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The socioeconomic context of Africa's vulnerability to HIV/AIDS

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Abstract. Although the proximate cause of Africa's AIDS crisis is HIV, the underlining societal causes are much broader and familiar. Across the continent, poverty structures not only the contours of the pandemic but also the outcome once an individual is infected with HIV. Thus, until poverty is reduced there will be little progress with either reducing transmission of the virus or creating an enhanced capacity to cope with its socioeconomic consequences. It follows that sustained human development is an essential precondition for any effective response to the pandemic in Africa.

Introduction

In less than a generation, HIV/AIDS has become one of the leading killers on the African continent, but its long-term impacts on the continent's already fragile development capacity threaten to be particularly devastating. Kofi Annan – Secretary General of the United Nations – puts the position this way: 'the impact of HIV/AIDS in Africa is no less destructive than warfare itself. By overwhelming the continent's heath and social services, by creating millions of orphans, and by decimating the educated elite, HIV/AIDS is causing social and economic crisis which in turn threatens political stability and economic development.' It is not difficult to see why Annan arrived at this conclusion: in both men and women, the virus is impacting heaviest on the most productive sectors of African economies – prime-aged adults – robbing these already besieged economies of scarce skills, children of their parents and a continent of a generation in the prime of their working lives.[1] Indeed, the statistics on the toll which the pandemic has already exerted are as grim as forecasts of the consequences which are still expected to flow over the medium-long term: at the continental level, 29 million people are now thought to be living with HIV or AIDS. Most will die in the next five to ten years, joining the 16.7 million Africans already claimed by the pandemic since the early 1980s.[2]

Crucially, these losses – in both human capital and intergeneration knowledge – are taking place against a background of declining economic capabilities with its related structural indebtedness; weak states with their deteriorating infrastructures, and societies already reeling from two decades of adjustment pressures. Herein lies

[1] N. Poku, 'Living with High Seropositive Rates: Africa', Background paper commissioned by the Social Science Research Council, New York, 2002; A. Whiteside, 'Poverty and HIV/AIDS in Africa', *Third World Quarterly*, 23: 2 (2002), pp. 313–32.

[2] World Health Organisation and UNAIDS, *Epidemic Spreading Rapidly in New Areas of the World* (Geneva: World Health Organisation and Joint United Nations Programme on HIV/AIDS, 2003).

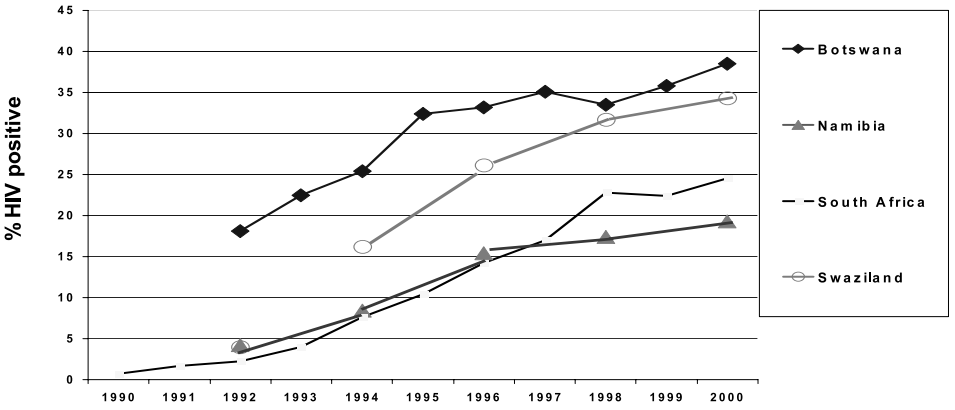

Figure 1. *National trends in HIV prevalence.*
Source: Centre for AIDS research 2003.

Africa's dilemma: how to respond speedily and effectively to the multiple demands of HIV/AIDS, whilst struggling to stem the tide of economic decline at the same time. For many African governments a near-impossible choice presents itself over how best to spend their limited resources. In what follows we will highlight the complex relationship between Africa's economic decline and the continent's vulnerability to HIV/AIDS, and argue for the two seemingly diverse issues to be seen as part and parcel of the same problem. As such, any sustainable engagement with HIV/AIDS must simultaneously engage with the continent's economic decline, if it is to be effective. It is, however, with the impact and challenges posed by the pandemic to the continent's fragile development capacity that we begin our analysis.

