Notes on Preparatory Brainstorming
for meeting of African leaders in Kenya

PRIORITIES FOR HIV/AIDS PROGRAMMES IN AFRICA

A brainstorming session on "Priorities for HIV/AIDS Programmes in Africa" was convened early in October 2001 by HIVAN's Biomedical Director, Professor Hoosen (Jerry) Coovadia, in order to coalesce a broad range of perspectives on HIV/AIDS issues from and across academic disciplines.

Coovadia was to chair a meeting of African leaders in Nairobi, Kenya, later that week. Pursuant to his belief that a multidisciplinary, multisectoral approach is required to ensure the efficacy of HIV/AIDS strategies, Coovadia had invited colleagues from the University's Social Science and other disciplines who are involved in various aspects of HIV/AIDS research to pool their knowledge and discuss priorities for future HIV/AIDS programmes in Africa.

The session was attended by Professor Alan Whiteside, Director of the Health Economics and HIV/AIDS Research Division (HEARD), Mr Mkhonzeni Gumede of DramAidE, Dr Adam Habib of the Centre for Civil Society and Ms Derseree Archary of Paediatrics and Child Health. HIVAN was represented by its Social and Behavioural Director, Prof Eleanor Preston-Whyte, Social Science Researcher Ms Chantel Oosthuysen, Finance and Admin Manager Ms Debbie Heustice, Media and Communications Officer Ms Judith King and IT Consultant Dr Dave Perlman.

Preparatory readings for the session consisted of:

A Consensus Statement on Anti-Retroviral Treatment for AIDS in Poor Countries by Individual Members of the Faculty of Harvard University, March 2001

A Declaration of Commitment on HIV/AIDS by United Nations Heads of State and Government and Representatives of States and Governments - 25-27 June 2001

The Declaration of the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases held in Abuja, Nigeria, 24-27 April 2001
The Report by Secretariat of World Health Organisation from the 54th World Health Assembly, 9 April 2001
The Department for International Development (DFID) HIV/AIDS Strategy - May 2001

After his presentation of prepared lists of core issues (which summarised the readings), Coovadia asked the group to prioritise these issues, and whether there was anything to add to the existing knowledge contained in the declarations. He had presented the lists in three sections, the first referring to the broader contexts and underlying factors contributing to the spread of the epidemic, the second outlining a range of important programmes by theme, and the third describing topics for focused action plans. (See Appendices for full summary-lists).

Preston-Whyte noted that a number of the cultural “underlying factors” listed could constitute both negative and positive influences in boosting prevention, but as a legacy of apartheid, few, particularly in contemporary political leadership, are willing to speak about matters such as the sexual behaviour of African males. Coovadia mentioned that studies of sexual behaviour in villages in India revealed a pattern

comparable with South Africa's, i.e. men having four to five concurrent sexual partners - so that while a superficial view of sexual mores in India also masks the reality on the ground, the factor of a racially divided past is not the common denominator perpetuating the silence and stigma around HIV/AIDS in the two countries' experience of the epidemic.

Noting the "Forms of Family" factor, 40% of women in South Africa are not part of conventional family structures, i.e. they are either in polygamous marriages or are themselves the heads of households.

Coovadia made the point that poverty does not cause HIV/AIDS per se but rather contributes to people's vulnerability to the virus. Whiteside emphasized that a distinction must be made between 'poverty' and 'inequality' as the latter contributes to high prevalence in specific countries. There are various types of poverty, such as service poverty, resource poverty, rights poverty. He said that the real issue is inequality, particularly in the sense of rich men and poor women and the distance between these polarities.

Habib felt that the way forward lies in fundamentally contesting entrenched cultural assumptions and introducing alternatives, acknowledging that this approach was a task of engagement, with race playing a crucial role. In present-day South Africa, non-Africans will not voice the issues for fear of being labeled racist. While fascinating debates are revolving around, for example, religious discourse in terms of HIV/AIDS, what is ultimately necessary is an intervention that disagrees with entrenched norms.

Whiteside mentioned that Botswana's key response in terms of intervention focuses on the prevention of young girls from having sex with older men. The Botswana government is supportive of this response, probably because the epidemic is very severe there.

Coovadia asked about issues relating to virginity testing, having read research done on the subject by Social Anthropologist Dr Suzanne Leclerc-Madlala. Oosthuysen pointed out that this practice loads responsibility and culpability onto women, leaving the role of men's sexual behaviour unaddressed. Whiteside suggested that virginity testing could contribute to greater social cohesion, but Preston-Whyte countered that it affirms the patriarchal social system, leaving sexually active women vulnerable to abuse and a range of other negative consequences.

