New approaches, new activities and new outcomes in international conferences on HIV/AIDS in Africa – Report of the 3rd African Conference on the Social Aspects of HIV/AIDS, Dakar, 10 - 14 October 2005

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ABSTRACT
Africa's HIV/AIDS situation remains cause for concern. The impact of HIV is considerable and threatens the survival and development of African societies. Although much has been attempted, the results still leave much to be desired. AIDS is an epidemic that needs to be addressed with much creativity and spirit of initiative. It is against this background that the 3rd African conference on the social aspects of HIV/AIDS brought innovations in the way international conferences are designed, activities implemented and results obtained.

The innovations concerned the approach to international conferences and take into account reconceptualising HIV/AIDS so as to encourage holistic approaches and better visibility of vulnerable groups. The activities of the conference were organised in such a way as to get people living with HIV/AIDS (PLWHA), grassroots communities and marginalised groups to play a focal role.

The conference offered an opportunity for developing cultural activities that would translate the African cultural concepts that had been identified as important in the HIV situation and response analysis. Interaction at the conference created an opportunity to analyse the various dimensions of the political, cultural and economic determinants.

The conference offered food for thought around response construction while singling out the themes of urgency and acceleration of response, synergy construction, and coordination and conception of political responses.

Keywords: conference, policies, HIV/AIDS, cultural aspects, responses, determinants.

INTRODUCTION
Africa south of the Sahara accounts for more than three-quarters of people living with HIV world-wide, and had the biggest number of new infections in 2005 (UNAIDS, 2005). Considering the estimated 17 million women living with HIV in the world, one could say that this part of the world is certainly the most striking illustration of the quasi-universal phenomenon of ‘feminisation’ of the epidemic, with 13.1 million women living with HIV. Women represent 57% of infected adults; among people aged 15 - 24 years there are 5 - 6 times more cases of infected girls than boys, and the risk of infection among women increases significantly in situations of war, conflict and population displacement (Spiegel, 2004). Moreover, among the world’s 2.1 million children living with HIV, 1.9 million (0 - 14 years old) live in sub-Saharan Africa (UNAIDS, 2005).

Most AIDS-related deaths occurred in sub-Saharan Africa (2.4 million among the estimated 3.1 million in the world). In the most affected countries, it is estimated that up to 70% of deaths of children less than 5 years old were due to AIDS. In sub-Saharan Africa, 12 million children have already lost one or both parents to AIDS. Some surveys anticipate that by 2010 Africa will have 18 million AIDS orphans (UNAIDS, 2005).

Social impact studies reveal deterioration in the quality of education due to the high number of AIDS-related deaths among teachers, school drop-outs among orphan pupils and those living with HIV, absenteeism, lack of motivation and fear of stigmatisation, etc. (UNAIDS, 2004). Agriculture, on which most African people rely, recorded decreases in productivity, abandonment of a number of crops, reduction in cultivated lands and manpower as a result of AIDS (World Food Programme, 2004). In the industry, even if the access to antiretroviral (ARV) treatment tends to improve the PLWHA’s quality of life, HIV is still considered as the cause of a significant amount of absenteeism, decrease in productivity, increase in the cost of overtime work as well as in the costs related to burials and medical expenses (UNAIDS/World Bank, 2001; ILO, 2004; Quattek, 2000).

However, we have to note that African communities, societies and states, as well as the rest of the international community, have risen to the challenge of AIDS. The meeting, in 2001, of the United Nations General Assembly’s Special Session (UNGASS) on
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AIDS was an important event in the international mobilisation against the pandemic. This session considered AIDS as a major threat to global safety and adopted a declaration whereby the international community commits itself to lead a global struggle against the pandemic (United Nations, 2001).

In Africa, the struggle against AIDS was registered as an important priority in the agendas of the heads of states and governments of the African Union, of the NEPAD and the sub-regional organisations (the ECOWAS, the SADEC, the Economic and Monetary Community of Central Africa, etc.). Besides political commitment, most African countries implemented national multi-sector prevention strategies. Access to treatment was improved, thanks to several public and private initiatives and the WHO/UNAIDS ‘3X5’ joint initiative. The resources allocated to AIDS have significantly increased, but they still remain insufficient and are subjected to implementation problems (UNAIDS, 2004).

Moreover, while mobilisation by official structures is the most visible, a number of individuals, social networks, grassroots communities and religious associations have led mostly silent and varied struggles to generate significant advances in the field of sensitisation, access to treatment and struggle against stigmatisation (UNAIDS, 2003). The fact remains that the epidemiological situation shows signs of hope with, in some countries, a lower prevalence rate among young people and/or pregnant women younger than 24 years. We may, in this regard, quote the case of Uganda, where continued lower prevalence rates have been experienced since the second half of the 1990s, or Senegal and Mali, where relatively low and stable prevalence rates have been recoded for decades (UNAIDS, 2004; UNAIDS, 2001).

