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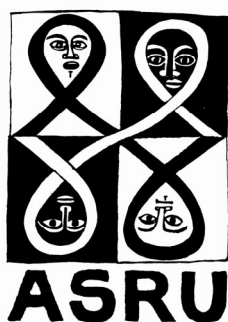


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**TREATMENT FOR HIV/AIDS IN THE
WORKPLACE: A CASE STUDY OF A
MINE IN BOTSWANA**

Fredah Medupe
Kathleen Collins

CSSR Working Paper No. 88



Published by the Centre for Social Science Research
University of Cape Town
2004

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Centre for Social Science Research
University of Cape Town
Private Bag
Rondebosch, 7701
Tel: (021) 650 4656
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Price in Southern Africa (incl. VAT and postage): R 15.00

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ISBN 1-77011-019-4

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CENTRE FOR SOCIAL SCIENCE
RESEARCH

Aids and Society Research Unit

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December 2004

Fredah Medupe is completing a masters degree in clinical social work at the University of Cape Town.

Kathleen Collins is a Senior Researcher in the Department of Social Development at the University of Cape Town.

Treatment for HIV/AIDS in the Workplace: A Case Study of a Mine in Botswana¹

Abstract

This research was conducted in mid-2003 on a cross-section of mine employees ranging from top management to the least skilled mineworkers in Debswana's Orapa mine in Botswana. The objectives of the study were to establish the perceived benefits that provision of anti-retroviral therapy has had on the mine at all levels and to identify reasons for slow enrolment in the newly established treatment programme. The first researcher is from Botswana and worked for 7 years with AIDS affected patients in hospital. It was this experience which alerted her to the importance of popular discourse regarding AIDS and antiretroviral treatment. Her subsequent research at the Orapa mine was designed to probe the nature of shop-floor discourse about AIDS. Interviews and questionnaires with open-ended and closed questions were used with five management personnel and 20 mineworkers of both genders. Findings reveal many discrepancies in the data surrounding HIV/AIDS and also indicate that formal research methods do not adequately capture the nature or importance of popular perceptions and discourses about AIDS.

HIV/AIDS in Botswana

Botswana, a country of 1.7 million people has the highest AIDS prevalence rate in the world, with 34% of Botswana's adult population infected with HIV (The National AIDS Co-ordinating Agency [NACA] 2002). In 2001, at least half of

The writers acknowledge the Centre for Social Science Research, University of Cape Town, for financial support for this research.

the natural deaths were from AIDS related diseases (NACA, 2002). Mining companies, particularly diamond mines which employ large numbers of workers, are for the most part vulnerable to AIDS-related productivity losses. According to a recent study of diamond mines in Botswana, 28% of the workforce was HIV-positive and 60% of deaths were caused by AIDS (Susman, 2001). Management was reportedly also concerned about the negative impact of AIDS mortality and morbidity on the morale and productivity of the remaining workforce (ibid). Given the importance of mining to the Botswana economy - diamond revenues account for over 80% of export revenues - the adverse impact of AIDS extends far beyond the level of the individual mine.

The Botswana-DeBeers (Debswana) diamond mining company, under joint ownership of the Botswana government and De Beers Company, employs over 6000 workers.

Treatment Policy at a Mining Company

The Orapa mine (which is part of the Debswana Company in Botswana) is an open pit diamond mine. It employs a total of 2,500 employees, all of whom live on the mine or in the village nearby. This means that their situation differs from the migrant mineworkers of South Africa on which most research has been conducted (e.g. Williams, 1999).

The company embarked on an anti-retroviral treatment (ARVT) programme on 14th May 2001 in order to extend the productive lives of its employees. Debswana paid 90% of the costs of the drugs and the government, through partnership with The Bill and Melinda Gates Foundation, paid the remaining costs. In addition to the provision of medication, an extensive awareness and educational programme for mine employees was put in place. The programme included training every 20th worker in peer education of health issues surrounding HIV/AIDS to boost general knowledge of these issues amongst the company. This initiative, which promotes health and safety policies and allows all employees and their spouses to benefit from anti-retroviral therapy, is an

example of a company holding the welfare of its workers at heart, as well as considering standards of productivity.

