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Challenging Norms, Changing Practices

THREE days after the August 30 UN deadline lapsed for Khartoum to intervene in the humanitarian crisis in Sudan's Darfur region, the secretary-general's special envoy, Jan Pronk, told the Security Council that the government had failed to disarm the Janjaweed rebels or halt their campaign of violence against civilians. Now what?

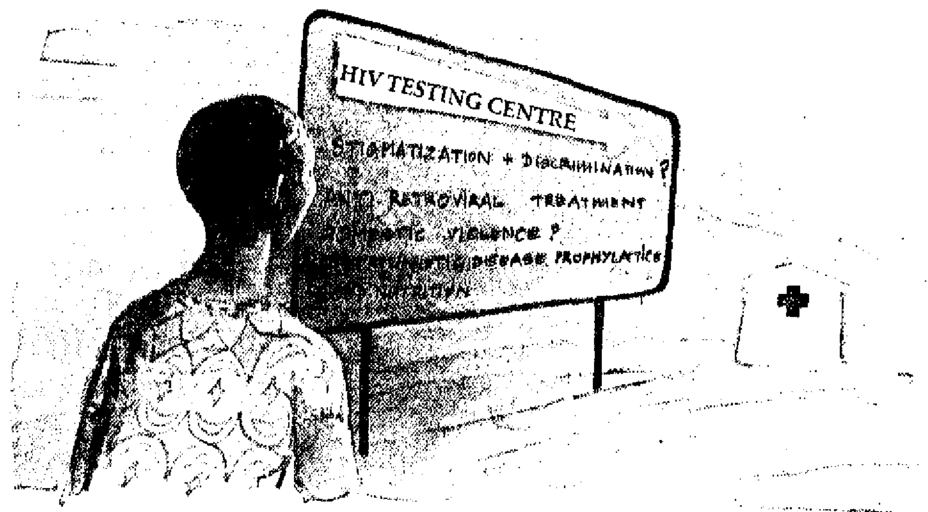
Ten years ago, neither the UN nor African leaders acted to stop the genocide in Rwanda. Now, Nigeria, through the African Union, is hosting crisis talks on Sudan and the UN is expressing more than meek concern. But decisive action against Khartoum remains elusive.

At the other end of the continent, southern African leaders have adopted new standards for elections. The question now is whether they will be applied. For four years, as Zimbabwe has slid further into tyranny, South Africa has shrugged off critics of its 'soft diplomacy' with a glib question: Would you rather we invade?

President Thabo Mbeki is too intelligent a statesmen to believe in such simple 'either-or' constructs. And now, through the new SADC rules, regional leaders have provided a clear third response. With five months to go before Zimbabwe's next parliamentary poll, SADC should call on Robert Mugabe to implement the new standards immediately. Restoring the independent media and allowing opposition gatherings would be welcome first steps down the road to credibility.

In a similar fashion, African and world leaders have faltered in their response to HIV/AIDS, tripped up by funding, stigma and the human rights implications of pro-active testing. Now, as treatment becomes more widely available, there is an opportunity to try new approaches.

Sudan, Zimbabwe and HIV. Changes in approaches to these problems provide cautious optimism, but they also pose a test: Will action follow? Pledges are comforting on parchment; in practice, they invite controversy. Resolve is the difference between rhetoric and renaissance.



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Ross Herbert – Editor/Project Leader
Kurt Shillinger – Managing Editor
Luleka Mangquku – Sub-Editor
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To subscribe:
eafrica-subscribe@saiia.wits.ac.za
Send comments and suggestions to:
editor@saiia.wits.ac.za
www.saiia.org.za

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Verbatim

“Despite growing global attention to the crisis in Darfur, neither the international community nor the Sudanese government has taken the steps needed to ensure protection for civilians on the ground.” – Peter Takirambudde of Human Rights Watch, on the humanitarian crisis in western Sudan.

“The maximum of our estimation for those who died until now doesn't exceed 5,000, including 486 police that were killed or slaughtered by the rebels. Those who say 30,000 or 50,000, we challenge them to get us their names, their tribes, and their graves where they are buried.” – Mustafa Osman Ismail, Sudanese foreign minister, challenging estimates of the number of civilians killed so far in Darfur.

“We are tired of being lectured on democracy by the very countries which, under colonialism, directly denied us the rights of free citizens or were indifferent to our suffering and yearnings to break free and be democratic.” – Benjamin Mkapa, president of Tanzania, at the Southern African Development Community summit in Mauritius in August.

“One would have hoped the SADC leaders to explicitly demand that [President Robert] Mugabe revisit all the draconian pillars he has already put in place to stifle free elections. How can we honestly believe that they can now take action against a fellow comrade?” – Lovemore Madhuku, chairman of Zimbabwe's National Constitutional Assembly, after SADC heads of state adopted a new charter on election standards.

“Embassies must remember that they are here because we want to strengthen our friendship. We do not go to their countries to meddle. It is better for the Americans to concentrate on regime change in their own country, which is the worst, than to come here and talk about regime change.” – Didymus Mutasa, secretary of the ruling Zanu-PF, on the monitoring of cash flows to foreign embassies in Zimbabwe.

“I have not ruled out an offensive against the DRC aimed at making them respect our country's borders.” – Brigadier-General Germain Niyoyankana, head of the Burundian army, accusing Democratic Republic of Congo troops of taking part in a massacre that resulted in the death of more than 150 Tutsi at a refugee camp in Burundi in August.

“Our deployable force is shrinking due to medical reasons.” – Brigadier-General Pieter Oelofse, revealing that 23% of the South African military is HIV-positive.

“If you say to the nation that you are providing anti-retrovirals, then you will wipe out all the gains made in the promotion of a healthy lifestyle and prevention.” – Manto Tshabalala-Msimang, South African health minister, on the possibility of not meeting the presidential target of supplying AIDS drugs to 53,000 people by March 2005.

