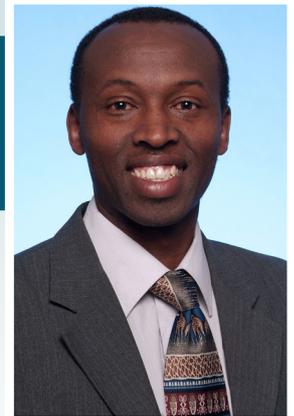




Civil society organizations and the fight against HIV/AIDS in Africa

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The economic development impasse of the 1980s and the explosion of HIV/AIDS on the African scene spawned the emergence and participation of civil society organizations (CSOs) in the implementation of international national and local health and development agendas. The paradigmatic shift in the 1990s championed a 'people-centered development' approach, emphasizing local 'ownership' in developing countries, and 'partnership' relations with developed countries. Externally-driven reforms to enforce fiscal austerity for debt control and governance, resulting in the shrinking of government's role in service provision, were met by a deliberate strategy to encourage the participation of CSOs in social and political life. CSOs would serve the dual purpose of engendering political democratization, and participating in an unprecedented and urgent response to this new disease.

Virtually unknown a decade earlier, HIV/AIDS emerged and spread with a rapidity in sub-Saharan Africa which was unlike any past pandemic, baffling epidemiologists. In South Africa, new cases rose from barely 1% in 1990 to 23% eight years later, while in Uganda the pandemic was in rapid retreat during the same

period. Currently, of the more than 34 million people living with HIV/AIDS worldwide, 68% are in sub-Saharan Africa and 60% are women. Although rates of infection are declining in the sub-region, 70% of 2.7 million new HIV cases and 67% of 1.8 million global deaths in 2010 were still in this region.

The landscape of HIV/AIDS programming in the past two decades cannot be characterized without the role of CSOs, which include a broad spectrum of non-governmental organizations (NGOs), faith-based organizations (FBOs) and community-based organizations (CBOs). While the geographic distribution of HIV/AIDS is uneven in the sub-region, with a high prevalence belt running from Uganda and Kenya to southern Africa, CSOs were among the first to respond to the crisis in every country. The most impressive declines witnessed anywhere in the early 1990s were in Uganda, the country that was the epicenter of the epidemic, and these were largely the result of grassroots community-led HIV/AIDS initiatives (CHAs), since government's role had been limited by civil war in the previous decade. Thus, in that decade, Uganda became a model for the rest of the world, as political leadership recognized the urgency of the situation and embraced

joint participation between government and NGOs, legitimating the grassroots-led culturally-based approaches. On the other hand, in South Africa, the country with the largest population living with HIV/AIDS in Africa, reluctance on the part of government to provide life-saving drugs for people living with HIV/AIDS set it on a collision course with CSOs. A rallying point of CHAI power, the Treatment Action Campaign (TAC), utilized Constitutional safeguards to force the government through court action to provide much needed treatment. Today, in every country in the sub-Saharan region, there are hundreds of NGOs working with the international AIDS regime that entered the arena towards the end of the 1990s.

This regime is made up of global health initiatives (GHIs) which control the annual \$10 billion industry. At the top, the United Nations AIDS agency (UNAIDS), established in 1996, sets global policy and priorities. It is the first UN agency to have formal CSO representation on its governing body. The UN Millennium Development Goals (MDGs) framework has a focus on HIV/AIDS as one of three health goals. Three GHIs – the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which is a private-public partnership; the US



Lwala Community Hospital, Rongo, western Kenya. A community intervention project of the NGO Lwala Community Alliance started in 2007 by Kenyan doctors and supported by US donors in response to the impact of HIV/AIDS. Image shows Dr. Wamai and Program Director, Robert Kasambala. May 28, 2012. <http://lwalacommunityalliance.org/>



Mural at Tuungane Youth Transition Centre, Kisumu Kenya. A center of the NGO Impact Research and Development Organization with regional offices in 8 districts across Nyanza where HIV prevalence is about 3 times the national average. Among services provided is male circumcision for HIV prevention. May 31, 2012. <http://www.impact-rdo.org/?page=tuungane>