By providing access to life-prolonging medication, the project had the potential to instill a sense of hope amongst workers and management and to ensure that workers and their families lived longer and more productive lives. It also, perhaps, had the potential to lessen the stigma surrounding HIV-positive people and to encourage more people to test for the virus and make themselves available for treatment. The fact that the Botswana government also started providing free antiretrovirals through the public health sector (in January 2002) may also have been expected to promote greater awareness of and demand for treatment by people living with AIDS in Botswana. Yet the enrolment of workers in Debswana's treatment programme has been slow. By 2002, only 163 of the 1,242 estimated to be living with AIDS had been enrolled. (Knowledge, attitude, practice survey, 2002)

Research on Treatment

A number of studies point to the potential economic benefit of giving anti-retroviral therapy to employees in firms (Kennedy, 2002; Nattrass 2002; Rosen, 2000) but there are no studies as yet of the impact of AIDS and antiretroviral treatment on those companies that have already introduced antiretroviral therapy to workers in Africa. In the present study, the research questions investigated the possible benefits of a company's ARVT programme as perceived by its employees. Answers given to these questions by workers and by management are presented briefly below. A discussion on the discrepancies embedded in the answers follows thereafter.

Workers' Knowledge and Perceptions of HIV/AIDS Issues

The table contains questions and quantified answers.

Table 1: Knowledge and Perceptions on HIV/AIDS Issues

<i>Question</i>	<i>Yes</i>	<i>No</i>	<i>Don't know</i>
Do you consider HIV/AIDS a problem in your workplace?	70%	5%	25%
Is there a benefit in knowing your HIV status?	100%	-	-
Have you heard about the mine's ARVT program.	100%	-	-
Are you aware that the mine is providing ARVT	80%	20%	-
Does ARVT cure HIV infection?	-	100%	-
Can a person taking ARVT transmit HIV?	95%	5%	-
Because of ARVT are you less afraid of becoming HIV positive?	5%	95%	-
Is stigma a barrier to enrolment into the mine's ARVT program?	85%	15%	-
Is lack of confidentiality a barrier to enrolment into the mine's ARVT program?	90%	10%	-
Are you satisfied with management's way of handling HIV/AIDS issues in your work place?	80%	20%	-
Would you enroll with the mines ARVT program if you were HIV positive?	55%	45%	-

In answer to the question, “Do you consider HIV/AIDS a problem in your work place?” one quarter of interviewees stated that they did not know. “I don't know anyone suffering from AIDS,” said one person. Despite 5 respondents not knowing whether HIV/AIDS is a problem in their workplace or not, 100% stated that there was indeed a benefit to knowing HIV status because, for example, “I can be helped by treatment,” and “I can make plans for my family only if I know what is happening to me.” Although 100% had heard of the existence of the mine's ART programme, 20% were not aware that medication was being provided, indicating that the mine's extensive education programme was insufficient to allow all employees to benefit from policies already in place. “I don't have a peer educator so I don't know (that medication is being provided),” said one. Despite some being unaware of the provision of medication on the mine, all the workers responded correctly negatively to the statement, “Does ARVT cure AIDS?” Repeated company, government and media communication that treatment cannot destroy the virus, that medication does not cure but rather maintains a healthy state and has to be continued for the rest of

life, has clearly borne fruit with this issue. Only one person gives the incorrectly negative answer to: “Can a person taking ARVT transmit AIDS?” and another 95% answer “No,” this time appropriately to: “Because of ARVT are you less afraid of becoming HIV positive?” Education has here succeeded in conveying that the virus can be transmitted despite treatment. Only just over half the respondents state that they will use the mine’s treatment facilities. This does not contradict the previously expressed need to know HIV status; the remainder intends to find public or private facilities based outside the mine, or obtain traditional African medicine from the tribal healer *dingaka tsa setso*.

