ORAL HISTORY PROJECT

Chronicles of The Lost Decade

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Interviewee: **Kgosi Letlape**

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AM: Normally with these things I ask you, kind of cryptically to start at the beginning.

KL: Is there are beginning to these issues? I guess for me, I got involved not voluntarily. I was just an ophthalmologist in private practice, minding my own business. But I'd been involved in medical politics before. I've been in leadership of an organisation called the South African Medical and Dental Practitioners, which is a non-racial organisation but the majority of the members were largely Black. Uhm. There was a time when the medical representation was still divided. So after unification of the medical profession, at the insistence of the first Minister of Health, Dr Nkosesana Zuma. Uhm, and because of the challenges inside our own organisation, I was part of the initial talks of the Medical Association coming together. And I put forward the proposal of a 50-50 representation, which happily was carried out. Eh, but for many other reasons, I went into the background, I went out of medical politics, went into my practice and got into corporate medicine with South African Drug. But was then asked by the SAMDP to be a councillor in the Medical Association.

And one Sunday I had a nice golf game arranged, and I was egged to attend National Council. And you know, I just went you know by the by, when the opportunity presents. I had my golf clubs in the car, I'd leave to go and play my game golf. I got there and found a divided Association, and because of comments, I was made, by the following day I had been elected as the new Chair. The whole board had been cleaned out and a new board was put up and I was elected the new Chair. That was in September 2001.

AM: I'm curious, what with the comments that you made that resulted in your election.

KL: Well there was a lot of wasteful expenditure, there was a lot of infighting, there were lots of personality clashes, we going back to a black-white divide. And then I said, all this is irresponsible, we gotta get on with the business of the Association, we gotta put this thing behind us. And the people must forget their differences and do what they were elected to do. You know, to say you know this is a mess. And we need to clean this mess up. This is unacceptable. And for my troubles I was elected as Chair of the Association.

Eh, having been elected as the chair of the Association, this was 2001. I mean in the periphery of the International AIDS Conference, in 2000. Because we had a group of doctors that used to come in from the US, and we used to do outreach work, with African American specialists. I mean that would come here at their own time on their own expense and they'd team up with African specialists in the country and would go out do outreach work. So we came to the conference as a group.

AM: Yeah.

KL: So you know, but my involvement with HIV was just as an ophthalmologist. Presentations of HIV patients to ophthalmology and nothing more. And I was in medical politics but not in the HIV arena. But what became painfully clear, you know I still have the memory of an *Nkosi Johnson's* speech at the AIDS Conference. And that stayed with me. But I did nothing about it you know, was just a silent victim like most of us, most of us are.

And having become Chair, it was at the height of a policy of no treatment. And as the Chair I now had to engage, on behalf of the profession. And when I got into the Association I said; But there are no policies or statements that the Association making on the most pressing health issue in our country which is HIV and AIDS. You know, and I said to the Association; You need to get engaged. So at the next National Council in 2002, I force the Association to get involved. I force the Association to become a corporate member of TAC. And that coincided with the time that *Zachi Agmad* took a stance that he'd rather die, then take ARV's. So I then got the Association to become involved, become a member of TAC and as the Chair, I undertook to go and see *Zachi*. I went to *Zachi Agmad* and I said to him; You know, you're gonna be a martar, and everybody's going to forget and move on with our lives. Take treatment. And *Zachi* said no, I will not.

So I moved back from, when back home, left a sick *Zachi* in Cape Town. And I said what are we gonna do? If you can't treat, not interested. Within 24 hours, I got a call from the past president *Nelson Mandela*, it so happened that he'd also go and see *Zachi* on the same issue. And I guess he got information from *Zachi* that I've been to see him. You know, and I think I went to see *Zachi* before the past president. So I got call from *Nelson Mandela*, said come and see me. He was in a retreat, somewhere in Limpopo.

And I had to drive out to *Naboomspruit* to go see *Nelson Mandela*. Spend an evening with *Nelson Mandela*, had dinner with him, and we spoke about the issues. And the dilemma that *Zachi* presented. And I said to the past president; If we want to stop, we'll have to start a treatment plan, that's the only way he's going to stop. And from there I was then forced to go to HIV clinicians, and I went to get remittance in Cape Town.

