For a "Decolonization of aid" AFRAVIH 2024 closing ceremony Yaoundé - Cameroon April 19, 2024

Introduction

I deeply question the language used in the field of development aid. Starting the story of “development” and “aid” in the present, without taking the past into account, seems to transform questions of responsibility and structural reform into simple notions of empathy and generosity. Strikingly, the development sector tends to gloss over colonial histories, giving “aid” the appearance of a purely altruistic movement. Rita Trias Prats’ inspiring words resonate with me when she says: Why do we speak of “aid” instead of “reparation”? [1]

But I’m aware that today’s topic is not to revisit the history of aid, but rather its effects from a decolonial perspective. So, the subject of the decolonization of aid is so vast that I have chosen to focus on the decolonization of aid in the context of the fight against HIV.

The first time I used the term decolonization of aid in the fight against HIV was at a meeting here in Yaoundé, and I was struck by the unexpected reaction it provoked. I felt a shock in the room. At the end of the meeting, some people came to warn me about the potential risks involved. They warned me of possible negative repercussions, including the risk of upsetting backers and even harming my career trajectory.

We were in 2022, and I didn’t expect the very topical subject to be perceived as risky. My comrades in the

struggle suggested several euphemistic expressions to avoid using the term “decolonization”. They suggested terms such as “de-Westernization” or “localization of aid”. That’s a good start… But what particularly saddened me was that their motivation for convincing me was not so much to challenge my decolonial convictions, but rather a motivation imbued with fear. Fear that I would be discredited, fear of upsetting technical and financial partners, fear of losing resources, fear of sharing frustrating day-to-day experiences that perpetuate a vertical North-South partnership model, even though I recognize that many efforts are being made to justify the existence of equity, justice, and human rights in current practices in our milieu.

As you will have gathered, the subject of decolonizing aid in the fight against HIV is one that makes us all uncomfortable [2] . But this discomfort is necessary if we are to remain faithful to the ideals, we have defended for over 40 years of struggle.

Compensation

We’re all familiar with the condition known as presbyopia, a vision disorder that makes it difficult to focus on near objects, making reading or any activity requiring close vision difficult. Symptoms include the need to move a book further away to read it, and as the book gets closer, the visual field diminishes. This analogy reflects the distortion inherent in development aid, a distortion we absolutely must deconstruct.

Why does aid in the fight against HIV continue to tirelessly favor international organizations, while when we get closer to the field, it seems to dissipate? Why do national and local implementing organizations receive so few development resources, even though they operate on the front line? Doesn’t investing in the development of a local organization contribute to the sustainability of the fight, a theme we’ve discussed at length during this conference?

I’d like to raise here the question of equitable access to organizational development resources for local and national organizations in so-called implementing countries.

Aren’t we all suffering from presbyopia in validating this model, which generously consolidates the organizational development of international organizations far removed from the field, while under-investing at grassroots level, where the field of vision is clearest?

As Chisomo Kalinga so aptly put it, the practice of decolonizing global health is not simply a matter of “offering a seat at the table”. Rather, it’s about critically questioning whether that table belongs to us in the first place. It’s about structural change, not simple adjustments [3] . As we know, within international organizations, there are indeed seats reserved for countries of the South and communities on boards of directors. This is a very good thing. However, it would be a good idea to have more seats where programs are designed. Unfortunately, there are insurmountable structural obstacles for civil society and local

experts, especially those from French-speaking countries. Having a degree from a university in the South and not being fluent in English often means it’s impossible to put one’s expertise to work for international organizations.

Testimonial

In the fight against HIV, we have unfortunately adopted the same patterns of privilege that we denounce in so many of our campaigns. We have created a political and symbolic dynamic that reinforces the stereotypical image of the savior from the North and the victim from the South.

I note with some dismay that our advocacy model, for example, consists of staging a kind of play in which the Westerner is presented as the expert who develops the model, while people from the South, in a certain caricature, are invited to high-level meetings in Northern countries to testify to the seriousness of the disease and ask for continued funding. While this model is useful and effective in generating the emotion needed to mobilize resources, it’s high time it evolved.

If testimony is indispensable in advocacy for resource mobilization, it must be recognized as a strategic exercise. It is imperative that we think hard enough to propose solutions that no longer resort to instrumentalizing the words and lives of affected people to mobilize resources.

In the field of advocacy, which is my profession, I know full well that scientific data is essential, but not enough on its own to convince politicians. Scientific data and evidence, without testimony, are like chocolate without wrapping. If we’re willing to pay for chocolate packaging, why not recognize testimony as an essential part of the result? It’s time to put an end to free community intervention for testimonial purposes.

International conferences

Let’s take a closer look at the organization of international AIDS conferences. In 2022, of the 39 million people living with HIV worldwide, 25.6 million are in Africa, compared with just 2.9 million in Western and Central Europe and North America [4] . We are faced with a ratio of 25.6 million to 2.9 million. Despite this reality, we continue to organize our international conferences in regions where the epidemic is less aggressive, knowing full well that delegates from southern countries will encounter difficulties in obtaining visas.

We find all kinds of excuses to disqualify the countries of the South, arguing a lack of infrastructure, logistics and security.