President's Emergency Plan for AIDS Relief (PEPFAR); and the World Bank's Multi-country HIV/AIDS Program for Africa (MAP) – dominate the industry, providing three quarters of HIV/AIDS funding to Africa. A unique feature of these GHIs is that they provide direct support particularly to CSOs and the private sector for local HIV/AIDS initiatives. To be specific, about 30% of PEPFAR's \$48 billion largesse is channeled through CSOs. For instance, in South Africa, PEPFAR supports more NGO facilities in treating HIV/AIDS patients than the government, although the NGO share of patients is only about 10%. Since starting operations in 2000, MAP has supported more than 60,000 CSOs in sub-Saharan Africa. These CSOs implement a larger share of the \$1 billion MAP budget than the ministries of health and line ministries combined, with 85% of the half a million staff trained during 2000-2006 being in the CSO sector.

African-based or indigenous CSOs implement these funds in partnership

with international NGOs, which often have more power to navigate the global infrastructure. At the country level, other opportunities for influence in policy design and funding decisions are maintained by these GHIs. Although governments are the only ones that participate in the GFATM funding rounds, the GHI requires countries to have a Country Coordinated Mechanism that submits a Country Coordinated Proposal. While this exercise has room for improvement, GFATM is the largest NGO of its kind. Among the three big diseases this GHI tackles – HIV/AIDS, malaria and TB – HIV has received nearly 60% of the \$22 billion disbursed since inception in 2002. Of this amount, CSOs have been responsible for implementing about one third.

This is the first time in the modern history of public health interventions that NGOs have played such a prominent role. More than any other disease, HIV/AIDS is responsible for a legacy of vertical (disease-specific) programming, where a system

parallel to the general health system has embedded itself in society to such an extent that some countries in southern Africa spend more on this single disease than on all the rest of healthcare needs. As it is, HIV/AIDS is probably the only MDG Africa will achieve owing to the vast amount of funding (albeit not enough) and programming, to which CSOs deserves much credit. HIV originated in Africa and remains firmly an African pathology in its complexity of programming and the elusiveness of a cure. The West has played a central role throughout the progression of the epidemic, in its science and politico-economy. The NGO-isation of programming for HIV/AIDS will remain a part of this legacy. As Uganda showed the rest of Africa, CHAs will remain the backbone of defeating this predominantly behavioral pandemic, even as a search for a biomedical miracle continues and governments attempt multiple structural interventions.

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Craig Timberg and Daniel Halperin, Ph.D,

Tinderbox: How the West Sparked the AIDS Epidemic and How the World Can Finally Overcome It.

The Penguin Press, New York, 2012, 421 pp., notes, index, \$29.95 (hardcover).

Combating the spread of HIV/AIDS has remained one of the most challenging efforts in global health for over three decades. Its complexity and elusiveness upon first detection spawned an epidemic during the 1980s that has evoked politically charged responses, stigmas and stereotypes, and a race for a cure. In *Tinderbox*, Timberg and Halperin weave a detailed narrative about the origins of HIV/AIDS and the subsequent combination of science and politics that led to failed attempts and missed opportunities by the international community to prevent the deaths of millions.

Tinderbox opens with a historical explanation of how HIV/AIDS came to exist in humans. The pandemic was sparked unknowingly by colonialists during the 1800s in Africa, as they opened new routes through the forests of Cameroon in search of lucrative resources such as rubber. Africans were pushed into remote areas never explored before, where they would be the first to contract the strain of HIV that would eventually be responsible for 99 percent of AIDS deaths worldwide. After outlining the origins of the epidemic, Timberg and Halperin dive into the political landscape of the virus, including the billion-dollar industry of AIDS prevention programs and the constant disconnect between Western approaches and African lifestyles.

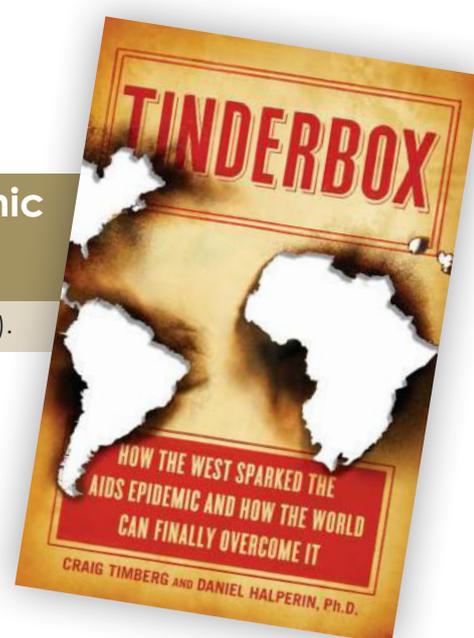
Although many African nations gained their independence during the 1960s, the battle against AIDS in the following decades had familiar hints of colonialism, as health interventions were largely westernized. This remains one of the strongest criticisms in *Tinderbox*, setting the stage for how the international community fell short in their attempts to curb infection rates. At the forefront of this failure was the undermining of local