AM: Tell me, can we go back to that conversation with *Madiba*? How long did that conversation go on?

KL: I spent more than four hours with him.

AM: What was the tone of it? Was there a kind of urgency to it?

KL: Oh, there were a lot of things that came up, there was a sense of urgency. He'd tried to see the President, the President wasn't available for him . He was referred to the Deputy President, *Zuma*.

AM: This was *Madiba*? He was referred around?

KL: Yes, and the President said; I don't deal with HIV, it's the Vice Presidents portfolio. And, uhm, *Zuma* was in the Great Lakes, and you know. So *Madiba* had to wait his time for an appointment with *Zuma*. And, and, and it was distressing.

AM: I guess.

KL: He had to stand in a queue, and he was extremely agitated by that. You know, he wouldn't express it but you would see it. And he, you know, the humble but resolute men that he was said; What can we do about this issue? And you know, but the whole swab of discussions, I had to inform him about HIV and AIDS. That you can't get it from hugging people or shaking their hands, so we went to, end up a discussion between a medical doctor and a leading lay person. Who needed all the information about HIV and AIDS.

AM: it's a pity you can have a conversation with *Mbeki*.

KL: Well we tried to have a discussion with Mbeki that was not successful. We'd ask for an appointment with the president that was not successful. On th that you are at issue and many

other issues. And even he couldn't get in there. So for me, I sat down with *Madiba* and I made a commitment, that we will go, and we will start a treatment plan. So I left, went to the Association, and told them we need to start T*he Tsebang Trust*, start a treatment programme, eventually it was named *The Tsebang Trust*, after baby *Tsebang*, and after a lot of upheavals, we had a fundraising dinner and we had *Madiba* to come and speak at Emmerentia Dam. Openly on HIV and AIDS and he became an HIV activist, following on *Zachi Achmad's* action. We then started the *Tsepang Trust* as a corporation between the South African Medical Association and the Nelson Mandela Foundation. The Nelson Mandela Foundation pledged 10 million Rand. And the first person to put on treatment in a public facility was paid for by the Tsepang Trust and the Nelson Mandela Foundation, at the GF Jooste Hospital. So, and 1 December 2003 *Madiba* launched the first treatment program in a public facility.

AM: 2003.

KL: We'd already do it in the Eastern Cape, the plan was to have two sides in every province, one urban one rural, but we could only operate in the Western Cape because and eight other provinces the ANC ruled, it was unlawful to put people on life-saving medication. It was illegal, it was unlawful. And to do that, you'd be treated like a traitor to the cause.

AM: The cause? The cause being?

KL: The cause being, the cause charted by the ANC government. You are defying the government. Now there was a pledge of 10 million Rand from the Nelson Mandela Foundation, we put a treatment plan together, that had to conform to the recommendations of the WHO, we didn't want a treatment plan that was based on private regiments. So we base that on the United, the UN AIDS and WHO plan for HIV. So the drug regiments were sent out on those. And we negotiated with the drug companies for access pricing, which would be what they would charge the government if they were selling to government. And the treatment plan was started and we put ARV's in GF Jooste Hospital, there was a great team of HIV clinicians they ran a HIV clinic and they just watched people die. So we put drugs in that made a difference. In between July 2003 and September when we launched, Cabinet made an order to the Department of Health to go and put a plan together, that they could present a government. So by April 2004 the government claims that they would start treatment.

AM: That was *Mantu Tshabalala's* plan that she was working on?

KL: Yes, that there was instructions from government to put a plan together. So basically treatment was started. But you know prior to that, I led a delegation to the Minister of Health on various issues. We were in battle with certificates of need, doctors were going to be restricted and told where to work, with I can't work, and before that from the Association. But we also took the HIV issue to the Ministry. And we got there, and it was during the time of the summit on sustainable, environmental sustainability that was held in Sandton. And the Minister came into the meeting and she said to us, I've only got five minutes for you because I have to be with the president at the summit. She spent two hours, two hours were spent lambasting me for things that I'd said, because I'd referred to what was happening publicly as genocide. And the Minister took offence at that, and we sat there with the then Director General, *Ayende Solome*. And the Minister and their team. And they clearly said to us, if you can't treat everybody you treat nobody. Which I found objection with.