Meanwhile, social science researchers still face many challenges. Thus, for example, in spite of commitments in favour of access to treatment, in Africa south of the Sahara, only 11% of PLWHA receive ARVs and only 5% of pregnant women have access to the services that would have protected their child from HIV infection (USAID/UNAIDS/WHO/UNICEF, 2004). There are still too few studies on the problems related to the ignorance of serological status, while it is estimated that, in Africa, more than 90% of the PLWHA ignore their serological status (De Cock et al., 2003).

There are also few studies dealing with stigmatisation or with the socio-economic constraints limiting the access to ARV (remoteness of medical care centres, food problems, cost of biomedical care, etc.) and the few studies done in these fields have little influence on response policies. Furthermore, only 13 countries are estimated to be on the way to reach the millennium’s development objectives that aim at reversing the HIV propagation trend by 2015 (ECA, 2005). In fact, in many countries sexual behaviours seem to change but very slowly in comparison with the speed at which the epidemic is spreading.

Serious disparity exists between African countries regarding response policy achievements and outcomes. Behind those differences there are often differences in strategic choices or differences in material and human resource availability. Also, as a result of complicated historical relationships between African countries, inadequate results or national policy failure in one country may have repercussions in neighbouring countries. Exchanging experiences and establishing a critical mass of African researchers capable of a comprehensive view and of influencing policy makers, therefore become challenges in efforts to reverse the epidemic’s current trends.

The SAHARA programme, presented by Shisana, had defined its main objective to take up these challenges. That is why the general theme: ‘Bridging the gap between research, policies and interventions’ had been carried as the one to be discussed at the 3rd African conference on the social aspects of HIV/AIDS. The conference took place from 10 to 14 October 2005 in Dakar (Hotel Méridien Président). Its specific themes were the following:

• Cultural and socio-economic contexts of vulnerability and access to treatment.
• Socio-economic and psychological impact of HIV/AIDS on children, women and communities in Africa.
• Stigmatisation and the social aspects of prevention, voluntary testing, treatment and care.
• The impact of HIV/AIDS on health care systems and private sector involvement in the struggle against AIDS.
• Policies and responses at international/national and local level.
• Nutrition and feeding of PLWHA, and the social aspects of disease transmission from parent to child.
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- Behavioural changes, structural changes and evaluation of intervention.
- Behaviour surveillance and sociocultural aspects of epidemiological surveillance.
- Street children, sexual violence, children in war and conflict situations; ethical and legal issues regarding children’s and women’s rights.

The thinking that preceded the conference organisation had processed a critical analysis of the ways in which big international meetings on HIV/AIDS are held in Africa. Those meetings seem to suffer from a lack of debates aimed at a comprehensive analysis of Africa’s situation and response priorities. They are also noted for their weak level of interactivity between policies, researchers, PLWHA, community representatives and socially marginalised groups, while also offering very little room for local languages, cultures and historic heritages; they are presented in European languages (English, French) that are seldom spoken by the majority of African populations.

SAHARA is of the opinion that a new look at AIDS conferences in Africa should offer an extension to holistic approaches to HIV, approaches that insist on reaching beyond the medical field in order to consider solutions based on social, economic, cultural and political dynamics.

INNOVATIVE APPROACHES AND ACTIVITIES

For the organisers, the conference had to show that it was unfolding on African land and that it reflected the concerns and the modes of expression of African communities and societies. That is why the option of using African languages in the course of that conference was considered a major challenge to be taken up so as to allow social groups usually culturally excluded to take part in the debate on AIDS. Those groups include those who have never been taught literacy in European languages (they represent more than 70% of the population of countries like Senegal), and are very often the poorest layers of the population and the most remote from the centres of political decisions.

At all stages of conception, implementation and evaluation of the conference, PLWHA, sex workers and males having sex with other males (MSMs) were involved in a partnership with the researchers, NGOs, civil society organisations, United Nations and other international organisations, public authorities, the private sector and elected representatives. The conference recorded the participation of more than 500 delegates from about 30 countries, most of them African, but also from the USA, Europe, Brazil and Asia.

The opening session was chaired by Mrs Viviane Wade, First Lady of the Republic of Senegal, representing the Association of the First Ladies of Africa. Also present were several key figures such as: Dr Zola Skweyiya, South African Minister of Social Affairs, Mr Abdou Fall, Senegalese Minister of Health, Dr Olive Shisana, CEO and Chairwoman of the HSRC, Mr Abdou Salam Sall, Chief Education Officer of Cheikh Anta Diop University and representatives of United Nations’ agencies based in Dakar, Abidjan, Brazzaville and Nairobi (UNAIDS, UNICEF, UNDP, UNIFEM, IOM, UNESCO, ILO, UNFPA, WHO). The role of master of ceremony was performed by El Hadj Mansour Mbaye, leader of the statutory group of the ‘Guewel’ who act as traditional communicators of Wolof society in Senegal. The welcome address was made by Dr Ibra Ndoye, executive secretary of the National Council of Struggle against AIDS in Senegal. The conference theme was introduced by the successive addresses of Dr Bekele Grunitzky (UNAIDS), of Dr Olive Shisana, CEO & Chairwoman of the HSRC, and of Cheikh Ibrahima Niang, professor at Cheikh Anta Diop University of Dakar. The conference’s political dimension was highlighted by the communication of Dr Zola Skweyiya and by the projection of a video message from President Nelson Mandela, former Head of State of the Republic of South Africa, and by the interview granted to a delegation of the conference by Senegal’s Head of State, President Abdoulaye Wade.