“The previous government was like a man who goes in a shop with only K200 in his pocket but deliberately picks items amounting to K2000. Leaving the items at the till, he goes outside the shop asking for money from friends to settle the amount.” – Matthews Chikaonda, a former Malawi finance minister fired for insisting on spending within confines, on financial mismanagement under former President Bakili Muluzi.

“We have had enough of the bad reporting. It really destroys our image as a nation and that of our king. These journalists should come to Swaziland to get first-hand information. You may find that they do not even know where Swaziland is. It is just a typical example of a case whereby a monkey thinks it knows how domestic animals such as goats live.” – Prince Masitsela Dlamini, defending Swazi King Mswati III, who has been named as one of the world's 10 worst dictators by the British writer David Wallechinsky in collaboration with Amnesty International and other international human rights groups.

“These men are nothing but blood-thirsty pirates and thieves with no regard for human life.... If I were to be the judge, I would apply the maximum penalty – execution by firing squad.” – Teodoro Obiang Nguema, president of Equatorial Guinea, on the alleged mercenaries accused of plotting to overthrow him.

“Give her a farm!” – Edward Dembezeko, a Zimbabwean, on how Kirsty Coventry should be honoured for winning an Olympic gold medal.

SADC Nails Flag to Polls

New guidelines set higher standards for the way campaigns and elections are conducted

FREE and fair are the crucial words for assessing the quality of elections. They denote the international standard for measuring credibility at the ballot box. But what they mean is often the subject of dispute, especially in Africa. All too often, election monitoring teams reach very different conclusions about the conduct of polls on this continent, with Western and African observers splitting on the verdict. Tragically, boycotts, enduring political acrimony and even civil wars follow.

Cote I'voire, Sierra Leone and Zimbabwe offer compelling evidence of the need both to change the conduct of elections and define a universal standard for judging them. On August 17, leaders of the Southern African Development Community took an important step in that direction when they adopted a code for elections in southern Africa.

The SADC Principles and Guidelines Governing Democratic Elections marks the first time that regional leaders have committed themselves to a set of rules for political contests. The guidelines share many points in common with the SADC Parliamentary Forum's Norms and Standards, and therefore diminish – at least on paper – the potential for split verdicts between the two branches, a problem that occurred in Zimbabwe's 2002 presidential poll.

Provisions

The charter states that citizens have the right to fully participate in the political process – to enjoy freedom of association, to vote and to run for office. Governments are obliged to ensure political tolerance, the independence of the judiciary and impartiality of electoral institutions. All political parties must have equal access to the state media; voters rolls should be up to date and open to public scrutiny; polling dates should be announced sufficiently in advance to allow all parties to participate fairly; campaign financing should be transparent for all parties; polling stations should be in neutral places; ballot counting should take place at voting stations; observer missions should be invited to monitor the period running up to an election and not merely the balloting; states should ensure impartial voter registration, create an environment for 'free, fair and peaceful elections,' and ensure constitutional guarantees of freedom and rights of citizens.

By offering a more detailed standard for judging elections, SADC leaders have removed the argument that international observers are somehow imposing alien rules. But the new code contains several worrying loopholes. Most importantly,

> **'How much violence and denial of rights is sufficient to judge an election illegitimate?'**

SADC heads of state will only send an observer team if requested to do so by the country holding elections.

The new code also obliges all political parties to accept the election victor declared by the legally constituted national election authority. Thus, if an incumbent government manipulates the rules, the opposition has little legal recourse to contest the results.

The guidelines also leave a critical question unanswered: How much violence, denial of rights or other rule-bending is sufficient to judge an election illegitimate? In this, the upcoming parliamentary elections in Zimbabwe, expected in March 2005, provides a crucial test case. Government has closed all major independent newspapers, and state media only features fawning coverage of the ruling party's rabid attacks on the opposition.

No longer by the book

In both the 2000 parliamentary elections and 2002 presidential elections, Zimbabwean police arrested dozens of opposition candidates and supporters while ruling party activists conducted a reign of terror. Farm workers were forced to attend all-night indoctrination sessions where they were beaten if they did not shout ruling-party slogans with sufficient zeal. Government failed to follow its own rules in making the voters roll available. Different identification standards were applied to people seeking to register in opposition strongholds than in areas supporting the government.

But governments in the region never mobilised their diplomats and intelligence agencies to examine what was really happening. Many election observers from the region came late, rarely left their hotels and accepted the flawed logic that accusations of violence levelled by government supporters, although far less frequent, somehow balanced out the larger body of evidence of orchestrated government violence. Governments in the region dismissed reports of atrocities from the media and non-governmental organisations.

With the independent media demolished and the courts systematically purged of politically disinterested jurists, local and international political observers express little hope that the March poll will be more credible than its two predecessors. Frustrated by prevailing conditions, the opposition Movement for Democratic Change has already indicated it will boycott.

Having adopted new standards, the SADC heads of state have done the easy part. The question now is whether they will enforce them. – **Ross Herbert**

SPECIAL FEATURE

States, AIDS Experts Test Boundaries of HIV Testing

As treatments become more available, particularly in developing countries, the line between a patient's health status and right to privacy is beginning to shift

MORE than 2 million Africans died of AIDS last year and 3 million others were newly infected with the virus that causes the disease, yet it is estimated that in most African countries fewer than 10% of the population know their status.

Testing for the human immuno-deficiency virus is one of the thorniest aspects of a health debate fraught with human rights implications. AIDS activists have long argued that infringing on the right to privacy -- by, for example, making HIV testing mandatory – effectively drives the AIDS epidemic further underground. Why find out if you're infected if the consequences are persecution, ostracism, violence and destitution?