approaches, and the reluctance to accept evidence of the role of the old tradition of male circumcision as a cost-effective prevention method, combined with an over-zealous promotion of condoms instead.

Timberg and Halperin place most of their focus on Uganda, South Africa and Botswana, while also touching upon other countries highly infected with HIV/AIDS, such as Kenya and Zimbabwe. While the use of the condom had been adopted as "the public symbol of the war against aids" in the United States (p. 83), it was not the silver bullet for African countries, despite the efforts of international AIDS prevention programs. It is here that Timberg and Halperin contend that the international community missed an opportunity to implement effective global health interventions.

Tinderbox demonstrates this by combining the stories of significant researchers from the last three decades who made the compelling connection between low rates of HIV infections among circumcised men, as well as emphasizing the importance of behavior change. However, the international community largely ignored, and even scoffed at, such research, while behavior change efforts were often politically influenced by messages driven by Western donors. Consequently, millions of dollars were poured into programs that showed low levels of effectiveness, and the focus remained on bio-medical approaches such as condoms and HIV testing.

The politics of HIV/AIDS expands beyond treatment methods, as *Tinderbox* also highlights the role of UNAIDS in exaggerating the "explosion" of the epidemic. This fueled the business of the AIDS industry, as major donors based their funding decisions on UNAIDS estimates of the epidemic's severity. In contrast to these estimates, HIV was



sporadic in its spread and confined to particular groups. The revelation of these discrepancies, along with today's acknowledgement of the benefits of male circumcision, creates the crux of *Tinderbox's* argument for using these lessons to effectively overcome HIV/AIDS in future interventions.

What Timberg and Halperin accomplish in *Tinderbox* is a thorough account of the epidemiology and politics that make HIV/AIDS such a unique and unprecedented disease. Furthermore, their contribution lies in stressing the importance of adopting tailored prevention efforts, rather than relying solely on the Western mindset of one-size-fits-all biomedical approaches. *Tinderbox* brings important examples of successes and failures in the fight against HIV/AIDS to the forefront. Learning from missed opportunities, such as the failure to take into account the early evidence of male circumcision, harnessed with behavior change, as an effective prevention method, makes it hard to ignore the need for more encompassing approaches to treating and preventing HIV/AIDS.



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ISTR Africa Workshop

9 July 2012

ISTR Africa looks forward to the upcoming ISTR TrustAfrica Workshop, which will take place on 9 July 2012, preceding the 10th international ISTR conference from 10 – 13 July. The workshop will be held at the Università Degli Studi Di Siena in the picturesque town of Siena in Italy, and promises to be exciting and stimulating.

The theme of the workshop is Economic Spaces and Political Opportunities for African Civil Society Organizations. There will be three focus areas within this broader theme, namely: i) The Impact of Economic and Political Developments on Collective Mobilization Strategies, ii) Social Action and the Composition, Identity and Nature of Civil Society, and iii) Accountable Civil Society.

Presenters include ISTR regulars such as established researchers Alan Fowler, Jacob Mati and Susan Wilkinson-Maposa, as well as first time presenters such as PhD student Beyene Tessema. Thanks to the generous support of TrustAfrica, we were able to provide travel grants for five participants.

The ISTR Africa team also want to use this opportunity to thank Priscilla Wamucii for the countless hours invested in organising this workshop and Jacob Mati for his help in reviewing the proposals and compiling the programme. Additionally, we need to thank the rest of the team, including Ebenezer for providing the concept and helping with fundraising, Alan for this prudent advice and strategic thinking and Dineo for her creativity and ingenuity in supporting the whole venture. As always, thank you also for Margery Daniels and Robin Wehrin from ISTR Baltimore for providing guidance and keeping us on course.