Is stigma a barrier to enrolment into the mine’s ARVT program? “Yes,” says 85% of this sample. “This is a bad person doing bad things since associated with sex.” “There is discrimination seen on pay slips.”² “They will see people queuing at the dispensary for drugs and laugh at them (for the misfortune of being ill with AIDS).” “Health workers speak to others (about those being treated for AIDS who can then be identified).” “This mine is too small and people talk a lot, what will they think of me? That I have been promiscuous.” Finding stigma a barrier relates necessarily to confidentiality, the lack of which in treatment at the mine is identified by 90% of respondents. With so many respondents aware of a lack of confidentiality in AIDS treatment at the mine, it is consequently difficult to understand why only one quarter of the sample blames management, who would be presumed responsible for ensuring confidentiality for their handling of HIV/AIDS issues in the workplace. The blame that is expressed, partially reflects a desire for management to be public in their own behaviour, thereby normalising the issues of awareness, diagnosis and treatment in living with AIDS. Some comments were: “Most employees who attend are in lower positions. Managers are not at all involved; they do not attend HIV/AIDS gatherings.” “Managers and white people get different drugs; they must get the same as we do (suggesting discrimination in the medical prescriptions for different race groups).” “Management must participate physically; those HIV positive should even go public so as to de-stigmatize HIV/AIDS.” Management however is rather seen as tending towards concealment by attempting to, “..... *keep the balance score card green* (representing absence of accidents).” It would be reasonable to question the respect for confidentiality in the programme’s policy by the accusations implicit

²The division of costs between company and government was recorded on the pay slip, allowing administrative personnel to have access to this information and to identify that the payee was HIV+

in two observations: “Records are not kept by doctors but at archives (where record staff have access to them and can identify patients).” “AIDS tests are last in the application of study sponsorship and then sponsorship is refused (the refusal denoting that the applicant is HIV+).”

Workers make several recommendations for improving compliance with a treatment programme in the workplace.

- Attach an incentive (money) for workers who undergo a voluntary HIV test from the mine and enroll for ARVT with the mine. This will be an encouragement to the workers and it will improve enrolment into the programme.
- Hire more staff for the hospital to avoid long waiting hours for consultation and long queues at the dispensary.
- Dispense ARV drugs in consultation rooms instead of publicly at the dispensary to protect the interests of those employees who may not desire to be seen at the dispensary.
- Because it seems as if top managers and white members of staff are given superior drugs, management should ensure that workers are given the same good drugs irrespective of position and race.
- Since health workers “leak out” information about medical conditions, health workers must be given extensive training on issues of confidentiality.
- Top management must have voluntary testing and counseling publicly so that other mine employees may learn from their example and be drawn to utilize the programme.

How does management itself view the company’s HIV/AIDS policy?

Management's Knowledge and Perception of HIV/AIDS Issues

In addition to quantitative questions on epidemiology and costs of the issues, the following qualitative questions were asked of management.

1. What managers' impressions were on the HIV/AIDS situation in their operations.
2. Managers' knowledge on the employees' understanding of ARVT benefit.
3. Measures in place to sensitize employees about ARVT benefit and to encourage enrolment into the mines' ARVT programme.

The benefit of Debswana's HIV/AIDS policy is well accepted by management, respondents consider themselves "aware and informed" of its principles and they promote its practices.

Economically, according to the analyses by Kennedy (2002), Nattrass (2002) and Rosen (2000), many companies cannot afford *not* to treat AIDS (especially with regard to their most skilled workers) and the present management is conscious of this kind of discourse, yet remains divided on the issue. There is strong opinion that the financial benefit is negligible and that the provision of drugs makes no difference to the company's returns. One respondent put it this way, "The motivation is not about increasing company profit but to improve the welfare of employees and their partners. It is all about public responsibility." However, there was also the recognition that providing antiretrovirals saves costs, for example, the cost of treating opportunistic infections. Several managers pointed out that bed occupancy in the mine hospital by mine workers has dropped, thereby saving the mine hospital costs and the costs of replacing the sick workers (Annual General Report, 2003). As one mine manager put it, "The cost of doing nothing will be much."