International organisations such as UNAIDS and the World Health Organisation (WHO), consequently, hued strictly to the view that voluntary counselling and testing, in which the patient elects to find out his or her status, was the only appropriate approach.

But tiptoeing around the issue of testing did little to either check the epidemic or alleviate stigma in the countries with the highest infection rates and most entrenched and aggressive discrimination against people with HIV. Now, however, as more countries consider or begin making costly AIDS drugs more widely available, views on testing are starting to shift. In an era of treatment, more governments, businesses and health organisations are pushing a proactive approach to HIV testing, hoping to strike a more constructive balance between individual rights and the need to monitor and contain the epidemic.

'Hopes to put 3 million people on treatment by 2005 are likely to fail unless more people learn their status'

In a fundamental policy shift that underscores the changing course of the AIDS epidemic globally, both UNAIDS and the WHO have now embraced an approach that encourages health-care providers to offer HIV tests as a routine part of patient check-ups in AIDS-stricken countries.

'At the moment there are millions of missed opportunities' to test people for HIV, said Peter Piot, head of UNAIDS, during the XV International Conference on HIV/AIDS in Bangkok in July. 'The environment of AIDS is changing dramatically.... [There is] a fundamental shift in the response, where treatment is becoming far more available.'

Not everyone backs the shift. Some AIDS experts and human rights activists remain sceptical, warning that many developing countries do not yet have the means to effectively apply new strategies like routine, or 'opt out', testing, in which health-care providers make a point of offering HIV tests. They fear that the rights of patients – bought at a great price over many years of battling stigma – are at risk.

'I don't have a problem with routine testing as a concept,' said Shannon England, manager of voluntary counselling and testing (VCT) for the Washington-based NGO Population Services International. 'But you need to ensure that it's done correctly and sensitively. I worry that it will be used as an excuse to ignore people's rights.'

Despite such reservations, the new approach is starting to catch on. So far, four African countries are either implementing or drafting policies to adopt the new testing guidelines endorsed by the WHO and UNAIDS in June.

The change in strategy has been driven largely by the realisation that ambitious plans to provide anti-retroviral drugs to people with AIDS – like the WHO's '3X5' programme, which hopes to put 3 million people in developing countries on such treatments by 2005 – are likely to fail unless more people learn their status.

At least 20 African countries have begun or have plans to roll out limited public anti-retroviral programmes. But according to the Global Business Coalition on AIDS, a New York-based coalition of multinational companies, 500,000 people will need to be tested every day in order to meet the WHO's goal using the current VCT model, which relies on people taking the initiative to find out their status and often misses those at highest risk of infection.

HIV testing has long been seen as primarily a preventative measure: Numerous studies have shown that people who know their status and have

received counselling are more likely to change their behaviour, although little research has been done on the effect on behaviour of testing without counselling. As a result, until recently, the only testing provided in most African countries was through a handful of VCT centres run or funded largely by international non-governmental organisations.

'AIDS exceptionalism'

In the absence of anti-retroviral treatment many health professionals believed there was little value to widespread HIV testing in a medical context. Consequently, such testing was largely separated from other medical programmes and most hospitals and clinics did not offer HIV tests.

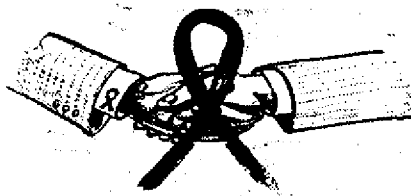
The international community's emphasis on counselling may also have served as a disincentive to test. In many public hospitals and clinics, heavy case loads made offering the kind of personalised counselling supported by international organisations impossible.

While universal anti-retroviral access for people with AIDS is still years away, many countries have now changed their position on HIV testing, realizing that neither prevention nor treatment programmes will succeed until a majority of people know whether they are infected.

The potential costs of inaction are staggering: By 2010, according to the UN, there will be 20 million orphans in Sub-Saharan Africa, 60% of the continent's current 15-year-olds will not reach the age of 60 and the labour force will be as much as 35% smaller.

In some countries high-profile politicians have led the drive to promote testing: Lesotho's prime minister, Pakalitha Mosisili, and former Zambian president Kenneth Kaunda, for example, have gone publicly to get tested. The government of Namibia launched a media campaign to promote 'Know Your Status' year and has opened several new testing centres in co-operation with international NGOs, while in Swaziland the UN Children's Fund and the University of Swaziland have piloted a new method of rapid testing among students. The Tanzanian government is advising people to get tested before they marry, while a Kenyan organisation, the Kenya Medical Research Institute, has begun producing rapid HIV test kits.

Perhaps the most promising new strategy in Africa, however, is the opt-out approach to testing. In the past year, Botswana, Malawi and Lesotho, with guidance from a group of international scientists in Nairobi, have begun to offer HIV tests regularly in public hospitals



and clinics to people exhibiting signs of infection, mothers seeking prenatal care and clients at clinics specialising in sexually transmitted infections. A fourth country, Kenya, is drafting a policy framework to do the same.

Patients still have the right to refuse testing, but the hope is that by offering HIV tests as a routine part of treatment at regular health-care systems, more people will be encouraged to find out their status and, over time, stigma will lessen.

Routing testing 'integrates. It normalises the disease more,' said Banu Khan, head of the National AIDS Council in Botswana, the first country to implement the new system. 'It doesn't make it stand out as a separate thing. And it provides people with different options.'

The primary motive behind the change in policy, says Ernest Darkoh, head of Botswana's anti-retroviral programme, is to identify people who would benefit from newly introduced treatment strategies. Botswana, Dr. Darkoh points out, has a free, universal anti-retroviral programme called *Masa,* or 'new dawn', as well as a short-course ARV treatment regime that can reduce viral transmission from mother to child during birth. While enrolment in these programmes is on the increase, many people still come forward too late, he says, either when the disease is too advanced to treat effectively or they are about to give birth.

