Report of the Planning Meeting on Strategic Options for HIV/AIDS Advocacy in Africa

Joint United Nations Programme on HIV/AIDS

UNAIDS

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FOREWORD

The United Nations Population Fund (UNFPA) is a committed partner in efforts to halt the advance of the HIV/AIDS epidemic in Africa. As a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Fund collaborates with other partners and African Governments and civil society in actions at national and regional levels.

The UNFPA mission and mandate position it to address the challenges of HIV/AIDS in Africa by integrating population, reproductive health and gender perspectives. The experience of implementing the agendas of the International Conference on Population and Development (ICPD), Cairo, 1994, and the Fourth World Conference on Women, Beijing, 1995, and the reviews undertaken in connection with them, have enabled field operations at the country level to include HIV/AIDS-related efforts in national population programmes and projects. Working at the country level where development assistance employs joint frameworks, UNFPA is also sensitive to the importance of poverty and human rights considerations in HIV/AIDS interventions.

Advocacy has emerged as one of the major strategies for promoting leadership commitment to the goals of enhancing human life and development. For HIV/AIDS, generally considered the greatest development challenge facing mankind, the role of advocacy is fundamental in securing the continued interest and support of political, cultural and economic leaders. In Africa, leaders at the highest levels of society are increasingly involved in defining visions for the rapid rebirth and progress of the continent. They have recognized the special challenges posed by the HIV/AIDS epidemic and have pledged their determination to confront them, as clearly expressed during the Africa Development Forum 2000, "AIDS: The Greatest Leadership Challenge." Their commitment was reiterated at the African Summit on HIV/AIDS, Tuberculosis and Related Infectious Diseases in Abuja, Nigeria, and at the Summit of African First Ladies, in Kigali, Rwanda.

This report documents some of the efforts that have been made, the major issues that still need to be tackled, and what partnerships at various levels can do to improve African responses to HIV/AIDS. On behalf of the International Partnership Against AIDS in Africa (IPAA), UNFPA initiated and oversaw the process that led to the publication of this report. The Government of Sweden, through the Swedish International Development Cooperation Agency (Sida), sponsored the fact-finding mission to six African countries as well as the printing and dissemination of this report. UNFPA is grateful for the support from Sida, which is contributing to scaling up advocacy against AIDS on the African continent.

UNFPA is grateful to the many individuals who contributed to the production of this report. Participants at a March 2000 meeting in New York discussed the framework for the initiative and provided valuable information and other inputs for the mission to six African countries. In the field, UNFPA country offices facilitated contacts with key partners, including UNAIDS Theme Groups, bilateral and other development partners, national HIV/AIDS coordination structures, civil society entities and HIV/AIDS

advocacy groups, including associations of people living with HIV/AIDS (PLWHA). Special acknowledgement is made of the assistance provided by the UNFPA Country Support Team (CST) in Addis Ababa, the UNAIDS Regional Team in Abidjan and the Country Programme Advisers in the countries visited.

UNFPA is especially grateful to the authors of this report: Alfred E. Opubor, UNFPA Consultant and Team Leader; Bertil Egero, UNFPA Consultant; and Opia Mensah Kumah, UNFPA/CST Regional Adviser

Colleagues at the Africa and Technical Support Divisions of UNFPA, New York, as well Mr. Martin Foreman of The Panos Institute participated in the review mission organized to complete the report in June 2001. The contributions of these and other individuals and organizations that the mission was privileged to meet are deeply appreciated, as are their willingness to share their experiences and plans and their obvious commitment to confronting the daunting challenge posed by the HIV/AIDS pandemic in Africa.

In presenting the report, UNFPA hopes that the strategic framework proposed for advocacy and the related tools for its application will help to advance actions by all partners at the levels in which they intervene. UNFPA, for its part, will seek to integrate the outputs of the report into its ongoing programmes at both country and regional levels. Thus, together, we shall overcome this threat to Africa's march towards a better and healthier future for its peoples.

Fama Hane-Ba
Director
Africa Division
UNFPA

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AIM	AIDS Impact Model
ART	Anti-retroviral therapy
AZT	Azidothymidine
BCC	Behaviour change communication
CRDA	Christian Relief and Development Association
CSSC	Christian Social Services Commission
CST	Country Support Team
DHS	Demographic and Health Survey
ECA	United Nations Economic Commission for Africa
ECOWAS	Economic Community of West African States
GDP	Gross domestic product
GSMF	Ghana Social Marketing Foundation
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
ICT	Information and communication technology
IEC	Information, education and communication
IPAA	International Partnership Against AIDS in Africa
MARP	Millennium African Renaissance Programme
MTCT	Mother-to-child-transmission
NGO	Non-governmental organization
OAU	Organization of African Unity
PLWHA	People Living with HIV/AIDS
POP/FLE	Population/Family Life Education
RR/RC	Resident Representative/Resident Coordinator
SADC	Southern African Development Community
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TANESCO	Tanzania Electricity Corporation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VCT	Voluntary counselling and testing
WHO	World Bank

EXECUTIVE SUMMARY

This report distils the observations and recommendations of a mission to six African countries undertaken on behalf of UNFPA and UNAIDS within the framework of the International Partnership Against AIDS in Africa (IPAA). The mission resulted from the recommendations of a three-day meeting of IPAA partners held at UNFPA, New York, in March 2000 to discuss a framework for new advocacy thrusts against HIV/AIDS in Africa. The report is informed by experiences garnered in the field, a review of relevant documents and discussions with programme and technical staff at UNFPA headquarters.

The report is envisaged as a tool to stimulate a common understanding of the nature and dimensions of advocacy for HIV/AIDS. It aims at creating a framework for joint action by UNFPA, UNAIDS and their partners at international, regional, subregional and national levels. The report can also be used as the basis for building consensus about priority advocacy interventions and activities. To this end, a set of tools is proposed to guide advocacy programme planners in designing advocacy interventions appropriate to specific settings.

The recommendations presented in the report constitute a concrete set of short- and medium-term programme ideas which can be implemented at various levels, from the regional to the national, so that advocacy can support efforts to enhance the response of institutions and communities in confronting the menace of HIV/AIDS in Africa.

The report is organized in six chapters. The first chapter is a brief introduction covering the background and purpose of the mission and report. Chapter 2 presents information on the background, evolution and impacts of the HIV/AIDS epidemic in Africa. It covers epidemiological, sociocultural, gender, population and development aspects as well their interrelationships with poverty, sexual and reproductive health, and conflicts in the region. The chapter also discusses various opportunities, challenges and debates about the HIV/AIDS situation in Africa, the responses of different leaders and actors, and international collaborative efforts, especially through IPAA, to complement African initiatives.

Chapter 3 discusses structures for advocacy. It highlights the role of leaders and other actors in Government and civil society. The discussion of leadership also covers regional and subregional development institutions. Chapter 4 is the heart of the report. It details the areas in which advocacy can intersect with concerns about HIV/AIDS and the purposes which it can serve. It specifies how various social groups, including leaders, their constituents and interest groups from the civil society, can create enabling environments for the design and implementation of advocacy. Chapter 5 provides a framework and practical tools (in the form of tables) to assist advocates in making strategic choices for advocacy interventions. Chapter 6 offers recommendations.

1 INTRODUCTION

1.1 Origin and Purpose of the Mission

The meeting of IPAA partners on HIV/AIDS advocacy in Africa in March 2000, convened by UNFPA in New York, came to a general agreement on the need to strengthen advocacy efforts against HIV/AIDS in the Africa region. It was agreed that a mission should be fielded to a number of countries and regional and subregional institutions to undertake situation analyses and to gather information concerning advocacy activities, capacities and materials, including research results that may be useful for designing advocacy interventions. Many aspects of a proposed Joint Advocacy Initiative, along with a framework to guide its development, were also discussed.

A team of three persons undertook the mission in July and August 2000. The countries selected for the mission were: Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana, Malawi and the United Republic of Tanzania. These were among countries which had already signalled their willingness to collaborate actively with UNAIDS in implementing an expanded national response to HIV/AIDS.

With a view to exploring the possible involvement of African regional and subregional institutions in the proposed advocacy initiative, the team also held discussions in Addis Ababa with the secretariats of the United Nations Economic Commission for Africa (ECA) and the Organization of African Unity (OAU). However, proposed visits for the same purpose to the secretariats of the Economic Community of West African States (ECOWAS) and the Southern African Development Community (SADC) were, in the end, not undertaken.

The mission, in fulfilling its terms of reference, encountered a wide spectrum of stakeholders in the various countries, ranging from organizations of people living with HIV/AIDS (PLWHA) to civil society groups, non-governmental organizations (NGOs) involved in the gamut of HIV/AIDS interventions, researchers, ministers and other government officials, the military and uniformed forces, traditional rulers, religious leaders, private-sector and economic operators, representatives of labour unions and employers, members of UNAIDS Theme Groups and other donors. Although constraints of timing and logistics did not permit the mission to observe the activities of, or hold discussions with, all these groups in any one country, it was possible to make up any gaps, so that the total experience of the visits, taken together, included as wide a range as possible of relevant activities on the ground.

1.2 Purpose of the Report

The report is envisaged as a tool to stimulate common understanding of the nature and dimensions of advocacy for HIV/AIDS and to create a framework for joint action by UNFPA/UNAIDS and their partners at international, regional, subregional

and national levels. The report can also be used as the basis for building consensus about priority advocacy interventions and activities, in the light of the realities of HIV/AIDS challenges and necessary responses in particular settings.

The recommendations presented in the report constitute a concrete set of short- and medium-term programme ideas which can be implemented at various levels, from the regional to the national, so that advocacy can support efforts to enhance the response of institutions and communities in their daunting task of confronting the menace of HIV/AIDS in Africa.

2 HIV/AIDS IN AFRICA: AN URGENT CHALLENGE

2.1 Epidemiology and Impact

The HIV/AIDS epidemic in Africa is an unprecedented crisis for the continent. Sub-Saharan Africa is home to 70 per cent of the adults and 80 per cent of the children living with HIV. By the end of 2000, more than 25 million Africans were estimated to have been living with AIDS. More than 17 million Africans have already died of AIDS, three times the number of AIDS deaths in the rest of the world combined, creating 10 million or more orphans. In the next 10 years, HIV/AIDS may kill one quarter of Africa's people, while, in the worst-hit countries, AIDS threatens to roll back decades of hard-won progress in health, literacy and economic development. In the words of United Nations Secretary-General Kofi Annan, HIV/AIDS is the greatest development challenge facing not only Africa but also the global human community.

It is important to recognize that Africa comprises many cultures and economies and that generalizations are not true of every country. Nevertheless, the burden of HIV/AIDS on sub-Saharan Africa is staggering, especially as the region contains only 10 per cent of the world's population. During 2000, an estimated 3.8 million people became infected with HIV in sub-Saharan Africa, and 2.4 million people died. In seven countries, all in the continent's southern cone, at least 20 per cent of adults are infected. In these countries, AIDS will claim the lives of about one third of today's 15-year-olds. Botswana has the world's highest adult prevalence rate, with 35.8 per cent infected. South Africa has the largest number of people infected (4.2 million), with an adult prevalence rate of 19.9 per cent, up from 12.9 per cent two years previously. In 16 sub-Saharan African countries, more than 10 per cent of the adult population is infected with HIV. Across the continent, it is estimated that 20 per cent more women than men are HIV-positive.

Over 90 per cent of HIV infection in sub-Saharan Africa is transmitted sexually. This occurs in a variety of relationships, including between husband and wife and other long-term partnerships; in casual or secondary relationships; between sex workers and clients; and, despite widespread taboos, sex between men, which may be forced (e.g., in prisons), commercial or mutually consensual. Non-sexual transmission occurs predominantly in newborn children. It also occurs in the transfusion of infected blood products and in medical procedures if equipment is not properly sterilized. Transmission through equipment shared during the injection of illegal or recreational drugs is rare in the region, although it may be on the increase in certain areas.

The impact of the African HIV/AIDS epidemic is felt in every sector of national and community life. In agriculture, the effects of HIV/AIDS are manifested, among other indicators, in the reduced cultivation of cash crops or food products, as farmers with the virus fall ill.

In the area of the economy and business, AIDS has begun to exacerbate the severe shortage of qualified men and women in most sectors of the economy, creating major bottlenecks in business and production. As HIV prevalence rates rise, gross domestic

product (GDP) falls significantly. African countries where prevalence is 20 per cent or more may experience GDP declines of up to 2 per cent a year as the cost of the epidemic rises. Among the impacts of HIV/AIDS are days of labour lost to illness; a drop in production; an increase in funeral expenditures; and an increase in health costs. Meanwhile, households see a radical reduction in spending on school education and food consumption and a dramatic increase in health-care expenditure when one or more members of the family has developed AIDS.

The education sector in many countries has recorded major negative consequences. Nearly as many teachers are dying as are being trained every year; AIDS is reducing the number of children in school; orphans of primary-school age are dropping out of school; and, in many countries, hardly any secondary-school orphans continue their schooling.

In the health sector, the impact of HIV/AIDS is felt in the increased demand for care from people with HIV-related illnesses. Already weak health systems are overstretched, as demonstrated in the rising costs of infrastructure, drugs, training and personnel. Public health spending on AIDS alone exceeds 2 per cent of GDP in several countries, compared with 3.5 per cent for all other diseases. There is an explosion of tuberculosis, coupled with increasing sickness and death due to AIDS among health-care personnel.

A marked increase in the number of orphans has been documented. Since the epidemic began, 13.2 million children under the age of 15, 95 per cent of them in Africa, have become orphans. Widespread premature death from AIDS is radically altering the life expectancy and structure of many populations. From 44 years in the early 1950s, life expectancy rose to 59 in the early 1990s. Now, a child born in Africa between 2005 and 2010 can expect to die before his or her 45th birthday.

2.2 Background of the Pandemic

Why has HIV/AIDS affected Africa so badly? Epidemics arise when two key elements are in place: a vector of transmission and an environment that facilitates transmission. Malaria depends on conditions that allow anopheles mosquitoes to proliferate. In contrast, the spread of HIV is facilitated largely by social and cultural factors. The social environment may vary in different parts of the world. This explains why, for example, Eastern Europe is seeing an epidemic spread primarily by shared drug-injecting equipment and why, in North America and Northern Europe, gay men are heavily affected. In Africa, gender inequality and poverty are among the factors in the environment enabling HIV to spread.

2.2.1 Gender inequality

Gender inequality is not unique to Africa. With respect to HIV/AIDS, it particularly refers to men's greater power, in sexual and social relations, than women's and more opportunity to dictate the frequency and form of sexual intercourse. Men often control women's sexual lives through gender-based violence and sexual abuse, which may include rape. Such violence is usually condemned in law but is often condoned by culture. Gender-based violence may be exacerbated by social conditions, including

poverty, as some men compensate for their lack of economic and social power by exercising their physical, social and psychological power over women.