The official position for Debswana at the time of implementing the programme was that actuarial studies concluded that the cost of antiretroviral therapy exceeded the cost of doing nothing and that the equivalent of 10.7 per cent of the payroll would be required to provide antiretroviral drugs at the existing prevalence of infection (Susman, 2001). Although managers disagreed about the relative costs and benefits of providing antiretrovirals, they were all in agreement that the humanitarian benefit of their treatment programme far outweighs any disadvantage of its financial costs. Such comparisons between the nature of benefits are in fact considered unworthy in the context of company philosophy and principles. Respondents expressed with pride the fact that they are happy to be known as a company that cares so much for its employees to the extent of accommodating a high cost of treatment. They noted with gratitude that the health of those who had enrolled for ARV therapy had improved, and that some had returned to work to resume their duties. It would be reasonable to assume that the good will expressed by management in this research and readily recognized by an outside researcher, as well as being applauded in local and international media (Susman 2001), is also conveyed within the company to the employees.

Respondents are concerned about poor enrolment into the mine's ARVT programme, to the extent of informing the media that, "Management believes that the reason for the low registration is that most people do not know their status." (Orapa Weekly News May 14, 2003)

The percentage of employees who are utilizing the treatment programme is estimated at 20% of the total HIV-Positive group, which respondents acknowledge as unsatisfactory and to be addressed by continued and even more persistent peer education and communication strategies devised by management. Further objective evidence of the avoidance of treatment is that sick leaves and absenteeism by workers due to AIDS related illnesses are still as high as they were before inception of the programme although there is a decrease in the number of deaths (according to the doctor responsible for medical management at the mine).

Discrepancies in Findings

This study demonstrated that workers' knowledge of the virus is accurate and up to date, at least as expressed in the formal environment of question and answer (see Table 1). Research further afield has indicated that there is already sufficient knowledge of AIDS in most sub-Saharan countries and that a resistance to behavioural change cannot be ascribed to limited knowledge (Caldwell 1999). Consistent with these other observations, the extensive education embarked upon by Debswana described above, has also had good effect at a cognitive level as indicated by the responses to the questions. In analysis of the coherence of responses, several discrepancies between responses to questions, between words and behaviour and between constructions of meanings by management and workers can be noted in the data presented above. Firstly with reference to discrepancies between responses, we see contradictions surrounding the answers themselves as presented above by both groups of respondents. It is unlikely that workers were so well informed at a cognitive level (effects of the virus) on one hand and then unaware on the other (problems in living with the virus). It is more likely that they were reluctant to confront the problems of the virus in any personally involved way in the formal research situation. In addition, while aware of the efforts made by management to educate and provide treatment concerning HIV/AIDS (peer education, general knowledge of company policy) and while there is no direct blame of management (for lack of confidentiality), there is no reflection from workers of the good will expressed by management indirectly in being concerned about health and directly in being the first company in the country to offer expensive treatment. At management level we can see that expressed views of the economic value of the programme differ from official policy constructed by the very people who contradict it. These views were communicated not at all reluctantly in the study, for which only anonymity and not confidentiality were guaranteed, thus are likely to be in the forefront of consciousness for general discourse. It is consequently to be expected that contradictory messages concerning the value of the programme are communicated not only within the level of management itself but also from management to lower levels within the company and to the community outside the mine.

Secondly, referring to discrepancies between words and behaviour, informal discourse amongst workers on the mine suggests that once on treatment, the

patient is physically safeguarded and can live a sexually liberated life. Research questions probing this view refuted it as expressed in the answer to being “less afraid of contracting HIV because of ARVT.” Nearly all (95%) indicated that they continue to be afraid of contracting the virus. Integrating behaviour with verbal statement would lead to lifestyles of abstinence and safe sex. Yet, as an objective measure and inconsistent with an environment of safe sex, the incidence of sexually transmitted infections (STIs) on the mine is rising (Annual General Report 2003). The increase in STI’s is consistent rather with multiple sexual partnerships in the absence of safe sex.