Unlike South Africa, which primarily uses a single-dose anti-retroviral treatment to reduce the transmission of HIV from mothers to their children during birth, Botswana gives pregnant women a course of ARV drugs that lasts several months and is more expensive but also more effective and less likely to cause future resistance to the drugs.

Government officials in Botswana, where close to 40% of adults are HIV-positive, according to UNAIDS, hope that when more people know their status, they will talk more openly about the disease and be more willing to take steps to protect themselves and their loved ones.

The rights equation

Although the directors of both of the WHO and UNAIDS embraced more proactive policies on HIV testing at the Bangkok AIDS conference, routine testing remains a controversial issue and efforts to implement new approaches in some countries, like Zambia, have been blocked by local activists and religious groups.

Many human rights organizations worry that offering routine testing could erode the rights of patients to withhold their consent or that patients will be coerced into deciding without full knowledge of the procedure and its potential impact.

For these critics, the word 'routine' suggests mandatory testing, which is still considered a rights violation in all but rare circumstances. Many countries, for example, require testing of military personnel, a position the UN still

opposes despite anecdotal evidence that international peacekeeping forces contribute to the spread of the epidemic.

Prior to the policy shifts both at the national and international level, standard practice for HIV testing emphasised not only that a patient must consent to being tested, but that they must be educated as to the consequences of that decision. In some countries, such as South Africa, the courts have ruled that the burden of providing adequate information on the costs and benefits of taking an HIV test falls on the health care provider. In the 1996 case C v. Minister of Correctional Services, a South African court ruled that although a prisoner had consented to an HIV test, he had not given informed consent because he had not received pre-test counselling and was required to make his decision on short notice.

Increasingly, however, the emphasis on confidentiality and consent is being re-evaluated, especially in Africa, where the epidemic is devastating the social and economic fabric of whole regions. But the heavy burden placed on health professionals to ensure that the patient is fully informed has been a barrier to widespread testing.

In an 'opt out' system, in theory, a patient must still give his consent, and the health-care worker must still inform a patient of the costs and benefits of being tested as well as their right to refuse. But this information need not be administered in as formal a manner as in the VCT approach, which usually includes 15 to 30 minutes of individual pre-test counselling. In some antenatal clinics in Botswana, for example, the government is conducting group counselling in the waiting room, using the idle time before patients are seen by the doctor to explain the benefits of getting an HIV test (in particular the availability of short-course anti-retroviral therapy to prevent mother-to-child transmission).

The increasing availability of treatment for infected people has also changed the human rights equation, many AIDS experts say. When treatment was little but a distant dream for most poor people with the disease, many – including some involved in AIDS work – believed that the disadvantages of finding out one's status, including stigmatisation and, for women, domestic violence, outweighed the advantages. **(See story, page 9)**

But as anti-retroviral treatment becomes more widely available, proponents of the policy changes argue, the scales are starting to shift in favour of more proactive approaches to testing.

'Many ministries of health were and still are grappling with these issues, not quite knowing what to do, in a way waiting for permission to change and push forward with more routine and diagnostic testing,' said one Western researcher based in Africa who supports routine testing. 'It either takes a senior leader like the president of Botswana or it takes the international organisations like the WHO and UNAIDS putting out a statement saying this is an okay thing to do.'

New Strategy for Tracking the Epidemic

IN JUNE 2004 the World Health Organisation and UNAIDS released a policy statement that cautiously endorsed a new approach to HIV testing in hopes of increasing the number of people worldwide who know their status. While the two organisations emphasise that all testing still needs consent, should be confidential and offered with appropriate counseling, they now say a variety of approaches to testing should be embraced, in addition to voluntary counseling and testing.

Adopting the definitions proposed by a group of researchers from the Centers for Disease Control in a 2003 article in the in uential medical journal *The Lancet*, UNAIDS/WHO now offers the following guidelines for HIV testing:

1. Voluntary counseling and testing

Client-initiated testing offered in conjunction with pre- and post-test counseling. Pre-test counseling may be provided in a group or individual setting, but results and follow-up must be given on an individual basis. UNAIDS/WHO recommend the use of rapid tests so that patients can learn their status immediately and post-test counseling can be administered in a timely manner.

2. Diagnostic HIV testing

A routine offer of testing should be offered to any patient showing signs or symptoms of an HIV-related disease or of AIDS as part of standard health management. This offer should be extended automatically to all tuberculosis patients.

3. Routine offer in select health-care settings

HIV tests should be offered to all patients assessed for sexually transmitted infections (in specially designated clinics or elsewhere), to any patient seen in the context of pregnancy, and to all patients seen in clinical and community-based health service settings where HIV is prevalent and anti-retroviral treatment is available – even if the patients are asymptomatic.

4. Mandatory testing

UNAIDS/WHO support the mandatory screening of donated blood for HIV and other blood-borne viruses and the mandatory screening of donors of body uids or body parts. They do not support the mandatory testing of individuals on public health grounds, but emphasise that countries requiring HIV tests for immigration purposes or for enrolment in the military should conduct such testing only with appropriate counseling.
– Nicole Itano

The human-rights ethos of AIDS dates to the early days of the epidemic. Stigmas developed in part because of the nature of the disease: HIV is infectious, fatal if not contained, and transmitted through the some of the most-often condemned of human activities. In the US, where AIDS was first identified, fear of the disease was exacerbated in the early years by moral condemnation of the main methods of transfer – intravenous drug use and homosexual sex.

Since identification as HIV-positive imposed the dual burden of carrying a frightening new infectious disease and membership in an already stigmatised group, gay-rights groups demanded steps be taken to protect them. Worried about driving the epidemic 'underground,' American health professionals agreed not to adopt prevention methods that would put people with AIDS at greater risk of persecution or discrimination.