Sociocultural and legal constraints on men's sexual behaviour are frequently weak, allowing men to be less prudent in their sexual relations. For example, in parts of eastern and southern Africa, much higher rates of infection among young women (under 25) than among young men of the same age group, may be explained to some extent by the fact that older men, who are more likely to be HIV-positive, have sexual relations with young women. Young women are also physiologically more vulnerable to infection than older women because their vaginal tracts present a less effective barrier to infection.

Society often ignores such behaviour and the attitudes that underpin it. For example, mothers as well as fathers may condone sexual adventurism in their sons at the same time as they condemn such behaviour in their daughters. In the same way, many women excuse their sexual partners' having outside relationships either because they fear losing their partner or because they believe that that is "normal" male behaviour. Meanwhile, men themselves frequently exhibit such behaviour (multiple sex partners, violence and abuse, etc.), because they fear that to behave differently might lose them the respect of their peers.

Although studies suggest that on average no more than one in four men has more than one sexual partner in any 12-month period, on the whole, men have many more sexual partners than women. This means they have more occasions to contract and transmit HIV than women do. Expressed differently, it is men's behaviour that drives the epidemic, but women who are disproportionately affected. Studies reveal that most women contract the virus either from their husbands or from long-term partners. Yet women who are revealed to be HIV-positive are often accused of infidelity by their husbands or their husbands' families, and they frequently suffer the consequences of violence, loss of home and, occasionally, loss of life.

Not only are women more affected by the epidemic in terms of numbers, but also the burden of care tends to fall on women, rather than men. Moreover, studies suggest that when household income is depleted as a result of spending on care and treatment, it is the mother, rather than father and the children, who bears the brunt of the deprivation.

2.2.2 Poverty

Poverty and HIV/AIDS are closely linked. At national and community levels, poverty prevents the establishment of needed prevention, care, support and treatment programmes. Poverty also reduces access to information, education and services that could reduce the spread of the virus.

At an individual and household level, income poverty often forces women, and some men, into sexual situations they would not otherwise choose. Poverty may also be associated with migration, both within and outside a country. Studies have identified certain categories of migrants as high-risk or vulnerable groups.

In turn, HIV/AIDS generates poverty. As those with the virus fall ill and die, a family or community loses much needed productive resources. As mentioned earlier, the impact may be felt in all sectors, including agriculture, education, health and industry.

Consideration of the linkages between HIV/AIDS and poverty is of special importance in Africa because 34 of the 49 least developed countries are in Africa, and higher percentages of the populations live below the poverty line that is, on less than $1 a day. People living under conditions of abject poverty may be so preoccupied with immediate survival that concerns about preventing HIV/AIDS, the impact of which will be felt only in the long term, may be given low priority. Hungry people will not listen to the AIDS music.

2.2.3 Population and development considerations

HIV/AIDS impacts negatively on population variables. AIDS deaths are premature deaths. These premature deaths are radically altering the structure of the population. For example, in southern Africa, AIDS is altering life expectancy gains. The structure of the population of high prevalence countries is changing from a "pyramid", with a broad base of young children, to a "chimney", where the base is less broad, as more infants die, and young adults infected early in their reproductive lives begin to die. The AIDS epidemic is a gender issue. Infection rates in young African women are far higher than in young men, with rates in teenage girls in some countries five times higher than those among teenage boys. Among people in their early twenties, the rates were three times higher in women. Beyond the statistics, the gender questions have to do with women's cultural and economic disadvantages.

2.2.4 Conflict and emergency situations

It is a sad reality that Africa is racked by conflicts. Wars and civil strife rage in at least 15 countries, with spillover effects in at least another 15. These have made Africa home to millions of refugees and displaced persons, many more than in any other region of the world. The relationship between HIV/AIDS, conflicts and the emergencies they engender is well documented. Conflicts drive the epidemic in a variety of ways. Gender inequities, as manifested through rape and other forms of sexual abuse, are exacerbated during wars and civil conflict. This contributes to the spread of the virus. Soldiers and others engaged in conflict, who confront danger and death on a daily basis, may adopt a cavalier attitude towards HIV/AIDS. It has been amply demonstrated that displacement and refugee circumstances undermine families and traditional authority structures, a situation that may lead to an adjustment of moral standards. Conflicts aggravate poverty, thus increasing the susceptibility of families and communities.

2.2.5 Sexual and reproductive health

As stated above, more than 90 per cent of HIV infections in Africa occur as the result of sexual intercourse. That fact presents a challenge for behaviour-change programmes. Past behaviour-change interventions seemed to assume that sex is a simple mechanical act

onto which abstinence, mutual fidelity[1] or condom use could be imposed. However, when the external factors of gender inequality, poverty, migration and high rates of sexually transmitted infections (STIs) are brought together with physical and psychological factors unique to each human being, such as hormonal activity, age and self-confidence, it becomes clear that sexual activity is a highly complex phenomenon.

Today, sexual and reproductive health programmes cannot be effective without integrating HIV/AIDS prevention. Similarly, effective HIV/AIDS prevention cannot be achieved if education programmes do not include wider aspects of sexual and reproductive health. However, given that sexual activity is driven by a wide range of factors, it is likely that that long-term, consistent behaviour change requires not only deep-rooted psychological conviction on behalf of the individual but also broader social change, including poverty alleviation and gender equality.

2.3 Responding to the Epidemic

Since the beginning of the epidemic, national and international efforts to combat HIV/AIDS have focused on four main areas: research, prevention, treatment and care, and impact mitigation. In recent years, gender and human rights elements have also been given increasing consideration. These themes constitute zones of intervention within which a broad range of actions may be conceived and implemented.

2.3.1 Research

Biomedical and epidemiological research has led to growing understanding of the nature of the virus, its variants and mutations. Research has also helped to map the course of the epidemic in different parts of the world. Pharmacological and vaccine research continues at numerous centres across the globe, yielding a range of pharmaceutical products and holding out hope for ever more promising treatments and, eventually, even a vaccine. Sociocultural and behavioural research have sought to explain or shed light on the epidemiological evolution of the disease among various societies and communities, whereas operations research and impact studies have continued to guide the formulation and implementation of prevention and care interventions.

2.3.2 Prevention

Since no cure exists, preventing infection and controlling the spread of the virus constitute the prime line of defence against HIV/AIDS. This includes attempting to prevent sexual transmission to men and women through education programmes designed to promote abstinence, mutual fidelity and the use of condoms. Other prevention measures include ensuring the safety of blood supplies and averting the transmission to newborn children through short-term provision of anti-retroviral drugs. In Africa, promoting individual behaviour change as the sole or even principal prevention

[1]Fidelity *per se* is no protection against HIV infection, since one may be faithful to a partner who has sexual relations with others. Only mutual fidelity guarantees freedom from infection if neither partner is HIV-positive before the relationship begins.

intervention has proved to have severe limitations.[2] This is attributable in part to the lack of resources to maintain sustained education programmes and in part to the failure to address deep-rooted social and psychological factors that determine sexual attitudes and behaviours.

2.3.3 Treatment and care

With the development of anti-retroviral drugs such as AZT, which reduce viral load and delay the progression from HIV infection to AIDS, the disease need no longer be an automatic death sentence. However, because of the high cost of these drugs, few Africans living with HIV/AIDS can afford to buy them. In this regard, recent developments have opened a window of hope. Intensive negotiations and pressure from HIV/AIDS advocacy groups have led pharmaceutical companies to reduce drastically the price of anti-retroviral drugs and to ease their opposition to the importation of cheaper generic versions of drugs they have patented. However, other obstacles to widespread distribution remain: weak health infrastructures and the shortage of skilled medical personnel to prescribe the drugs and monitor their impact are likely to minimize the impact of these promising developments. In the short term, therefore, treatment options in Africa are likely to be limited largely to palliative treatment and the treatment of opportunistic infections, such as tuberculosis. In the poorer countries and among poorer PLWHA, access to even these forms of treatment is limited.

2.3.4 Impact mitigation

As the HIV/AIDS epidemic grows and manifests itself in widespread morbidity and mortality, its impact is felt on individuals, households and communities. It imposes a heavy burden of care and support on individuals and families. The burden on the larger society is no less traumatic. An increasing number of orphans, single-parent or no-parent households and costly funerals strain community resources. In response, a broad range of innovative care and support mechanisms has been tried in many countries. Many approaches are community-based, calling upon traditional African social solidarity and mutual support systems. Home-based care for sick relatives is at the heart of these initiatives. Programmes to integrate AIDS orphans into extended families and other existing community solidarity networks (as opposed to creating orphanages) are proliferating. It has been observed that women and girls bear the brunt of care and support, as many cultures assign to them the role of caregiver and comforter.

To make impact mitigation an early and high priority implies improving the capacity of society to halt and reduce further spread of the virus as well as to provide necessary support to surviving family members. The agenda for addressing impacts has several components. The first step is to estimate levels of human resource loss over time. Second, these estimates need to be equally incorporated into macroeconomic and into sector planning. A third step is to search for ways to reduce the impact, for instance, through substitution, reorganization of work or investment in time-saving devices. Finally, the

[2] See John Caldwell, "Rethinking the AIDS Epidemic in Africa", *Population and Development Review,* 26, No. 1 (March 2000). In this article, the author argues that the behaviour change approach has failed in Africa because it does not take adequate account of sociocultural impediments.

very act of calculating estimated impacts can be turned into a major motivational factor to identify and address both underlying and proximate causes of HIV transmission.

2.3.5 Human rights protection

As the HIV/AIDS epidemic evolves in a community, it brings forth a number of human rights issues. Discrimination based on HIV status is widespread. At the most basic level, this is manifested in the stigmatization of PLWHA as individuals who are immoral, sinful or cursed. Other forms of human rights violations include the dismissal of employees diagnosed with the disease as well as other forms of discrimination in the workplace. The refusal of insurance companies to cover infected individuals may also be construed as a form of discrimination. An important debate with a human rights dimension is the right of infected persons to privacy. In other words, should their HIV status be divulged? If so, to whom? How does this right to privacy cohere with the rights of sexual partners to protect themselves based on knowledge of their partner's status. Sometimes entire population groups or segments may suffer discrimination based on perception that HIV is prevalent in their communities. For instance, in the early days of the epidemic, some groups such as the military, long-distance truck drivers, migrants and commercial sex workers were tagged as "high-risk" or agents for the spread of the epidemic. This may lead to violations of the human rights of individuals belonging to these groups. For instance, some countries require applicants for entry visas from specified countries to undergo HIV tests, as well as degrading treatment.

These five dimensions research, prevention, treatment and care, impact mitigation and human rights provide an appropriate lens through which to view responses to the epidemic. However, the fact that the causes and consequences of the disease are multisectoral, rather than confined to the health sector, increasingly dictates a response, from Governments, civil society and development partners, that involves macroeconomic and development strategies.

2.4 Opportunities and Challenges

An effective response to HIV/AIDS in Africa faces many challenges and constraints. A meeting of UNAIDS co-sponsors in 1999 in Annapolis, Maryland, U.S.A., which established IPAA, identified primary constraints as: the inadequacy of current plans and action, national awareness, commitment, and mobilization; the existence of too few successes and on too small a scale to reverse the epidemic; and the inadequacy of external support, which remains too small, slow and disjointed to have a critical impact. Other obstacles have been detailed above (see 2.2). Still others include the following.

2.4.1 Databases and research

A considered and effective response to the epidemic requires concrete and up-to-date biomedical, epidemiological and impact-related information. This is, by and large, missing or insufficient in many countries.

The creation and maintenance of networks for regular and representative sentinel surveillance data, which indicates how widespread the disease is in the general population, often depends on donor commitments, a clear sign that national leaderships have not yet realized the importance of such work. Nor is donor commitment always sufficient, as seen in the United Republic of Tanzania, where today only about 10 of 24 sentinel surveillance sites are active, all located in one region and supported by one bilateral entity.

Workplace data indicating the potential impact of HIV infection on a company or a commercial sector could be a powerful tool to strengthen management commitment in the private and parastatal sectors (although there is a danger that some data, e.g., on HIV infection, may breach confidentiality and lead to abuse). Workplace data can be found in individual enterprises and sectors, such as the Tanzania Electricity Corporation (TANESCO) in the United Republic of Tanzania and Lever Brothers in Malawi and the insurance sector in South Africa, but the potential value of such data has not yet been fully recognized and acted upon.

In many countries, there has been no widespread change of behaviour despite almost universal awareness of the threat of HIV/AIDS. This is a serious obstacle to progress, although not surprising, given the limited successes of earlier efforts to influence reproductive behaviour (fertility patterns) in the region. Open-minded and innovative research efforts from anthropological to participatory approaches are a necessary complement and support to practical work to stem HIV transmission. The urgency of achieving visible changes, which themselves would be powerful inputs in advocacy, requires that dynamic and creative relations to social science are established. Yet, research into the social causes, context and consequences of the epidemic is still often heavily influenced by the health perspective. In at least one country, the National AIDS Control Programme, under the Ministry of Health, has effective control over all national research on HIV/AIDS issues, irrespective of its disciplinary orientation. In no country investigated by the authors of this report was social science organizationally brought in as a partner, and research production emanated either from individual researcher initiatives or from consultancies.

2.4.2 Essential capacities and tools

Basic information material for awareness-raising and improved factual understanding is generally available in every country, usually locally produced. In most countries, however, no central pool exists, making it difficult for individuals and organizations to obtain an overview of or access to the range of materials available. Lack of such a central pool also makes it difficult to compare good and poor material and so does not provide an incentive for the production of increasingly high-quality material. In addition, the extent of training in its use is likely to vary widely. In particular, material for internal awareness-raising and elementary knowledge within government departments and similar bodies may be limited in both quality and quantity.

2.4.3 Media and communication

The news and entertainment media press, radio and television and, increasingly, the Internet should play a key role in providing information and enabling the public and policy makers to facilitate both individual and community responses to the epidemic. However, in many countries in Africa and elsewhere, a range of factors prevents the media from fulfilling this role, and coverage of the epidemic is often poor. Lack of training, poor pay and a high turnover of staff all prevent media organizations from developing in-depth skills on complicated issues such as HIV/AIDS. Lack of resources limits the amount of material broadcast or printed. Occasionally, political interference prevents the airing of reports critical of government policy on issues such as HIV/AIDS, and social and economic pressures may compel the suppression of information or views considered sensitive by cultural or religious leaders or groups.

The politics of cost recovery (or cost sharing) has penetrated almost every institution in society. Public radio and television essential tools in education campaigns may be forced to sell broadcasting time, even for programmes supporting government policies. Organizations wanting to use such channels need financial resources. Foreign-based or foreign-financed organizations with more money may contribute to a rise in pricing, to the detriment of local organizations with fewer resources. Where HIV/AIDS-engaged organizations have the resources, such media are important channels of information. TV is usually accessible only in major cities in the region. Still, it has a key role as a channel to national leaderships and other elite groups.

Media practitioners, often with the support of donor agencies, have made efforts to strengthen the response to HIV/AIDS. These have, however, been generally short-term and inconsistent, with the result that little significant impact has been made. In Zambia, a special association of media workers was created to intensify media output. Similarly, in Nigeria, Journalists Against AIDS (JAAIDS) is a network of more than 300 members exchanging information and delivering packaged advocacy products for national and international media. In Ethiopia, the party radio had initiated a series of programmes to alert the public and various leaders to the epidemic. However, cooperation with other media was absent.

