Theorizing Points of Consensus in Regional Policy Approaches to Combatting HIV/AIDS in Sub-Saharan Africa

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ABSTRACT

The Millennium Development Goals (MDGs) assign great importance to the need for global cooperation to ameliorate the effects of HIV/AIDS and to aiding the African continent. The extent of effective action, however, has been varied. This paper examines national and regional approaches with respect to the delivery of aid to Africa, and the particular challenges associated with provision of HIV/AIDS medications and education programmes in sub-Saharan Africa. The paper interrogates the points of consensus regarding the most efficient methods of ameliorating the transmission of the HIV virus. Case studies from Malawi, South Africa and Uganda demonstrate that education programmes within the school system and for sex-workers are both crucial and cost effective in slowing the spread of the virus. A key point of consensus is that women must be a focus for targeted education and empowerment due to their status as the group most affected by HIV/AIDS, and as those who bear the burden of care for others. This leads us to conclude that a range of regional policy approaches can be formulated to specific local circumstances.

INTRODUCTION

The global HIV pandemic has been well documented over the past 30 years since the identification of the virus, and its epidemiology well tracked. The global community has acknowledged HIV as one of the major challenges for human society as a whole, but particularly in the global south, and even more particularly in sub-Saharan Africa. Worldwide, 34 million people are currently infected with HIV, of whom 69% can be found in sub-Saharan Africa; and 89% are in the global south (UNAIDS, 2010; UNAIDS, 2012). Whilst HIV/AIDS can affect anyone, living in any country, there is a very clear disparity which can be seen as being caused by a number of factors: culture; lifestyle; and the origin of the disease (believed to be in west or central Africa) just to name a few, but there is a consensus that the best means of tackling the major challenges associated with HIV/AIDS transmission and infection is to view it through the lens of development. Due to the vast disparity between developed and developing world in terms of HIV infection and transmission, this appears to be wise (provided that instances of HIV infection in the developed world are also tackled).

As a part of its global development strategy for the new century, the United Nations held the Millennium Summit in New York City in 2000, out of which came the Millennium Declaration and the Millennium Development Goals, which provide a clear and simple set of goals for the international development community. The goals range from poverty reduction, support for women, a special focus on Africa, and the environment, but they do include a special provision for global health, and in particular HIV/AIDS. Millennium Development Goal 6 reads as follows (targets in bold, updates on progress in list):

> **Target 6.A:**
> **Have halted by 2015 and begun to reverse the spread of HIV/AIDS**
> - The spread of HIV appears to have stabilized in most regions, and more people are surviving longer

- Many young people still lack the knowledge to protect themselves against HIV
- Empowering women through AIDS education is indeed possible, as a number of countries have shown
- In sub-Saharan Africa, knowledge of HIV increases with wealth and among those living in urban areas
- Disparities are found in condom use by women and men and among those from the richest and poorest households
- Condom use during high-risk sex is gaining acceptance in some countries and is one facet of effective HIV prevention
- Mounting evidence shows a link between gender-based violence and HIV
- Children orphaned by AIDS suffer more than the loss of parents

Target 6.B:
Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

- The rate of new HIV infections continues to outstrip the expansion of treatment
- Expanded treatment for HIV-positive women also safeguards their newborns

Target 6.C:
Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

(Source: UN Millennium Development Goals, 2012)

As a whole, the Millennium Development Goals (MDGs) are a clear statement of support from the international community to the most vulnerable people within our globalised human society. Issues of vulnerability and poverty are never far removed from the wider realities of life with HIV in the developing world and, fortunately, are becoming the central focus of global efforts to combat the spread of HIV as well as the search for effective treatment regimes. Due to these links, improvements in provision of universal education and poverty reduction will help to change the socio-economic structure of some of the communities hardest hit by the HIV pandemic, and so for proper management the Millennium Development Goals must be implemented together, and by the wider international community, of whom all UN member nations ratified the Millennium Declaration.