Understanding the dynamics of HIV/AIDS in Africa

Across the African continent, HIV/AIDS manifests itself both as an immediate crisis and an endemic condition – with countries in Southern and Eastern Africa forming the global epicentre of the pandemic. South Africa counts 1,600 new infections a day, the highest rate by volume in the world, while in Namibia, Botswana, Zimbabwe, and Swaziland one in four adults carries HIV. In contrast, the general rates of infection in West and North Africa have been consistently lower, with countries registering between 0.5 and 5 per cent prevalence rates among adults. The discernible nature of the crisis is particularly observable at the level and pace of new cases of HIV infectivity. In many countries, infection rates have increased from 5 to 25 per cent in adult populations in less than a decade. Our research in a number of Southern African states, for example, confirms that the level of infections has risen roughly ten-fold in just the last eight years – see Figure 1. Thus, before people are even aware that infected families and friends surround them, their communities have been deeply penetrated. The first and greatest impact is at the level of individuals and households. Although Alan Whiteside is right in arguing that 'macro-economic impact takes

Table 1. *The three stages of loss management*.

Stages	Loss management strategies
Reversible mechanisms and disposal of self-insuring assets	Seeking wage labour or migrating temporarily to find work
	Switching to producing low-maintenance subsistence food crops (which are usually less nutritious)
	Liquidating savings
	Tapping obligations from extended family or community members
	Soliciting family or marriage remittance
	Borrowing from formal or informal sources of credit
	Reducing consumption
Disposal of productive assets	Selling land, equipment, or tools
	Borrowing at exorbitant interest rates
	Further reducing consumption, education, or health expenditure
	Reducing amount of land farmed or crops produced
Destitution	Depending on charity
	Breaking up households
	Distress migration

Source: Donahue (1998).

longer to evolve and the scale and magnitude of macro-impact will depend on the scale and location of micro-level impacts',[3] it is nevertheless possible to make a number of key observations from recent community-based studies.

From the limited studies available, we can draw the following conclusions: first, the impact of adult illness and death and the way households cope suggest that individuals and households go through processes of experimentation and adaptation as they cope with immediate and long-term demographic changes – see Table 1. Over a period of time one episode of illness may be followed by others which gradually deplete the resources and labour of one or more interdependent households. The Kagera (Tanzania) study showed movements of households or family members into and out of the household within six months prior to and soon after death and these changes were identified to have an important role in household coping strategies.[4]

Second, the effect of illness and death on poverty in households depends on the number of cases the household experiences; the characteristics of deceased individuals; the household's composition and asset array; community attitudes towards helping needy households and the general availability of resources – the level of life – in that community; and the broader resources available for assistance to

[3] Whiteside, 'Poverty and HIV/AIDS in Africa', p. 315.

[4] V. A. Bond and S. Wallman, 'Community Capacity to Prevent, Manage and Survive HIV/AIDS'. Report on the 1991 survey of households in Chiawa, University of Zambia, 1993; J. Donahue, 'Community based Economic Support for Households Affected by HIV/AIDS' (USAID HIV/AIDS Division, 1998).

households. In other words, the poorer the households and communities the worse the impact.[5]

Table 1 also confirms the fact that morbidity and mortality is putting enormous strain on the capacity of families to cope with the psychosocial and economic consequences of illness, such that many families experience great distress and often disintegrate as social and economic units.[6] The precise nature of these disintegrations is something we know very little about. Similarly, there is no literature on the implications of the process of fragmentation for the survival or maintenance of deeply affected communities. Evidently, countries are living with high HIV/AIDS cases in their communities and the fact that people are not dying on streets would suggest that they are coping. Yet, we are also witnessing family break-ups and their members – orphans, widows and the elderly – joining other households. As such, the notion of 'coping' has to be judged in relations to the systematic intergeneration implications of HIV/AIDS. A brief review of the impact of the pandemic on a number of key sectors will serve to illustrate this point.