Although much work in the media sector has been focusing on news media, carrying factual material and some editorial comments, more attention is now being given to the possibly greater impact of using entertainment media in HIV/AIDS communication, especially for inducing behaviour change. Many new initiatives in several countries are emerging, along the lines of the highly successful South African broadcast series *Soul City*, carried extensively on radio and television in that country. A number of productions are now being exchanged among countries. For example, *AIDS in the City,* carried on Zimbabwe television, is actually the English-language copy of an Ivoirian production originally in French.

2.4.4 Sociocultural factors

Traditional attitudes and practices can provide both opportunities for and obstacles to effective HIV/AIDS education programmes. On the one hand, strong community and family values provide emotional and financial support systems. On the other hand, traditional practices such as widow inheritance and the subordination of women's interests to those of men play a role in the further spread of the virus. Traditional sex education, whereby aunts or other relatives teach adolescent girls how to please their future husbands rather than the facts of conception, contraception and STIs, discourages young women from protecting themselves and their future children from HIV.

So-called traditional practices are addressed more or less explicitly by many organizations, but usually outside of the official sphere. In Ethiopia and Malawi, NGOs are responsible for studies of various practices and for advocacy measures to get local communities to address them. The prevalence of practices such as female genital mutilation, male circumcision, initiation rites, skin cutting, widow inheritance is high in many countries, and changing such practices is a complex issue.

2.4.5 Stigma and denial

Because of its association with sex – particularly the association with "immoral" sex – and death, HIV/AIDS is a highly sensitive topic. In both the private and the public sphere, silence, social stigma and denial are commonplace. At the individual level, denial of risk prevents many men and women from protecting themselves from infection. Denial also prevents those who believe or know they are HIV-positive from seeking counselling and treatment. At the community and national level, denial prevents many leaders from speaking out on the issue; those who do speak out may do so infrequently and restrict their remarks to generalizations that do not address the reality of the disease.

2.4.6 Resources

Perhaps the greatest constraint to an effective response to HIV/AIDS in Africa is the lack of resources. Not only do countries lack the resources but, across the continent, international development partners, including United Nations and bilateral agencies, also face resource constraints. Globally, they are under increasing pressure to streamline their programmes to focus resources on core competencies and mandates. Despite their goodwill, many are obliged to assign HIV/AIDS to a lower order of priority.

In many countries, dependence on external financial support is high, in the public sector as well as elsewhere. The Malawi national defence forces initiated an AIDS-prevention programme in early 1996, with support from two external sources. When financing ceased in 1999, activities ground to a halt. The effects were felt not only in the defence forces but also in the network of "disciplined" forces where HIV-prevention experiences had been exchanged.

Organizations with links to regional or international networks may receive both financial

and technical support of considerable importance for their work. Local trade unions may find support from their counterparts elsewhere in the world. International or bilateral organizations often support local NGOs in their work, sometimes in full partnership, but sometimes seeing the latter mainly as executing agencies. Religious organizations are often part of a network of material flows from richer to poorer communities. However, in virtually all the institutions visited, the scarcity of financial resources was seen as a serious constraint to beginning, maintaining or scaling up activities.

Widespread awareness about the epidemic and its impact has, by and large, not been translated into new budget priorities, although this may change in 2001 (see 2.5 below). Furthermore, the need to guide local funding through a national strategy and action plan sometimes leads donors to withhold funding until such documents have been completed. This may lead to unfortunate losses of momentum where programmes have already been started or to lack of action in areas where work can be done even in the absence of a major strategic framework. Malawi is an example of such a case, where drugs against opportunistic diseases are often lacking, where the diagnosis and treatment of STIs needs upscaling and where condoms are not yet available everywhere in sufficient quantities.

2.5 A Coordinated Response

The first responses to HIV/AIDS in Africa, in the early 1980s, were by a range of governmental, non-governmental and religious organizations and courageous individuals across the continent. Increasingly, the responses to the pandemic have been coordinated at national and international levels. Uganda and Senegal are the two countries most often identified as having successful national responses which have either reduced the rate of HIV infection or kept it low. Despite these examples, much still remains to be done to ensure that resources are used efficiently, efforts are not duplicated and gaps in prevention and treatment are identified and met.

2.5.1 African leadership

On paper, at least, regional and national leaders and leadership groups are increasingly speaking out and making AIDS a central development, social and national security issue. The Summit of OAU Heads of State and Government in 1997 in Zimbabwe and in 1999 in Lome, Togo, made declarations concerning HIV/AIDS. However, these have not been followed up with equal response by member States.

Nonetheless, several high-profile events have increased the visibility of HIV/AIDS in Africa and set the stage for enhancing the commitment of African leadership groups and their national and international partners to fighting the spread of the disease. The December 2000 African Development Forum organized by ECA in collaboration with UNAIDS co-sponsors, including UNFPA, focused on the importance of securing committed African leadership. The resulting “African Consensus and Plan of Action” was presented at the African Summit on HIV/AIDS, Tuberculosis and Related Infectious Diseases in Abuja, Nigeria, in April 2001, where African leaders from 43 countries, in their Abuja Declaration, pledged to increase spending on health, especially on AIDS.

It was also in Abuja that the United Nations Secretary-General called for the establishment of a global AIDS Fund (or "war chest") to provide the $7-10 billion required annually for effectively responding to HIV/AIDS. In the aftermath, the Bush Administration's contribution to the Fund of $200 million, announced at the White House in the presence of Secretary-General Kofi Annan and Nigeria's President Olusegun Obasanjo, prompted a *New York Times* editorial stating that recent public attention to Africa's AIDS crisis had not been matched with money and indicating that U.S. leadership in providing resources was being regarded within that country and internationally as inadequate.

There is already an indication from the Italian Foreign Minister that a proposal would be made at the July summit of the G-7 for additional contributions to the Global Fund from the 1,000 largest corporations in the world, with matching commitments from G-7 countries, to achieve a starting target of $1 billion.

In The Millennium African Renaissance Programme (MARP): A Partnership for African Renewal, several African leaders at the level of heads of State and Government recognized that a successful partnership towards African renewal will be measured by poverty reduction and an enhanced quality of life for the people of the continent. They also referred to the prevalence of infectious diseases, including HIV/AIDS. In their African-led and African-driven response, expressed in the Programme of Action, the leaders participating in the Partnership for African Renewal resolved to take responsibility, among other things, for revitalizing and expanding education, technical training and health services, and urged that high priority be given to tackling HIV/AIDS. The Presidents of Algeria, Nigeria and South Africa were designated as spokesmen for MARP, to conduct a dialogue with the international partners.

Similarly, the Summit of African First Ladies, meeting in Kigali, Rwanda, resolved to participate actively in searching for solutions to the problems of children in difficult circumstances and the prevention of the spread of HIV/AIDS.

A meeting of the United Nations Secretary-General with heads of agencies in Nairobi, in April 2001, focused on poverty-reduction strategies and targets. This meeting emphasized the need to consolidate many ongoing initiatives and to channel resources for greater impact on development efforts, including concerted action on reducing the spread of HIV/AIDS.

In the meantime, there have been important developments in managing the epidemic within Africa itself. The South African Government's success in negotiating with major pharmaceutical companies for easier access to low-cost generic medication for the treatment of AIDS-related infections has already energized a number of African countries to undertake similar initiatives and provided an incentive for concerted regional action. In 2001, Côte d'Ivoire became the first African country to appoint a Minister responsible for HIV/AIDS and epidemic diseases, an innovation that needs to be followed with interest by other countries and partners.

The forthcoming United Nations General Assembly Special Session, 25-27 June 2001,

will undoubtedly provide another important focus on the African HIV/AIDS crisis and how it is being addressed, within the context of global responses to the epidemic, and the politics of international resource allocations.

All of these events have generated lively discussions in national and international news media and led to several follow-up consultations at national, regional and international levels. The involvement of civil society and the active participation of PLWHA in these events indicate a dynamic and unfolding advocacy environment. The many possible scenarios and opportunities they offer need to be examined in the light of the findings and recommendations of the mission.

2.5.2 The international contribution

The international community's response to HIV/AIDS in Africa peaked in the early 1990s and fell during the rest of that decade. Renewed awareness of the impact of the epidemic at the beginning of the twenty-first century appears, at least temporarily, to be reversing that decline. In January 2000, the United Nations Security Council met to discuss the global HIV/AIDS crisis the first time that the Council devoted a meeting to a development issue. These initiatives have created an enabling environment for African leaders for dealing with HIV/AIDS on the continent.

2.6 The Current Debate

While Governments discuss the sums available for HIV/AIDS prevention and care in Africa, a debate persists as to how the money raised can best be spent. Although many issues are involved, two primary discussions can be identified. The first of these is whether a sustained reduction in the HIV transmission rate can be achieved in the current state of poverty in which most Africans live, or whether poverty eradication is essential in creating an environment in which sexual relations are not determined by need. The second discussion, closely related to the first, is whether behaviour change can be achieved through a combination of prevention messages and condom promotion alone (often characterized as the "health-only perspective"), or whether deep-rooted changes in society, in particular the improved status and empowerment of women, are essential.

In both discussions, the truth almost certainly lies in between. The rapid reduction in fertility rates in Bangladesh in the 1980s proved that it was possible to change some fundamental aspects of sexual behaviour without first reducing poverty. HIV transmission rates fell in the 1990s in Uganda and Zambia, again without a significant allieviation of poverty. However, it is almost certain that long-term sustainable reductions in HIV transmission rates can be achieved only when poverty is less of a motive for sexual behaviour and when most other STIs receive rapid and effective treatment. Similarly, although many women and men can achieve sustainable behaviour change solely as the result of acting on publicly available information, it is likely that widespread behaviour change will result only from broader social changes that improve the status and power of women and encourage greater restraint and responsibility among men.

Despite increasing recognition of the need for a broad-based approach, however, much of

the response to HIV/AIDS in the region remains narrowly focused. There is a persistent dominance of a health perspective on solutions to the epidemic. Simple messages such as a-b-c (a for "abstention", b for "be faithful" and c for "use condom") exclude the complex environment within which people lead their lives and the implications of certain types of behavioural change. It also excludes other important messages, including the need for communities to provide and for individuals to seek treatment for other STIs and treatment of opportunistic diseases. Where these broader messages are adopted, people can engage in demands on government to make drugs and treatment available. This is an important step in broadening the issues and may act as a facilitator to enable people to reconsider their own behaviour. Failure to break out of a more limited perspective is a sociocultural constraint on important actors. Advocacy efforts are required to improve their awareness of important social and cultural dimensions behind individual behaviour.

This narrow response is not confined to Africa. In many cases, international actors on AIDS have yet to fully assume the implications of redefining the HIV epidemic as a development challenge rather than a health issue. In development cooperation agencies, health divisions still tend to be the main units responsible for AIDS interventions. In affected countries, ministries of health are generally responsible for AIDS control programmes and often assume secretariat functions in relation to AIDS councils or boards. The donor community continues to give priority to prevention and gradually to care and support needs. Impact issues remain to be seriously addressed.

There are, however, increasing signs of movement among United Nations organizations. The Food and Agriculture of the United Nations (FAO) and the International Labour Organization (ILO) are explicitly addressing the impacts of the epidemic in their respective domains. They thereby provide models for mainstreaming which need to be applied to relevant sectoral ministries in affected countries and also directly to medium- and large-scale production units. Other sectors in which the loss of human resources has begun to make significant impacts are transport and infrastructure, education, and health.

3 STRUCTURES FOR ADVOCACY

3.1 Leaders and Actors

Leadership is essential to ensure an effective and sustained response to HIV/AIDS at regional, national and subnational levels. The power, influence and access to resources of many individuals, groups and institutions occupying leadership positions in various sectors have produced and have the potential to produce even more contributions to the fight against the pandemic. The evolution of multisectoral approaches and the enlargement of the response to HIV/AIDS are creating opportunities for the involvement of new actors, including those with leadership obligations. Identifying and understanding the nature of appropriate leadership is thus a dynamic and creative process, based on evolving social realities.

Leaders are important in advocacy against HIV/AIDS for a number of reasons. They have credibility within their mandates; provide a rallying point for decision and action; help to define issues and possible, acceptable solutions; have the authority to require others to do what is necessary; can organize communities and groups for effective responses to the epidemic; and can help to mobilize and distribute internal and external resources.

Successful advocacy would seek to have leaders acting in their prescribed roles, within their "mandates", facilitating desired advocacy outcomes. In seeking to involve leaders in programmes against HIV/AIDS, planners may find it useful to pay attention to the specificity of leadership mandates and jurisdictions, in order to profit from their comparative advantages. Doing so would avoid the temptation to want to involve every leader in implementing every intervention, a tendency fostered by the increasing urgency of the threat posed by the deteriorating HIV/AIDS situation in many countries. Even where leadership appears to be polymorphic, with some leaders whose mandates seem to cover various domains, it is probably still a good idea to focus on a few advocacy outcomes for any one such leadership group or institution. For example, religious leaders, who have a major social and spiritual welfare mandate, should probably not also be targeted in advocacy to encourage vaccine research, except where the special profile of a particular leader may expand his or her role in this regard, such as the traditional "prime minister" of the Moro kingdom in Burkina Faso, who is also a senior pharmacist and former health minister.

Despite their diversity and variety, leaders and leading institutions may be placed in broad sectors and categories as shown below.

3.2 Leaders in Governmental Institutions

3.2.1 Policy makers

At the national level, leaders in the Government have major responsibility for making policy, often in collaboration with others. They include:

- The head of State (President);
- The head of Government (Prime Minister);
- Cabinet ministers;
- Other persons of ministerial rank; and
- Top civil servants (e.g., permanent secretaries)

These political leaders are expected to create an enabling environment for the management of the overall response to HIV/AIDS. They are expected to facilitate the setting up of institutional frameworks and to legitimize them through legislative and other normative texts. Hence, the enunciation of national positions and policies, and the setting up of national anti-AIDS commissions or committees, the secretariats which service them, and various other structures, are often the result of successful advocacy to political leaders, including heads of State, the Government and members of the cabinet.

The most common form for the organization of government work on AIDS is a national AIDS control programme, usually under the responsibility of a ministry of health. Additional forms may include cabinet committees, advisory boards and councils all with varying membership. These structures are often created as the Government's response to UNAIDS or to donor suggestions, in which case they may have little real influence within the Government. Their institutional capacity is a central issue, not least where a unit has commanding and/or controlling power over government action. In one country, for example, the national AIDS control programme, with a total of seven professional staff, is responsible for implementing a national strategic plan and for coordinating all government action on central and district levels.

3.2.2 Legislators

The making of laws is the function of the legislature, represented by:

- Members of parliament (including members of the House and Senate);
- Officials of the legislature (Senate President and House Speaker); and
- Chairpersons and members of legislative committees (e.g., social welfare, gender affairs, health and budget).