AM: A sort of solidarity of death.

KL: You know, and that had been repeated in other meetings before.

AM: If you can't treat everybody, you treat nobody?

KL: That was the explanation for the policy of no treatment. Besides the other issues of toxicity and other alternatives.

AM; How did you feel when you heard those words. If you can't treat everyone you treat no one?

KL: I told them that's genocide, and that we're not going to stand by and watch how people die. We can't as a medical profession stand by and see how people die.

AM: But did you at any point try and reflect on, you know, what were the ideological underpinnings of that? If you can treat everyone you'll treat know one, or was it just bloody-mindedness and defensiveness?

KL: I think it becomes speculative, once you get into that arena and, and you could speculate on many things. I hate speculating.

AM: But you must have speculated?

KL: You know, uhm. And for me, I think there must have been a sense of guilt amongst the ANC leaders about how the epidemic had been managed. Uhm, if you look back at our figures, we had rumbling tiling type epidemic up to the late 80's. And getting into the early 90s it started rising. And the rise in the epidemic, coincides with the cleric making pronouncement the bending of political movements, people coming back. And, and, and when people came back unfortunately they left in high prevalence countries. So the prevalence amongst our retaining fellow South Africans was much higher, but there was no plan to manage HIV and AIDS. Everybody, the previous government had their heads buried in sand. And during that period of '89 to 94, the virus thrived and multiplied. And when the people took over, they didn't put any coherent plan to stop it and may be part of that was, you know, we should have known better. We came from high prevalence environment, we managed camps in certain countries with a prevalence was quite high. So they knew more about the dangers of HIV then we did inside. And they might have been ambivalence with respect to that.

AM: Ja

KL: And when the sort of the cost implications of treating. Remember in '94 there was still a lull, because you know there was no treatment. HIV was a death sentence. Help only came about in '97. And when *Thabo* launch the HIV plan is deputy president in Doornfontein, what was available at the time. But the cost was horrific, it was US$500 a month to treat a person. So I think there might have been in their minds the background of not having done anything concrete, because remember, the Ugandan experience was there. So dealing with HIV required leadership, not just money.

AM: I think the Zimbabwean experience to, because their epidemic peaked a number of years before, before South Africa's did. Why didn't we learn anything from Zimbabwe?

KL: But I'm not really sure what there was to learn from Zimbabwe, the main learning experience was from Uganda. With their zero grazing policy, I'm not sure what the lessons from

Zimbabwe would have been, because what happened in Zimbabwe was the treatment was made available, so I'm not too sure if there was strong on behavioural change.

AM: I'm sorry, I made you speculate which you said you'd like to do.

KL: I don't like speculating, but what was clear was that the cost implications were massive, because help was available, you know, the sleepiness goes back to before *Thabo*. And by his own admission, *Madiba* said, I wasn't aware that HIV was a major problem. So one thing that we should be truthful about, is to understand that *Thabo* inherited a full-blown epidemic. But he wasn't president, when it was, the fire was alight. The fire was really alight during *de Klerk's* time. And during the first five years of a Democratic South Africa. When *Madiba* was president then, and he admits that. So there's a lot of things that could have happened, their position just aggravated a terrible situation. And people were dying, and you know what is ironic is that, even if they had a policy that was consistent with the policies elsewhere, we never had chemotherapy for cancer patients but you never had a policy of no treatment. So it was left to the institutions, so the little they could do they would do.

