

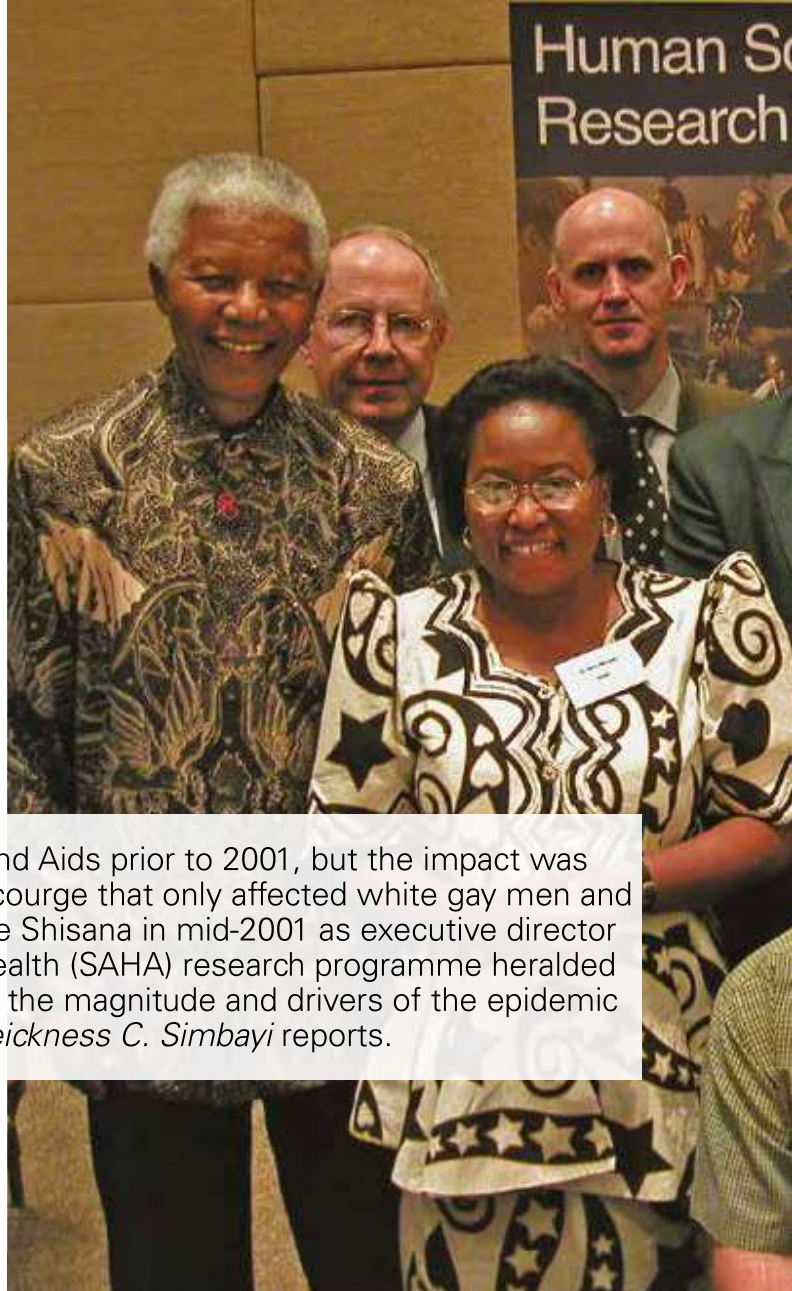
UNDERSTANDING THE SOCIAL ASPECTS OF HEALTH: THE CASE OF HIV AND AIDS SINCE 2001

The HSRC undertook some research on HIV and Aids prior to 2001, but the impact was limited, as the disease was still viewed as a scourge that only affected white gay men and poor black people. The appointment of Dr Olive Shisana in mid-2001 as executive director of the then Social Aspects of HIV/AIDS and Health (SAHA) research programme heralded an exciting new era, which shed more light on the magnitude and drivers of the epidemic and suggested possible interventions, *Prof. Leickness C. Simbayi* reports.

The rationale for setting up the SAHA programme was the acceptance that HIV/Aids was both a medical and a social problem. It was therefore imperative to investigate the underlying socioeconomic and cultural drivers of the epidemic and inform the development of policy and intervention programmes to help alleviate the impact of the disease. At the end of 2001, I joined Dr Olive Shisana in the SAHA programme as a research director. Soon afterwards, the late Efua Dorkenoo, a gender expert involved in the fight against genital female mutilation, was appointed as a research director. Along with several other brilliant researchers, we developed a research programme to investigate the social aspects of HIV/Aids. It included HIV surveillance, orphaned and vulnerable children and theory-based risk-reduction interventions. In this article, I share the impact of each of these three lines of research in South Africa and how they were replicated in other African countries.

A model for HIV surveillance

In 2000, the World Health Organization (WHO), the Joint United Nations Programme on HIV/Aids (UNAIDS) and international organisations such as Family Health International (FHI) recommended the use of second-generation surveillance for HIV. This included combining



biological and behavioural surveys to understand the magnitude and determinants of the epidemic. Prof. Thomas Rehle, who had joined SAHA as a special advisor to Shisana, was part of the FHI team that developed the original idea.