The judiciary has the important role of interpreting and administering laws, and its major officers and institutions are important targets and sources of advocacy action, viz.:

- The Chief Justice;
- Supreme/High Court judges;
- Judges of other courts, including industrial and family courts; and
- Magistrates.

Legal reform is one important tool in the struggle against HIV/AIDS. It may come as a result of reports from NGOs operating in the field, from concerned ministries identifying areas of action or from donors. However, it well known that the implementation of a law could be considerably more difficult than its enactment. In some countries, as long as local community leaders are unaware of, or unmotivated to carry out, new legislation, little is likely to change. When different legal structures are operating simultaneously, e.g., modern law of the State and local traditional law, reform in modern law may have little impact on people's lives until corresponding changes are made in traditional law.

3.2.3 Programme and resource managers

The translation of policy into programmes and their implementation is handled at different levels of the civil service, through the technical work of ministries, including specialized parastatal organizations and agencies, whose chief officers for advocacy purposes include:

- Permanent secretaries;
- Secretaries for particular functions (e.g., women's affairs);
- Directors of technical departments, (e.g., finance and budgeting; public health);
- Heads of parastatal organizations and specialized agencies;
- Division/departmental heads; and
- Experts and senior technicians.

The Government's position vis-à-vis finance and budgeting on HIV/AIDS is widely considered a key indicator in an estimate of its commitment. The Government's mobilization and allocation of financial, technical and human resources are organized through mechanisms within public administration which include, as important components:

- The ministry of finance;
- The ministry of planning;
- The treasury;
- The reserve (or central) bank;
- Sectoral ministries; and
- Financial regulations and procedures, all of which can be involved in advocacy to increase and improve the management of resources channelled towards HIV/AIDS, from whatever sources.

Advocacy for HIV/AIDS within the Government and its structures and functions has been and could be enhanced through the strategic targeting and involvement of the

individuals and institutions mentioned above or their functional equivalents in various countries and at various government levels (e.g., provincial or local administrations).

3.3 Civil Society Leaders

In many countries, HIV/AIDS advocacy is the result of efforts by individuals, groups and institutions outside the Government. Increasingly, these are being seen as partners with the Government in defining and implementing an effective national response. Often, the context of that response is a structure (such as a national AIDS council) that combines governmental and non-governmental representatives. Among the major actors in the non-governmental sector are: religious organizations; cultural and traditional leaders; leaders in finance and industry; sports organizations; professional and community-based associations; and coalitions, networks and partnerships.

3.3.1 Religious organizations

The major religious organizations and adherents are involved in HIV/AIDS advocacy through individual or joint action. Among them are:

- Churches and church groups (including lay men, women and youth associations);
- Christian councils;
- Councils/synods of individual denominations;
- Church leaders (e.g., archbishops, bishops, pastors, priests and nuns);
- Islamic councils;
- Islamic movements (e.g., Ahmadiyya);
- Chief imams;
- Imams of mosques/heads of Koranic schools; and
- Ecumenical/interfaith organizations.

Religious institutions and related organizations are well established in most if not all countries in the region. A distinction should be made, however, between the formal church structure itself and church-based organizations established to serve communities in practical aspects. Among the latter are the Episcopal Conference of Malawi and the Christian Social Services Commission (CSSC) in the United Republic of Tanzania. Both of these have made important contributions towards a better leadership role for church institutions. In Malawi, the Catholic Church has decided to speak openly about condoms in the context of general information on reproduction and sex. In the United Republic of Tanzania, four major religious institutions (Protestant, Catholic, Muslim and Hindu), having recently initiated internal consultations on their respective social services and areas of coordination, are now preparing for closer collaboration with respect to AIDS-related work.

3.3.2 Cultural and traditional leaders

In many countries, traditional institutions and leadership structures predating the colonial era are still operational and effective. They often constitute a parallel, if not alternative, system of governance. Even where there have been attempts to integrate them into more

modern structures, they seem to have a life and influence of their own. They have an important advocacy position both as initiators and recipients of advocacy actions, especially those based on traditional values and norms. Elements of this system include:

- Royalty (e.g, King, Queen Mother(s), Queen, members of the royal family and senior household officials);
- Nobility (e.g., traditional prime minister; titled chiefs such as generals and medicine men); and
- Council of chiefs (e.g., women chiefs, elders and notables, non-hereditary chiefs).

3.3.3 Leaders in finance and industry

Leaders in the economic and financial sectors have clear contributions to make to the national response to HIV/AIDS. As the major operators of the economy, they can be brought fairly quickly to a recognition of the need for economic and social action. The growing interest in, and encouragement of experiences with, workplace prevention and care programmes in some countries demonstrate the potential value of successful advocacy directed at economic leaders.

Because of the professional and social solidarity of this group of leaders, the demonstration effect of these early programmes is an advocacy asset. Directors of companies with HIV/AIDS workplace programmes can reach their follow executives in meeting of service clubs or of chambers of commerce, and either informally, or through solicited presentations, they can share information about the rationale for their company's programmes and the results of interventions.

An important subsector of this group involves insurance companies and their leaders. Increasingly, attention is being drawn to the implications of HIV/AIDS for workers' compensation and the cost of health programmes for the infected and affected. Insurance companies can take the lead both in providing the information required for impact assessment and in creating new insurance products that are worker- and employer-friendly, many of which could also benefit government. The role of insurance companies is becoming a major focus of public discussion in countries like South Africa, where employers and insurance companies are under scrutiny by vocal NGOs. The outcomes of initiatives in that country, especially in public and industry-wide policy platforms, may be useful for consideration by other African countries, even those where the private sector is not yet highly developed.

Already in Burkina Faso and Côte d'Ivoire, national "solidarity funds" have been established to provide for the welfare of poorer citizens, including those affected by HIV/AIDS. In Côte d Ivoire, an additional dimension has been added by the army's "friendship and welfare society", in which members are creating an insurance fund to assist affected colleagues. Such models can be documented, with the collaboration of insurance professionals, as useful tools for advocacy, demonstrating both impact and effective response within and among economic and financial sector operations.

The wide range of cultural and civic leaders and organizations with mandates and spheres of influence covering a variety of issues includes the following:

- Chambers of commerce and industry;
- Business councils;
- Women in business;
- Chief executives of enterprises;
- Heads of market women's organizations; and
- Directors of banks, finance houses and insurance companies.

3.3.4 Sports organizations

Sports organizations are an important part of civil society with the capacity to mobilize younger generations across the nation. One important aspect of their work is the growing space offered for women to engage in sports. Their work provides them with good access to media, and some sports take their active members to other countries in the region for soccer matches or athletic events. For example, Africa Sports, from Abidjan, was invited to South Africa to participate in a tournament to raise money and awareness for HIV/AIDS. This sector of society appears to have been insufficiently approached in the context of HIV-prevention work, possibly due to lack of action of responsible government departments /ministries of sports. Where this is the case, other actors need to be identified to mobilize the sports sector. NGOs could be approached for the task.

The organization of the sports sector is generally composed of the following:

- National Olympics Committee;
- Football federation;
- Amateur athletics association;
- Associations/federations for other sports (boxing, basketball, cricket, rugby, swimming etc.)

3.3.5 Professional and community-based associations

Professional and community-based associations exist in every country. Traditional healers' associations and professional and student associations are examples. Some, like lawyers' associations or associations of media workers, are already making important contributions to AIDS-related advocacy, whereas others are open to dialogue about their participation in the struggle against HIV/AIDS. They should not be expected to have a high awareness and knowledge about the epidemic. Work to be done consists of identifying these organizations, clarifying their respective potential contributions and developing a suitable strategy for their advocacy work.

Local community leaders constitute a well-recognized category of leadership, which appears to exist everywhere, not exclusively in rural areas. Generally, there is a need to distinguish among subcategories; for instance, in the United Republic of Tanzania the earlier "10-cell leader" system of the Tanzania African National Union was a political

construction whose current resemblance to the status and functions of traditional leadership needs to be clarified in studies or consultations with local specialists. Local communities may also have designated specialists such as persons responsible for initiation rites or for local conflict resolution. These specialists can be of considerable significance, for instance, in relation to traditional practices (circumcision, skin cutting, initiation rites, widow inheritance) which may transmit the HIV virus.

Local communities exist in urban as well as rural areas. The Ethiopian "funeral societies" are a potentially significant ally in mobilizing local action against the epidemic. Traditional male-dominated associations and service organizations such as lodges, Odd Fellows, Rotary and Lions, are as yet untapped channels to certain strata, for advocacy and resource mobilization.

Local community leaders are potentially important in mitigating the local impact of the epidemic and in protecting the rights of affected households and persons. Legislation to secure the rights of surviving family members to land and other property of a deceased head of household needs to be supplemented with local action to defend the same rights.

One particular kind of community leadership is that which may exist among migrants abroad. Where international labour migration is prevalent, some migrant communities have developed organizations for social or protection purposes. They may also, as in the case of Burkinabé migrants to Abidjan, have strong links to the home country. To reach such communities is strategically important, given their members' vulnerability to infection through temporary sex relations.

Political parties are potential partners in the work. The shift to multi-party political organization in the region has changed the character of mobilizing networks in society. One-party states often had a party hierarchy in parallel with the government structure, and reaching further down, to the level of local communities. Even though, in principle, any party under multi-party systems is free to build and maintain such a structure, financial and other conditions make this less likely. The role of parties is, however, also to engage in programmatic issues, not least around election time. To ensure that HIV/AIDS and government action is made an election issue, political parties need to be sensitized.

The extent of government leadership and commitment is likely to influence party leaderships in their perceptions of the political value of engagement. On the whole, parties should not be expected to develop a higher awareness without clear political signals from government. For parties to engage in the HIV/AIDS issue, two conditions need to be fulfilled: public demand for action must be visible and special interventions have to be made to reach and educate party leadership, so that party organs and activities reflect HIV/AIDS concerns.

Party structures which are potentially effective for advocacy often include:

- National chairman;
- Trustees;
- Executive committee;
- Secretary-general;
- Regional/provincial executives;
- Women's league;
- Youth wings; and
- Special committees (e.g, health and education).

3.3.6 Coalitions, networks and partnerships

Among the most important opportunities for HIV/AIDS advocacy in Africa is the growth of coalitions and networks, a trend that has been accelerating over the past decade following various United Nations global conferences and conventions. Networks operate at regional, subregional and national levels. In the HIV/AIDS field, regional and subregional networks include the Society of Women Against AIDS in Africa (SWAA), with chapters in a number of African countries; the Africa Council of AIDS Service Organisations (AFCASO); and the AIDS NGO Network of East Africa (ANNEA) and other subregional NGO networks; as well as regional and subregional networks of PLWHA.

At the national level, HIV/AIDS networks and coalitions abound. Associations or networks of PLWHA exist in practically every country. In Côte d'Ivoire, for example, several PLWHA associations operate under the umbrella of the Collectif des Organisations contre le SIDA. In Ethiopia, the Organization for Social Services for AIDS (OSSA) has "franchised" a network of 668 anti-AIDS clubs in schools, each led by student "Missionaries of HIV/AIDS". Similarly, the Ghana AIDS Network (GHANET) brings together 120 organizations drawn from the Government, NGOs, the private sector and research institutions all working in the field of HIV/AIDS. These networks have been encouraged and supported by UNAIDS Theme Groups and other international development partners in the various countries.

National and regional networks formed to advocate for a variety of development causes may also be tapped for HIV/AIDS advocacy. Under UNFPA-supported advocacy subprogrammes, coalitions and networks have been formed in many countries to advocate for issues on population and sexual and reproductive health. The broader field of gender and women's rights has seen a blossoming of coalitions and networks. The Tanzania Gender Network Programme and the Tanzania Women Lawyers Association are prime examples of coalitions that constitute natural allies in the promotion of gender and human rights aspects of HIV/AIDS. Media networks in a number of countries focusing attention on gender, health and other development issues also offer a vehicle for advocacy. Examples include Ghana's Women in Broadcasting, the Nigerian Association of Women Journalists, l'Association Rwandaise des Femmes de Media and the Tanzania Media Women's Association. Other relevant regional networks include the Federation of

African Women Educators, the national chapters of the International Federation of Women Lawyers, the Federation of African and Arab Parliamentarians for Population and Development, and the Network of African Women Ministers and Parliamentarians, the last two supported by UNFPA.

Many of these coalitions are active. However, others are restricted because member organizations are lack sufficient resources and are unable to play a full and active part in coalition activities. Often the presence of one or two key individuals determines whether a coalition is active and would be an effective tool for advocacy.

3.4 Regional and Subregional Institutions

Regional and subregional governmental institutions are involved in creating and managing the multinational framework for development and cooperation in Africa. The oldest and most influential of these are the OAU (the African Union, since the end of May 2001) and ECA. Both institutions have been recently active in HIV/AIDS advocacy, OAU having organized the Abuja Summit in April 2001, and ECA, the earlier African Development Forum on AIDS and Leadership, in December 2000.

Some of the institutions are political in nature, and their leadership structure reflects their mission, with political-level authorities and a bureaucratic/technical supporting secretariat, that may have a high-profile, usually elected, head. Other institutions are more technical, such as ECA and the African Development Bank. All of them contribute in different ways to the mosaic of decisions and actions that shape the character and the possible destinies of the region and its constituent parts. Obtaining their commitment to treating HIV/AIDS as a regional and subregional emergency could have major consequences for policies. The components of some these institutions are shown below.

3.4.1 Organization of African Unity/African Union and Economic Commission for Africa

- Authorities
  - Current chairman;
  - Summit of heads of State and Government; and
  - Conference(s) of ministers (foreign affairs, education, information, social welfare, and finance/economic development).

- Secretariat
  - Secretary-general;
  - Assistant secretaries-general; and
  - Heads of specialized agencies and offices.

3.4.2 Subregional development institutions

a) Southern African Development Community

- Authorities
  - Current chairman;
  - Summit of heads of State and Government; and
  - Conference(s) of ministers (foreign affairs, education, health, information, population/social welfare, and finance/economic development).

- Secretariat
  - Executive secretary;
  - Deputy executive secretary;
  - Heads of sectoral departments; and
  - Heads of sectoral coordinating units (currently undergoing restructuring).

b) Economic Community of West African States

- Authorities
  - Current chairman;
  - Summit of heads of State and Government; and
  - Conference(s) of ministers (foreign affairs, education, health, information, and finance/economic development).

- Secretariat
  - Executive secretary;
  - Deputy executive secretary;
  - Heads of departments; and
  - Heads of specialized institutions and commissions (Organization of African Trade Union Unity, West African Women's Association, West African Health Community, and ECOWAS Fund).

c) African Development Bank

  - Council of ministers;
  - Board of governors;
  - President;
  - Vice-presidents;
  - Directors; and
  - Heads of departments.

4 ADVOCACY FOR HIV/AIDS: AREAS OF FOCUS

Any attempt to categorize the purposes of HIV/AIDS advocacy is likely to provoke debate. The categorization proposed here is informed by the team's review of the literature on advocacy and HIV/AIDS as well as its observations and findings during the mission.[3] It provides a framework for discussing options for advocacy interventions.