If we had just had that, it really wouldn't have made a difference to people dying. But it would have made a difference in terms of their outlook. Because left to do what you cab within your budget and it's not illegal to buy ARV's, most institutions would not have bought ARV's. They would have continued to battle with what we're battling with. You know, and that for me is what puzzles me. Why, why they felt they had to make that call, when they didn't have to make that call. And then, and really nothing would have changed. I mean, TB has been curable, and we've never had a high cure rate. It's gone down with HIV and AIDS, but we muddled along. You know, everybody that needs asthma treatment, doesn't get asthma treatment. Everybody that needs epilepsy treatment doesn't get the best drugs for epilepsy treatment. But we don't have a policy, if you can't treat all don't treat anybody. This was just tailor-made to HIV, not applied to any other illness. And that was frightening. So for me that's how I got involved in HIV. I'm not in HIV clinician, even to date, I am still an ophthalmologist, because that's my trading. I'm an activist, but not a clinician. So I'll treat a variety of complications of HIV when they come into my discipline. But I don't provide ARV's, I don't treat people, I don't do VCT, I don't give counselling, an ophthalmologist. But I was ensure that there are resources,

and I assist the people they have the responsibility to treat. So basically historically that's where I come from. But you know, so we've seen denialism about cause and treatment. But unfortunately for us, we've perfected denialism, and denialism continues today.

AM: What's the incarnation of denialism?

KL: You know, denialism isn't about cause and treatment. We are in denial about prevention. Because you see what I find frustrating, is that there is a Ugandan experience, and the Ugandan experience, the bat dropped on the Ugandan experience in a time when help was not available, you died. If you got HIV, you waited to die. Testing was not accessible, you had to do a blood test that went to the lab for two weeks if your country had a lab and it was very costly. You did the antibody test and it was very expensive and you waited for two weeks. Condoms were not really accessible even then. They didn't have access to them, they didn't have a campaign to distribute them. But what was known was that HIV was a sexually transmittable disease. And the Ugandan miracle was based on two issues. If you're sexually active you are at risk, it's a sexually transmitted disease. And if you reduce the number of partners you have, we can reverse the impact of HIV and AIDS. Fairly simple, they called it *zero grazing*. It was in their hands, most of them lead by example, they enforced it from the top and the prevalence of HIV in moved from double figures at around 11% in Uganda, to around 5%. From the late 80s to the early 90s, behaviour change. You know, there's no donor funding, there were no jealous, there was none of the things that we have right now, that confusing as right now. Extremely effective program.

AM: Confusing us? Things that are confusing us? The donor funding and the policies?

KL: Yes, Oh yes. And the neo politics and the scientific community and the interventionist approach, you know. If I can't sell you something I can't help you. Why can't I tell you that you can help yourself by changing your behaviour? The most powerful drug against reversing HIV is in the hands of people. Behaviour change.

AM: I've always found it remarkable that you know, that the denialists message became so pervasive and it moved so quickly throughout the health system in the population. Do you think that what Musafeni did was the reverse of that? I mean the power of his messages that come from leadership is there, it's obvious. But I mean, how do you retract, I mean. Why could that

information network not be used, used in the service of behaviour change in South Africa as it was in Uganda?

KL: we had denialims about treatment, and we went on head on with that. It had started with people living with HIV and AIDS. But as soon as denialism about prevention, and it's convenient it's business as usual. I mean, I am amazed at the fact that the fight against multiple partners, has disappeared from the vocabulary of this conference.

AM: You noticed who our president is?

Kl: Yes, but now we've joined him, in being in denial about what needs to be done. That's why I'm saying we are entering a second phase of denialism. Much, much more dangerous in my opinion than the previous phases of denialism about cause and treatment. We are in denial about prevention. And, and that's what puts us at risk as a population. That's way, you know, because I find that this newfound joy of a working relationship between the DOH and activists, both of us are in cahoots about being in denial about behaviour change.

AM: *Gustaaf* called that the Mandela moment, the moment of euphoria and celebration when we. But you know, I think that's the political culture of South Africa. We give into these, these almost violent confrontations. And then we make up with each other, and then there's this euphoria when we forget that the battle has been won, but the war is still going on.