The stigma attached to HIV/AIDS remains a major barrier to utilizing the ARV programme by workers. Two thirds of the respondents shared this view and related it to the publicity of promiscuity. Yet to be considered promiscuous is not a shameful epithet in traditional black culture. Schapera writes in 1940 on marriage and family life in the Kgatla of Botswana (then the Bechuanaland Protectorate), describing concubinage as the order of the day rather than polygamy and that adultery in both men and women was tolerated. More recent observations conclude that unprotected sex with many women, coupled with disregard for the consequences, contributes to the formation of strong male identity (Campbell, 2001). There is also evidence of an absence of guilt in a public discussion of sex amongst male mine workers (Dunbar Moodie, 2001). Accordingly, a construction of shame attached to a modern symbol of male promiscuity at least is dissonant with cultural value constructions. In this study there is no concern about disfavour or disrespect by mine management; the disparagement would come from ordinary co-workers in ordinary situations, the very people who are considered by discourse to be more commonly infected than those in superior positions. Objective evidence in this company is figures for AIDS infection, which are 30% in the workers as opposed to 20% in management (Susman, 2001). The disparagement at co-worker level spreads amongst those who would be sharing the same lifestyles and discourse on sex. Their fear is in the situation of being laughed at and subsequently shunned by fellow employees when seen queuing at the dispensary for drugs (see quotes above). The humiliation is associated with *being seen by peers to be ill*. Exactly what constitutes the shame surrounding illness has yet to be researched. But this is not likely to be associated with being branded as promiscuous if we follow the above argument.

While not being the source of discrimination, management is expected by workers to play a prominent role in reversing it. Management can publicly display that HIV is not a problem confined to subordinates but affects every person. Such demonstrations will carry weight in claiming equality in illness. Stigma will be reduced by these acts and people will more readily seek treatment.

Thirdly with reference to different constructions of meaning between management and workers, workers clearly require more involvement than management is offering to the programme. Again, the good will expressed by management in extending the treatment programme has not been processed by workers, who, while appreciating the benefits of ARVT, do not acknowledge company concern and efforts and even go so far as to suspect discriminatory medical prescriptions because management amongst white staff could be obtaining “superior” drugs on the programme, while workers as black staff receive a different, “inferior” kind. Management is not aware of this attitude which is not only based on perceptions of racism but which also reflects complete misunderstanding of the composition and efficacy of medication in a biological context.

Management thinks that workers do not want to know their HIV status. This opinion is contradicted by 100% of the respondents who agree with the importance of knowing one’s status. The benefits are seen as prolonging life and being able to plan for children’s and own future as well as preventing re-infection for self and others; all very realistic reasons indicating responsible attitudes towards self, dependants and society. The peer education programme appears to have been successful in improving knowledge and management is justly proud of establishing a system that is active and well received by employees. However, workers consider that the peer educators must be allowed to contribute to company policy on HIV/AIDS and not merely act as channels for distributing pre-structured information.

Concern related to stigma and corresponding lack of confidentiality in the mine’s ARVT programme are uppermost in workers’ minds. Their reasonable complaints are that the moment one enrolls on the program all co-workers will “automatically” know that they are HIV positive. For example, the

administration department will know from salary slips since the mine used to pay 90% towards ARVT drugs before the government took over paying the full amount and from here the word will spread.³ There is also lack of confidence in medical staff keeping HIV status secret. Fellow workers queuing at the pharmacy for drugs can in addition see patients. For these reason respondents said they would avoid enrolling with the mine's treatment programme. By management design from the outset of the programme, company policy acknowledged the importance of privacy of diagnosis and treatment and kept names confidential (Susman 2001). Unexpectedly then in this study, not one manager referred to the threat to confidentiality as a possible reason for low enrolment in the treatment programme. It is difficult to understand how such a distance between worker and management attitudes can exist in a practice which involves both groups in education and action, unless we acknowledge that discourse on the issue between two groups of employees at the company is different and separate.