4.1 Harnessing Leadership Commitment

There is consensus that the commitment of African leaders is indispensable in combatting and, eventually, reversing the HIV/AIDS epidemic. In the search for responses to the continued spread of the epidemic, "commitment" is a dimension increasingly at the centre of international and national campaigns. The issue of commitment bears on all actors and would-be actors. When UNAIDS and African leaders call for debt relief for poor nations, the message has a bearing on the whole world of finance.[4] At the national level, actors rarely engaged in health programmes may be asked to contribute. If, indeed, combatting HIV/AIDS may be termed a "war", the next logical step is to ask for general mobilization that is, full commitment of all.

Commitment, in the present context, refers principally to national Governments and, by extension, to their higher order representatives such as regional and international organizations. All that Governments do, with or without reference to the epidemic, can in principle be interpreted with reference to commitment. Commitment is not an end in itself. It is a dimension of government whose value depends on its relation to the ultimate objective of reversing the current trend of the epidemic.

The question is: how is commitment manifested among Governments and individual leaders? What forms of advocacy can elicit it? These questions are not easy to answer because the perception and interpretations of commitment differ. Also, the motivations of African leaders and their attitudes towards the epidemic are varied and complex. Furthermore, different categories of leaders in different countries or communities exhibit varying levels of commitment. For example, it appears that the leadership of military and national security institutions in several countries, including Côte d'Ivoire, Ethiopia, Ghana and Malawi, were quicker to act on the epidemic than was the national political establishment. They collaborated with local health authorities and other HIV/AIDS-prevention advocates to establish a variety of programmes for military, police and other security personnel and their families. In the case of Côte d'Ivoire, HIV/AIDS-prevention

[3] The following definition of advocacy is pertinent: "Advocacy is the last step of behaviour change, when people are so convinced that they want others to share their satisfaction. Advocacy is the principle of communicating with other people to gain their support for an issue and influence their behaviour in a specified way. … The best advocates are committed volunteers who can share their experiences." Johns Hopkins University/Center for Communication Programs (JHU/CCP), *Advances in Family Health Communication* (1995).

[4] Robert Hecht (UNAIDS), "Poverty, Debt, and AIDS: Mainstreaming the Epidemic and Mobilizing Additional Resources to the Response", Meeting of Ministers of Health of the OAU on HIV/AIDS, Ouagadougou, 7-9 May 2000, pp.167-175.

services provided by the military were made available to surrounding communities with access to military health facilities. It has been surmised that the command structure and ingrained culture of discipline in military and security agencies enabled their leaders to proceed more quickly than civilian authorities. In addition, military leaders were confronted with the issue of HIV/AIDS among their personnel in concrete fashion early on. Routine testing required before participation in international training or peacekeeping missions turned up an embarrassing number of infected soldiers. In Uganda, it is generally believed that the scale of infection in military circles was one of the motivating factors in that country's determined response to the epidemic.

In the early days of the epidemic, many leaders engaged in denial. This persists even today, particularly in some countries with lower prevalence. Denial arises from many causes, not least from the fact that AIDS touches on many taboo topics – adolescent sexuality, sexual infidelity among married couples, homosexuality, prostitution, etc. Many political, religious and cultural leaders would like to believe, or have others believe, that "these things do not happen here".

Another contributor to low commitment is inadequate knowledge of the epidemic. Many leaders in non-health sectors simply do not comprehend the scale of the epidemic and how it can affect their communities or what they can do about it.

Other constraints to commitment include inadequate resources and capacity in the face of competing development priorities. In many African countries, the growth of HIV/AIDS to epidemic proportions coincided with the introduction of a slate of macroeconomic and development reform initiatives often driven by external donors and development agencies. Decentralization, health-sector reform and other sector-wide approaches (SWAps), privatization and other initiatives to improve governance and economic performance compete for the attention of leaders and the scarce resources of countries. In the United Republic of Tanzania, one committed leader in HIV/AIDS prevention noted that the Government's tackling of various reform initiatives simultaneously strains the capacity of the bureaucracy, as civil servants are shuffled from one reform workshop or seminar to the other. This view was reinforced by the United Nations Development Programme (UNDP) Resident Representative/Resident Coordinator (RR/RC), who noted the very low capacity outside Dar es Salaam, Mwanza and a few other regional capitals as a major constraint in implementing the district response initiative espoused by the United Nations country team.

It has been shown that individuals who are personally affected by the epidemic exhibit greater commitment. For example, a leader who has witnessed the death of a close colleague or family member is more likely to act on HIV/AIDS policies or programmes. Zambia's former President, Kenneth Kaunda has frequently acknowledged the 1986 death of his son Musugo from AIDS. In a speech at the United Nations, Zimbabwe's President Robert Mugabe admitted that ministers in his cabinet and close family members had succumbed to AIDS. On the other hand, hard-hit communities may feel a sense of helplessness arising from the notion that AIDS is an insoluble problem. In such situations, projecting messages of hope or, as one international development worker in Côte d'Ivoire put it, "AIDS is a disease you live with, NOT just a disease you die from"

can be a positive motivator. In Côte d'Ivoire, even the limited availability of anti-retroviral therapy (ART) and its beneficial effects has clearly helped to mobilize PLWHA and contributed to reducing the sense of hopelessness among some leaders.

Commercial or financial self-interest may also be an important inducement to tackle the epidemic. In the United Republic of Tanzania, the leadership of TANESCO and the Tanzania Ports Authority instituted prevention programmes when confronted with evidence of the scale of HIV/AIDS and its impact. Similar initiatives have been undertaken by Unilever in Malawi, an African Medical Relief Foundation (AMREF)-driven private-sector initiative in the United Republic of Tanzania and a consortium of factory owners and managers in Côte d'Ivoire.

It is, therefore, important to understand the underlying motivations and complexities of leadership commitment before plunging into advocacy to "enhance commitment" among African leaders. It is also evident that the approach to building commitment cannot be one-dimensional. Commitment may be manifest in many ways. Although public pronouncements by political leaders constitute one manifestation of commitment, it certainly is not the only one. Public statements that do not derive from a heart-felt attachment to a cause or that are not informed by full and accurate information may ring hollow. Leaders and advocates can show commitment by adopting personal behaviour or engaging in actions consistent with the positions they publicly advocate.[5] They may invest time and effort to acquire knowledge about the epidemic. Leaders may exhibit commitment by committing their institutions' resources to deal more effectively with HIV/AIDS. In short, commitment implies both personal attachment and sacrifice. Those who demonstrate these have what it takes to become effective advocates.

4.2 Reinforcing Response Interventions

Arguably, the most important forms of advocacy are those that enable or strengthen effective prevention, care or support programmes. For, it is programmes and other interventions on the ground that can halt the epidemic. In the early days of the epidemic in Africa, two main prevention approaches, namely communication for behaviour change and condom promotion, were favoured. This approach was opportunistic, building upon more than a decade of family planning experience that employed behaviour change communication (BCC) and condom promotion (for contraceptive purposes) as core strategies. After a decade, it is now clear that the two approaches alone are not sufficient to reverse the course of the epidemic. On hindsight, it now appears naïve that so much faith was put in just these two interventions in a region where religious and other cultural influences are so deeply rooted.[6] In addition, the twin BCC and condom approach did not adequately consider the variegated epidemiological landscape of HIV/AIDS and the significant variations in resources and capacities among countries in the region.

[5] Cf. JHU/CCP definition of advocacy.
[6] Cf. Caldwell, "Rethinking the HIV/AIDS Epidemic in Africa."

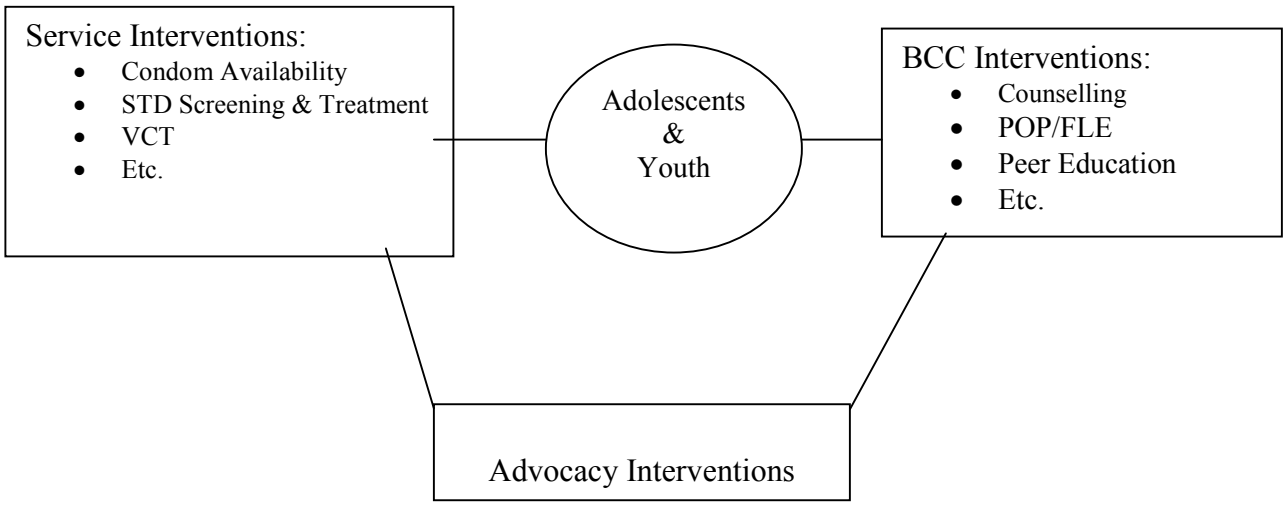
Under the leadership of UNAIDS, a broader range of prevention interventions has now been added to BCC and condom promotion. The full panoply includes screening and treatment for STIs, safe blood supplies, voluntary counselling and testing (VCT) and mother-to-child-transmission (MTCT) programmes. Care and support as well as treatment options are expanding, including, in a few countries, limited access to ART. The programme and response options now available make it possible to design an intervention package adapted to each country or situation.

However, deciding on intervention options involves difficult choices. It is essential to involve all stakeholders, particularly women's and youth groups, in devising programmes and strategies. This is to ensure equity in access for men, women, and youth as well as vulnerable and under-served groups. This calls for lobbying, dialogue and negotiation. Once the decision is made on the programme or other response intervention, it is necessary to mobilize the technical, financial and human resources to implement it hence, the need for advocacy. For instance, the decision to establish a comprehensive national sexually transmitted disease (STD) screening programme might require convincing health authorities and programme managers of the need to invest a disproportionate amount of resources into such a programme in the face of other urgent priorities such as malaria or nutritional deficiencies. Financial resources must be sought from the ministry of finance, private-sector entities and donors. Technical assistance agencies, research institutions and NGOs may be called upon to contribute the necessary technical inputs. Leaders of women's and youth groups and other target populations may need to be sensitized to mobilize their constituents to use the facilities made available through the programme. Similarly, a comprehensive advocacy package would be required to establish or expand a VCT programme or a condom social marketing programme. Indeed, despite the widely acknowledged importance of STD screening and treatment in the fight against HIV/AIDS and despite the fact that they constitute a major plank in UNAIDS-supported national strategic plans, one can find hardly any large-scale programmes in the region.

Another approach is to direct advocacy efforts towards strategic interventions addressing specific population groups or themes selected for their potential impact on the spread of HIV/AIDS. For example, the strategic plans of many countries, including Ghana and the United Republic of Tanzania, target adolescents and youth as a vulnerable or risk group. Others, such as Côte d'Ivoire and Burkina Faso, have identified commercial sex workers or long-distance truck drivers as risk groups. Côte d'Ivoire and the United Republic of Tanzania are also investigating the role of different forms of migration and refugee movements. In Ethiopia, the head of one United Nations agency suggested that the way forward is to target advocacy towards one specific intervention, and risk group, namely the half million soldiers to be demobilized after the recent border war with Eritrea.

Such an approach calls for designing a variety of interventions all focusing on the selected theme or target population. For instance, in Ghana and Zanzibar, programmes focusing on adolescents and youth include in-school family life education, peer education and counselling. In both countries, a variety of partners, including educational authorities, religious groups, youth-serving organizations and parents' associations, is connected with the programme. The role of advocacy in this regard is to enable the set-

up and implementation of the interventions. The diagram below illustrates the approach. Advocacy actions pave the way for and facilitate the various service and communication interventions that target the adolescent and youth population.



4.3 Mobilizing Resources

One of the most frustrating aspects of the fight against HIV/AIDS is the shortage of financial resources to carry out programmes and actions that are known to be beneficial. Due to inadequate funding, HIV/AIDS is becoming a disease of poor people, poor communities and poor countries. Funds are short at all levels and among all partners. Most PLWHA in Africa cannot afford available treatment regimes that would enable them to live longer and in dignity. Communities hard hit by HIV/AIDS morbidity and mortality struggle with meager resources to care for the sick, the dying and the orphans that the dead leave behind. Governments of poor African countries, saddled with debt and attempting to provide basic services to their citizens, cannot find the money to establish prevention, treatment, care and support programmes on a scale that would make a difference. In its 2000 budget, the Tanzanian Government approved TSh 8 billion (about $US 11 million), a substantial amount for this cash-strapped country, to combat HIV/AIDS. However it has been argued that under conditions of high indebtedness,[7] with most of the development budget and parts of the recurrent budget externally financed, the value of such contribution is not clear-cut in a situation where the government is juggling multiple development priorities and necessary reforms that drain governmental resources and stretch capacities. In such an environment, HIV/AIDS gets short shrift in resource allocation.

[7] Hecht, "Poverty, Debt, and AIDS."

International development partners, including the United Nations and bilateral agencies, also face resource constraints. Globally, they are under increasing pressure to streamline their programmes to focus resources on core competencies and mandates.

Under these circumstances, advocacy may play four key roles:

- Advocacy can explore new sources of funds;

- Advocacy can encourage Governments, civil society groups and development partners to provide more funds for HIV/AIDS prevention and control. In this regard, it is encouraging that more and more African countries are earmarking budgetary resources to combat HIV/AIDS;

- Advocacy needs to be directed at ensuring that scarce resources are utilized in the most cost-efficient manner. In the case of the United Republic of Tanzania, for example, there appears to be some debate among stakeholders as to the most efficient way to utilize the allocated funds when they become available. Should they be under the control of the Ministry of Health, through the national AIDS control programme, or be split among identified sectors? The country can ill afford such uncertainty, and advocacy efforts need to be deployed to accelerate a consensus; and

- Advocacy can be used to promote equity in the allocation of resources, ensuring that women's and youth groups obtain a fair share.