The challenges faced by those policymakers in charge of implementing the MDGs are vast, however. With so many countries and people affected, from a wide range of cultural, economic and historical backgrounds, a great deal of variation must be applied with regards approaching the issue. In some post-colonial nations, any outside (especially Western) interventions in the state of health of the people are viewed as neo-colonialist or imperialist attempts to reassert control. Whilst this can be seen as a valid fear, it is used to great effect by politicians in the developing world, such as Robert Mugabe in the 1990s, to deflect from the major health issues of their people, hindering the work of those trying to break the dangerous cycles of HIV on the ground. Furthermore, cultural barriers, especially around openly discussing sexual practices, must be broken down. In many cultures, both developed and developing, the taboo of discussing sexual practice, particularly in relation to condoms as a method of HIV prevention, has delayed action on educating the people with regards safe sexual practice. In areas where governments have taken action to change the dialogue regarding HIV to one of safe sex, such as Uganda, far greater drops in infection rates have occurred than in other jurisdictions whose leaders continued with AIDS denialism and creating doubt around the causes and effects of HIV/AIDS. Thabo Mbeki's refusal to link HIV with AIDS during his tenure as South Africa's President hindered progress in prevention programmes there for years (Miller, 2005).

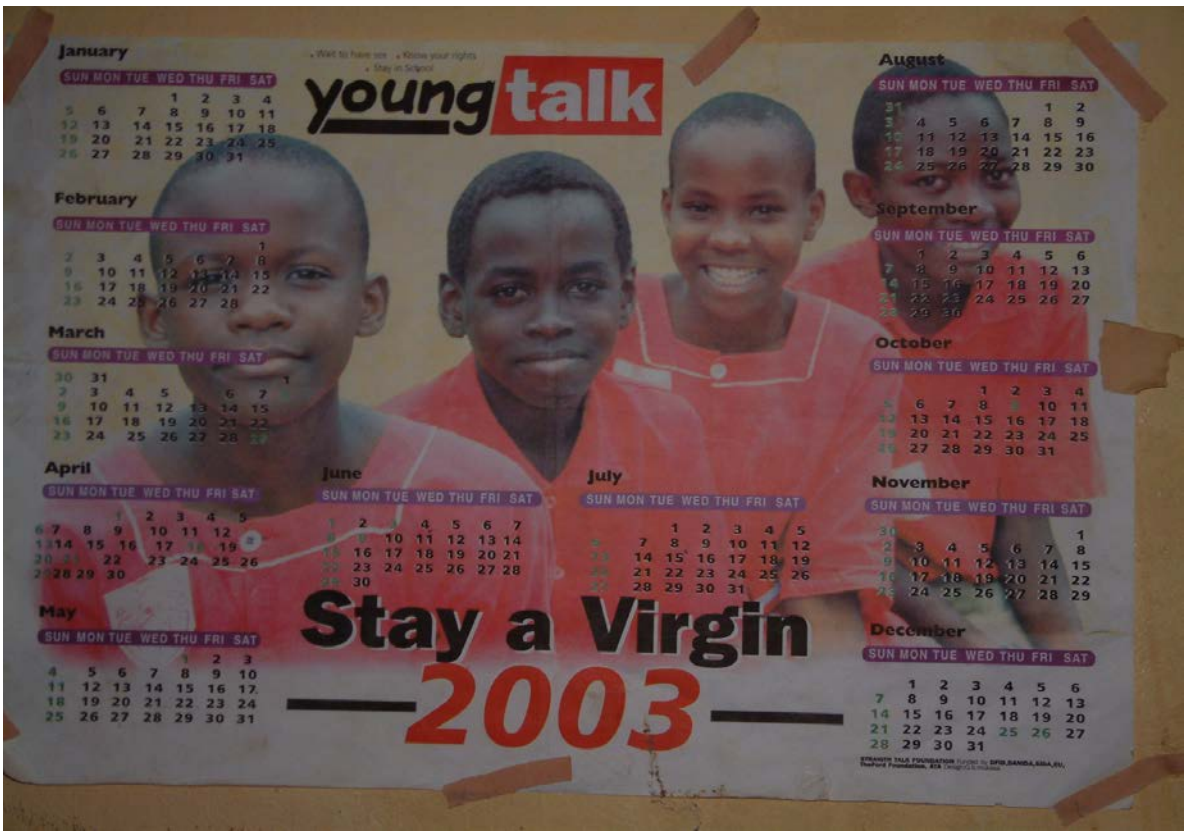

Fig 1: One of several HIV/AIDS prevention campaign posters in a school in Kumi, Uganda (Source: John Lightbound, 2003)

Provision of treatment to infected people is another major challenge. Whilst the anti-retroviral medications proven to reduce the impact of HIV infection, reduce transmission, and increase life expectancy of those infected have become far more affordable in recent years, there are still many millions of people worldwide in the advanced stages of HIV infection who have no access to medication, either due to lack of availability in their location, or more commonly due to lack of funding. Government health programmes can only be taken so far with regards the universal supply of anti-retroviral drugs, particularly in areas with huge healthcare challenges and small healthcare budgets, as can be seen across much of the developing world.