A pre-conference had been organised on the theme ‘Reinforcing research capacities on gender issues and HIV/AIDS’. This had as objective to reflect about theoretical, conceptual and methodological problems posed within the set of problems related to the relationships between sexes in the context of HIV/AIDS.

As is the case at most international conferences, the plenary sessions were opportunities taken by the specialists to review the most current knowledge about questions regarding various aspects of HIV. The conference in Dakar innovated by coupling addresses
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from specialists with interventions of United Nations and international organisations who had as objective to present their institutions’ policies and programmes. Another major innovation was that each of those plenary sessions was preceded by testimonies and accounts given by PLWHA and MSMs. Members of vulnerable groups participated actively in parallel sessions devoted to presentation of research outcomes. The exchange encounters were forums of interactive sessions, bringing together PLWHA, NGOs, representatives of civil society, representatives of public authorities, researchers, representatives of United Nations and other international organisations. The objective was to manage further discussions and to single out consensus around some recommendations regarding diverse thematic fields (gender and HIV/AIDS, HIV/AIDS and workplace, response prompting and intervention coordination, children, sexual reproductive health, North-South relations, human rights and political aspects of HIV/AIDS).

Another innovation lay in making the most of the encounter to organise satellite workshops of capacity reinforcement regarding the methods and techniques of research dealing with issues considered as crucial (intervention follow-up and evaluation, research on sensitive issues, ethical issues and intervention research with persons living with HIV, and gender and HIV/AIDS).

Moreover, for the duration of the conference, activities were organised to exhibit the symbols representing the cultural concepts that in several African societies are considered the ultimate references that clarify practices and behaviours of individuals and communities. The conceptual framework of the conference stemmed from the idea that representations, attitudes, practices and behaviours related to sexuality and to the relation to disease cannot be isolated from the cultural concepts and social constructions of birth, life and death, even if they are also linked to other determinants, namely economic and political.

Thus, a pyramid had been erected to symbolise the historical continuity link of the Africans with their remote past; the pyramid can be found in as diverse places as Pharaonic Egypt, Nubia, West Africa’s Empires (with the pyramidal shapes of the tombs of the Askia in Mali), the Serer kingdoms of Senegal (with the pyramidal shapes of the tombs of the Askia in Senegal), the Serer kingdoms of Senegal, and the Serer kingdoms of Senegal (with the pyramidal shapes of the tombs of the Askia in Senegal). The pyramid was covered with loin cloths brought from 23 countries from all the regions of Africa. The loin cloth symbolises sexual relations, protection of pregnancy, delivery, protection of children and adolescents, maternal affection, foreigner adoption into kin links, accompaniment of the dead and resurrection, etc. In several African societies, the deceased to be buried are given loin cloths which they will hand over to those who died before them and so renew their link with the living. The loin cloth is primarily the symbol of communication signifying alliance, solidarity in ordeal, transmission of the sacred… The loin cloths of the conference represented all these symbols that need to be remobilised in the struggle against the AIDS epidemic. One loin cloth was symbolically handed by a Senegal delegate to his Kenyan counterpart, to symbolise the passing of the baton between Dakar and Kisumu (Kenya), the city chosen to house the next African conference on the social aspects of HIV/AIDS.

In the same vein, a traditional music instrument called Bombolong (in the south of Senegal and in Guinea Bissau) a feature in the historic heritage of several countries of the Benin coast and central Africa, was exhibited and played during the entire conference. The Bombolong is generally reserved for funeral rites. It is used for communicating about death and with the deceased. At the Dakar meeting, the music of the Bombolong reminded delegates that Africa is in mourning due to AIDS. But mourning is succeeded by resurrection, birth and renaissance. That is why, at the end of the closing ceremony, the music of the Dimba took over the relay from the Bombolong. The Dimba, who were represented in the conference, are very ancient solidarity organisations of women whose objective is to protect women and children. Their music accompanies birth and fertility rites. It symbolises new Africa that will be reborn from the ashes of AIDS. In this process, the Laobe women who are the guardians of knowledge and of the symbolism of erotic products, intervened in the course of the encounter in order urge people to re-invent erotic sexuality in the context of AIDS.
UNDERSTANDING THE SOCIAL DETERMINANTS BETTER

The conference had been the opportunity to share new light cast on the HIV/AIDS situation and determinants in Africa. Most speakers in the opening session showed that HIV prevalence rate figures in Africa are constantly increasing, even if we may note relatively low and stable prevalence rates in a number of countries and in some others a decreasing trend. The recent demographic and health surveys that were conducted in several countries and the epidemiological ones that were carried out on household basis also revealed prevalence rates lower than the ones found by the sentinel surveillance system. Therefore, several speakers drew attention to the need to re-examine the methods used in collecting epidemiological data and to urgently release reliable data on HIV incidence. Some speakers insisted on the need to collect data in rural areas or areas weakly covered by health structures and among marginalised groups.