KL: But you know, what I find frightening is. I'm a medical doctor, and our background is that for us to accept something as standard, and as this is a victory, we talking 98% success rate. We're talking success rate in the high 90s, then we say the work is done. You know uhm, one of the landmark studies we talked about in medical school, in the 70s, was the study done by Johnson & Johnson about the effectiveness of condoms for prevention of pregnancy. And condoms found to be 80% successful in prevention of pregnancy. But they had a 20% failure rate, which we found unacceptable. And that's why alternatives was sought out, an oral contraceptives and injectable contraceptives were developed. Because 20% failure rate was unacceptable. We now, you fast track to 2011, we selling gels that are 39% successful. We're embarking on medical male circumcision 50% success rate, compared with condoms 80% success rate. Condom cost two cents to the government. We are bundling from medicalazation

of somethings that are far less effective than condoms. And we also are not informing the people, we give brief messages, you know our communication of scientific data is to promote the scientific procedure. It is not to promote an enabling environment were people make informed decisions, we now decide for people.

AM: Yes, fantastic.

KL: So, so we're in a era of denialism, that is far more dangerous that the denialism we come from.

AM: And we've gotten there by extracting the epidemic from its social context, as you say be given people statistics and figures and tell them what to do.

KL: we had a president who was in denial about cause and treatment, we now have a president that defies the basics about behaviour change. We have a president that has multiple partners. And before this president, we were open about the fact that we need to deal with multiple partners. We need to eradicate the socialisation in cultures that promote multiple partners. Now suddenly that has disappeared from our vocab, conveniently so.

AM: How could the personal life of the president, how is it possible that the personal life of the president can shutdown dialogue of multiple concurrent partners. How is that possible?

KL: I think it is, it is not correct to say how was it possible. Because you've seen that it is possible. We see debris, so not only is it possible but it's happening.

AM: I'm asking you to speculate again.

KL: No it's not a matter of speculation, it's a matter of convenience. And this is where I find it frightening, you know. When *Julius Malema* says, "One president, one wife", the press runs with it. When the Minister of Health put in his speech, of World AIDS Day of last year, "Stick to one partner and use a condom", nobody runs with it. Now we can't say leadership has not been provided, at least this Minister was brave enough to put it in his speech. None of us has picked it up and run with it, why? Why? So we can't say leadership or multiple partnership has not been provided, but at least this Minister of Health has provided it. It is there in black and

white, he put it in his speech for the World AIDS Day, the first of December 2010. Nobody has picked it up, nobody is running with it.

AM: But don't you think that under Mbeki there was a polemic conflict between science and nationalism? Now was president *Zuma* we have science versus culture?

KL: But that's rubbish, it's signs of human behaviour, this is not culture. This is misrepresentation of culture. No, we make it wear the cloths of culture. It is not culture, ok if you take the Muslim community, they practice polygamy on the cultural basis and they practice it as their culture dictates they should and they do not have an HIV epidemic. Ok, and that's a cultural practice. So here you have a misrepresentation of culture. And we now want to make it wear the cloths of culture.

AM: but it's a powerful conversation stopper though isn't it?

KL: No, it's a powerful conversation beginner we choose to not engage with it. Ok, and those of us that saying let's have this conversation, we won't get the airtime. We have a campaign called *Stop HIV, stick to one partner.* We don't get airtime. But then *Malema* Says, One President, one wife, he gets airtime. So it's the choices that the media makes, it's not that it's not out there, the media makes this. What goes into media, is what the media chooses to put into media. The fact that this misrepresentation of culture, the media is not putting out there because they choose not to. Multiple partners been crafted out of the dialogue of this AIDS conference, because the choice has been made to craft it out. We have a cosy relationship with government, we don't want to mess it up. It's not about scaling back, it's not about going to battle with the virus and regain territory. We're in a cosy relationship, so what do we do in that cozy relationship? We promote interventions. Because in interventions, there's papers, there's funding, there's money.

AM: There's research.