The issues of global development policy, provision of medication and the empowerment of women in relation to the global HIV pandemic will be examined herein. In order to abide by the Millennium Development Goal for HIV, global policy approaches will have to be implemented in a range of different ways by a range of stakeholders, to ensure maximum efficiency and efficacy of the programmes being undertaken. There are many examples from across the developing world of differing strategies. Based on the global data, there is cause to be optimistic, as the overall infection rates are dropping, medication is becoming more widely available and life expectancy of those living with HIV is increasing. However, care must be taken to ensure that the most vulnerable are given priority, and that the global impetus for action does not wane, otherwise the extremes of suffering will doubtless continue.

GLOBAL POLICY: THE MILLENNIUM DEVELOPMENT GOALS

From their inception in 2000, through the start of the implementation process in 2005 and to the current day, the Millennium Development Goals have remained a major aspect of the global developmental approach to poverty. Whilst the prominence of development issues within the

general media discourse in the West has declined, in large part due to the continuing economic crises in Europe and North America, development practice is still largely based upon these goals, and the fact that they were ratified by every UN member nation gives the MDGs a legitimacy and consensus in international politics rarely seen on any issue. However, there have been several factors hampering their progress. The sheer scale of the challenges being addressed raises economic problems, and as national aid budgets in the developed world are generally set as a result of domestic politics, variations can occur due to political expediencies. Admirably, the nations of Western Europe, despite ongoing economic problems, have committed to the United Nations goal of 0.7% of GDP being used for international aid. Australia, notably, has not, setting a goal of 0.5% by 2015-16, which has now been further delayed in the May 2012 budget. Jo Coghlan writing for UNSW argues that the political drive for budgetary stability and an insular focus based around party politics is leading Australia to sacrifice its duty to the most vulnerable internationally (UNSW, 2012). Whilst Australia is not the only country to let domestic concerns override international development funding, it is notable that even in a comparatively strong OECD nation such as Australia, short-term political gain is considered more important than a long-standing international commitment. The MDGs' success is dependent on every nation contributing 0.7% of GDP to international aid (Clarke, 2010). Furthermore, it can be seen that progress on all of the health related MDGs are hampered in countries with a high HIV prevalence due to the increased burden on those nations' healthcare systems and family budgets are constrained due to difficulties in the sick being economically productive, as well as the care burden on families (Stuckler, 2010).