What emerged, according to Ronald Bayer, a professor of medical ethics at Columbia University in New York, was a system of 'AIDS exceptionalism' under which AIDS was treated differently from other infectious diseases and the normal responses to a new health crisis, including widespread testing and contact tracing, were deemed violations of human rights.

The VCT model, which was developed in the US in the mid-1980s and brought to African countries by international health organisations almost a decade later, was born out of the stress on confidentiality and consent. By relying on people to come forward on their own initiative as well as protecting every patient's identity, the model addressed concerns that people would be tested without their permission and the results of those tests used to discriminate against them.

A system based on secrecy and consent, however, also limited responses to the epidemic. Prevention efforts were dependant almost entirely on messages about modifying personal behaviour communicated through individual counselling sessions at the time of testing and mass-media campaigns that did not necessarily target those most at risk from infection.

Attitudes towards consent and privacy began changing dramatically in the US in the mid-1990s after anti-retroviral regimes became widely available, but the rest of the world has been slow to follow. Even as industrialised nations were beginning to adopt partner-notification programmes and routine testing of pregnant women, poorer, harder hit countries unable to provide the public with expensive treatment were relying increasingly on the VCT model.

Into the breach

In the past few years, a growing number of African and Western health experts have been questioning the reliance on VCT and its appropriateness in the context of an epidemic that affects the population as a whole rather than specific high-risk groups.

They argue that many people who most need HIV tests were not coming forward to VCT clinics for fear of testing positive or being stigmatised. Few countries, meanwhile, had the capacity to supply VCT widely enough. Botswana, for example, has only 16 VCT facilities. Finally, by separating testing facilities from general health care and social services, health providers made it difficult for people who tested positive to access even the treatment programmes that were available.

'Attitudes towards consent and privacy changed in the US in the mid-90s, but the rest of the world has been slow to follow'

For several years, the debate questioning the value of VCT took place quietly in the background, until a group of American scientists working for the Nairobi office of the Centers for Disease Control and Prevention (CDC) published a controversial paper in the influential British medical journal *The Lancet* in 2002 calling for a re-evaluation of the influence of human-rights concerns in AIDS prevention and treatment.

In that paper, 'Shadows on the Continent,' Kevin de Cock and his colleagues argued that AIDS exceptionalism had hindered efforts to combat the spread of the epidemic: 'HIV testing, available since 1985, has been restricted for medical as well as prevention purposes because of a strong emphasis on informed consent and counselling. Unlike other infections diseases (e.g. syphilis and hepatitis B), for which consent for testing is implicitly assumed by virtue of medical consultation, and diagnosis is encouraged, the diagnosis of HIV infection has often been actively avoided.'

The 2002 paper, and another article by the same CDC group published a year later also arguing in favour of offering HIV tests in clinics that focus on antenatal care and sexually transmitted infections, re-ignited the debate.

In November 2002, a month after Dr. de Cock's first paper was published and at a moment when the prices for anti-retroviral drugs were falling dramatically and treatment for people with AIDS in resource-poor countries was becoming a possibility, AIDS experts at the UN met to re-evaluate international testing policies and agreed that a routine offer of testing should be made in health-care settings.

'What made us change our position is the fact that VCT wasn't working,'

SPECIAL FEATURE

says David Miller, now the WHO's ombudsman, but previously the organisation's technical adviser on HIV testing and one of the drafters of the UN's original 1985 testing policy. 'It was perceived by many people to be a bottleneck to enabling radically increased access to treatment. I think also, in many countries, the stigma related to knowing your status or to being positive had not been effectively addressed, so that there was still a great reluctance to engage in the testing and counselling process because it was felt by populations that the only thing they would get out of engaging in testing was social punishment.'

Although Miller says the outcome of the 2002 meeting constituted an official change in UN policy on testing, support for the new approach was poorly publicised and it wasn't until June of this year that the WHO and UNAIDS issued guidelines endorsing new approaches to testing, including routine testing, almost exactly as outlined in the second *Lancet* paper by the CDC Nairobi group. **(See box, page 6)**.

Testing ground

Botswana was the first African country to embrace the new guidelines. The government, including President Festus Mogae who has taken an active interest in AIDS issues, first became interested in routine testing after a visit from one of the Nairobi group. Initially, some government officials expressed their support for the idea in terms that alarmed the international community, arguing, for example, that the VCT model had in fact deepened stigma by setting AIDS apart from other illnesses. After meeting with civil society and AIDS groups, the government toned down its rhetoric and secured widespread support for the new approach.

'Botswana is a real laboratory for this,' Miller says. 'You've got a population where 40% of the adult population is affected and yet still people won't discuss it.

'When the Botswana policy was being discussed internally, it was being discussed in very passionate terms – in terms that were not always giving due observance to human rights. I think the triumph of the Botswana process was that they could include a rights-based process in the process of increasing access to testing,' Miller says.

Government officials say routine testing has dramatically increased the number of people getting tested in Botswana. In most clinics, Dr. Khan says, 90% of patients now consent to testing. And according to one study by BOTUSA, a joint project with the CDC and government of Botswana, routine testing in an antenatal clinic in the city of Francistown has substantially increased the number of pregnant women enrolling in programmes to prevent the transmission of the virus to their infants during birth.

But the gap between policy and implementation remains large, and some civil society groups, worried that the public remains largely uninformed about the new testing plan, are beginning to reconsider their support for the new strategy. In Lesotho, meanwhile, the new strategy is only slowly being communicated to medical staff and most clinics and hospitals face a constant shortage of testing kits.

> **'While people can't name what's killing their family members, there's going to be reluctance to learn their own status'**

In October 2003, the Botswana Network on Ethnics, Law and HIV/AIDS (BONELA) held a conference of government officials, AIDS organisations, doctors and lawyers to debate the implementation of routine testing in Botswana. After hearing from health department officials, Willem Landman, a professor at the Ethnics Institute of South Africa, and human rights organisations, participants concluded that the routine offer of HIV tests in medical settings was acceptable only if patients were informed of their right to refuse the test and their confidentiality was maintained.