We need to promote behaviour change, the most powerful tool to stop HIV is in the people's hands. When I say change your behaviour, I can't sell you anything. You know, then there's no commodity in that. So we're not gravitating to commoditization of the battle against HIV. And I'm not saying the commodities are not important. But when can you say to people, change your

behaviour, there's no commodity then and we're not engaging in the debate, we're not having that discussion. And part of it might be, you know, if you have to talk about behaviour change. The end has to come from those communities. We can't come as Western people, as westernised people and save those people. We need to give them the information to save themselves. And, and I guess, then the credit can't come to us. It's not a vaccine we've discovered, and that's why you'll even find people who'll say; Oh you know, the Ugandan miracle, you can't just explain it on zero grazing. Because we're in a walled brave we don't want to tell people, that saving yourselves is in your hands. We still want them to be grateful because they've been saved by medical circumcision. They've been saved by the gel, they've been saved by the ARV's. But the single most effective weapon, which is changing their sexual roles in, which is in their hands. We won't talk about that. It's now up in the back burner.

AM: What, what you just said there echo's a little bit Mbeki's idea of bio medical colonialism, I think. This notion that the, that salvation is coming from the West, that it's coming from science. I mean *Thabo Mbeki*, I mean that philosophy definitely permeated some of his, some of his speeches. But I see what you mean, I always been of the opinion that we can't entirely discard what Thabo Mbeki is saying, cause he had some extremely valid points about colonialism and the agendas of science and so on.

KL: Why are we putting so much effort into 39% effective gels, 50% effective circumcision. And we, we taking the foot off the pedal of the 80% effective condoms and the more than 90% effective, sticking to one partner. I don't want to trivialise it by glorifying colonialism, I think it would be a mistake, it's an interventionist approach. And people might not realise this. They're charlatans out there that are not colonials, the charlatans out there that promise you concoctions that will heal you. There are rats out there, but there are many other things. So I think we shouldn't trivialise it by trying to promote colonialism. The challenge that you have year, is an interventionist approach. Ok, and even traditional medicine is working as an intervention, and is woken up to the opportunities that the HIV arena presents. So let us not make this a black-white debate, let us not make it the West versus Africa live does not even get into the trap of colonial clap trap. This is the interventionist approach, you know, I went to do a talk to youth, youth colourists in a church in Daveyton two weeks ago. And I saw poster, on the door they have a post of the Department of Health HIV and AIDS. And I read it, and read it, and read it. It's a

poster that is after the fact. It's get infected, and come and talk to us. Literally, it doesn't talk about don't get infected, it's about what we can do, if you know your status and you're infected. There's nothing about if you know your status, and your negative, how can you stay negative. It's conspicuously absent from that poster. And it's about the interventionist approach, healthy lifestyle, come and see us, early treatment, know your CDC count, it's the interventionist approach. You know, if you look at all the immune boosters etc. it after you get infected, we can boost your immune system. So the challenge we have is the interventionist approach, and you know, all of us we sit here. Medicine is after the fact, if you don't get sick I'm no value to you as a doctor because that's how medicine has been. So that's the interventionist approach, but we can really overcome this thing to make medicines available to those who are infected. But we're only going to overcome by saying; the 40 odd million that are not infected, how do we ensure that not even one of you get infected? That's how we going to win the HIV battle.

AM: Tell me when did you, when did you start thinking this way? I mean where, over the years did you realise that we were sort of going down this narrow interventionist path. Were there a point where you though, wait a minute?

KL: You know, I've always thought about this things. But it's all about, when you have people that are dying, you can't even get to talk to people to change their behaviour. When there is something that can be made available to them, and they would not die.

AM: It's like talking to people in the middle of a war about the root causes of conflict, isn't it?