Regarding new sources of funding, considerable efforts have been deployed, and some successes recorded, under the aegis of IPAA, in securing funds from foundations (e.g., the Bill and Melinda Gates Foundation and the Turner Fund) and pharmaceutical companies, including Pfizer and Bristol-Myers Squibb. These funds have increased biomedical research, accelerated the quest for vaccines and enabled access to ART and palliative treatment to small portions of those afflicted in poor countries. The success of these initial fund-raising efforts underscores the need for intensified and better coordinated advocacy in this direction. For instance, although African leaders have been focusing increasingly on HIV/AIDS at regional forums, such as the annual summit of OAU heads of State and Government, they have not devised a clear global fund-raising strategy. Such an approach could include the designation of focal points among heads of State to make the case for Africa at global forums, such as the G-8, the United Nations Security Council and meetings of the Bretton Woods Institutions. Prior to the G-8 meeting in Japan in June 2000, three African presidents, Bouteflika of Algeria, Thabo Mbeki of South Africa and Olusegun Obasanjo of Nigeria, made a plea on behalf of Africa for debt relief. The topic could have been HIV/AIDS. Respected elder statesmen, such as ex-Presidents Nelson Mandela of South Africa and Toumani Toure of Mali, could be pressed into service as "goodwill ambassadors" to plead with identified foundations and philanthropic organizations. President Mandela's success in securing substantial funds from the Gates Foundation for the Nelson and Graca Mandela Children's Foundation indicates the potential of such an approach.

A scaled-up response to HIV/AIDS implies that all sectors and partners should join in the fight against the epidemic. As the epidemic affects all sectors, all must contribute resources. The health sector cannot be expected to bear the burden alone. This is a qualitative shift from the earlier perception of HIV/AIDS as a health problem. However, many sectors and partners have not acknowledged the full implications of this shift for their own resource allocation and budgeting processes. The typical response is to "mainstream" HIV/AIDS into ongoing activities. Translation: HIV/AIDS has no budget line; no specific funds are allocated to it; and the sector's activities will not be restructured to accommodate HIV/AIDS but, rather, HIV/AIDS programmes will be adjusted to fit into the strait-jacket of existing sectoral functions. In Ghana, a senior Ministry of Finance official suggested that one way to guarantee the disbursement of funds allocated for HIV/AIDS would be to classify them under "Item One", along with salaries and other untouchable budget lines. The role of advocacy in this regard is to persuade ministry of finance officials and parliamentary finance committees, through budget hearings, to earmark and protect funds for HIV/AIDS activities. This approach also applies to development partners, NGOs, private-sector enterprises and other civil society entities that demonstrate an interest in combatting HIV/AIDS.

A third role for advocacy with regard to resources is to ensure that, once available, they are utilized wisely. This is critical when resources are scarce and donors are looking for results. Which strategies and what interventions should resources focus on? There is an ongoing debate on the best approach to implementing a scaled-up response. One school believes that greater results will be achieved if resources are concentrated on a limited number of interventions proved to prevent infection or control the spread of the epidemic. Thailand's "100% condom programme", which achieved a 90 per cent condom use in commercial sex, is cited as a good practice in this regard.[8] On the other hand, it is argued that the tentacles of the epidemic are so far-ranging that it cannot be tackled with only a few interventions. This debate is of the essence, especially in African countries that cannot afford to dissipate their scarce resources on approaches that do not produce results in the short to medium term. Advocates need to guide leaders and decision makers to weigh carefully all options within their own context before deciding on the way forward.

4.4 Adapting the Legal/Legislative Framework

The HIV/AIDS epidemic has brought to the fore new human rights and ethical challenges. PLWHA have suffered and continue to suffer from discrimination and stigmatization everywhere. In the workplace, PLWHA may be fired or denied promotion and other rights. For example, Ethiopian Airlines embarked on a programme of HIV screening of its employees, a positive development that was counteracted by dismissing staff members found to be seropositive – in clear contradiction of national policy. Elsewhere, HIV-positive individuals may be denied health insurance. Their movement within their own country or across international borders may be restricted. PLWHA and those close to them can suffer psycho-social trauma and, at times, physical aggression. In Ghana, a teenage girl who voluntarily disclosed her HIV status was ostracized to the

[8] Martha Ainsworth and Waranya Teokul, "Breaking the silence: setting realistic priorities for AIDS Control in less-developed countries", *The Lancet*, 356, Issue 9223.

point that she committed suicide. In Côte d'Ivoire, a young woman was lynched. A recent court case in Kenya highlights the need for the protection of infected persons. A superior court had to intervene to prevent a seropositive woman from being thrown out of her conjugal home. A lower court had supported the action of the husband, whose own sero-status was unknown. Laws are needed to prevent such injustices.

The ethical and human rights aspects of HIV/AIDS are complex. They go beyond protection of the rights of the infected. At which point does protection of the rights of the infected and affected become an infringement on the rights of the non-infected? This is the central question surrounding the ongoing debate concerning notification. Who should be notified of an individual's HIV status? Must the sexual partner(s) of an individual who tests positive be notified? Must health-care providers and other caregivers disclose their HIV status to their patients and clients? Do they have a reciprocal right to know? Is it ethical to conduct tests on pregnant women for surveillance purposes without notifying them of their status? Under what conditions must vaccine research and human trials of new drugs be conducted? These and myriad other questions need to be pondered as the basis for legal and legislative action.

The legal and legislative responses to these new dilemmas must be debated and instituted at all levels – from community, national, regional or subregional to international. Local authorities can institute by-laws and local edicts. Parliaments and other law-making bodies need to promulgate appropriate laws or decrees. At the international level, conventions and treaties protecting the rights of migrants and regulating biomedical research on human subjects need to be revisited and updated where necessary. These are major challenges for advocacy.

4.5 Establishing a Positive Policy Environment

Many countries in the region are attempting to formulate comprehensive HIV/AIDS-prevention and control policies. This is in line with the scaled-up response advocated by UNAIDS. National policies are useful because they provide a framework to guide actors and actions. An added advantage is that the policy-making process itself is educational; participants become sensitized to the issues involved. As such, policy-making can be an advocacy tool in its own right. If properly conducted in a participatory and consultative manner, it can also build consensus and cohesion around approaches.

However, formulating a comprehensive national policy on HIV/AIDS is a formidable challenge. First, the epidemic and its ramifications are new and constantly evolving. There are few examples in the region to draw upon. As elucidated in the next section, the data and information essential for effective policy-making are seldom available. The lack of information and experience also means that consensus on priorities and strategies is difficult to achieve among stakeholders.

Another danger is that policy formulation may become an end in itself. Past experience with other policies in the region counsel caution. Sometimes the process drags on so long that it is overtaken by events. In other instances, institutions set up to coordinate the process evolve into permanent structures with activities far removed from their original

purpose. Another inherent danger in formulating a comprehensive policy for an issue as complex and emotion-laden as HIV/AIDS is the imperative of compromise. In other words, as different stakeholders may hold very strong views on some aspects, the only way to advance is to let go of some positions. For instance, it is conceivable that pressure from some powerful religious groups may lead to downplaying condom availability as a strategic response. Other groups, for different reasons, may object to targeting adolescent, migrants, prostitutes, or the military as vulnerable or risk groups. In the end, undue compromise may reduce the policy to its lowest common denominator.

Finally, one must consider the possibility that, after expending so much time and effort, the policy may not be implemented but remain a mere document on the shelf of government ministries. The African region is bestrewn with the carcasses of good policies. In some countries, one may count a National Policy on Women, a Community Development Policy, a Youth Policy, a Children's Policy, a National Health Policy, etc. So, one may ask, why would Governments and their partners invest time and resources in developing policies and not implement them? The answer may be summarized in three words: "commitment", "capacity" and "resources".

Commitment derives from ownership as well as awareness and conviction. If a policy is perceived to be driven by external interests, it has scant chance of being fully implemented. Decentralization offers a case in point. Countries committed to decentralization as an internal political imperative, such as Ethiopia, Ghana, Nigeria and Uganda, have managed to carry it off with a reasonable degree of success. On the other hand, countries that are "helped along" by external partners seem to make heavy weather of it. At times, Governments may be committed to the policy but lack the capacity or resources to carry it out. In this instance, the role of external partners is determining. The experience of national population policies is also instructive. After launching these policies with great fanfare in the 1980s, many countries went through elaborate motions, including setting up population planning and development units, to pilot the process. However, the implementation of these policies, some of them revised in the mid-1990s after the 1994 ICPD in Cairo, is uneven across the region. The bottom line appears to be that, despite the comprehensiveness of the policies, only those portions to which the Government or donors are committed will be implemented. In the case of population policies, this tends to be family and safe motherhood programmes that are appropriated by ministries of health and NGOs.

With this realization, what should be the focus of advocacy for developing comprehensive HIV/AIDS policies at the dawn of the twenty-first century? First, advocates should caution African Governments and their development partners about the pitfalls and potholes on the way to effective policy formulation and implementation. Advocacy should also focus on convincing African leaders to assume full ownership of the issues and process. Once the policy formulation process is under way, advocacy must address the critical issues of capacity and resources to implement it.

Experience from the population field also indicates that there may be an alternative route. Instead of formulating a comprehensive national policy, countries may choose to integrate HIV/AIDS aspects into sectoral and thematic policies. As many countries

already have, or are developing, policies for various sectors and themes, such as education, communication, gender, health and labour, a focus of advocacy could be to ensure that each of these policies incorporates HIV/AIDS as a key issue. This may be a sensible way to achieve multisectoral participation.

4.6 Improving National Coordination and Governance

Since the early days of the epidemic, national AIDS control programmes have been the focal institutions for coordinating HIV/AIDS-prevention and control efforts in most African countries. But with the scaled-up response, the typical national AIDS control programme faces a major handicap: as a unit within the ministry of health, it is limited in its ability to coordinate the activities of other sectors. To overcome this problem, some countries set up national AIDS committees, comprising high-level officials drawn from relevant sectors. By and large, however, these proved ineffectual. In the United Republic of Tanzania, an equivalent body, the Inter-Ministerial Committee on AIDS (IMAC) comprises principal secretaries of all ministries. It has proved difficult to assemble these busy officials for regular meetings. Indeed, the full IMAC is reported to have met only twice in eight years.

The inadequacies of the national AIDS control programme and other existing coordination mechanisms in coping with the scaled-up response have led to attempts to "scale up" the coordination bodies themselves. This approach takes two routes. The first is the creation of a high-level, multisectoral coordinating body. In Ethiopia, this has taken form of the National AIDS Council; in Ghana, the National AIDS Commission; and, in the United Republic of Tanzania, the National Advisory Board on AIDS. The second route is to locate the new body within the office of the President, Prime Minister or some other more authoritative centre. The idea is that placing the coordinating body within an institution with an existing coordinating mandate will enable it to overcome the difficulties that typical national AIDS control programmes encountered in dealing with non-health sectors.

Instituting and operationalizing "scaled-up" national coordinating bodies raises several advocacy issues. The first involves persuading national political leaders, policy makers and other key stakeholders of the need for such an institution. This task may be complicated by an attachment to the existing national AIDS control programme or other coordinating body. In the United Republic of Tanzania, a proposal to "promote" the national AIDS control programme to the Office of the President to serve as the secretariat of the proposed national advisory board on AIDS has been languishing in review since March 2000. Evidently, not all stakeholders are convinced that this move is desirable. Some officials fear that locating the national AIDS control programme within the President's office, where it will compete with more politically powerful programmes, will compromise its clout and effectiveness, producing the opposite effect from the desired one.

The leadership and membership of the coordination institution also needs to be thoroughly debated. In the United Republic of Tanzania, the selection of a respected former State President as chairman of the National Advisory Board on AIDS has given the board visibility and clout. However, some technically oriented stakeholders are concerned that access to the chairman is constrained because of his status. Requests to meet him must pass through the Ministry of Foreign Affairs and be vetted by security agencies. In Ethiopia, the State President is the chairman of the National AIDS Council, but the secretariat of the Council reports to the Prime Minister, the key executive authority. This may lead to confusion down the line. In Ghana, some experienced population and health professionals expressed concern about the choice of the nation's President as chairman of the National AIDS Commission . It was feared that a politically partisan personality might polarize rather than build consensus around HIV/AIDS control policies and strategies. A related issue to be resolved is the level of involvement of United Nations agencies and other development partners. Should such partners become members of the coordination body? If not, what is their proper role? These questions need to be properly studied and consensus reached among all stakeholders.

Another role for advocacy is to guide the set-up and operationalization of the coordination body to prevent it becoming just another government bureaucracy. Here again, lessons may be derived from the experience of population programmes. As mentioned in the above section, the process of formulating population policies was accompanied in many African countries with the establishment of national institutions to coordinate the process. In some countries, population planning and development units set up to coordinate the policy formulation process have become orphan institutions. In other instances, they have been replaced by high-level coordinating bodies, such as the National Population Council in Ghana or the National Office of Population in Ethiopia. Even with these high-level bodies, performance is variable. The main difficulty appears to be with defining and operationalizing the notion of "coordination". Whereas many programme implementers translate it to mean freedom from interference, some coordinating bodies seem to interpret it to cover, or even focus on, supervision, oversight and control. Many also find it difficult to resist the lure of implementation, thus confounding their role with that of the institutions whose activities they are supposed to coordinate. It is absolutely essential for the new HIV/AIDS coordinating institutions to avoid these pitfalls. This should be a major focus for advocacy.

4.7 Improving the Knowledge and Data Base

Good information and data are the foundation of good advocacy. For HIV/AIDS advocacy, three types of data are essential, namely:

- Epidemiological data mapping out the scope and evolution of the epidemic. For HIV/AIDS, this information is usually gathered through sentinel surveillance. Representative, population-based studies are rarely used because of their cost and survey-related issues;

- Impact data assessing the effects of HIV/AIDS on various population segments, development sectors or fields of endeavour. Impact data can be obtained through surveys, operational research and various forms of analysis; and

- Sociocultural data explaining the cultural, societal and behavioural underpinnings of the epidemic. A wide range of methodologies may be used to gather sociocultural information, including surveys, anthropological studies, focus group discussions and other forms of rapid assessment.

From an advocacy perspective, these data are essential for two purposes. First, they form the basis for message and materials development. Scientific and accurate information that is packaged in appropriate formats is necessary to sensitize and convince leaders. The most useful advocacy materials and presentation formats, such as wall charts and the AIDS Impact Model (AIM), rely on research data for their effectiveness. Second, scientific data provide a good weapon against denial. Without the evidence they provide, policy discussions on HIV/AIDS can degenerate into polemics or demagoguery.

So, given the indisputable need for good data for advocacy, planning and other purposes, how have African countries responded? Thus far, the picture is somewhat discouraging. In Ghana, the Ministry of Health operates a network of 25 sentinel sites in all 10 regions. These provide fair coverage and an up-to-date assessment of the evolution of the epidemic. They also constitute the cornerstone for most advocacy efforts. The revelation that the HIV prevalence rate had reached 4.6 per cent by the end of 1999 provided a rallying point for advocacy involving political and civic leaders at all levels. The message was that the country must not cross the 5 per cent threshold. Data from the sentinel surveillance also drive the advocacy actions of the Population Impact Project and Policy Project, the centerpiece of which is the AIM presentation. The experience of Ghana demonstrates both the promise and the frustration of the national sentinel surveillance system. As advocacy programmes direct their efforts increasingly towards grass-roots leadership, they find the national data to be an excellent entry point. However, they are seriously constrained by the absence of community-level prevalence or impact data. This realization has led efforts to encourage district assemblies to gather community-based data to aid the planning for district-level prevention and control interventions.