Some hope can be gained from the fact that several countries have implemented their own schemes, alongside the UN and World Health Organisation, to further fund the struggle to achieve the MDGs. The USA in 2003 implemented the United States President's Emergency Plan for Aids Relief (PEPFAR), providing US$3 billion per year to further address MDG 6. This funding is used for treatment and prevention programmes, implemented by the Center for Disease Control and its affiliates (Campbell, 2010). Funding of this nature undertaken unilaterally by the United States should be internationally applauded, but concerns can be raised regarding the targeted nature of this aid and that from many nations. A particular social agenda can greatly hinder development processes, as we have seen with US withdrawing funding for overseas clinics practising abortions under the George Bush presidency (the so-called 'global gag rule'). Whilst this policy has ended, it shows how political motives can have far-reaching influences over aid and development based on one particular world view, and is considered by many to be a statement of cultural imperialism (Boot, 2002), a view exacerbated when political and ideological beliefs in one powerful nation can be imposed upon others, putting them at the whim of political and public opinion in the most powerful nations. In order to overcome this, aid should be distributed fairly on a basis of need, and caveats should be put in place to prevent inappropriate imposition of cultural 'norms'. However, it is difficult for many nations to advocate for any particular treatment or prevention regime if the funding for these schemes comes from overseas. For example, PEPFAR, as the largest HIV/AIDS related donor to South Africa, has helped to prevent gender-based violence from being tackled alongside the HIV epidemic, despite all indications showing that the two are heavily interlinked, and that 90% of new HIV infections in South Africa occur in young women. PEPFAR also refuses to advocate condom-use *for all* as an effective prevention strategy. Put simply, a moral and religious agenda from the United States is preventing information regarding the efficacy and proper use of condoms being disseminated in the nation carrying the greatest burden from HIV, with a highly generalised epidemic which needs to be tackled across the whole of society (Ghanotakis *et al*, 2009).

Economic factors must of course be considered in any discussion of aid, in order to ensure cost-effectiveness so that the best possible outcomes can be achieved from the global funding available for HIV/AIDS prevention and treatment. Hogan *et al* (2005) show that the most cost-effective measures to achieve MDG 6 are to provide general education through mass media campaigns, and support for sex workers to reduce transmission rates. Further approaches, which involve a higher initial outlay but which would yield further positive outcomes, include preventing vertical HIV transmission (i.e. mother-to-child), and school education around HIV, its causes and effects. Provision of anti-retroviral treatment, whilst expensive, has the dual benefits of reducing HIV/AIDS mortality rates and reducing transmission of HIV, and therefore is also an important development goal.

A further challenge with implementing wide-reaching development goals is cultural. Culturally inappropriate interventions can cause damage through lack of consultation and understanding on the part of the interventionist, and can cause communities to become deeply distrustful of outside agents. Conversely, culturally appropriate healthcare can support local communities, utilising local arts and communication channels to spread healthcare messages and to support those affected. Some cultural practices are indeed damaging in the fight against HIV, however others should be supported and encouraged. Either way, development practitioners need to be aware of the cultural environments in which they are working, and to integrate the local culture into any scheme of education or treatment, in order to provide truly sustainable development and long-term reduction of harm from HIV/AIDS (Uwah & Ebewo, 2011).

Fig 2: A primary school dance telling the story of HIV transmission and death, Bumbo district, Uganda (Source: John Lightbound, 2003)