Gumede noted a basic flaw in the accuracy of virginity testing practice, which involves inspection of the vagina but not the anus, thus obviating any notional benefits the testing may have in terms of HIV/AIDS prevention. Responding to the idea of virginity testing being applied to males as well as females, Gumede felt that these cultural practices should be held up for scrutiny in terms of the Constitution. Seen in this perspective, the invasion of the privacy of both girls and boys (i.e. through male circumcision), especially without counselling, would be unconstitutional. He felt that taking a Constitutional stand against chiefs on these matters was called for. Habib supported this view, highlighting the irony of using virginity testing as an effective intervention for HIV/AIDS, whereby the message affirming virginity immediately ostracises non-virgins - clearly a violation of human rights; this reinforced his contention that a new set of values needed to be advanced.

Perlman queried whether, in cognisance of the power of faith-based organisations, some distillation of the positive messages emanating from these structures could assist in codifying modern interpretations of morality on matters such as sex before marriage and contraception. Habib responded that a strategic alliance between faith-based organisations would be a good foundation for such a process.

Coovadia reiterated the difficulty inherent in attempting to transpose models and lessons from one country or continent to others, citing the Philippines and Malaysia as examples of "success" (the Philippines having no epidemic to speak of and Malaysia experiencing a relatively minor spread of the disease). Habib felt that comparative studies were needed to extrapolate critical success factors from examples such as the Philippines, Indonesia, Malaysia and two or three African countries. Coovadia felt these would not be easy to determine since, for instance, the Philippines has had a turbulent track record of unstable and undemocratic government, the chasm between rich and poor is vast, and the society is far from homogenous in terms of ethnic grouping or religious systems.

Coovadia said that one aspect had emerged from various conferences and studies as an imperative for progress, that being the importance of effective counselling and testing mechanisms, and he felt that this should inform an urgent research programme. Whiteside felt that while a focus on care and prevention was recognised, the very important factor of impact was missing from the documents under consideration; he said that the numbers of sick, dying, dead and orphans had to be confronted, and in turn, the impact of these figures on political, economic, social and other systems analysed.

Coovadia recommended that Oosthuysen obtain World Health Organisation document packages on treatment, care and prevention from the UN office in Pretoria.

Other topics identified as being worthwhile for research focus areas and funded programmes were:-

* a study on the successful containment of the epidemic within an African country e.g. Uganda;
* a study on how to create regional stability, whether political, economic or military, not necessarily through protracted diplomatic discussions, but perhaps through one or two influential governments imposing order;
* a study on how to advance a health agenda in opposition to the State, given the general reluctance within our fractured society to approach this issue; (in suggesting this topic, Habib pointed out that had US citizens experienced the kind of infection rates ravaging South Africa, the US State Department would have been sued).

Whiteside reiterated the need for social cohesion, and submitted that social pensions should be doubled in order to assist the elderly caregivers in AIDS-affected households in sustaining their families. Habib agreed that social cohesion and the re-creation of viable communities was crucial.

Further discussion ensued around this subject, drawing in commentary on points such as:

* single-sex hostels versus married quarters for mineworkers and the repercussions for their families in neighbouring communities and rural areas who rely on them for support;

* the irony of some HIV/AIDS researchers admitting that they themselves enjoy multiple unprotected sexual encounters;
* the Swazi HIV/AIDS prevention slogan: "Be faithful within your polygamous family";
* the reduced pool of marriagable girls as a result of polygamy compelling young men to have their sexual debut with a prostitute;
* the erroneous perception that African culture is unassailable given that there is a TV in most rural areas;
* the collapse of much of local government through corruption and graft.

The session concluded with general consensus that intervention must be co-ordinated on the ground.

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APPENDIX I:-
UNGASS / ABUJA Statements – Contributory / Underlying Factors

1. Poverty, under-development, illiteracy
2. Armed conflicts, natural disasters
3. Human rights, fundamental freedoms
4. Role of culture, religion, family, ethical values
5. Economic, social, political, financial, legal
6. Human resources, health and social infrastructure
7. Stigma, silence, discrimination, denial
8. Forms of family
9. International bodies

APPENDIX II:-
PROGRAMMES

1. Political, community; leadership – 15% of national budget for health sector
2. Stigma, silence, discrimination, denial
3. Empowerment of women
4. Access to care
5. Prevention-care-support-treatment
6. Effective prevention: education, nutrition, information, health care services
7. VCT
8. Human resources, health and social infrastructure
9. Behaviour change, condoms, microbicides, lubricants, sterile injecting equipment, drugs (and ARV), diagnostic technologies, drug access
10. External debt, debt services
11. Role of: Communities, government, NGOs, PWA, medical/scientific/educational institutions, business and pharmaceuticals, trade unions, media, parliament, foundations, faith-based organisations, traditional leaders

APPENDIX III:-
WHAT IS TO BE DONE?

1. Prevent/resolve conflicts and disaster
2. Seek external debt relief
3. Strengthen human rights

4. Leadership
5. Resources: $7 – 10 bn by 2005
6. Reducing vulnerability
7. Alleviating socio-economic impact
8. Prevention (MTCT)
9. Care and support
10. AIDS orphans
11. Research and development
12. Follow-up