Grunisky and Shisana had from the start highlighted situations of vulnerability, whose analysis seems even more necessary than in the field of prevention. We may notice that, in spite of the high levels of sensitisation about the existence of AIDS, changes of sexual behaviour are not systematic nor permanent. The presentations on risk and vulnerability factors reported on countries as diverse as Kenya, Mauritania, Guinea Bissau, South Africa, Senegal, the Democratic Republic of Congo, Cameroon, Congo Brazzaville; they underline the vicious cycle linking poverty and HIV/AIDS. Other interventions stressed the need for a theoretical work of definition of poverty that would be more in line with situations experienced in Africa, because impact assessment surveys tend to measure only indicators of material condition, and not all socio-economic aspects are taken into consideration – for example, the reduction of social capital (families with PLWHAs benefit less from the solidarity networks).

The analyses of poverty contexts show tables where several situations of destitution or precariousness are interwoven. We may thus see that in the most affected regions e.g. in Shisana et al.’s communication on KwaZulu-Natal in South Africa, the population is also very young (43% are younger than 16 years old), the unemployment rate is very high (66% in the case of the KwaZulu-Natal) and a large part of the population live under the poverty line, has very limited access to education, electricity, potable water, sanitation and to ARVs. Several communications also discussed the theme of poverty through analysis of the situations experienced by orphans and vulnerable children. Others showed that feminisation of HIV goes together with and accentuates feminisation of poverty, at the very time when poverty reinforces gender inequities and gender violence.

Mutungu and Koné and several other participants insisted on the need to include the political contexts in the analysis of poverty. Poverty, they believe, is closely associated with war situations, social tensions or political instability. Thus, resolving the multiple conflicts currently affecting the African continent is an urgent necessity in the fight against HIV/AIDS.

The analysis of factors affecting risk and vulnerability included sectors which are important for a country’s development or the lifestyle of its population (education, informal activities, professional migrations). Regarding education, a South African study conducted by Shisana highlighted particularly high prevalence rates associated with factors such as marital instability, migration and family separation, residence in places remote from centres, irregular use of condoms with regular partners, serving in remote rural areas, alcohol abuse, etc.

Some are of the opinion that the HIV/AIDS situation in sub-Saharan Africa inherited the decay of official systems and policies of public health worsened by the rise of neo-liberal macroeconomic policies of the 1980s and 1990s. By reducing state intervention, those policies certainly contributed to reducing the access to health services of large sections of the population, particularly the poorest, the youth and women, while fostering other perverse effects like the development of parallel medical offers (informal sector of blood, injections trafficking, etc.), a higher incidence of self-medication (especially among people affected by sexually transmissible infections), the discrediting of public health services and deficit in their preventive functions.

In conclusion, many participants insisted on the need for generalising the studies on the impact that policies, programmes or economic projects might have on the evolution of HIV/AIDS.
Vulnerability to HIV appeared in several interventions as being directly related to control over the body. Numerous cases illustrated the fact that women, and young women in particular, have less power of decision than men concerning their sexual life or their own body. Several accounts mention the fact that the tendency is increasing for men to have younger sexual partners. According to some testimonies, the same phenomenon exists regarding relations between persons of the same sex, with more and more elderly men having sexual intercourse with young men, adolescents or young boys. Factors that play a role in cross-generational sexual relations, are the status of power relations between generations, parents' financial hardships to meet teenagers' specific needs (which make the latter more sensitive to the pressures of other adults) and relations of violence (rape, sexual exploitation). Many speakers pointed out that there are very few studies on factors like drug or alcohol abuse, often associated with violent behaviour, lack of self-control and sexual risk-taking.

On the other hand, according to several speakers, vulnerability among the youth is aggravated by the common fact that, although they often know about HIV modes of transmission, and although they partake in risky behaviours, youngsters often do not feel they are personally at risk.

In the structural interventions recommended in the exchange encounters, one notes the plea that children remain at school. School is perceived as likely to help children protect themselves from HIV infection, because of the knowledge it transmits and the changes it fosters in life projects. However, some participants pointed out that, in some rural communities, the idea exists that school bears the risk of precocious sexuality for young girls (risks of rape on the way to school, sexual harassment by some teachers, rejection of traditional values that used to allow them to control their sexuality…). But if such situations exist, other speakers reply, the point is not to discourage school-going, but rather to create secure conditions for schoolgirls.

Sangaré, Ouédraogo, Ly and several other participants showed that in some countries most infected women have been contaminated by their own husbands, who were their sole partners. Hence the study of HIV/AIDS determinants should also include those of marriage and should place young married women at the centre of the analysis. Researches on young married women and on marriage might provide us with data likely to help analyse sets of problems as complex as those related to levirat or sororat, to controlling one's body and to sexual rights, to breast feeding or to the discriminatory practices directed to widows or female spouses living with HIV – in many African societies, these factors raise complex questions that go well beyond the individual or even the couple.

