfaithful and was HIV positive⁹. According to a study conducted in India, 35% of the respondents reported having had extramarital sexual encounters, with more males than females engaging in these acts⁵. The study indicates further that with more males reporting premarital and extramarital sex, women who marry young are vulnerable to HIV/AIDS infection and other sexually transmitted diseases.

Condom use is widely encouraged and forms part of the public health strategy to prevent HIV infections. In marriage, condoms are seldom used. They are used as a method of contraception by some, but as a method of preventing HIV and other STI's, there is often the fear (usually amongst women) that insisting on condoms could raise feelings of suspicion, accusations of infidelity, and a possible violent reaction from her partner.

A survey among marital and cohabiting partners in KwaZulu-Natal found that 79% had never used condoms with their partners while 40% of men and 44% of women felt it was acceptable for married couple to use condoms⁴.

Due to the social, cultural and ethnic values and norms that surround sex, open conversation about sex and HIV, is taboo in South Africa and many other African countries. This is exacerbated by stigma and discrimination about HIV. How can a woman insist on condom use or HIV testing with this conservative, traditional and largely patriarchal backdrop? How can we ask her to risk the inevitable ostracisation and abuse?

As is evident in the research, where marriage may previously have been considered a barrier to contracting HIV/AIDS, in the age of AIDS, this is simply not true. There are abundant prevention messages, but stigma, denial, ethnic and cultural norms prevent many from adopting healthy, risk-averse behaviors. Developers of the HIV/AIDS awareness messages need to revise their strategies and come up with solutions to break the conservative barrier that exists in our society. It also remains for our role models – the many strong, influential African men that spread positive HIV/AIDS messages, to live by their words.

Shamola Pramjeeth holds a Master's degree in Commerce, specialising in research. She is a research assistant and a part-time lecturer in the Management Studies department at the University of KwaZulu Natal. She is currently involved in research in the following areas:

- HIV and its impact on consumer behaviour
- HIV and the role of alternative medicine
- A South African perspective of the growth of the complementary alternative medicine / traditional medicine industry - the threats and responses by the allopathic medicine sector

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a Metropolitan AIDS Solutions Communiqué

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The views and opinions expressed in this publication do not necessarily reflect those of Metropolitan. As always, we encourage responses on any of the issues covered.

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