In addition to criticising the government for failing to launch a public information campaign about the new policy – which Khan says is in the works – BONELA claims it has received numerous complaints from patients who say they were not adequately informed about the test or their right of refusal. In some cases, patients say they were not aware they were being tested until they were informed of the results.

'The way they describe what they are supposed to be doing, it looks a lot better than what is actually happening,' said Christine Stegling, director of BONELA. 'In many cases, there's no real conversation with the health-care provider about the test.'

Many experts also caution that adopting policies to offer routine testing should not result in abandoning VCT. Many young people, they argue, may not pass through the regular health care system and, as numerous studies have shown, counselling can help change people's behaviour and reduce their susceptibility to AIDS. In HIV testing, as in many other AIDS mitigation efforts, one size does not fit all.

'While people can't name what's killing their neighbours and their family members, there's going to be an immense reluctance to learn their own status,' Miller says. 'We felt it was important to do all we could to help populations come to terms with the reality of HIV, and there's more than one way to do that.' – **Nicole Itano, a journalist based in Johannesburg, is writing a book about HIV/AIDS in Africa**

SPECIAL FEATURE: OPINION

Testing: A Risk Either Way

WHAT good is getting tested for HIV/AIDS if there is no support system when the results come back? Where is the incentive in finding out your status if the penalty for testing positive is losing some of your rights as a human being? It's almost like playing dead in a desert while a group of vultures circles above.

Consider this: About 60 countries, including the US, require HIV testing for in-bound foreigners to prevent those carrying the virus from entering.

In Senegal, some women's groups have called for mandatory pre-nuptial testing to prevent 'marriage with people living with HIV/AIDS and giving birth to infected children', to recall the words of Marie Cisse Thioye, president of the Association of Disadvantaged Children, in her address to parliament late last year. A group of Pentecostal clerics in Zimbabwe wants to require the same of all pastors, marriage officers and couples planning to marry. Their reasoning is less punitive – though no less intrusive: so couples can be aware and 'adopt preventive measures in their sexual lives if they are found positive, or avoid any possible risks if they're negative'.

In Bukoba, a region in western Tanzania, village elders and Catholic priests have gone a big step further, requiring tests for all prospective brides and grooms. If either party tests positive, the marriage is off. **(See story, page 10).**

Fair enough, HIV/AIDS is one of the worst scourges mankind has ever faced. In sub-Saharan Africa alone, about 20 million people have died from AIDS in the past two decades. Presently, an estimated 26.6 million people in the region are living with HIV.

AIDS thrives on mobility. Conflicts and political instability in a number of African countries have resulted in thousands of refugees and internally displaced people. According to the UN High Commissioner for Refugees, 290,000 new refugees were registered in 2003, mainly from Sudan, Liberia, the Democratic Republic of Congo, Côte d'Ivoire, Somalia and the Central African Republic.

With conflict comes a need for peacekeepers, and in Africa many of those forces come from national militaries known to have high rates of HIV infection. The deployment of sexually active HIV-positive soldiers in civilian environments for the purpose of peacekeeping imports and exports the epidemic as surely as the displacement of people within and across borders.

All this means that assumptions of safety – the 'it won't happen to me' mentality – are dangerous: A casual approach to human relations is like playing Russian roulette. The statistics should prompt people to want to know their status – if for no greater purpose than to protect themselves and the ones they love. But what is the point of finding out if society rewards the courage it takes with potential rejection, ostracism, violence and destitution? Why volunteer to be rendered an outcast?

There are merits to mandatory testing. A more pro-active approach to monitoring the epidemic might do more to contain the virus and ensure that those infected are offered the right medical and social support as well as skills to 'live positively'.

But the so-called social benefits of knowing your status seldom occur in the real world, where a positive status can restrict where you go, who you associate with, how you run your life, and what jobs you can hold.

In an ideal world, the pace of scientific research would accelerate, resulting in less harmful and cheaper drugs. Instead of putting all the financial resources into defence budgets, in an ideal world countries would ensure their long-term security through bigger health budgets and better health systems. In that world, defending humanity from a deadly virus would be a national defence priority.

But in the world we live in, little thought is spared for the millions of families now headed by children because both parents have succumbed to a disease that causes governments to squirm and prevaricate. AIDS is devastating labour forces and the social fabric of nations, leaving millions of orphans to fend for themselves and be preyed upon. Place AIDS side by side with chemical, biological and nuclear weapons, count the dead and decide for yourself: What's the real weapon of mass destruction?

Early detection of the HIV/AIDS is without question one of the best ways to deal with the crippling effects of the disease. But promises of better health and longer life are not sufficient motivation, sadly, for people living in societies where the epidemic is wrapped up in a ribbon of stigma. We need more than just good policies on paper. We need financial commitment, the right messages about HIV/AIDS, and more capable health systems. Perhaps then there won't be a need for mandatory testing. People will feel the freedom to find out for themselves.