However, as the communications of Airhihenbuwa, Schoepf and Obbo show, analysis of the cultural factors of vulnerability presupposes that researchers keep a critical distance from the cultural approaches developed at the start of the epidemic. Those approaches in fact consider culture as rigid (often caricaturing) representations and practices generally perceived as obstacles to prevention. According to these authors, one needs to know which cultural resources may be mobilised in the framework of response construction and investigate the political, economic and social factors that influence these responses.

**BIGGER VISIBILITY OF VULNERABLE GROUPS**

The conference offered an opportunity to share some research outcomes and to discuss the disproportionate effects of HIV/AIDS on marginalised people and regions with regard to the location of administrative, economic and political centres (areas where the working classes reside, suburban settlements, people living in conditions of extreme poverty, mobile populations, migrants or displaced populations, sexual minorities, disfavoured ethnic groups, etc.). The relationships between, on the one hand, marginalising dynamics and mechanisms (that are often reproduced in programme construction processes) and, on the other hand, vulnerability to HIV/AIDS, were also analysed.

We need to reposition PLWHA in the processes of research and intervention. This was highlighted in many presentations, particularly Kalichman’s address; he demonstrated that, generally, in research and interventions with regards to prevention, risk is only considered in the short term, i.e. until testing, while there are still risks after testing. Kalishman points out that many people continue having unprotected sexual relations long after they have tested positive. There are indeed very few studies on the sexual behaviours of
PLWHA and their vulnerability situations. Consequently, there are few interventions targeting behavioural changes and vulnerability reduction at their level.

However, it was noted that, in spite of all, some persons living with HIV had particularly involved themselves in community mobilisation with the intention to give the disease a human face. According to Modibo Kane, President of the RAP+ network, the contribution of PLWHA consisted of their involvement in activities of sensitisation, promotion of voluntary testing and counselling, accompanied by psychosocial care and support at home, etc.

The conference at Dakar brought another important innovation in African conference organisation processes in the form of public testimonies by men who have sex with other men (MSMs). They also participated actively in the debates or chaired work sessions. It emerges from those contributions that there is huge denial of homosexuality in Africa (coupled with violence and stigmatisation situations that increase vulnerability to HIV/AIDS), while recent studies have assessed disproportionately high HIV prevalence rates among MSMs.

Regarding the situation of children, several interventions (among others, those of Hopwood, Kgobati, Tscheko, Casares) presented research outcomes on the impact of HIV on children and on programmes and interventions that mobilise resources and care for orphans and vulnerable children. But the translation of the results of those studies into practical strategies still remains to be done. It also appeared that only very few studies examined the emotional effects of HIV on children. The conference staged a children’s art exhibition (including children living with HIV) on the theme of HIV/AIDS. The objective was that, through those drawings collected in Dakar and Kinshasa, children would be able to express themselves. Moreover, some testimonies of PLWHA have sensitised people to the stigmatisation that children of PLWHA are subjected to at school.

Women involved in the sex industry also participated actively in the debates and contributed to highlighting denial and stigmatisation evident in some statements by public officials – e.g. some countries may publicly deny the existence of prostitution, since it is forbidden by their religion. Groupings of people using illicit drugs and associations of migrants or of displaced people also took part in the sessions. The IOM shared its experiences in matters of research and responses with regard to migrants.

Meanwhile, some participants stressed the need to lead actions within communities and societies as a whole so that the interventions targeting PLWHA or marginalised groups would not encourage more stigmatisation or reactions of rejection from the other members of society. Some children living with HIV or AIDS orphans were reportedly abandoned by families to whom they were assigned by an NGO or by an aid organisation. It therefore seems important, while recognising the specific needs of PLWHA or vulnerable groups, to include the fulfilment of those needs in the framework of comprehensive strategies.

REINFORCING CAPACITIES OF GENDER ANALYSIS
Gender analysis appeared to be relevant not only in studies of the causes of HIV/AIDS, but also in the response construction. Several participants recalled Kofi Anan’s words according to which, more and more, in Africa, ‘AIDS has a female face’. Others paraphrased a quotation attributed to a Malawian MP: ‘AIDS has the double face of a woman and the baby she carries on her back’. Some presentations, like that of Nyblade, showed that stigmatisation and discrimination related to AIDS affect women more than men.

Several speakers identified links between the situation of women with regard to AIDS and their political, economic and social marginalisation. In some countries, discriminatory laws and measures prevent women from exercising a number of power functions, certain professions, economic roles or social responsibilities. Links were also established between the HIV context in which women live and the denial of women’s human rights as well as the multiple forms of violence (including structural violence) of which they are the victims practically every day in Africa, even if, here and there, efforts have been made to eradicate those practices by law.

On another level, the presentations and debates showed that the gender analysis does not concern women only, but also involves men. Despite the fact that HIV transmission in Africa mainly occurs heterosexually, a number of participants still based their studies on
women's vulnerability in a unilateral way, without relating them to men or to the vulnerability associated with the establishment of masculinity.