Agriculture

It is likely that AIDS will cause a major agricultural labour shortage in many African countries, with 7 million agricultural workers already lost and at least 16 million more who could die before 2020 on the continent.[7] Anecdotal evidence suggests that for all types of households in farming communities, AIDS death also brings with it loss of productive resources through the sale of livestock to pay for sickness, mourning and funeral expenses, as well as sharp declines in crop production. Sickness also contributes to the scarcity of labour because of both the incapacity of workers and the time others have to devote to looking after them. In addition, the scale of the number of people dying from the agricultural communities is threatening to undermine the transmission of vital intergenerational farming knowledge in some communities. On this, a study in Kenya showed that 7 per cent of farming households headed by orphans have inadequate knowledge of agricultural production.[8]

Business community

The limited literature on the impact of AIDS on Africa's business community paints a very gloomy picture with significant negative consequences for the respective national economies as well. For example, in Zimbabwe, the cost of AIDS to the National Railways in 1997 was found to be equivalent to 20 per cent of company

[5] S. M. Munthali, *Socio-economic impact of HIV/AIDS in Malawi* (Malawi: National AIDS Control Programme, 1998). N. Namposya-Serpell, 'Social and Economic Risk Factors for HIV/AIDS-Affected Families in Zambia', Paper presented at AIDS and Economics Symposium, Durban, 2000.
[6] N. Poku, *The Politics of Africa's AIDS Crisis* (Cambridge: Polity Press, 2003).
[7] FAO, *The Impact of HIV/AIDS on Food Security* (Rome: Committee of World Food Security, Food and Agriculture Organization of the United Nations, 2001).
[8] UNAIDS, *Report on the Global HIV/AIDS Epidemic* (Geneva: UNAIDS, 2002).

profits; in Zambia, the costs to a petroleum company for AIDS-related medical and funeral expenses in the early 1990s exceeded their meagre profits of US$24,500; in South Africa it was estimated that the total costs of employee benefits due to AIDS would rise from 7 per cent of salaries in 1995 to 19 per cent by 2005;[9] in Kenya, a study of six firms projected that the AIDS-related loss in profit would increase from 6 per cent to 14 per cent between 1994 and 2005;[10] in Côte d'Ivoire, a survey of three firms found average annual costs per employee due to HIV/AIDS representing between 0.8 per cent and 3.2 per cent of the wage bill in 1997;[11] while in Botswana, projections indicate that the impact of HIV/AIDS on five surveyed firms could increase seven-fold between 1996 and 2004 to reach 5 per cent of their total wage bill.[12]

Education

For reasons that are not entirely clear, HIV infection rates are very high among teachers and school administrators in Africa. In 2000, an estimated 1 million children in sub-Saharan Africa had lost their teachers to AIDS.[13] Between 1996 and 2001, almost as many teachers died as retired in the Central African Republic, and Zambia recorded 1,300 teacher deaths in the first 10 months of 1998, more than twice the number of deaths in 1997 and two-thirds of the new teachers trained annually.[14] All over the affected countries in Africa, the teacher to pupil ratio is being substantially reduced due to the death of teachers from HIV/AIDS. This disrupts the teaching and learning process and, in turn, the quality of education suffers which then impacts negatively on the development process itself. Education and training remain key ingredients in the building of skills and capacity to promote indigenous-led growth and development.[15] If AIDS continues to kill teachers and prevent children from attending school due to illness, the circumstances of orphanhood, or simply because they are kept out of school due to the fear that they might become infected, then the previous gains in educational attainment will, ultimately, decline and national development will be constrained.

Health

The pandemic is having a profound impact on health services and delivery. In many of the countries with high seropositive rates, the percentage of hospital beds

[9] J. Stover and L. Bollinger, *The Economic Impact of AIDS* (Arlington, VA: The Futures Group International, 1999).
[10] World Bank, *Africa Development Indicators* (Washington, DC: World Bank, 2000).
[11] L. Aventin and P. Huard, 'HIV/AIDS and the Private Sector', *AIDS Analysis Africa*, 7: 3 (1999).
[12] UNAIDS and UNECA, *AIDS in Africa: Country by Country* (Geneva: UNAIDS and United Nations Economic Commission for Africa, 2000).
[13] UNICEF, *The Progress of Nations* (New York: United Nations Children Fund, 2000); E. Guest, *Children of AIDS: Africa's Orphan Crisis*, (London: Pluto, 2001).
[14] World Bank, *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis* (Washington, DC: World Bank, 2000).
[15] D. Cohen, *Human Capital and the HIV Epidemic in Sub-Saharan Africa* (Geneva: ILO, 2002).

occupied – due to HIV-related illnesses – exceeds 50 per cent. In Botswana, for example, it was estimated to be 60 per cent in 2000; while in Côte d'Ivoire, Zambia, Burundi, and Zimbabwe such occupancy is estimated at 50–80 per cent for urban hospitals. Illness and absenteeism of health staff has also had a major impact on health services delivery. On this, Baker argues that: 'in Africa, AIDS is not a consequence of HIV but of poverty'.[16] Baker's contention is not that poverty causes AIDS, rather that the capacity for health services delivery in Africa is virtually nonexistent. In support of this point, he cites the approximately US$32 m annual budget of a teaching hospital in London for the treatment of 2,000 HIV patients compared to the per capita health care budget of US$20 per person per year for all medical problems in the whole of Uganda.