KL: Yes, you know uhm, it is not inconceivable that in the Ugandan miracle, would have been more difficult to achieve, if help was available, at that time. So my point is, when, when we spoke to people about prevention they say; Why should I, it's too late for me. So, so I've always saw that prevention was key, I always tell people. Cure is costly, prevention is priceless. And I've always had that notion with me. But there comes a time when it's not right to have that conversation, people are dying. How can I tell someone that is dying about prevention, when I can't even make life-saving drugs available to them. But now, but now, prevention is a key, and it's got nothing to do with your status. Whether you are positive or negative, know about, prevention is key to life. Because of your positive, to stay alive longer you gotta prevent yourself from being reinfected. So now we can have that discussion, and everything is about

timing. There's a time when it was pointless talking to people about changing their behaviour, when they were dying. So, so, so, the time is now to talk about behaviour change. You know, the other things that *Mark* spoke about yesterday. Absent fathers, you know, and I mean, 70% of African fathers are absent. It is a direct correlation, of multiple partner socialization. A misrepresented cultural practices with absent fathers. Because you see, culturally when people did multiple partners for whatever reasons, when they did polygamy, you know, multiple partners is not promoted by any culture. But multiple marriages are promoted by some cultures, it is a difference, a big difference and nobody wants to talk about that.

AM: Can I tell you something, as a Western trained anthropologist I am forbidden to comment on those things in South Africa, forbidden.

KL: Why?

Am: As a white Western anthropologist, just because it's so much, it's such a minefield for me as a white Western woman to be, to be commenting on you know polygymist. To be making those associations it's just, uhm. I just can't step there. There's like a accordance around that, this is one of those conversation stoppers. I mean, people are, people fear to tread there, and the more distant you are from it, I mean me as a social scientist and somebody who works in HIV, there are places that I am just not allowed to step, and it's a common understanding you know, I have no business poking my nose into people's extended family structures.

KL: And you've barred yourself, and you've accepted this voluntary bar, barring of yourself?

AM: I have those discussions quite often with other white western anthropologist women, and you know people with who it is safe. But I would never, never stand up in front of a conference for example, even if I was the most eminent social scientist on HIV in the world. Would I ever presume to stand in front of the Durban Aids Conference and talk to people about behaviour change. Reducing the number of partners and so on. I mean it's, can you imagine? Can you picture it?

KL: Yes, I can picture it.

AM: They'd throw food at me; they'd throw rotten tomatoes at me. But I think, the reason I'm saying this, is when I talk about conversation stoppers, I mean, it's a dialogue that I think that we need to have and we're not having it yet. And one of the reasons is that some of us feeling we don't have , we're not entitled to step into it. I have no qualms up on the part of women, and women's rights, again from a very western feminist perspective, but you know, there's boundaries to where my authority is accepted. I'm talking more than you now, so...

KL: Well I, I hear what you say, but by the same token, you have the notion that because we're Black, we can't speak up against the Black leaders. You know, so it's the same notion. So if you go out and speak against Black leaders and your black, you are accused of being a member of the DA, or being a sell out and not being patriotic. So I understand where you come from. After 300 odd years of occupation, it's become easy to fight things that are black and white.

AM: Yes

KL: But things that are black on black are difficult to engage in. But someone has to engage in those issues.

Am: No, no I agree.

KL: So, so I hear you, but I can also sit here and say you know. This are our leaders, from the struggle. We can't stand up against them, we can't, if they are doing something it must make sense. You know, at the height of dealing with the denialism, I had medical doctors that use to stand up and say; You know, the president has a point, you know? And I asked one of them, tell me, if the president was white, would he still have a point? They went speechless. So there are areas, where we have to fight our own racial demons, our own tribal demons. And get to a point where we just become plain simple human beings. And we also have those battles, but those battles are battles that need to be fought. So I can't fight the battle of being a white woman for you, because I'm not one. You know, and I'm going to fight the battles of being an indigenous African man. Raised in a socialization of multiple partners as a right.

To say, it is not a right, because it violates other people's rights. If it's a right, why can't it be on a equitable basis? If I can have multiple partners, why can't my wife have multiple

partners? So we gotta deal with those issues. So, so for me we're not out of the woods. And the problem that I see is a problem where we are going to be creating a nightmare, a social and a medical nightmare. Because when you have women start using gels, that are hormone therapy, and most of them might not know their status. If your HIV positive, and you using those gels, you are going back to the days of mono-therapy. You are going to develop resistance, to those anti-retro-viral drugs. You know, I mean it's... What is wrong with us, why can't we measure as equal human beings? Why is 30% effectiveness good enough for African women? Why is 50% of male circumcision something that our leaders are selling to African men? 50% is good enough because I'm an African man? Why am I not being told, that a condom is 80&%, if properly used is far more effective, is twice as effective as mal circumcision? Are we lesser beings that lesser effectiveness is ok, if it's largely for African people? So you see for me, as an African, I see continuous discrimination. I see that we're still expected to have lesser standards in things that are not, you know, would a 40% effective gel be promoted in a world community? Would it be?

