Building innovative partnership for HIV/AIDS: “Walk the Talk”

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African governments have made commitments to manage HIV/AIDS effectively. They have made these commitments in the African continent and abroad, at times even pledging to achieve specific measurable targets. This makes it possible to verify achievements of targets. However, to succeed they need to work closely with all sectors of society, ensuring that the brightest minds, most energetic people and enthusiastic service providers are brought together to draw up and implement national strategic plans.

Here we first list the commitments the leaders of government in Africa have made; we then assess the progress they have made in meeting them.

In Abuja, Nigeria, African leaders declared in April 2001 that “AIDS is a state of emergency in the continent” and they committed themselves to make AIDS a high priority in their national development plans. They committed themselves to personally lead the national AIDS Councils/Commissions, and to encourage leaders at all levels to play their part in the fight against HIV/AIDS and other related diseases. Furthermore they committed themselves to make available resources from all sources to deal with this disease. They even went further to set a target of at least 15% of their budget to improve the health sector. During the Maseru Declaration, the SADC leaders in 2003 committed themselves again to this target. In addition, they agreed that the priority areas for HIV/AIDS control are access to treatment, prevention, social mobilization and speedy resource distribution.

These leaders did not only criss-cross the African continent to make the declaration, they went overseas to do so. In New York they committed themselves to time-bound targets in a UN declaration on HIV/AIDS. According to the review conducted by the United Nations, five years down the road, few countries have achieved the targets.

Progress in reducing prevalence has been noted in Uganda, Kenya and Zimbabwe. This is commendable.

Too few countries have ensured that eligible women participated in the prevention of HIV transmission from mother to child (PMTCT). Of all SADC countries, Namibia is the only country reporting more women and children (25%) receiving PMTCT. Most of the countries have too low coverage for PMTCT and therefore are unlikely to reduce vertical transmission of HIV. Failure to implement this evidence-based programme on a large scale means that for years to come HIV and AIDS will remain to be a problem for African children.

Although these countries have committed themselves to providing treatment to those needing it, only Botswana has exceeded the target for providing antiretroviral therapy to those eligible for treatment. Consequently, mortality will continue to increase in many of these countries.

Risky sexual behaviour is still common in those countries with high HIV prevalence. Data shows that countries with high prevalence have large proportions of men and women who still practice unprotected sex as measured by ‘condom use at last sex with a casual partner.’ This becomes clear if one analyses data on the percentage of young men and women who have knowledge of HIV prevention strategies. In this respect, countries are falling far behind the 2005 target of 90%.

Too many young adults are dying prematurely from AIDS, leaving children orphaned. What is disconcerting is that in many countries orphans are not attending schools at the same rate as non-orphans. This is likely to have detrimental long-term impact on Africa’s development.

Let me relate a short story I read in the paper in South Africa this past week. This is the story of an orphan who has become a criminal at an early age. So reads the Durban-based Daily News:

> “They call him the ‘the 11-year-old from hell’. Instead of doing his homework and thinking about school, this Houdini/cat burglar is terrorising a luxury Durban suburb entering homes

by scaling walls and squeezing through burglar guards normally too narrow for adults.

> Once inside, his light footfall is barely heard as he robs his unsuspecting victims, leaving via the same route. Not only can the 1.2m, 30kg boy get into homes unnoticed and with minimal fuss, he has also managed to wriggle his way out of police holding cells and escape, through the ceiling, from places of safety.
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> The official said the child, who claims to be an orphan, was being used by older members of a gang to break into homes." Daily News 25 April 2007.
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> What future does this child have? One wonders if his parents were alive, would he have turned criminal at such an early age. According to the paper, he began criminal activities at the age of nine. One also wonders how many orphans are forced to live a criminal life. This example shows that the impact of HIV/AIDS on society goes beyond health.

Judging by the progress made since the 2001 UNGASS HIV/AIDS declaration, most African governments have not implemented the very commitments they made. Resource allocation is still not adequate. While political commitment in Africa is high, without resource allocation, that commitment cannot be translated into action.

African governments are far from achieving the targets they have set for themselves, despite the availability of the means to attain them.

To achieve these objectives we need key sectors of society to participate. The efforts of bilateral governments- and multi-lateral efforts, as well as mega-private foundations have made it possible for Africa to have access to billions of dollars to pay for evidence-based approaches to prevention, treatment and care. The pharmaceutical companies have also responded positively to pressure to make drugs affordable, though prices still have to fall significantly before they can be truly affordable to poor countries.

We must now ask ourselves, what will it take to achieve the targets to which African governments have committed themselves? We need innovative partnerships that bring together key stakeholders: the government, the donor community, private sector, NGOs, researchers, academic institutions and most important people living with HIV/AIDS.

These partners must come together to walk the walk to

- develop consensus on appropriate policies and strategies, informed by evidence
- support each other in implementing evidence-based interventions
- put pressure on the private companies to reduce the cost of diagnostic equipment and further reduce the cost of medicines.
- act quickly to adopt new knowledge, because the virus is spreading faster than their ability to use the new scientific information
- consider AIDS as an emergency because it is—each day 14 000 more people become infected, and 8 000 are dying, and are dying prematurely, adding to the 25 million already dead, the majority of whom were in Africa (UNAIDS, 2006).