What the above examples reveal is the interdependence of social, economic and political systems, and it is precisely their capacity to function normally which is being undermined by the pandemic. A recent survey, for example, revealed that illness and death – attributable largely to HIV – have leap-frogged from last to first place in the reasons for people leaving a company. Old-age retirement, the leading cause in the 1980s, accounted for just 2 per cent of employee dropout by 2000.[17] Moreover, across the continent many countries are witnessing deterioration in child survival rates, reduced life expectancy, crumbling and over-burdened health care systems, the breakdown of family structures and the decimation of a generation in the prime of their working lives. Against this background of sustained losses of human capital, one of the important issues facing countries on the continent – particularly those with high-seropositive rates – is how to maintain production in circumstances of high morbidity and mortality across wide swathes of the active labour force. Unfortunately there are major gaps in knowledge about what is actually happening here. Across the continent, there is very little knowledge in all countries about the distribution of the epidemic in terms of its impact on skills and experience across all sectors. Moreover, although anecdotal evidence suggests that some businesses in the private sector are now hiring and training two or three persons for every job in the expectation that some will die prematurely, there is no evidence that any country has begun to address comprehensively the human resource planning issues raised by the HIV epidemic. Neither have they systematically addressed the question of whether or not there is a capacity domestically or externally to meet the needs for critical skills and training.

Macroeconomic impacts of HIV/AIDS

Early forecasts about the long-term macroeconomic impacts of the HIV/AIDS pandemic in Africa were sometimes relatively optimistic, even suggesting in some cases that the effects of the pandemic would be to ameliorate the economic condition of survivors. A study based on a two-sector growth models for Malawi, for example, estimated that a prevalence rate rising to 11 per cent by 2010 would be likely to cause a drop in the level of per capita income of about 1 per cent, whilst the growth rate

[16] R. Baker, 'HIV Does Not Spread AIDS', *The Spectator*, p. 26.
[17] UNAIDS, *Report on the Global HIV/AIDS Epidemic.*

of aggregate real GDP would shrink by only 0.2 per cent; similar results were obtained in models of Tanzania and Cameroon.[18] Bloom and Mahal presented econometric evidence based on cross-country regressions which showed that, after controlling for other influences on growth, AIDS had a statistically insignificant effect on real wages and growth rates of per capita output in the period 1991–95, and that no evidence of reverse causality from growth to AIDS could be detected from the data.[19] Even the World Bank endorsed the view in 1997 that the net effect of AIDS on the level of output per capita and growth might be 'small relative to other factors'.[20]

These first-generation economic forecasts failed, however, to take account of some of the specific features of the HIV/AIDS pandemic, features which mean that its impact cannot be easily compared to those of other high-prevalence infectious diseases. As noted above, AIDS disproportionately affects the economically productive members of society, thus having a more severe long-term macroeconomic impact than other diseases such as TB or malaria. Further, many of the earlier forecasts neglected to take into account the six to eight year estimated incubation period for AIDS, and thus underestimated the long-term costs to society both for treatment and palliative care, as well as costs associated with losses in human, physical and social capital.[21] More recent forecasts on the long-term macroeconomic impacts of HIV/AIDS, which take these features into account, reveal a much more negative outcome. Bonnel, for example, uses a cross-country regression to show that the estimated reduction in the growth rate of GDP per capita is increasing with the HIV prevalence rate. In countries with prevalence rates of around 20 per cent, he shows that real GDP per capita was reduced by 1.2 per cent per year between 1990 and 1997. Projecting these results over a twenty year timeframe indicates a reduction in per capita income of 67 per cent.[22] Similarly negative conjectures on the long-term impact of HIV/AIDS on African economies are made by Arndt and Lewis[23] and Haacker.[24] These macroeconomic impacts will occur in countries which are ill-equipped to deal with them, given the context of economic retrogression in many parts of Africa. It seems that HIV/AIDS will thus become an integral part of the poverty cycle in Africa.