If we consider that the fight against HIV should be waged where the virus is most active, then AIDS conferences should give priority to regions where HIV is most active. I would like to salute the Afravih board's judicious decision to organize this edition in Cameroon. Beyond any political considerations, Cameroon is a country where it is essential to discuss HIV and human rights. There's still a lot to do, but above all, a lot to learn.

Producing the obvious

Let's turn now to the question of data. The production of data and knowledge has brought about major changes in the fight against HIV. However, let's take a closer look: who produces this data, who researches it, who carries it out? When programs launch biobehavioral studies at national level, they mobilize people in the field: peer educators, community health workers, psychosocial counselors and others. It is they who mobilize communities, accompany them to screening sites, and sometimes carry out the screening themselves. Once the data have been produced, they are analyzed by various analysts and consultants, then presented at validation workshops and international conferences, sometimes without even acknowledging the contribution of community organizations to this work.

My question is: who works the most? The one who seeks out drug users in sensitive areas? The one who persuades his peers in often restrictive contexts to get tested? Or the one who analyzes the data? Is it the one who writes the final report? The one who presents the results at a conference? My aim is not to accuse, but what everyone here knows is that in this process of producing evidence, we often forget to recognize the workers in the field. Peer educators don't get the recognition they deserve. They are the essential links in this chain that our limited vision, due to our presbyopia, fails to perceive.

Peer educators are the product of a deeply unhealthy system that aims to pay them as little as possible, offer them no basic guarantees, no social security, no insurance, no decent living conditions, and above all, no recognition of their profession. We urgently need to rectify this situation.

We have the capacity and the responsibility to act. Decolonizing aid in the fight against HIV is an absolute necessity. The world around us is changing rapidly. The countries of the South are demanding greater justice and equity. We are witnessing a mistrust of multilateral financial mechanisms. Political challenges, particularly in the Sahel region, climate issues and the emergence of new pandemics mean that we need to redouble our efforts to prepare for the many geostrategic changes that are taking place as we speak. To achieve this, we must :

1. Review our vocabulary, especially the term "empowerment" How can someone who has no experience of an environment, society, language, climate, culture, faith or orientation claim to build capacity? Let's be humble, dear consultant friends. Empirical mastery of a subject is a skill, but not a

superior one. I challenge any senior international consultant to develop an advocacy strategy to mobilize the traditional chiefs of my village in the Bamboutos department, west of Cameroon, in favor of access to ARV treatment for young Balatchi girls. Only local experts who have mastered the linguistic and cultural codes and the tone of discourse can succeed in such an undertaking. So why are the fees for local experts so low? Let's put that right.

2. We need to understand local economic dynamics. I've observed the expense justification practices imposed on local organizations. How can we ask a rural organization to work with suppliers and structures that are aligned with the justification standards of Northern countries? How can we choose to pay for a coffee break in a large international venue that has the means for modern accounting, when there's a local mom who offers local dishes appreciated by all the beneficiaries, but who can't justify so-called modern accounting? Our current system favors the big venues and weakens the local economy.

3. We need to apply a coordinated methodology to decolonize global healthcare. A number of works have been produced on this process, and Mishal Khan's roadmap for moving from rhetoric to reform seems to me to be appropriate, as it can be adapted to the context of the fight against HIV. Firstly, it proposes a critical examination of the role each organization plays in maintaining power asymmetries. Secondly, it suggests the publication of reforms aimed at decolonizing practices. Finally, it calls for the development of measures to monitor the progress of organizations active in the field of global health, and to share results transparently. At Coalition PLUS, we have begun this essential work by launching an internal equity, diversity and inclusion program, to establish an inclusive and equitable environment for deconstructing representations based on privilege and structural racism.

Conclusion

In conclusion, I would like to say without the slightest hesitation, and with great pride, to all the local players present in this room, to all the Peer Educators, to all the local and national principal beneficiaries, sub-beneficiaries and sub-sub-beneficiaries of the Global Fund, PEPFAR and other donors: you are experts. YOU ARE EXPERTS. Your expertise in the field is singular, unique, complex and profoundly excellent. When I look at the situation in Mali and Burkina and the work carried out by local NGOs and key population networks such as Arcad Santé PLUS, RENAPOC, REVSPLUS, and all the associations intervening in security crisis contexts, I can only testify to my profound respect. What courage… Working in such a complex security context demands extraordinary physical, intellectual, political, and scientific skills, which no one from Geneva, Paris, Brussels or Montreal can match. YOU ARE EXPERTS.

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[1] "It's Time to Decolonize Aid" (First edition published May 10, 2021, Second edition published May 12, 2021) published by Peace Direct, Adeso, the Alliance for Peacebuilding and Women of Color Advancing Peace and Security.

[2] Vuyiseka DUBULA MAJOLA, representative of the Africa Centre for HIV/AIDS Management, South Africa, speaking at the "Anti-racism and decolonizing the AIDS response: Moving from rhetoric to

reformation” session at the AIDS 2022 conference in Montreal, Canada. https://www.youtube.com/watch?v=3j2rfOms_hA

[3] Kalinga, Chisomo. “Practicing decoloniality”.

[4] https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_fr.pdf

[5] idem

[6] Khan, Mishal et alii: “Decolonizing global health in 2021: a roadmap from rhetoric to reform.”

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