to offer, however, until I read something VS Naipaul wrote about the relationship between the people of his native West Indies and the first generation of leaders after independence.

The people had more than adulation for their leaders, Naipaul wrote. What they wanted was that their leaders would represent them, and not just in "a parliamentary way". Instead, they wanted their leaders, who had once been as poor as they, to be rich and powerful and glorious. Precisely how leaders became rich was irrelevant. All that mattered to them was that their glory would also be the glory of their people, so that the latter could live through the former. If the leader were grand, larger than life, his people too would be grand.

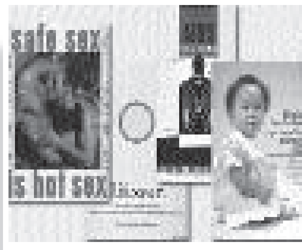
This, I think, is at the heart of the challenge of building respect for the kinds of social values our Constitution protects in places like Elsies. Too often, these are places where power, whether exercised by cops or by the gangsters, was a raw, untamed force. People bowed before it or were crushed. The courtesies demanded by our law of our law enforcers, the legal checks and balances, the cultivated social graces in our Constitution, none found an echo in the social rules by which these communities lived. The result was that policing here was as tough and uncompromising as was the world in which it functioned.

LB

Antony Altbeker is a senior researcher at the Institute for Security Studies. This is an edited extract from his book, "The Dirty Work of Democracy: A year on the streets with the SAPS," written while at the Centre for the Study of Violence and Reconciliation. It has recently been short-listed for the Alan Paton Award. This is the last in a series of three articles.

The crisis of HIV prevention
Where to now?

Leadership in the struggle against HIV/AIDS is in disarray. **Warren Parker** examines why this is the case and posits an urgent strategy for dealing with the crisis.



HIV prevention is a slippery concept. Over the past decade, despite the rhetoric and promises of some prevention campaigns, and the overarching reach and knowledge base produced by others, there have not been tangible gains in terms of reducing HIV prevalence in South Africa.

Ambitious promises to halve prevalence amongst youth through high cost 'scaled-up' interventions such as *loveLife* have been demonstrably hollow, despite massive investments. Vulnerabilities to HIV infection are distinctly imbalanced with girls and women considerably more likely to be HIV positive. The poor and marginalised are disproportionately living with and affected by HIV and AIDS. Groundswells of popular mobilisation in line with the scale of response to apartheid have not materialised, and overall leadership in the struggle against the disease is in disarray at every level. Where to from here?

BEYOND INDIVIDUAL SEXUAL BEHAVIOR

'Abstain, be faithful, condomise' – ABC – is the oft repeated mantra of HIV prevention and we need to look at why this concept has not brought the epidemic into check. 'ABC' is a prevention response that is often attributed to underpinning 'the successes in Uganda'. It is important to recognise that 'ABC' was only one element of the Ugandan response. The HIV prevalence declines that were documented amongst youth in Uganda took place in a context of very little national funding and/or programmatic response to the epidemic (including quite limited supplies of resources such as condoms).

The focus of the 'ABC' concept is on individual sexual behaviour. It is based on a number of poorly grounded assumptions that people

independently determine their sexual behaviour – through rational choice. Further, that such choices are absolute guarantees for HIV prevention and that we are consistent in our sexual behaviour, for example, that condoms are used consistently for every sex act, or that faithfulness is absolute. And finally that once behaviour is established it is permanent.

There are important gaps in understanding human sexuality and human society in this way. The focus on the individual and individual sexual behaviour neatly skirts some of the more important dimensions of 'what happened in Uganda', notably the interlinking of community-based responses and political leadership in a country emerging from an extensive civil war. Community mobilisation around HIV/AIDS was a vital aspect to the Ugandan response and this response included the building of support mechanisms for people living with, and affected by, HIV/AIDS as well as addressing aspects of prevention. National and local leadership was key to legitimising this form of response.

In South Africa in the late 1980s and early 1990s, HIV/AIDS response was closely embedded in politicised responses to health by the democratic movement and included the development of a comprehensive National AIDS Plan to be implemented under the new regime. Surprisingly, although South Africa had a plan in place and communities and political organisations were still steeped in the practices of community mobilisation, response to the emerging epidemic was fragmented at all levels. Whilst you could point to some of the hallmarks of failed concepts such as Sarafina II and debates about the substance of the science of AIDS, what is more important is the failure to mobilise around the epidemic at the point when it was considerably less severe than it is today.

In the late 1990s there were some attempts to effect such multi-sectoral leadership led by government and including a national declaration on AIDS, but these were largely top-down and thus bound to failure. These initiatives and parallel processes have continued in the form of declarations of commitment made by government, unions, corporates and other sectors, but none have been substantive enough at sectoral level to change the course of the epidemic.