[18] J. Cuddington, 'Modelling the Macroeconomic Effects of AIDS with an Application to Tanzania', *World Bank Economic Review*, 7 (1993), pp. 173–89; J. Cuddington and J. Hancock, 'The Macroeconomic Impact of AIDS in Malawi', *Journal of African Economics*, 4 (1995), pp. 1–28; G. Kambou, S. Devarajan and M. Over, 'The Economic Impact of AIDS in an African Country: Simulations with a General Equilibrium Model of Cameroooon', *Journal of African Economics*, 1 (1992), pp. 103–30.

[19] D. Bloom and A. Mahal, 'Does the AIDS Epidemic Threaten Economic Growth?', *Journal of Econometrics*, 77 (1997), pp. 105–24.

[20] World Bank, *Confronting AIDS: Public Priorities in a Global Epidemic* (Washington, DC: World Bank, 1997).

[21] E. Gaffeo, 'The Economics of HIV/AIDS', *Development Policy Review*, 21: 1 (2003), pp. 27–49.

[22] R. Bonnnel, *HIV/AIDS: Does it Increase or Decrease Growth in Africa?* (Washington, DC: World Bank, 2000).

[23] C. Arndt and J. Lewis, *The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment* (Washington, DC: World Bank, 2000).

[24] M. Haacker, *The Economic Consequences of HIV/AIDS in Southern Africa* (Washington, DC: IMF, 2002).

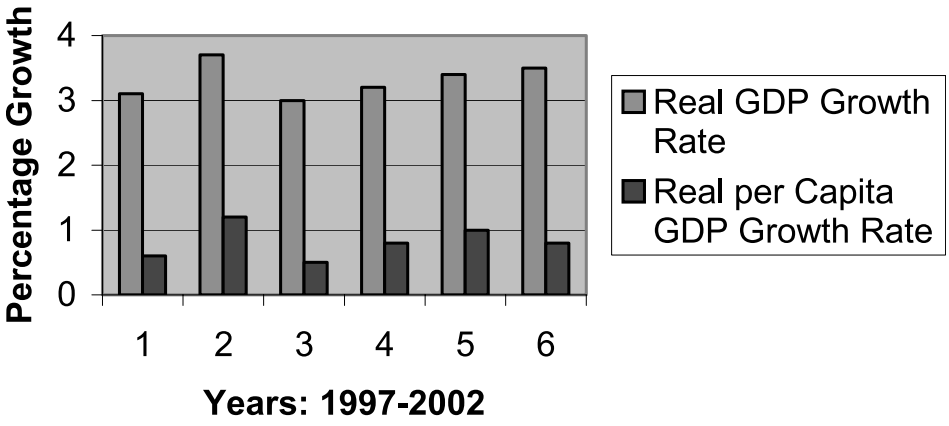

Figure 2. *Africa: economic indicators 1997–2002.*
Source: Adopted from ADB Statistics 2002 and IMF.

Table 2. *Debt to health and education profile: selected African countries.*

Country	Percentage of population with HIV/AIDS*	Percentage of govt. spending on primary education**	Percentage of govt. spending on health***	Percentage of govt. spending on debt servicing 2001****
Malawi	15.5	15.8	14.5	34
Mozambique	13.0	20.2	11.1	57
Rwanda	8.9	9.2	9.8	32
Tanzania	7.8	25.4	14.9	42
Uganda	5.9	21.1	9.3	39
Zambia	21.5	14.6	12.6	62

Sources: *UNAIDS 2002 (December), **World Bank (various sources), ***WHO (2002 Health Reports), ****UNDP/World Bank figures.

AIDS in the context of economic retrogression

In many of the countries worst affected by the pandemic, poor economic mismanagement, high inflation, rampant corruption, and deteriorating infrastructure are commonplace, and conflicts and population displacement are far from rare. The latest economic indicators from the African Development Report 2002 underline the extent of Africa's economic decline. The Report's celebrated headline growth of 3.5 per cent in Gross Domestic Product (GDP) in 2002 compared to 3.2 per cent in 2001, belies the systematic decline observable in real per capita GDP growth from 1.0 per cent to 0.8 per cent in the same period – see Figure 2.[25] In developmental terms, this means that the combined economies of Africa actually shrunk by 0.2 per cent in the 12 months up to the end of 2002. To put this in context, all other regions in the world are already outperforming Africa, and efforts to redress this poor performance over the past two decades have not been successful – see Table 2. In 2002, for example, the average Gross National Product (GNP) per capita in the

[25] ADB, *African Development Report 2002* (Oxford: African Development Bank, 2002).