The definition of gender adopted by the diverse activities of the conference is that it is a social and cultural construction that structures social relationships between and among men and women. This definition was made an operational concept and given a plural and contextual content. Gender, as a social construction, bears some meaning only in so far as it is related to cultural issues, social classes, race, ethnic group and cast belonging and national and international economic and political relationships, etc. According to several participants, namely UNDP, Commonwealth and UNIFEM representatives, the notion of gender should take into account all that determines the relationships between males and females in all sectors (economy, administration, education, politics, fields of formal and informal activities, etc.) and at all levels of analysis (international, regional, national, community, family, interpersonal, individual).

The analysis of the gender issue appeared to address the fundamental issue of power and decision making. The question was asked how and by whom the notions of masculinity and femininity are defined. The ways in which concepts such as masculinity and femininity, as well as sexual identities are defined were analysed as bearing consequences on interventions. Gender inequalities are not only to be identified in individual and collective behaviours and practices, but also in institutional, academic, political and religious discourses as well as in the culture of silence, all discourses that very often mask the critical situations experienced by women.

ANALYSING STIGMATISATION AND DISCRIMINATION

In various sessions of the conference, AIDS-associated stigmatisation and discrimination was the most prevalent theme, and delegates found it very difficult to come up with exhaustive theoretical approaches and operational concepts. Stigmatisation constitutes a blocking factor with regard to access to care as well as efficiency of prevention.

Some exchanges allowed a deep examination of beliefs, attitudes, practices of discrimination and stigmatisation in institutions, namely in the areas of education, health care structures, workplace, family and community. International organisations, namely those working in the field of labour, family, HIV/AIDS and population policies, gave information on the researches they are leading and on the specific programmes they are implementing to tackle stigmatisation and discrimination. As a feedback, a number of interventions emphasised the hypothesis that the relative weakness of the results of programmes as ambitious as programme ‘3 X 5’ may be explained by the fact that they are based on medical, health or financial approaches, while the fear of stigmatisation constitutes one of the main obstacles to knowing one's serological status, which, in turn, influences access to treatment. Attention was drawn to creating stigma through 'new indicators' regarding programmes and interventions addressing the PLWHA. For example, some mothers refuse to take the milk they are given for bottle-feeding and some PLWHA refuse food or nutritional assistance, because that would indicate that they had tested positive and they would run the risk of being stigmatised.

The social contexts of HIV stigmatisation were also tackled in an attempt to compare the latter with the forms of stigmatisation related to other diseases and those that occurred before the advent of AIDS. AIDS stigmatisation becomes consistent and reinforces pre-existing forms of social exclusion and power relationships (social process of social relation construction and expression), so that the theme of social transformation was recurrent in the discussions. The studies led by Simbayi and Kalishman singled out the importance of constructing differentiated levels of analysis: society, community, institutions, interpersonal level and individual level, as well as the need to define indicators enabling analysis of the multiple forms and expressions of stigmatisation and discrimination (practical cases, explicit policy or laws, implicit rejection, physical violence, isolation, devaluation, social exclusion, self stigmatisation, etc.).

Meanwhile, as the paper by Adegoke demonstrates, a fundamental difficulty lies in the fact that the concepts and frames of analysis dealing with stigmatisation date back to the most famous Western studies carried out in the 1960s, which pose a problem of inadequacy with the historic and sociocultural contexts of Africa or elsewhere. Specific words or terms to designate
stigmatisation often do not exist, although the practices do exist. Researches on the modes and mechanisms of social stigmatisation would help to define HIV-associated stigmatisation better.

SENSE OF URGENCY AND RESPONSE PROMPTING
At the inaugural session, Dr Olive Shisana insisted on the need to include the notion of sense of urgency in response construction and response programmes. It was also stated that it is necessary to intensify HIV/AIDS prevention campaigns in order to make treatment financially accessible and viable. Sustained progress regarding responses will only be obtained through simultaneous intensification of both prevention and treatment programmes. Promotion of prevention was viewed as a type of watchword needing to be constructed transversally in all sectors of activities, e.g. sensitisation, training, community-based intervention, voluntary counselling and testing, access to care, education, etc.

As Shisana emphasised, the actions of prevention have to be based on enlightened research outcomes and on actions that have proven efficiency. The translation of research results into programmes is still inadequate. However, there already exists many completed researches and studies that can be translated into recommendations for programmes and policies. Given the similarities of situations, Africa’s cultural unity and the relative similarity of historic heritages, research studies carried out in one area may be relevant to other areas.

Dr Ndoye (CNLS)’s address emphasised that the teachings from successful interventions are likely to be reproduced on a bigger scale through comprehensive African policies.

Several participants also insisted on the need to accelerate political and social mobilisation to perfect new prevention techniques such as vaccines and antibiotics. Existing techniques such as female condoms should also be better received by women as well as men. Other interventions proposed that steps based on faith be supported and reproduced in all the African regions where they may prove to be useful. Countries like Kenya, Uganda, Nigeria and Senegal have accumulated several successful experiences in AIDS sensitisation, counselling, voluntary testing and care. One of the main lessons learned is that involving representatives of all religions in a country to work together in a concerted way, will considerably reduce religious stigmatisation risks. Consultation between religious people, policy makers, researchers and marginalised groups encourages consensus regarding the global objectives and specific missions of each of the stakeholders.