In 2001, SAHA conducted the first population-based survey on HIV/Aids in South Africa, in collaboration with the South African Medical Research Council and the Centre for Aids Development, Research and Evaluation. This was after the Nelson Mandela Children's Fund organised a meeting to discuss why the epidemic appeared to be out of control. Attendees agreed that an alternative approach was needed to augment annual surveillance data among pregnant women at antenatal clinics used to estimate national HIV prevalence rates. While the country welcomed the release of the Nelson Mandela/HSRC Study of HIV/Aids, in December 2002, a controversy broke out when the WHO and UNAIDS and other researchers questioned the findings, which suggested a much lower



Former president Nelson Mandela with members of the HSRC research team and collaborators who worked on the 2002 Nelson Mandela/HSRC Study of HIV/Aids. Back: Dr Mark Orkin, Dr Kevin Kelly, Dr Leickness Simbayi, Warren Parker, Julien Chauveau and Yoesrie Toefy. Middle: Dr Olive Shisana, Dr Heather Brookes and Prudence Ditlopo. Front: Dr Mark Colvin.

prevalence than expected. The main criticisms were a) the questionable use of oral fluids for testing HIV antibodies among children, b) the high refusal rate for testing, and c) that the research team consisted mostly of unknown and inexperienced researchers. At roughly the same time, ORC Macro International, which runs the Demographic and Health Surveys, started to include a module on HIV/Aids and undertake HIV testing in several African countries and came up with similar findings, which were much lower than previous estimates. Furthermore, the 2002 Nelson Mandela/HSRC Study of HIV/Aids was also successfully repeated in 2005.

The surveillance data from these first two HSRC surveys complemented data obtained from surveys of pregnant women attending antenatal clinics that became available in South Africa. On a global level, the data from the two surveys, together with data from similar studies conducted in other African countries, contributed towards more accurate estimates. Consequently, national, regional and

global estimates were adjusted downwards in 2004 and 2005, particularly in southern Africa and India.

Soon after the wide dissemination of the Nelson Mandela/HSRC Study of HIV/Aids in 2002, other Southern African countries, especially Botswana, Swaziland and Mozambique, became interested in implementing similar studies. We provided them with technical assistance, with support from the Southern Africa Development Community (SADC), which was itself supported by a grant from the European Union. Botswana undertook its Botswana Aids Impact Survey (BAIS) II in 2004, BAIS III in 2008 and BAIS IV in 2013, followed by Swaziland in 2006-2007 and Mozambique, with its Mozambique Aids Indicator Survey in 2009. In November 2007, I had the privilege to present our model of HIV surveillance to ministers in charge of HIV/Aids in all SADC countries during the SADC Leadership Conference, at Victoria Falls, Zimbabwe. It was adopted as a gold standard for national HIV surveillance that all SADC countries should try to implement at least once to benchmark their national estimates derived from antenatal clinics.

Orphans and vulnerable children

Between 2002 and 2006, SAHA ran a project entitled *Strategy for the care of orphans and vulnerable children in Botswana, South Africa and Zimbabwe*, funded by the WK Kellogg Foundation in the USA, to obtain evidence-based best practices to improve the conditions of, and reduce HIV infection among, orphans and vulnerable children. The main goals were to: a) establish an implementation framework; b) evaluate and monitor the impact of home-based child-centred care programmes; c) evaluate the impact of families and household support programmes; and d) strengthen community-based systems for sustaining care for these children and their households. The project involved working with government departments and influential grant makers as well as universities and research institutions in each of the countries, in what is known as implementation networks. Many interventions were identified and recommended to sub-Saharan African countries to help mitigate the impact of the HIV/Aids epidemic on orphans and vulnerable children. About 27 research reports and 4 peer-reviewed journal articles from all 3 countries were published and are available on the HSRC and Social Aspects of HIV/Aids Research Alliance (SAHARA) websites.

The researchers also convened public meetings for dialogue between the ministers responsible for orphans and vulnerable children, researchers, non-governmental organisations, community-based organisations and donors on the key issues emanating from research that had policy implications. The path from research to policy often meanders; and it is usually difficult to demonstrate that research has informed policy afterwards. However, a



Researchers at work

systematic examination of South African policy on orphans and vulnerable children, presented to the South African parliament in 2005 by the then deputy minister of social development, showed concordance between social science research findings and the strategy. Similar impacts on policy and programmes were realised in Botswana and Zimbabwe.

Social and behavioural risk reduction

Between 2003 and 2013, the HSRC was involved in the testing and development of a set of theory-based behavioural risk-reduction intervention programmes known by the name Phaphama (meaning “wise up” or “be wise” in Nguni languages) in South Africa. These were mainly aimed at providing evidence-based behaviour change interventions to reduce new HIV and sexually-transmitted infections, gender-based violence and HIV infections; alcohol abuse (all as related to HIV infection); and re-infection by other strains of HIV among people who were already HIV positive (positive prevention). The studies, a collaboration between Prof. Seth Kalichman of the University of Connecticut and me, were mainly funded by the US National Institutes of Health.

Other research, involving a multi-country study in South Africa, Botswana, Lesotho and Swaziland, sought to promote HIV disclosure by people living with HIV. This was funded by SAHARA, which was funded in turn through pooling funds from the UK Department for International Development, the Canadian International Development Agency (2004-2006), and the Directorate-General for International Cooperation in the Netherlands (2005-2008).

The final line of research was on the implementation of behavioural-risk reduction interventions, targeting men who had been traditionally or medically circumcised to reduce the chances of HIV infection, and was funded by the Bill and Melinda Gates Foundation. This intervention has been adopted by many practitioners involved in the scaling up of medical male circumcision in the country.

The above work resulted in a bouquet of theory-based behavioural risk-reduction interventions. These include the Phaphama intervention, targeting alcohol abuse and HIV infections, which has been successfully adopted by organisations undertaking HIV implementation science work in South Africa, Namibia and Malawi.

Acknowledgement

Most of this text is drawn from the SAHA Self-Evaluation Report, of which I was the lead writer and whose preparation I coordinated as the deputy executive director of SAHA in 2007.

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