PROVISION OF ANTI-RETROVIRAL MEDICATIONS

Universal provision of anti-retroviral medications is a key facet of Millennium Development Goal 6. Advances in both standard and combination (HAART) anti-retroviral medications have vastly improved the outlook for those people living with HIV, with key indicators of infection such as CD4 blood cell counts and viral loads returning to levels seen in non-infected patients with proper provision of healthcare. This can raise life expectancy from infection to 50 years or more, and patients who develop AIDS symptoms can expect to fight opportunistic infections more effectively and live many times longer than only a decade ago. These achievements are phenomenal, but their true efficacy can only be celebrated if treatment can be provided to all in need, as per MDG 6B. Unfortunately, rate of spread of infection continues to outstrip the increasing availability of medications (UNMDG, 2012). At the time of the Millennium Declaration in 2000, the provision of anti-retroviral medication to all those in need seemed virtually impossible, due to the costs of providing this medication (over US$10,000 per year). Advances in drug manufacture and pressure on the global pharmaceutical industry have led to the cost of a year's course of anti-retroviral medications dropping as low of US$320. This gives hope to the international community, however it is clear that subsidies for medication must exist for as long as possible, as even this greatly-reduced cost is still far beyond the scope of a family supporting themselves at the global poverty line, of around $360-370 per annum. As a result, treatment must be targeted. Providing universal treatment for pregnant women with HIV is seen as a major step (Houston, 2002).

Several challenges exist in the developing world with regards provision of anti-retroviral treatment. Economics, healthcare infrastructure and politics are dominant in determining what treatment is available in which locations, and for whom. Security challenges further obstruct the progress of treatment. In northern Uganda, in the aftermath of a 25 year civil war between the Ugandan government and the Lord's Resistance Army, thousands of people were internally displaced and sought refuge in camps in major population centres such as Gulu or Lira. Once in these camps, they could be easily targeted by government HIV awareness education and treatment regimes, again with a focus on women. However, problems occurred when people being treated moved home. Often, through their experiences of war and illness, they were no longer able to work productively in their home villages. They were often ostracised by their communities as it was thought that HIV had been brought to the rural communities from the camps. Whilst this would have been accurate in some cases, more likely is that HIV testing was only available in the camps or urban centres. Lastly, as anti-retroviral medication needs to be taken permanently and the drug regime controlled, once treated people returned to their village homes, they often had to suspend their HIV treatment. Clearly, whilst the camps were a way of testing and treating a range of people living with HIV for the first time, the logistics of following treatment as well as relocation have raised issues of cooperation between NGOs in different areas, community-based grassroots healthcare, and increased support for those with HIV to adapt their lives suitably (Wilhelm-Solomon, 2010).

The government of Malawi has implemented a scheme whereby all HIV-positive pregnant women will be treated for HIV throughout their pregnancies and for the remainder of their lives. This is an innovative step for such an impoverished nation, but will have far-reaching positive consequences for the nation as a whole. Firstly, it has been shown that providing HAART treatment during pregnancy and breast feeding can reduce the risks of vertical transmission of HIV almost to zero. Providing lifetime healthcare will greatly reduce the risks of any further pregnancies being complicated by HIV, and will ensure that one of the groups most at risk, young women of childbearing age, will be better protected. As a model for treatment and prevention of HIV in the developing world, this is as yet untested, but it shows great potential if put in place alongside

treatment of sex workers, provision of barrier contraceptives (particularly condoms) and widespread education (Schouten, 2011).

GENDER

Gendered issues relating to HIV infection and transmission have been well documented, and form a substantial focus of the Millennium Development Goals. In addition to the focus on provision of peri- and neo-natal care for women with HIV, educating and empowering women to take control over their bodies, their sexualities and their health is a major concern for HIV epidemiologists. In addition, MDGs 3 and 5 relate directly to the empowerment and health of women in developing nations. As the majority of people infected by HIV, particularly in developing nations, are women, and as the burden of care for the sick in families tends to fall upon women, this is clearly a vital area to focus HIV treatment, care and amelioration policies onto.

There are substantial challenges, however. Across the world, women remain underrepresented or unrepresented in governments, professions, and discourses around development. Women have traditionally had very little say in family or national economics, bear the burden of care and food provision, and in many areas have little access to health care facilities. Furthermore, gender imbalances in the home have made it difficult for many women to prevent themselves from becoming HIV positive, as they may have little knowledge of how HIV is transmitted, no access to barrier contraceptives and very little sexual control over their lives. This last matter is particularly important, as sexual assaults and gender-based violence are a major cause of HIV transmission, both within and without marital structures.