Am: No.

KL: Now for me, at this conference, this is the questions I ask myself. And you know..

AM: I think if you, uhm. I'm starting to see a parallel here with psychiatry. Where we have similar rates of efficacy of drugs. But uhm, ja.

KL: So just understand for me, that we getting deeper into the woods, but they are different woods. Where the scientists and government are in agreement. And society, society is not being told the complete truth so they can make informed decisions. Do you know what happens to my colleagues, educated highly professional African men when I tell them, a condom is no guarantee? A condom is as good as it gets, but it's got a 20% failure rate if properly used. And if your drunk and you forget it, in your wallet, it's got zero percent effectiveness. And you know, when people are given the information, then they change their behaviour.

But people think I don't have to change my behaviour because there's an alternative, they will not change their behaviour. People will not do things because it's the right thing to do, people do things for their own self interest. Men are not going to change having multiple

partners, because it's good to be a man. They're not going to change because they treat women unequally, they'll only change, when change is good for them. And when they're not being given the full information off what 80% effective means, what elaborative conditions for condom use means, what 50% effectiveness means, what 30% of effectiveness of a gel means. They will not make the right decision. Why are we treating women as lesser human beings? When we're saying to them, secretly put the gel in, or find a way that you can put it 12 hours before and put it 12 hours afterward so that the men doesn't know that you put it in.

AM: So you don't have to negotiate.

KL: You don't have to make, to negotiate. So people will now be putting a gel, hoping for action, and action might not come your way. And you've put an anti-retro-viral in your system, just in case. You know, a key thing in our program, of stick to one partner. Is we take *Einstein's* theory of relativity. E=mC square. And we use it in our teaching, and we've had this for many years. Even prior to now, we started this five years ago we put it into our documents. E is for Empowerment of women. The small "m" is for male, I call it rehabilitation, my team calls is reaffirmation. But I think African men need to be rehabilitated before we can be reaffirmed. And the C square is for squaring our efforts on prevention. Where we still talk about; A;B;C;D; and E. And we say to people; It's your choice, but understand, abstinence is 100% protective. Nothing works better than abstinence. Sticking to one partner is the next best thing to abstinence, very, very protective. More than any intervention that anybody is going to give you. We're not saying don't do sex, but if you do sex. Let it be intimacy between two people, that's the best form of protection. If you can't do that, we then cascaded down into intervention. You use a condom, properly use, not drunk etc etc. 80% effective. And our issue is, this are no substitutes, you know. Stick to one partner and use a condom and circumcise, you know. We haven't gotten to the, and use a gel. Because at 40% effective, as a medical scientist, I say; That you put in the bin.

AM: Your perspective is really fascinating it's a lot to think about, it's really a lot to think about.

KL: Medically we discard anything that's not above 90%, even at 80% we do more research, now to be promoting, for human consumption 39% effectiveness with all the other pit falls, is it

because we don't want to challenge, respect for women? You can't reverse the epidemic if you're not going to deal with the blatant disrespect for women.

AM: You know, that thing about that message is, it's just so. It's kind of become such an obvious statement. I mean I, I carried around, I don't know, it's like this huge silent burden, I don't know, don't really know what to say about it. It's something that when I first started learning about HIV, I ranted and raved about it. You know, respect for women, and you know, eventually you realise I'm just being relegated into the corner of other strident women, you know who are.

KL: Ja, but you see, for me it's not just respect for women it's respect for family, respect for community. Rebuilding family, rebuilding community. All this other challenges that we have. Because if you don't respect women, you cannot have functional, strong family units. Then you have a breakdown of those things.