Yet, with all its weaknesses, the Ghana situation appears to represent one of the better cases with regard to the availability of prevalence data and their utilization for advocacy. In the United Republic of Tanzania, the national sentinel surveillance system has been reduced to eight functional sites in one region, Mbeya. In Ethiopia, the National Health Research Institute bemoaned the inadequate coverage of the infant surveillance system and the shortage of skilled technicians. In Burkina Faso, Côte d'Ivoire and Malawi, the stories are similar: inadequate and sometimes diminishing coverage. The high cost of establishing and maintaining an effective surveillance system coupled with the shortage of skilled technicians compromises the reliability and validity of prevalence data in many African countries.

With regard to impact data, these appear to be in short supply everywhere. Yet, anecdotal evidence suggests they could be effective for advocacy. The previously cited examples of the involvement of TANESCO and the Ports Authority in the United Republic of Tanzania, and private-sector enterprises in Côte d'Ivoire and Malawi as well as military authorities in Ethiopia, Côte d'Ivoire, Malawi and Uganda are all likely due to their exposure to impact data. In addition to cost, one main reason for the scarcity of impact data is inadequate technical capacity.

Sociocultural information is generally abundant in African countries. Over the past two decades, thousands of knowledge, attitudes and practice (KAP) and other behavioural research and community studies have been carried out by development projects in practically all sectors. In addition, university-based scholars and other researchers have carried out numerous anthropological studies. The problem is that, in most countries, no database exists to enable access to this information.

The advocacy challenges with regard to HIV/AIDS information and data are three-fold. First, African Governments, donors, private-sector enterprises and other stakeholders need to be persuaded to invest in HIV/AIDS-related data systems. The notion that surveillance and other data-gathering programmes are expensive to operate is short-sighted. Without credible data, denial will persist and opportunities for effective advocacy will be missed. Second, African countries need the technical expertise to better exploit and utilize existing data for effective advocacy. Technical expertise is required, especially for impact analysis and the packaging of data into print or electronic formats that speak to leaders. Third, there is a great need for HIV/AIDS databases and management information systems that facilitate access to data and the sharing of information.

4.8 Influencing Cultural Norms and Religious Beliefs

Cultural practices, norms and taboos regarding sexual behaviour, the use and exchange of blood, marriage and inheritance, etc. are known to affect the progress of HIV/AIDS. Religious beliefs and doctrines – Christian, Islamic or traditional – pervade the daily lives of most Africans. Cultural and religious leaders often exert a more significant influence at the grass-roots level than Government and other formal and "modern" institutions do. Often the laws and policies promulgated by parliament hold less sway in rural, traditional communities than religious edicts or centuries-old customary laws enforced and reinforced by community sanctions and taboos. For instance, the United Republic of Tanzania and other East African countries have passed laws according men and women equal rights to inheritance and ownership of laws. By and large, however, these laws are ignored in communities where customary laws dictate that only men can own land or inherit property. In Kenya, there is an ongoing debate about abolishing the custom of wife inheritance prevalent among some ethnic groups. This practice, conceived in the past to "protect" widows and their children from destitution, is now widely suspected to be a key culprit in the spread of HIV/AIDS. However, public pronouncements by some conservative elements of these communities indicate that this effort will encounter resistance.

So, how can advocacy be used to affect cultural norms and deeply rooted religious beliefs that impact on HIV/AIDS prevalence? One key approach is to target cultural and religious leaders who wield their influence to ensure adherence to cultural and religious norms. Often these "custodians of culture" can reinforce or counteract new ideas and practices through interpretation of customary law or religious texts. Some traditional leaders can pass edicts that have the force of law in their communities. They can also establish and implement programmes through their authority systems. In Ghana, the Asantehene (King of Ashanti) has established an HIV/AIDS fund and instructed all his paramount and junior chiefs to use all public occasions to educate their subjects about the epidemic. In Uganda, the Kingdoms of Buganda, Toro, Busoga and Bunyoro-Kitara are all engaged in programmes to promote reproductive health and gender equity. In Burkina Faso, the Moro Naba Supreme leader of the Mossi has lent support to various social/health programmes, including one for the protection and empowerment of the girl-child. However, the response of this traditional leadership structure to HIV/AIDS, as to other challenges, is seldom pro-active; prodding from the Government and NGOs is usually needed to put their considerable network and influence to work.

The two dominant religions in Africa, Christianity and Islam, both exert significant influence on public life. Religious leaders are viewed as moral leaders. They also represent institutions that affect communities and families through their community-development undertakings. They run schools and hospitals and are involved in environmental protection, water supply and sanitation as well as all sorts of community-development programmes. Above all, their evangelization programmes provide a well-oiled machinery for information and education. Religious organizations are at the front line of the fight against HIV/AIDS in many African countries. They run counselling, care and support programmes through their health institutions or through the community-based organizations they foster. In Côte d'Ivoire, l'Equipe de Lutte contre le SIDA en Zone Rural (ELUZOR) embraces the Methodist Church, the primary school teachers union (Syndicat d'Enseignants Primaire en Côte d'Ivoire, SYNEPCI) and l'Organisations Ivoirienne Chrétienne pour la Protection de la Santé (OICPS). ELUZOR undertakes information, education and communication (IEC); counselling; hospital and home-based care and support programmes; and it deals with the social impact of HIV/AIDS. In Ethiopia, the Christian Relief and Development Association (CRDA), an umbrella organization that brings together 130 church-affiliated NGOs, has been at the forefront of HIV/AIDS advocacy. CRDA members also offer IEC, counselling, care and support through its various programmes. In the United Republic of Tanzania, the Christian Social Services Commission, established by the Christian Council of Tanzania (CCT) and the Tanzania Episcopal Council (TEC), support member churches of all denominations to conduct a variety of HIV/AIDS-prevention and control interventions, including counselling and testing, home care, IEC, blood safety and condom promotion (for some Protestant churches). CSSC support comes in the form of policy advocacy, capacity building and technical support, including research.

In a promising new development, an ecumenical response to HIV/AIDS prevention and control is emerging. In the United Republic of Tanzania, religious leaders of different faiths and denominations have formed an Inter-Faith Forum, comprising the CSSC, Bakwata (the Supreme Islamic Council of Tanzania), the Hindu Mandal and the Agha

Khan Foundation, to deal with poverty and HIV/AIDS. In Côte d'Ivoire, a similar ecumenical approach that embraces Islamic and Christian denominations has come up with the notion of *"théologie de crise"* to harmonize strategies to combat HIV/AIDS. Similar examples of religious organizations collaborating in the fight against HIV/AIDS may be found in Ghana, Senegal, Uganda and other countries.

These examples demonstrate the significant potential and actual contribution of cultural and religious leaders in the fight against HIV/AIDS. However, the role of these leaders has not always been positive. Many cultural leaders defend or condone circumcision, various blood rites, widow inheritance and other traditional practices that are known to spread HIV infection. Some Christian and Islamic groups, on doctrinal grounds, are staunchly opposed to some key prevention strategies, including condom distribution, popoulation and family life education, and other interventions aimed at adolescents.

Based on the above analysis, it would appear that two different advocacy approaches must be adopted in dealing with cultural and religious leaders. On the one hand, they must be encouraged to collaborate with other groups fighting to contain HIV/AIDS in the interventions on which there is clear consensus, such as counselling and home care. Where there are irreconcilable differences, as in the matter of condom promotion or sexuality education for unmarried adolescents, efforts should focus on persuading leaders not to oppose or derail efforts by other groups working in those areas. This is the approach adopted in the UNFPA-supported youth peer education project run by the Catholic Diocese of Nakuru in Kenya. This project builds upon the church's existing youth education programmes to promote youth-to-youth education and counselling on HIV/AIDS. Condom use is not promoted under the project.

4.9 Reinforcing Global Solidarity

The international community has reacted to the growing epidemic in Africa with a number of global initiatives. The UNAIDS Secretariat in Geneva has led the effort to define a strategic approach that emphasizes preventive interventions while piloting promising, cost-effective treatment and care options. HIV/AIDS Theme Groups, coordinated by the United Nations Resident Coordinators, assist African Governments in translating the strategic plan into action. In January 1999, IPAA was formed. This unique initiative brings together United Nations agencies; bilateral partners; NGOs; private-sector corporations, including pharmaceutical companies; and African Governments to devise joint strategies and plans to combat the HIV/AIDS epidemic.

Among the key strategies of the partnership is advocacy, with an emphasis on resource mobilization and increasing political commitment. Since the formation of the partnership, a number of global corporations, including Rio Tinto, Pfizer, Bristol-Myers Squibb and Glaxo, have pledged significant funds to support HIV/AIDS-prevention and treatment interventions as well as vaccine research. The Bill and Melinda Gates Foundation provided $57 million to fight the spread of HV/AIDS among adolescents in Botswana, Ghana, Uganda and the United Republic of Tanzania. The Gates Foundation also joined with Bristol-Myers Squibb to provide $100 million to pilot ART in Bostwana. In addition, most of the international development partners have stepped up their

HIV/AIDS support programmes. In June 2000, the World Bank announced a $500 million emergency fund for HIV/AIDS initiatives in Africa.

The United Nations family has demonstrated its concern. The Security Council held a special session on HIV/AIDS, with a special focus on Africa, the first time the Council has held such a meeting on a development issue. The Secretary-General convened a special session of the General Assembly to debate the issue. At these gatherings, both the Secretary-General and the director of UNAIDS made eloquent pleas for the international community to support Africa's fight against the epidemic. The final communiqué of the Millennium Summit, attended by 150 world leaders in New York in September 2000, highlighted HIV/AIDS as a global challenge and established targets for arresting and reversing the epidemic. Several United Nations and bilateral organizations and agencies have refocused their strategies and allocated additional funds. The Executive Council of the ILO approved the Organization's application to join UNAIDS after two years of studying the relevance and impact of the epidemic on the world of work. FAO is also considering membership. UNFPA, a founding member, is currently refining its overall HIV/AIDS strategy.

Political leaders of the world's leading economic powers have begun to lend their voice and considerable influence. During his African tour, former U.S. President Bill Clinton emphasized the danger posed by HIV/AIDS and announced a $1 billion fund that African countries can access at low interest. The final communiqué of the June 2000 G-8 meeting in Japan cited HIV/AIDS as a global challenge. Evidence of the commitment of donor countries is manifested through the support of bilateral partners. The Swedish International Development Cooperation Agency (Sida) established a subregional office in Harare, Zimbabwe. Sida also funded the first phase of the HIV/AIDS advocacy initiative that UNFPA is implementing on behalf of IPAA. The British Department for International Development (DFID), the United States Agency for International Development (USAID), the Danish International Development Agency (DANIDA), and the Netherlands and Japanese aid agencies have all increased their funding for HIV/AIDS programmes. The motivation of developed countries is not merely charity; self-interest is involved. The United States has pronounced HIV/AIDS as a national security threat.

As the support of the international community is essential to defeat HIV/AIDS in Africa, it is important to sustain it. What advocacy approaches are needed to achieve this? And what should the message be? The UNAIDS Secretariat and its director, Dr. Peter Piot, provide an example of one approach. Dr. Piot has used the occasion of the United Nations Security Council, the United Nations Economic and Social Council (ECOSOC), G-8 and similar meetings to plead with leaders of the developed countries and transnational corporations to help find solutions to the HIV/AIDS tragedy in Africa. This approach seems sensible and needs to be expanded. An effort should be made to recruit leaders of other development organizations to address political and business leaders of the developed countries on the issue. Many leaders of development institutions, including the World Bank and United Nations agencies, have focused recent efforts on eliciting political commitment from African leaders. It is necessary to address similar efforts to increase donor commitment.

International NGOs and HIV/AIDS activist groups have carried out a parallel advocacy effort by capitalizing on key global meetings to increase awareness and support for various HIV/AIDS causes. However, the tactics of the various groups differ widely. Some, such as ACT UP, adopt deliberately provocative and controversial methods to get their message across. Although such approaches may have their value, their representation in the media as either disruptive or frivolous diminishes their effectiveness. IPAA, which embraces NGOs, might provide a "respectable" avenue for some of these groups to channel their messages if they chose to operate under its umbrella. IPAA members with abundant media expertise, such as Panos, might also assist in relations with the media.

African leaders also have a role to play in soliciting support from their counterparts in developed countries. In the past several years, they have used the occasion of the annual summits of heads of State and Government to reaffirm their commitment to combatting the HIV/AIDS epidemic. However, African leaders may not have sufficiently stated their case for international support in the fight against HIV/AIDS, as compared to other pressing issues. A collective effort needs to be deployed on behalf of HIV/AIDS as was been done for African debt forgiveness, for example, at the G-8 2000 Summit. Africa-led advocacy efforts could focus on access to ART and other expensive treatment regimes, and a more significant involvement of African scientific institutions in vaccine and pharmaceutical research as well as additional financial resources to carry out prevention, care and support interventions. It is discomfiting that African leaders should leave other world leaders and development institutions to speak on their behalf on an issue that so clearly affects the long-term survival of the continent. The OAU secretariat, ECA and other regional and subregional development bodies have a key role in preparing African leaders for this global advocacy effort. The second African Development Forum organized by ECA in December 2000 provided an excellent opportunity for African leaders to hone their message and strategies for global advocacy.

4.10 Undertaking Advocacy for Behaviour Change

Many have argued that the most effective antidote to the spread of HIV/AIDS in Africa is for Africans to change their sexual behaviour, as heterosexual transmission accounts for about four fifths of the HIV infections on the continent. However, the record of BCC interventions, along with promotion of the use of condoms, has been dismal thus far. Although the purpose of advocacy is not to affect behaviour directly, it can be used to improve the environment and effectiveness of behaviour change programmes. In Ghana, the support of the National Population Council and the Ministry of Health has enabled the Ghana Social Marketing Foundation (GSMF) to expand its condom promotion programme to become a major plank in the national HIV/AIDS-prevention and family planning programmes. According to the 1999 Ghana Demographic and Health Survey (DHS), the GSMF programme accounts for two thirds of condom use. The current enviable position of the GSMF is the result of over two decades of persistent advocacy with media institutions, religious bodies and government officials to accept a large-scale condom programme through a social marketing approach. By comparison, the condom social marketing programmes in Côte d'Ivoire, Ethiopia and the United Republic of Tanzania are still in their infancy, with limited coverage and market penetration. In

addition to social marketing, condom distribution through community-based distribution (CBD), youth-to-youth and work-site programmes needs to be considerably expanded in many countries. Cohesive advocacy is needed to convince government officials, media, religious bodies and even health authorities to support a significant expansion of male and female condom distribution programmes.

Advocacy can also foster the organization or expansion of counselling and educational programmes of all kinds, including VCT, preventive and supportive counselling, peer education, and population and family life education, that are known to affect attitudes and behaviour that influence the spread of HIV. Thus, advocacy, although not directly changing behaviour, can create an enabling climate for programmes that do.