The study revealed that HIV and AIDS remain a big problem to the mine. The fact that some employees, notwithstanding factually correct responses to the implications of AIDS on a questionnaire, want to be given incentives to test for HIV and to enroll for therapy, shows a distorted understanding of HIV as a health problem and of any sense of humanitarian intention by mine management. This kind of response suggests that the treatment programme was imposed on employees when they did not see the need themselves; another attitude which is difficult to understand in the face of sick and dying people in the close proximity of the workplace accompanied by constant written and spoken warnings. These discrepancies are interfering with better understanding of the nature of HIV/AIDS and with lifestyles which militate against disease.

Two future directions emerge from the data of this research. Firstly for action with a work-based treatment policy and programme, a participatory approach (Collins, 1999) involving interaction within company hierarchy is recommended. A start could be made with empowering peer educators to participate in planning and policy decisions, forming a link for management-worker communication and co-operation. Secondly for purposes of understanding discrepancies and the discourses that inform HIV/AIDS, we have

³ Although this is no longer the case due to a changed situation, it continues to be viewed as a practice denoting lack of care on the part of management

to prepare for more participatory techniques in the research process itself. When respondents become researchers themselves, they are able to recognize the value of research results and consequently feel encouraged to express their views more fully, coming closer to their own consciousness.

References

- Agence France-Presse, 2001, *Botswana-AIDS: Big Botswana diamond company to subsidise AIDS drugs for staff*. March 7.
- Annual General Report 2002, Orapa, Debswana Mines Botswana.
- Annual General Report 2003, Orapa, Debswana Mines Botswana.
- Campbell, C. 2001. Going underground and going after women. *Changing Men in Southern Africa* Ed. R Morrell, London: Zed Books.
- Caldwell, John C. 1999. Reasons for limited sexual behavioural change in the sub-Saharan African AIDS epidemic, and possible future intervention strategies. *Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries*. Eds. J Caldwell, P Caldwell, J Anarfi, K Awusabo-Arare, J Ntozi, I O Orubuloye, J Marck, W Cosford, R Colombo and E Hollings Canberra: Health Transition Centre.
- Collins, K. 1999. *Participatory Research a primer*. South Africa: Prentice Hall.
- Dunbar-Moodie, T. 2001 Black Migrant Mine Labourers and the Vicissitudes of Male Desire. *Changing Men in Southern Africa*. Ed. R Morrell London: Zed Books.
- Kennedy, C. 2002. From The Coal Face: A study of the response of a South African colliery to the threat of AIDS. *CSSR working paper no. 5*, University of Cape Town: Centre for Social Science Research.
- Knowledge, attitude, practice (KAP) survey*. 2002. DEBSWANA Orapa and Lethakane Mines.

- Nattrass, N. 2002 AIDS, Growth and distribution in South Africa. *CSSR working paper* no. 7. University of Cape Town: Centre for Social Science Research
- Orapa Weekly News*. 2003. DEBSWANA Orapa and Lethakane Mines, 14 May.
- Rosen S. 2000 Care and Treatment to Extend the Working Lives of HIV-Positive Employees: Calculating the benefit to business. *South African Journal of Science*. Vol 96. No 7.
- Schapera, I. 1940. *Married life in an African Tribe*. London: Faber and Faber.
- Susman, E. 2001. *Diamond Company Battles AIDS in Botswana*. United Press International. Washington, 9 July.
- The National Aids Co-ordinating Agency 2002. *Botswana 2002 Second Generation HIV/AIDS Surveillance*. Gaborone: Government Printer.
- Williams, B. 1999. The Carletonville Baseline Survey. Unpublished report. Johannesburg: Council for Scientific and Industrial Research.

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The Southern Africa Labour and Development Research Unit (SALDRU) was established in 1975 as part of the School of Economics and joined the CSSR in 2002. SALDRU conducted the first national household survey in 1993 (the Project for Statistics on Living Standards and Development). More recently, SALDRU ran the Langeberg Integrated Family survey (1999) and the Khayelitsha/Mitchell's Plain Survey (2000). Current projects include research on public works programmes, poverty and inequality.