Gender issues are still low priorities in many developing nations, and some of the discourses being presented around women and HIV/AIDS are shocking in their objectification of and bias against women. A recent statement from Morgan Femai, a Zimbabwean senator, that legislation should be enacted to force women to shave their heads and not bathe, as HIV infections has been caused by women being too attractive (Globalpost, 2012). This is dismaying in the sheer magnitude of the sexist discrimination, and in the reality that the dominant vectors of HIV in sub-Saharan Africa are male carriers. The fact that Femai represents the more liberal Movement for Democratic Change in Zimbabwe further indicates the work which must still be done to overcome these prejudices, especially in a nation where it is still thought in some areas that HIV is a product of (female) witchcraft (Rödlach, 2006). Whilst this example is extreme in its outlook towards women, it further indicates attempts on the part of male elites in the developing world to blame women as the cause of HIV infection. By doing so, men can continue to behave as they have been, and can continue to treat women as second class citizens not worthy of protection or support. This continuation of discrimination by political elites is a threat not only to discourses on HIV prevention, but gender issues in the third world as a whole (Ailio, 2011).

Arguments have been made to further focus on gender in examining the consequences of HIV on communities, and in HIV amelioration strategies. Ailio (2011) argues that women's issues should be considered on a local, rather than national or supranational, scale, as differences occur between communities which are often ignored. This is further highlighted in Kalipeni *et al* (2007) with regards condom use being seen in some communities in Malawi as vital for extramarital sex, but not within marriage, where procreation takes precedence. Clearly, the gender balances of relationships change from place to place and different strategies of education and empowerment will be required in different circumstances. However, these disparities do not only exist in geographical spaces. Class is also a major factor.

An interesting set of interviews conducted amongst women in Johannesburg by Pettifor *et al* (2012) show clear disparities between the attitudes of South African women to safe sex, gender-based violence and female autonomy in relationships depending upon their levels of education, their social class, and their income. Women from more deprived backgrounds, with lower incomes and less education are far more likely to be unable to advocate for safe sexual practices in their relationships, and to protect themselves from gender-based violence. These women feel dominated by their male partners who control the finances of the family. At the other end of the scale, more educated women with larger incomes have a greater sense of the importance of female empowerment, feel more able to control their lives, and feel more able to negotiate safe sex with their partners. The more educated the respondents, the more likely they were to believe in female empowerment (both in relationships and society as a whole), and the less likely they were to be in relationships characterised by high-risk behaviour. This follows numerous aspects of feminist discourse advocating education for women as a pathway to reduce gender-based violence and HIV transmission.

Female sex workers are accurately seen as a major source of HIV infections, which are then carried to other women, either other sex workers or other sexual partners, including many wives. Rather than stigmatizing sex work, many development practitioners are advocating focusing sexual health treatment and peer education on female sex workers as an effective and comparatively cheap way of reducing infection rates (Hogan, 2005). Issues of poverty and lack of empowerment block advances such as safe sex education and provision of free condoms, however, as many sex workers are financially unable to decline condom-free sex, often more sought after by clients, and often better-paid. The horrific situation of sex workers being forced by financial constraints to engage in life-threatening sexual acts indicates a need for greater female empowerment. Not only would fewer prostitutes become infected if condom use was universal, but male infections would reduce, and this reduction would flow through the population (Nag, 2003).

A further task for the Millennium Development Goals as a whole is to increase female engagement in all areas of society. Seeley and Butcher (2006) describe the efficacy of a scheme in Papua New Guinea's oil palm industry to provide work for women as well as their male partners, and to further provide work for people living with HIV/AIDS in their communities when health allows. What the researchers have discovered is that by providing income for women and those otherwise normally unable to be economically productive, the plantations have increased their profits, household incomes have increased, and conflict and domestic violence has reduced, largely due to the lower levels of stress around meagre budgets. Reducing incidences of domestic violence is a vital first step in increasing female empowerment, from which control of both disease transmission and fertility can hopefully follow. Papua New Guinea faces many of the challenges of sub-Saharan African nations in terms of development, and has the highest HIV infection rate in the Pacific region, along with an agriculture-based economy with large-scale plantation employment. Utilising experiences and advice from a global range of locales can help regional policy makers to find the best solutions for their local situations.