Knowing your status helps you keep two steps ahead of this tricky beast. 'Living positively' is more than a euphemism, more than a salve. How would I know? I know my status. Knowledge is power, and there is power in knowing how to outsmart, outrun and outlive your enemy. – **Luleka Mangquku**

SPECIAL FEATURE

Where Betrothal and Betrayal Are Decided in a Petri Dish

Marriage in a Tanzanian village hinges on both bride and groom testing negative for HIV

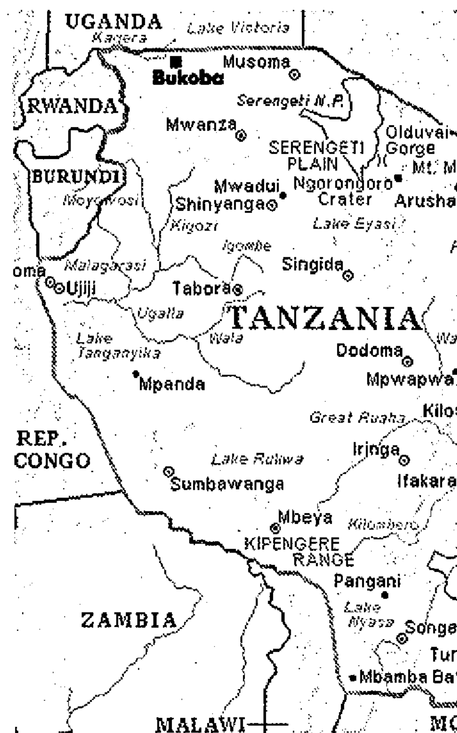
ON THE western shores of Lake Victoria, in a village in the north of Tanzania, an important social experiment has quietly been taking place for more than a decade. But now, as international health organisations shift strategies in the battle against HIV and AIDS, getting married in Bukoba suddenly has international consequences.

Tying the knot in rural Tanzania, as in many places in Africa where cultural traditions are still practiced, has always been serious business, involving a complex sequence of careful negotiations between the families of the couple where pride and reputation are critical concerns. Courting involves exchanges of bed sheets and machetes, cows and calabashes of home-brewed beer. Often, outside mediators are called in. One offensive cow or sour pot of brew can kill the deal and create lasting ill-will.

The diocese steps in

In 1983, Tanzania's first case of AIDS was discovered in Bukoba, and within a few years, the village and the surrounding region became a land of widows, orphans and abandoned old people. Desperate for a solution, the local Catholic Diocese worked out a plan with village elders in the late 1980s to require all prospective brides and grooms to be tested for HIV twice – once before the marriage negotiations and again just before the wedding. If either side tests positive, the relationship is severed.

HIV testing is a complicated issue. Human rights advocates have long argued that, given the stigma attached to AIDS in societies all over the world, testing should be strictly voluntary and confidential. But that has done little either to encourage people to find out their status or slow the rate of infections, and as treatments become more available in developing countries, more states and international health organisations are starting to take a pro-active approach to testing.



The World Health Organisation and UNAIDS set out new guidelines in June recommending that health-care providers automatically offer HIV tests as part of any medical consultation. As more people find out their status, they argue, patterns of behaviour will change and stigma will lessen. Human rights activists aren't so sure.

'If more places required pre-nuptial testing, fewer lives would be lost'

Bukoba provides ambiguous lessons. Infection rates have dropped since the region adopted mandatory testing for people seeking to marry, but for those who are found to be HIV positive, the stigma can be much worse.

The National AIDS Control Programme (NACP) of Tanzania announced recently that the village and the surrounding region no longer lead the country in infections and AIDS-related deaths. Consequently, 'everyone is considering to go the Bukoba way because the testing-twice approach has worked effectively and with little pressure from authorities,' said Muhingo Rweyemamu, an AIDS expert in Tanzania.

A tale of two sons

Edward Kashaija, a resident of nearby Mafumbo village, agrees. In 1989, his son, David, was due to be married. 'His spouse was found positive a few weeks before marriage in 1989 on the second testing,' Kashaija recalls. 'Our entire family felt betrayed and we demanded back the bride price, which he later paid for another lady.' If more places required pre-nuptial testing, he argues, fewer lives would be lost.

But another father, Ludovick Kashonje of a village named Rwanda, tells a sadder story. Five years ago his son, Kambona, tested positive before his wedding. 'We found him dead in the garden,' Kashonje says. 'The bad thing about the testing exercise is that the entire process is never secret. Once the results are out, a positive partner suffers from serious stigmatisation. I suspect it was this that happened to my son.' Kashonje thinks his son committed suicide.

SPECIAL FEATURE

The testing process in Bukoba involves the families of the partners, church leaders and hospitals. If the prospective bride and groom receive initial approval from their families to marry, they then consult a parish priest for an official endorsement for HIV testing at a hospital (to avoid misuse of the medical service, especially with infected parties).

The test results are sent in a sealed envelope back to the priest, who unveils them to the couple. If both parties test negative, the betrothal process, which normally lasts between six months and two years, proceeds. A second round of testing takes place just prior to the wedding. Again, both parties must test negative.

When one stumbles

Many prospective engagements have been derailed after the first testing. Most of the time, 'it was men who were found HIV positive,' says Juma Hamdani, a village chairman. 'So the marriages are aborted and the ladies' lives saved.'

Johannes Rweyemamu, a Roman Catholic priest at Rutabo village, concurs. 'Very few ladies have caused cancellation of marriage arrangements. In most cases, whether at first or second testing, it has been men who were found positive,' he says.

When a man is found positive, the woman withdraws and her family retains the bride price paid by the man's family. If the woman is found positive, the man withdraws and his family imposes a deadline for the woman's family to repay the bride price and any additional expenses already paid toward the betrothal.

Critics of the mandatory testing say the practice violates human rights. Geoffrey Ijumba, a lawyer working with the United Nations Children's Fund in Dar es Salaam, believes that the involvement of priests and village elders infringes on people's right to privacy. He argues that doctors alone should be allowed to disclose test results directly to their patients.

'Without testing, there would be few people left'

The new WHO and UNAIDS guidelines encourage medical practitioners to offer HIV tests as a part of routine health services, especially when patients exhibit symptoms typically associated with AIDS. Both organisations, however, stress the importance of confidentiality.