5 STRATEGIC OPTIONS FOR ADVOCACY

5.1 Factors Affecting Strategic Choices for Advocacy

The choice of an advocacy strategy to deal with HIV/AIDS in Africa must recognize that the continent is neither homogenous nor static; it is complex, variegated and rapidly evolving. Therefore, the epidemiology of the disease and responses to it vary widely. As this section attempts to devise a strategic framework for advocacy, it highlights some of the factors in the environment that have influenced the evolution of the epidemic and how leaders in different settings have reacted to it.

The first set of factors is socio-political. Africa is undergoing a quiet revolution in governance. A number of external and internal pressures, including the end of the cold war, globalization and disillusion with various homegrown or externally driven economic and political experiments through the first three decades of independence, have set off a lively debate on governance throughout the continent. Democratization is in vogue, with many countries moving towards a multi-party political regime. There is a trend towards decentralization as a way of increasing the participation of local communities and others at the periphery of the political and development process. Nigeria and Ethiopia are at different stages of establishing a federal system that grants a large measure of autonomy to states/regions and local government areas (LGAs)/woredas. Ghana and Uganda have moved to devolve considerable political and administrative authority to districts. These changes offer opportunities as well as challenges to HIV/AIDS advocates and programme implementers.

Another political reality is the existence of internal and cross-border conflicts. From Burundi to Congo, from Eritrea and Ethiopia to Liberia and Sierra Leone, civil wars, and ethnic and political conflicts rage unabated despite the efforts of regional and international mediators. These conflicts often draw in neighbouring countries, either as co-combatants, as the case of the Democratic Republic of Congo, or as peacemakers/enforcers, as with the ECOWAS Military Organization (ECOMOG) in Liberia and Sierra Leone. Even countries not directly involved in the fighting may be affected by an influx of refugees. This is the case in Côte d'Ivoire, Kenya and the United Republic of Tanzania. The link between conflicts and the spread of HIV/AIDS is well documented. Mass displacement of populations, increased incidence of violence against women, mobilization and de-mobilization of young men and women of fighting age all constitute risk elements.

In many countries, civil society has emerged as strong force that demands, and increasingly obtains, a voice in political and development decision-making. The growing support of the United Nations system for NGOs and other civil society groups since the 1992 United Nations Conference on Environment and Development in Rio de Janeiro has strengthened the hand of local operators and given rise to networks that span countries,

subregions, regions and continents. In Côte d'Ivoire, Ethiopia and the United Republic of Tanzania, NGOs, religious organizations and other civil society groups initiated the fight against HIV/AIDS years before many government departments did. In Ethiopia, when CRDA held a conference in 1996 on the theme "Breaking the Silence", it was ground-breaking.

Civil society groups have also brought to the fore development issues that are closely linked to HIV/AIDS. The increasing gender awareness in many countries may be ascribed largely to civil society pressure, although ministries and other government departments responsible for gender or women's affairs often played a significant role in policy guidance. In reproductive health, NGOs played a signal role. In many countries, they pioneered condom distribution, adolescent sexuality education and male-involvement programmes long before these interventions became mainstream.

The socio-economic environment is also relevant to a discussion of HIV/AIDS advocacy in Africa. Persistent poverty and inadequate basic social services, notably health and education, provide a conducive environment in which HIV/AIDS can thrive. On the positive side, the media landscape is changing rapidly. Private newspapers are booming, particularly in urban centres, and, perhaps more significantly, community-based/focused radio stations are sprouting everywhere. Even television is reaching more Africans. In Ghana, the 1988 DHS recorded regular TV viewership of 5 per cent. The figure rose to 25 per cent by 1993. By 1999, the DHS showed that more than 50 per cent of Ghanaians watched TV regularly. A number of countries, including Cameroon, Côte d'Ivoire, Kenya, Nigeria and South Africa, have similar or greater TV penetration. There has also been a rapid rise in information and communication technologies (ICTs) – albeit from a very low base.[9] Growing access to the Internet in urban centres, and in strategic areas such as the media, schools and universities, makes it easier for African to share knowledge on HIV/AIDS and other development issues.

On the sociocultural front, African societies are caught in a double bind. On the one hand, traditional practices and beliefs still govern many aspects of individual and community life. Some of these practices, such as polygamy, wife-sharing or inheritance, are known to favour the spread of HIV. Some traditional beliefs that ascribe diseases to witchcraft of divine retribution may lead individuals not to take necessary precautions. Yet, these practices and beliefs exist, especially among youth and urban dwellers, side by side with "globalized" cultural norms acquired from mass information and entertainment media. Some of these "modern" trends encourage attitudes, such as a more liberal or casual attitude to sexual relations, that compound HIV/AIDS risk.

The HIV/AIDS epidemic is unravelling against the background of an international development partnership that is increasingly questioning aid and development strategies. The current jargon favours globalization over development, and trade and investment

[9] See Opia Mensah Kumah, "Advocacy for Population and Reproductive Health: Key Concepts and Their Implications for Emerging Information and Communication Technologies (ICT)", in Technical Report on the UNFPA International Seminar, "ICPD Advocacy in the Global Information and Knowledge Management Age: Creating a New Culture", Ankara, 1998. The paper proposes strategies to capitalize on ICTs in technology-deprived African societies.

over aid. Africa's crippling debt burden has merely elicited vague promises from the G-7 countries and led to the institution of the Highly Indebted Poor Indebted Countries (HIPIC) programme by the Bretton Woods institutions. The failure of structural adjustment programmes to deliver African countries from poverty has contributed to the atmosphere of gloom. One recent fiasco is the collapse of the Cedi, the currency of Ghana, long promoted as one of the good pupils of the Bretton Woods institutions. More and more, the talk is of "donor fatigue" and the hopelessness of Africa and other developing areas. In its May 2000 issue, *The Economist* magazine splashed across its cover the words "HOPELESS AFRICA". This is not an environment that favours global partnership.

5.2 Practical Tools for Making Strategic Choices

The following tables have been prepared as practical tools for use by groups of stakeholders working on the development of advocacy for HIV/AIDS. Tables 1, 2 and 3 are designed to be used in that order. The tables present an opportunity for a participatory process in which working groups arrive at a consensus on how to complete them through sharing information and making decisions about the relevant HIV-related facts and realities in their domestic environments.

Table 1: Strategic Options Framework

Table 1 is designed to enable group members to situate a country/community within the HIV/AIDS "advocacy space".

Across the top of the page, from left to right, there are six "scenarios", explained in the Note at the bottom of the table. After discussions, the group should decide which "scenario" best reflects where the country/community country is today. The group then places an **x** in the appropriate box in the first row.

Down the left side of the page, there are 10 interventions which are currently being used in HIV/AIDS-related work. The group should choose the intervention(s) considered to be a priority for the country in its current scenario stage, and mark with an **x**. When all the x marks have been made, the form is completed. It can be used to provide information needed to design an advocacy strategy for HIV/AIDS for the country/community.

Table 1. Strategic Options Framework

Areas of focus for advocacy	Advocacy Scenarios10					
	Scenario 1 Low prevalence, with low level of advocacy preparedness	**Scenario 2** Low prevalence, with high level of advocacy preparednes s	**Scenario 3** Medium prevalence, with low level of advocacy preparedness	**Scenario 4** Medium prevalence, with high level of advocacy preparedness	**Scenario 5** High prevalence, with low level of advocacy preparedness	**Scenario 6** High prevalence, with high level of advocacy preparedness
1. Harnessing leadership commitment						
2. Reinforcing programmes and response interventions						
3. Mobilizing resources						
4. Adapting the legal/legislative framework						
5. Fostering a positive policy environment						
6. Improving national coordination and governance						
7. Improving knowledge/data base						
8. Influencing cultural norms and religious beliefs						
9. Reinforcing global solidarity						
10. Undertaking advocacy for behaviour change						

[1] Note: These scenarios derive from consideration of a combination of factors, notably the stage of the epidemic in a given country as well as the level of national commitment towards combatting it.
The stages of the epidemic may be conceived in terms of the HIV seroprevalence rate, as follows: stage one: <5%; stage two: >5% to 10%; and stage three: >10%. The level of commitment or advocacy preparedness is a more qualitative measure that takes account of several factors, including: existence of a national policy framework, including an action plan; an institutional framework (such as a national AIDS control council); public declaration of commitment by high- level political, cultural and other opinion leaders; level and mechanism of resource mobilization and allocation from national sources; and level of decentralization of HIV/AIDS interventions.

Table 2: Checklist: Priority Interventions for Advocacy in HIV/AIDS Work shown by Channels of Intervention

Table 2 is designed to help the group create a "map" of how a country/community might handle the priority advocacy interventions through selecting appropriate channels, media and actions.

Across the top of the columns are numbered categories of leaders and stakeholders (numbered 1a through 1f); types of media and channels which could be relevant for advocacy (numbered 2a through 2f); and various advocacy actions (numbered 3a through 3g). The Key at the end of the table identifies each of the numbered items.

Down the left side of the table are various types of priority interventions applied in HIV/AIDS work. Under each intervention, sub-interventions are shown (e.g., BCC under "Prevention").

The task of the group is to select which interventions are desired, and to place an **x** in the boxes which, in the group's view, are appropriate for the country/community. There can be several boxes marked **x** from right to left and from top to bottom.

Table 2. Checklist: Priority Interventions for Advocacy in HIV/AIDS Work shown by Channels of Intervention

Priority interventions for advocacy	Categories of Leaders and Stakeholders							Type of Media/Channels						Advocacy Actions						
	1a	1b	1c	1d	1e	1f	1g	2a	2b	2c	2d	2e	2f	3a	3b	3c	3d	3e	3f	3g
Prevention • BCC • VCT • PTCT • Condom																				
Care and Support • Orphan care • Home care • Hospice care • Etc.																				
Treatment • ART • Palliative care/Treatment of opportunistic infection																				

Impact Mitigation • Macroeconomic level • Key sectors (education, health, agric, industry, tourism, etc.) • Communities • Households/ families																				
Research • Epidemiological • Sociocultural • Impact • Operations research • Pharmacological • Vaccine																				
Gender aspects • Differential incidence among different age groups by sex • Sexual preferences • Harmful practices • Sexual abuse;other forms of gender-based violence • Care economy (differen-ial burden of care)																				
Human rights, ethics, & stigmatization • Notification • Right-to-work • Social/cultural ostracism																				

Key:

1 Categories of Leaders and Stakeholders: 1a -Political , 1b-Economic and financial, 1c-Cultural/traditional/religious, 1d-Civil society,
1e-Media, 1f-Secondary stakeholders/Partners, 1g-Primary stakeholders/Beneficiaries (e.g., PLHWA)

2. Media/Channels: 2a-Mass media, 2b-Traditional/folk media, 2c-Counselling, 2d-Group meetings (conferences, seminars, workshops, etc.),
2e-Print/audio-visual, including computer-based projection/simulation models, 2f-ICT-based media

3. Advocacy Actions: 3a-Building coalitions, network and partnerships, 3b-Sensitizing/awareness creation, 3c-Community/social mobilization,
3d-Lobbying, 3e-Dialoguing/debating, 3f-Negotiating, 3g-Petitioning and other forms of pressuring

BCC = Behaviour change communication VCT = Voluntary counselling and testing ART = Anti-retroviral therapy
PTCT = Parent-to child-transmission

Table 3: Checklist: Priority Areas for Advocacy shown by Channels of Intervention

Table 3 is similar to Table 2. The difference is in the left column, going down the page, which lists areas of advocacy. The task of the group is to decide how those areas relate to the various channels and actions listed by number across the top and described in the Key at the end of the table. As with Table 2, the group will decide on the appropriate choices and mark them with **x**'s.

Table 3. Checklist: Priority Areas for Advocacy shown by Channels of Intervention

Priority areas for advocacy	Categories of Leaders and Stakeholders Actions													Type of Media/Channels					Advocacy	
	1a	1b	1c	1d	1e	1f	1g	2a	2b	2c	2d	2e	2f	3a	3b	3c	3d	3e	3f	3g
1. Harnessing leadership commitment																				
2. Reinforcing programmes and response interventions																				
3. Mobilizing resources																				
4. Adapting the legal/legislative framework																				
5. Fostering a positive policy environment																				
6. Improving national coordination and governance																				
7. Improving the knowledge/data base																				
8. Influencing cultural norms and religious beliefs																				
9. Reinforcing global solidarity																				

10. Undertaking advocacy for behaviour change																				

Key:

1 Categories of Leaders and Stakeholders: 1a -Political , 1b-Economic and financial, 1c-Cultural/traditional/religious, 1d-Civil society,
1e-Media, 1f-Secondary stakeholders/Partners, 1g-Primary stakeholders/Beneficiaries (e.g., PLHWA)

2. Media/Channels: 2a-Mass media, 2b-Traditional/folk media, 2c-Counselling, 2d-Group meetings (conferences, seminars, workshops, etc.),
2e-Print/audio-visual, including computer-based projection/simulation models, 2f-ICT-based media

3. Advocacy Actions: 3a-Building coalitions, network and partnerships, 3b-Sensitizing/awareness creation, 3c-Community/social mobilization,
3d-Lobbying, 3e-Dialoguing/debating, 3f-Negotiating, 3g-Petitioning and other forms of pressuring

6 RECOMMENDATIONS AND THE WAY FORWARD

This report has shown that advocacy for HIV/AIDS in Africa is a multifaceted bundle of specific and coordinated strategic actions. These actions can be focused on aspects of the evolution of the epidemic, according to the situations, needs and capacities on the ground. The 10 purposes described for advocacy actions in chapter 4 indicate the extent of what can be accomplished through advocacy in strengthening cooperation, in reinforcing programmes and in enhancing the impact of interventions. The variety of these advocacy outcomes clearly shows that more rather than less advocacy will be needed at various levels all across the continent, until the scourge of HIV/AIDS is thoroughly understood in all its dimensions and its spread is contained.

The most important efforts should be deployed at the country level, even when regional and international resources are involved. Especially in HIV/AIDS advocacy, the building of national and local capacities, networks and partnerships should be given top priority. The following short- to medium-term actions are suggested as a follow-up to this report:

1. The capacity of civil society organizations at the national level should be enhanced to undertake and sustain advocacy for HIV/AIDS. To this end, competent African regional NGOs should be identified to provide capacity building for national organizations;

2. Partnerships with regional and national media institutions should be fostered to develop and exchange quality media and advocacy products for distribution in African countries;

3. Entertainment-education approaches in the use of media for HIV/AIDS should be highlighted to capture the imagination of African audiences and to stimulate behavioural change; and

4. UNFPA, UNAIDS and their IPAA partners should:

    - At the African continental level, discuss with the top leadership of the OAU/Africa Union Secretariat and ECA ways to bring together their various advocacy initiatives; and

    - At the subregional level, assist subregional development institutions in building and sustaining capacity for HIV/AIDS advocacy. In this connection, the UNAIDS Inter-country Teams in Abidjan and Pretoria and UNFPA/CSTs in Addis Ababa, Harare and Dakar could provide technical assistance.