What has been shown to be an obstacle in some cases is lack of skill to implement evidence-based interventions. Where this occurs HIV thrives.

What kind of partnerships are needed to make an impact on HIV/AIDS in Africa?

Partners who can help to change the socio-cultural context which makes it difficult for people to adopt safe sex practices. These partners need to work together with African governments to

- End early childhood marriages. Early marriages are common in most of Sub-Saharan Africa. Using the Demographic Health Survey and the World Fertility Survey, data shows that early marriages are common in Central and West Africa and over four in ten young women have entered marriage or co-habitation by the time they turn 18 years. (UNICEF, 2001). One of the reasons advanced for early marriages is economic. Young girls are married to older men for to receive dowry to support the family or at times

orphans been married off early because care givers are unable to maintain them (UNICEF, 2000).

- End treatment of the practice of same sex as taboo. Many African countries do not accord the rights of persons who engage in same sex sexual relationships. Only South Africa so far protects their rights through the constitution. Denying men to engage in same sex causes them to go underground, meaning that prevention programmes do not reach them, therefore they continue having unprotected sex between their male and female sexual partners.

- Encourage men to undergo safe medical circumcision. Scientific evidence exists to show that medical male circumcision significantly reduces the risk of HIV acquisition in young men in South Africa (Auvert, et al., 2005), Kenya (Bailey, et al (2007) and Uganda Gray, et al, (2007). Millions of HIV infections could be prevented over the next ten years if African governments can provide affordable, safe and voluntary medical male circumcision services.

  End the practice of widow inheritance. There are societies in East and Central Africa which practice widow inheritance. Often the widows are inherited by a married man, who may have multiple sexual partners, high frequency of exchange between widows, and low levels of condom use (Okeyo & Allen, 1994).

Partners who can develop interventions that end gender discrimination are needed. They can help to

- work with men to treat women as their equals
- end sexual violence
- end cultural traditions that make women to be subservient to men
-end myths that lead HIV positive men to have sex with young girls, and
-create society that frowns upon those who have multiple sexual partners as well as those who have sex with children.

We need partners in the media to promote HIV prevention through clear, accurate and informative messages.

We need partners in the private sector to contribute to ending poverty by creating more jobs to absorb unemployed women. This may help women who are unable to negotiate safe sex because of power and gender dynamics.

We need partners who can build capacity of heavily affected countries to deliver HIV prevention, treatment and care services. The partners from the North should work with partners from the South to train and replace health workers who have immigrated. African governments should also work hard to create positive conditions that encourage health workers to remain in their country of origin.

We need research partners to continue to track behaviour change and the epidemic. They also may develop monitoring and evaluation programmes, as well as assess the impact of policies and programmes on the course of HIV/AIDS epidemic. Researchers can play a critical role in conducting demonstration projects to kick start implementation of new interventions.

We need activist partners to advocate for change, constructively make inputs into the strategic plans, and encourage meaningful change in policy.

There are examples of stakeholders that can be partners with governments. A few will suffice.

The South African Treatment Action Campaign has worked tirelessly, not only to advocate for scaling up of the prevention of transmission of HIV from mother to child programme, but also for treatment literacy. One just has to listen to those taking ARVs explain the importance of treatment adherence, the side effects to look out for, the tests to do and the timing of visiting health facility for follow-up, to know the full impact of their intervention. The Treatment Action

Campaign is a model group to partner with government because they don't just advocate - they also make a meaningful contribution to the programme to manage HIV and AIDS.

The Baylor-Bristol-Myers and Squibb HIV/AIDS programme under the Secure the Future Programme provides another example of an organization to partner with. The provide HIV/AIDS clinical care for children in a few African countries, such as Swaziland, Botswana and Lesotho. They have helped to bring capacity to deliver clinical care for children living with HIV/AIDS by bringing 50 doctors. This is important because lack of capacity is one of the key challenges that African governments have in delivering HIV/AIDS services. This partnership will contribute to the meeting the need.

Another contributing stakeholder is the MedEcinS Sans FrontierES(MSF), which provides testing and treatment for people living with HIV/AIDS in several African countries such as South Africa, Zambia, Nigeria, Ivory Coast, Uganda, Malawi, and the Democratic Republic of Congo. What is exciting about this - is that this stakeholder helped to kickstart delivery of ARV programmes in some countries even before governments were able to step in. In some cases they still continue to provide the care. They do not limit themselves to diagnostic and treatment services. They also deal with sexual violence as a means to reduce new infections.

Finally, the Social Aspects of HIV/AIDS Research Alliance (SAHARA), which is a flexible network of researchers, governments, NGOs, donors and academics, who come together to conduct, support and use social science research to prevent further spread of HIV and mitigate the impact of its devastation in Sub-Saharan Africa. The network is currently piloting the implementation of the Positive HIV prevention programme and advocating for its inclusion in the HIV prevention effort in ten African countries. This stakeholder could also be a valuable partner to more governments.

We need governments to work with these stakeholders and more to mount a credible comprehensive HIV prevention, treatment and care programmes which will help to reverse the direction of the HIV/AIDS epidemic. I am sure there are many Africans willing to contribute to such an effort. We have all talked the talk – now lets walk the walk together.

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