Even so, Marc Deru, a medical doctor with Partage Tanzania, a non-governmental organisation providing health services in the region, rejects the change in approach. He argues that 'pursuing testing is unreasonable and even harmful. It is unjustifiable on either a scientific or medical basis. The only reasonable attitude to take is to return to the simplicity and objectivity of clinical practice, to the diagnosis and treatment of clinically visible illnesses.'

One problem with testing is that the virus can incubate for months without detection, making the Bukoba approach questionable.

But village elders and local priests argued that something had to be done. NACP figures showed that the Bukoba region had 800,000 HIV-positive patients by 1992, just nine years after the first case was discovered. Annual deaths were reported at between 20,000 and 30,000. The region accounted for 80% of all HIV infections countrywide, according to the Tanzania Assessment and Planning Study, which was sponsored by the World Bank in 1992.

'Many prospective engagements have been derailed after the first testing.'

The impact is measurable today. By 2002, 33% of all school pupils in the region were orphans, said Titus Kamwamwa, co-ordinator for the Kagera Zone Aids Control Programme.

Father Rweyemamu resists calling the double-testing policy mandatory. Everyone saw the wisdom in it, he says: 'Without testing, there would be few people left.'

Changes in behaviour

Deru admits an obvious improvement: 'A ghost town in 1988, Bukoba is now a lively and busy place. The spectre of a deadly epidemic has receded and the region is no longer referred to as the "epicentre of AIDS in Africa."'

A study by the Kagera AIDS Research Project on the impact of marriage testing suggests significant changes in sexual behaviour away from activities considered to increase the risk of infection. It cites an increase in condom use, abstinence, monogamy and voluntary HIV testing.

The decline in infections in Bukoba and other nearby villages has inspired other regions to try the approach. The Mennonite Church in Mbeya region in Southern Tanzania has already announced plans to emulate the Bukoba experience. Seventh Day Adventists and Muslims have also backed the approach.

'We are not copying religion, but reasonable and viable approaches in the fight against AIDS, which President Benjamin Mkapa has declared a national calamity,' says Moses Byarugaba, a Seventh Day Adventist pastor. – **Ansbert Ngurumo**

ESSAY

A Shot Put to Governance

Lessons in achievement from the Olympic arenas of Athens

THE world's greatest sporting spectacle, the Olympic games, is a testament to the power of money, planning and sports science. In Athens, the nations that dominated the medal rankings – the US, China, Russia, Australia, Japan and Germany – all dedicated fabulous funding to the high-tech art of making humans go faster.

Against such technologically enhanced competition, the mere participation of Africans in this or any other such games was Olympian in itself. Hailing from the world's poorest continent, they traveled to Greece on the backroads of disadvantage. In the developed world, thousands of secondary schools and universities offer free coaching, facilities and regular travel to competitions. In Africa, such funds and facilities are meagre or non-existent.

Yet, 34 times in Athens, laurel wreaths were rested on African heads. In the pool, on the track, along the ancient course from Marathon to Athens, African athletes were feared and hailed. The names Kenenisa Bekele, Meseret Defar and Ezekiel Kemboi are etched in record books. The anthems of Ethiopia, Kenya, South Africa and Zimbabwe hushed crowds with distinctly Africa strains. On the world's most troubled continent, there is excellence, too.

The human spirit

Africa's shining moments in Athens provide more than an occasion to celebrate the sporting achievements of an exceptional few. The continent's performance at the Olympics offered a glimpse of a most potent force that is sorely neglected in debates about African politics and development: the human spirit.

Haile Gebrselassie was the eighth of 10 children born to a farmer's wife in a mud hut in Ethiopia. Like all his siblings, he toiled on the family farm, chopping wood and threshing grain. Long after his older brothers had abandoned their chores for the day, young Haile would carry on, goading the oxen to plough another furrow. And when he had finished his three-hour journey to fetch the family water, he would run, barefoot and hungry, challenging the hilly countryside.

The impoverished Ethiopian youth of yesterday retired in Athens as one of the greatest athletes of all time. In his final 10,000-metre race, it took his countrymen to beat him. The baton has been passed, but stays in Africa.

'The stamina that won medals is partly an expression of biology, but equally a reflection of years of determined effort'

'We African athletes train for the glory of winning and not for the money,' Gebrselassie said in an interview from Athens. 'We don't have the technology, the fancy equipment or the training facilities like the Americans, Russians or the Chinese, but we win because we have the determination to win.'

George Bernard Shaw once mused: 'The reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.'

From business to science to politics, things that today seem ordinary were once deemed impossible. And yet the unreasonable few persevered with the idea that somehow, through methods as yet undiscovered, the route to success would be found. Men like Nelson Mandela, Strive Masiyiwa and Mark Shuttleworth adapted the world to suit themselves.

Africa, for the most part, did not choose its challenges, but they must nonetheless be confronted: colonialism and its legacies of imbalance, the Cold War and its legacy of small arms, apartheid and its legacy of racism and poverty, unfair trade and its legacy of fallow fields, debt and its legacy of economic bondage.

A question of determination

In daily life, Africans show no less determination than any other peoples. But often, leaders swap talk for action, mistake intention for endeavour and point fingers instead of rolling up their sleeves. Lack of money, capacity and technology are easily accepted as immovable obstacles. Health, education and agricultural research are allowed to wither. Yet money for ministerial Mercedes can always be found.

In talking about sport in Africa, David Okeya, the head of the Kenyan Olympic delegation, could be commenting on governance in Africa. 'It's the same old story,' he said, speaking on the phone from Athens, 'African countries don't have the money for fancy equipment and facilities, our priorities are far greater. If we could get more money we could train more athletes and win more medals, but right now we have to make do with what we have.'

If. The longest word in the English language. If the rest of the world made good for the wrongs it did and does in Africa, the continent would more easily thrive. Then again, if Africa embraces the creative, inspiring determination shown by her Olympic champions, more children on this continent might grow up regarding the unreasonable as achievable. – *eAfrica*