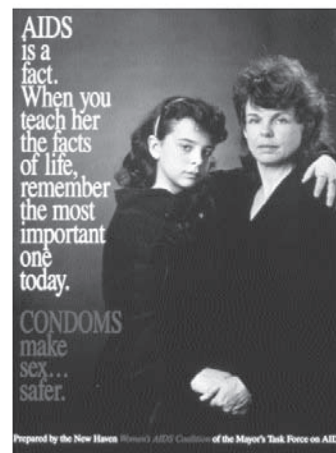
What we need to understand explicitly is that successes elsewhere have largely taken place in countries and contexts where HIV prevalence was relatively low – less then 10% in terms of antenatal prevalence levels – whereas our national antenatal prevalence was nearly 30% at the end of 2004.

Other studies show enormous disparities in terms of gender vulnerability to HIV – females under 30 are three to four times more likely to be HIV positive than males. This is a serious health crisis and reversing an epidemic of this scale is no easy task. It requires concerted action on a scale not imagined before, and while national and sectoral leadership is relevant, what needs to be emphasized is the need for decentralised leadership and grassroots mobilisation. But where should the focus of this response lie?

MOVING TO CONTEXTS OF RISK AND VULNERABILITY

The 'ABC' concept simplifies understanding of mechanisms for preventing sexual transmission, but in its simplification, it is overly simplistic. Because it is simplistic it is misleading.

The greatest weakness of 'ABC' is



that it assumes individual action in sexual choice-making. All well and good, but what is immediately overlooked is that sex is not something that is determined by a single person in isolation. It involves an interaction with a sexual partner. Sex is not determined in the same way that other behaviour is because the needs and perspectives of another person must be taken into account.

Sex is also *not* a deeply rational process. It involves a complex of psychological factors such as emotional needs, feelings of love, need for affirmation, and sexual desire. Physiologically it involves feelings of pleasure and other physical responses. Sex is also not uniformly 'pleasure' driven. It may include ambivalence and worry about consequences of sex including, for example, pregnancy and/or HIV transmission, but also about the relationship with a sexual partner that lies beyond sex itself. Sexual practices and behaviour are also not consistent over time, and remain dependent on sexual partners.

What has been acutely recognised in the South African epidemic is that sex is closely interconnected with systems of

power. Vulnerability to HIV infection is strongly linked to disempowerment. Many factors undermine sexual decision-making and these occur along a continuum of disempowerment. Examples of forms of power that diminish individual choice include rape, physical violence, physical and psychological coercion. Then there is institutionalised power such as that wielded by police, teachers, and others in social and economic heirarchies and cultural power, such as the expectation to respect ones elders, or expectations entrenched in marriage, family and other relationships. There is also reduced power as a product of basic economic needs such as food and shelter which may be exchanged for sex or needs linked to material consumption such as cellphones or fashion items that may be exchanged for sex and alcohol and drugs. These diminish decision-making capacity and many other similar factors.

Whilst knowledge about prevention mechanisms such as 'ABC' are useful, it is becoming more and more important for people to know their status. More empowering forms of knowledge are vital and these include knowledge of contexts of vulnerability and risk to HIV. These are interdependent with economic life.

People living in poverty are at risk as a product of their poverty and the risks to infection that might occur through the exchange of sex for basic needs and compounded by globalisation and the centrality of material consumption. Labour migration separates families and disrupts intimate relationships and produces vulnerability as a product of such separation. Women are increasingly going into casual short-term migration, with female migrants being vulnerable at a number of levels. Living in informal settlements where communities may be fragmented is also strongly associated with higher levels of HIV prevalence.

The contexts of institutionalised disempowerment and the risks these produce must be highlighted and emphasis must be placed on delimiting such power. For example, children are vulnerable to sexual abuse and HIV is a product of cultural powers and secrecy around sex and the power that adults have over children. Girls and women are vulnerable because of the secrecy that surrounds sexual violence as well as the failure of institutions such as the health, police and justice systems to protect their rights and address violations.

Children, girls and women are disproportionately vulnerable as a product of differences in physical power and violence generally. Women workers too are vulnerable as a product of the hierarchies that exist in workplace structures and so on.

AN INTEGRATED RESPONSE

Addressing HIV prevention cannot be delinked from a parallel process of addressing the epidemic including integrating treatment, care, support and rights. More importantly, we have to move beyond the focus on individuals and blaming individuals for failing to heed calls to behave in particular ways.

Knowledge is power, but the shallow knowledge that focuses on the individual and that slides past social inequalities, disempowerments and vulnerabilities produced as a product of social and cultural systems, needs to be exposed and addressed head on. This means a return to the grassroots mobilisation on the scale that characterised the response to apartheid.

This requires analysis and understanding of risks, a focus on contexts of risk and vulnerability, and articulation of the links between disempowerment and vulnerability to HIV infection.

Ultimately, it requires leadership that goes beyond vacant declarations towards a united voice that has to do with immediately and urgently addressing the pressing social crisis of AIDS. It requires a social movement that shifts the locus of power from centralised top-down forms of response to decentralised and grassroots responses.

LB

Warren Parker is the executive director of the Centre for AIDS Development, Research and Evaluation (CADRE).

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