There were also comments about the lack of exhaustive comparative studies on the involvement of the media in the sensitisation about the HIV. Often, the images broadcast by the media contribute to stigmatising behaviour towards PLWHA or marginalised groups. Several participants insisted on the need to renew the content of prevention messages. Very often, these are repetitions of those worked out in 1980s, i.e. at the beginning of the epidemic. Creating feedback devices in order to re-direct messages and construct new types of prevention messages should be the main objectives of a new generation of studies on HIV-related communication.

On another level, several participants emphasised that it is urgent to encourage prevention in the workplace. One of the arguments put forward in this regard is that, to mitigate the impact of AIDS, states and companies need to commit themselves to ensure that public and private sector workers have access to ARVs. One conclusion drawn from that official statement is that prevention in the workplace should be encouraged in order to avoid eventual loosening of behaviour changes or breakdown in the supply of ARVs. If access to ARVs is not coupled with prevention, there is a risk of unsustainable development curves in private companies and in the public sector. It is against this background that representatives of employer organisations of countries such as Senegal, Ivory Coast and the Democratic Republic of Congo, representatives of about ten trade-unions, and the United-Nations agencies (FNUAP, ILO), reviewed the crucial problem of obstacles to the efficient prompting of responses in the workplace – little knowledge of HIV and its impact on companies, ineffective action, insufficient social dialogue, weak links between actions within sectors and global policies.

Nevertheless, despite the urgency to proceed to responses, it is also convenient to holistically work out long-term programmes tackling the profound (social, economic and political) causes of vulnerability. So,
regarding care and treatment, it was noted that access to ARVs is also slowed down by socio-economic factors (transport problems, lack of acceptance and accommodation, high cost of biomedical follow-up, problems related to nutrition, etc.) and by psychosocial and cultural factors (bad management of emotional impacts, stressed professionals, fear of stigmatisation and discrimination).

The issue of response prompting also raised ethical questions. Several participants were of the opinion that the ethical protocols often do not correspond with social relationships as they prevail in Africa. Thus, for example, the individual decision figuring in the core of those protocols do not, in several African societies, always exclusively depend on the individual. It appeals to interactive processes between the individual and several reference groups. The information which the protocol assumes is known before adhesion to clinical tests is not always so. Some participants also wondered about the ethical value of therapeutic tests which use placebos, and which therefore deny certain groups treatment currently available internationally. A number of participants emphasised the need to urgently rethink the issue of clinical research ethics in Africa.

SYNERGIES AND RESPONSE COORDINATION
Multisector response includes sectors as diverse as schools, universities, social institutions, the army, the state service, the private sector, health services, judicial services, cultural, religious or social organisations. The response strategies should enable the development of open, flexible and sustainable partnership relations with traditional women and marginalised groups (MSM, prostitutes, drug addicts). Often, public authorities and international cooperation agencies tend to recognise only organisational methods that conform with Western rules of administration and management, while traditional frameworks of social mobilisation or sensitisation already exist. Often the latter need only to be acknowledged and possibly adjusted in order to fulfil an operational role in the conception, implementation and evaluation of strategies.

The interventions of Sow and Sow helped to point out the operational challenges to the interaction between communities and health structures, and how these challenges can be solved as soon as one establishes what type of dynamic and relationship needs to be created so that communities and health services act in synergy to reinforce prevention and care in consensual systems that ensure continuity of care and of processes of behaviour changes.

Some papers (e.g. that of Traoré) showed that regarding sexual workers, synergies can be created by combining prevention actions with programmes of access to care and with advocacy actions in favour of more legal protection.

The discussions singled out the possibilities of mutual reinforcement of the strategies in sexual and procreation health and those of HIV prevention. Preventing HIV transmission from mother to child is based on sensitisation and prevention activities that could be included during pregnancy (including the prevention of unwanted pregnancy), delivery and neonatal care management activities. But the papers of researchers like Mosala from South Africa pointed out the under-utilisation of prenatal consultation services and medically assisted delivery services – a situation that exists in practically all African countries. It points not only to the issue of medical coverage of the rural areas, but also to the issue of acceptance of health care structures and of the cultural concepts related to pregnancy and delivery management (women who deliver at home often have the support of a companion, and have psychosocial support that is lacking in health structures).

According to NGOs like AIDS Service and ICA, the centres of free voluntary testing and counselling could play a major role in that respect, because they are located at the interface between the actions of sensitisation and those responsible for access to care and treatment. Several participants proposed operational enlarging of test centres in order to include testing for tuberculosis and other diseases affecting communities, so that the most vulnerable groups, who seldom come to test centres, can be reached.

Multisector response prompting poses operational coordination problems that, if not solved, may reduce the impact of the response. In the course of the debates the lack of visibility of current interventions evolving in isolation from each other was mentioned. Cooperation agencies being more concerned about showing the successes of their own interventions than anything else, was given as the reason for this lack of
visibility. Their interests and zones of intervention often vary, with consequent failure of financial support. Several participants thought that serious problems of spatial and temporal continuity threaten the strength and durability of responses.