OTHER FACTORS

Given the positive results of widely increasing HIV screening and treatment programmes in sub-Saharan Africa, there is cause for optimism, and indeed each new achievement should be heralded. The concern from this point is that positive progress may lead to complacency, both within the aid-donating world and within countries in sub-Saharan Africa. Whilst we can hope that the devastating effect of the HIV pandemic in Africa will prevent people from losing awareness of

the severity of the challenges associated with HIV/AIDS infections (as can be seen to be happening in much of the developed world), some of the interventions being put forth may lead to some unforeseen consequences. For example, whilst it has been clinically shown that correct surgical (as opposed to 'traditional') circumcisions can help to reduce HIV infection in heterosexual males (Williams *et al*, 2006), this could further lead to an increase in men engaging in unsafe sexual activity if they believe themselves to be 'immune'. Similar consequences could unfold with newly-trialled intra-vaginal antiretroviral implants for women (Malcolm *et al*, 2010). Furthermore, without continued focus on the breadth of the challenges surrounding HIV-affected communities, complacency will prevent effective action in preventing gender-based violence, and may prevent women from controlling the use of effective HIV prevention methods during sexual activity. This is analogous to the horrifying gender-violence seen in South Africa as a result of rumours that sex with virgins will protect the (male) perpetrators from AIDS, and must be challenged immediately.

CONCLUSION

Through this analysis it is confirmed that the challenges associated with the HIV pandemic are vast, and that these challenges range from the global to the local scale. The international community, in the aftermath of the confusion and fear surrounding this disease in the 1980s, has worked together on a scale not seen since the drives to wipe out smallpox and polio in the early years of the World Health Organisation, and has mobilised on a scale never before seen. The recognition of HIV as being a major impediment to development globally in the Millennium Development Goals spurred the international community into action, and the statistics of transmission, infection and morbidity associated with HIV/AIDS are improving. However, we can see that this improvement is uneven, and subject to a range of factors from economics, class, gender, politics, culture and many others.

Many of the challenges being faced regarding HIV/AIDS in the developing world are shared with other (particularly health-related) developmental challenges. A concerted effort and will on the part of the aid-donating world are vital. Understanding of cultural specificities and sensitivities is needed if development is to be equal, appropriate and sustainable. Education is vital, both in understanding the causes of HIV and in providing an intellectual outlook which will help cultures to understand the effects of the epidemic on their communities more fully. Gender is consistently a major facet of development practice, and the focus placed on vertical transmission of HIV not only improves the overall statistics on HIV transmission and prevents children from being born with an incurable and fatal illness, but has the added benefit of empowering women to take further control over their sex lives, their bodies, and by extension their communities. This will further help development in all spheres by improving productivity and protecting the most vulnerable groups in society: women, children, and the sick.

The challenges for global policy makers from this point are in finding a globally acceptable policy to follow the Millennium Development Goals once their implementation period expires in 2015. Groups of academics including Academics Stand Against Poverty are beginning to negotiate with development practitioners and governments to find points of international consensus in order that the future poverty reduction goals will not be hampered in the same way that global environmental policy has been as a result of political differences between groups of nations. Any future response should be based on treatment, prevention of transmission, and providing proper protection of at risk people, starting with contraception and education, hopefully culminating in a vaccine and cure. Providing cultural specificities can be accounted for and the international community works as one, there is no reason why the encouraging progress made thus far cannot

be continued. Africans can use the knowledge and skills of Africa as well as the wider world to affect policy which will protect their people, societies and economic prospects for decades to come.

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