Grunisky explained that at the international level, the issue of intervention coordination and evaluation was the object of a consensus around the need to give consistence to the 3X1 principle (a single action framework, a single national coordination body and a single evaluation system). National response coordination will have to be based on the construction of operational and strategic frameworks taking into account international and local level and including an appropriate representation of PLWHA, marginalised groups and communities. This pre-supposes that questions related to the working language and institutional practices that result in social exclusion, will be solved.

Another finding in this exchange encounter is that, to be efficient, prevention has to be designed in such a way as to be lasting. Therefore, it must benefit from permanent investments. Researching miraculous solutions or sensational activities has to be replaced by systematic efforts integrated in coherent visions supported by mechanisms of feedback and evaluation.

FOCAL POINTS FOR POLITICAL RESPONSE CONSTRUCTION

For a number of participants, political responses are all the more urgent, in that HIV/AIDS threatens the political systems of their countries. Chirambo showed that HIV/AIDS might have a negative impact on electoral processes due to the many deceased that are to be deleted from the electoral rolls, due to the high cost of by-elections to replace MPs or elected councillors who died from AIDS and due to the fear of stigmatisation that keeps the PLWHA from exercising their democratic rights. All the above factors may negatively affect political systems and democratic governments.

From the exchange encounter devoted to the political aspects of the epidemic, it emerged that, in order to obtain notable successes likely to radically and durably reverse the trends, we need to couple the activities of sensitisation and training with responses touching the profound structures of society and tackling the issue of human rights protection. Policy makers should commit themselves more to defining and promoting human rights, particularly the rights of PLWHA, of women, young girls and individuals having plural sexual identities, in order to help them to have control over their sexuality; these categories of people need to be protected from violence, abuse, sexual harassment and discrimination. Thus, special measures should be taken to protect the rights of marginalised groups better. But recognition of rights alone is certainly not sufficient. It is important to develop programmes aimed at reinforcing the capacity of women and marginalised groups to face the situations that increase their vulnerability.

Numerous African countries have attempted to change laws and regulations the order to promote prevention, but those legal actions are still insufficient (repressive laws against MSM or sexual workers exist in many countries). Furthermore, even if effective laws and policies exist, their enforcement still remains insufficient. This then poses the problem of the inability of communities and civil society to persuade the political and judicial authorities to enforce effective prevention measures, and to abolish discriminatory and unfavourable laws. It should also be noted that more and more associative or community movements are being created to claim universal access to treatment and care. These movements are often opposed to private interests whose aim is profit accumulation. It is important that policy makers support these movements, so that they can obtain the international interest they need to succeed.

The personal commitment of politicians has known diverse fortunes. Currently, in several countries, one sees more and more of the highest political and religious authorities publicly taking position. However, the AIDS issue figures very little in the electoral agendas of political parties.

Several participants stated that African parliaments must consider the need to ensure long-term investments and to reduce financial dependency vis-à-vis foreign donors. Dependency vis-à-vis foreign funds was mentioned as a factor affecting the durability of care-giving actions. Long-term investments suppose concerted actions by beneficiaries, communities, national governments and international partners to ensure judicious utilisation of the resources and
guarantees of continuity in research, interventions and response policies.

CONCLUSION

Following the two first African conferences on HIV/AIDS held in South Africa, Dakar’s conference reinforced the orientations of the SAHARA Programme by bringing innovations in the conception of international conferences, in the implementation activities and obtained new outcomes.

The innovations related to the way of conceiving international conferences take into account the current new conceptualisation of HIV/AIDS, a re-thinking which extends beyond the limits of approaches focusing on biomedical perspectives, in order to reorient reflection on issues related to the contexts of vulnerability, identities and social construction of the relations to the disease (UNAIDS, August 2003).

Besides the symbolical and operational aspects, the cultural approach put into effect by the conference is in accordance with the orientations expressed by several international organisations and by the commitment statement of the United Nations General Assembly’s Special Session on AIDS which underlines ‘...the major role that can be played by culture, family, moral values and religion in preventing the epidemic and in the activities of treatment, care and support, taken into account the particularities of each country and the need to respect all human rights and basic liberties’ (United Nations, 2001).

The activities of the conference were organised in such a way that PLWHA, grassroots communities and marginalised groups were able to play a focal role. This orientation extends the debate about the political, social or institutional concept changes that are needed accelerate responses. The importance the conference granted to gender issues is in accordance with the key concerns raised in the international debate about the control of vulnerability factors.

The conference studies contribute to the universal debate which attempts to construct new definitions of stigmatisation and to analyse the ways in which it manifests itself. The analysis of HIV determinants enabled the conference to propose holistic approaches and elements of response constructed on the basis of a set of interactions between research and action, behaviour changes and structural changes of the policy makers, the base communities and the marginalised groups.

The conference reinforced thinking about response construction while singling out the themes of urgency and response prompting, of synergy construction, coordination and design of political responses. All participants agreed that the conference was a great success, a sentiment echoed in the local press and in the international media.

The next African conference on the social aspects of HIV/AIDS is scheduled to take place in from 29 April to 3 May 2007 in Kisumu in Kenya and will most certainly offer an opportunity for consolidating and even exceeding the achievements of the Dakar conference.

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