Organisation for Economic Co-operation and Development (OECD) countries was $28,086, compared with $528 in Africa. This means that the industrialised countries are roughly 51 times wealthier than African states. Assuming that the OECD countries could stop stretching this development gap further, and hoping that African economies could grow at an annual rate of 3.5 per cent over the coming years, it would take the continent some 135 years to reach today's level of wealth enjoyed by OECD countries.

The scale of the continent's economic decline is brought into even sharper focus by looking at the latest indicators from the United Nations Development Programme (UNDP). According to this data, some 80 per cent of the Low Human Development Countries – these are countries with high population growth rates, low income, low literacy, and low life expectancy – in 2002, are located in Africa.[26] There are only eleven African countries in the middle category – Algeria, Botswana, Egypt, Gabon, Libya, Mauritius, Morocco, Seychelles, Swaziland and South Africa, five of which have a combined population of just 4.6 million – Mauritius, Seychelles, Botswana, Gabon and Swaziland. The remaining 41 countries on the continent are in the low human development category. This, however, does not tell the entire story. There are 55 countries in this category, which means African countries account for 85 per cent of the category. Even more telling is that, of the 30 countries with the lowest human development indices, 26 (or 89 per cent) are African. Not surprisingly, poverty has increased at a faster rate on the continent than anywhere else in the world. With a fifth of the world populations, the continent is home to one in three poor persons in the world[27] and four of every ten of its inhabitants living in what the World Bank classifies as 'a condition of absolute poverty'. More worrying still, Africa is the only region in the world where both the absolute number and the proportion of poor people are expected to increase during this millennium.[28]

The report also highlights a number of equally depressing statistics about the general state of the continent. Take for example, the continental situation with respect to health, food, nutrition and education. The percentages of the population having access to health services, safe water and sanitation are 59, 45 and 31, respectively; and average calorie supply per capita is only 92 per cent of the daily requirement of the World Health Organisation (WHO). In the sphere of education, only 49 per cent of adults can read and write while the enrolment ratio for all levels is 35 per cent, suggesting a very low level of human capital formation. Critical as the general situation is, it is even worse for children and women. The mortality rates for infants (under twelve months) and children (under five years) are, at 101 and 160 respectively, again the highest of all regions in the world. The percentages of children who are underweight, wasted and stunted are 31, 13 and 44 respectively. Trained medical personnel attend only 40 per cent of births and only 49 per cent of one-year-olds are fully immunised. The literacy rate of women is only 60 per cent of that of men and the corresponding figure for mean years of schooling is 40 per cent. Similarly, the gaps in school enrolment are also wide, the figures being 85 per cent, 67 per cent and 35 per cent for primary, secondary and tertiary level education,

[26] UNDP, *Human Development Report* (Oxford: Oxford University Press, 2002).
[27] World Bank, *African Development Indicators* (Washington, DC: World Bank, 2002).
[28] UNDP, *Human Development Report.*

respectively. While the life expectancy of women is higher than that of men, other indicators of health are biased against women. Maternal mortality rate is 700 per 100,000 live births, and only 64 per cent of women get prenatal care.[29] There have also been reversals in school enrolment ratios and increases in school dropout rates relative to the appreciable gains made in the 1960s and 1970s.

Any account of the continent's condition must attempt to unravel what is cause and what is effect. It is precisely at the level of interpretation, however, that one must be careful not to resort to simplistic causalities or reduce Africa's plight to a series of causal or tautological clichés, most of which carry distinct racist connotations. Clearly, decades of domestic economic mismanagement with its associated corruption, violence and resultant debt, cannot be overlooked. But in emphasising these factors, we must also be careful not to overlook the fact that the continent has also been a victim of particularly bad advice. Kwesi Asante of Ghana, spokesperson of the United Nations Office for Emergency Operations in Africa, summarised the position this way:

> Africa's problem – Africa's biggest problem – is too many people going around the continent with solutions to problems they didn't understand. Many of these solutions are half-baked. But this is not to put all the blame on the North. Some Africans don't understand the African problems.[30]

James Wolfensohn, the president of the World Bank, pursues the theme further, noting:

> We . . . have failed in Africa, along with everybody else. We have not fully understood the problems. We have not identified the priorities. We have not always designed our projects to fit. . . . But we will continue to try.[31]

This admission of failure by Wolfensohn belies the true culpability of the World Bank and other International Financial Institutions (IFIs) in shaping contemporary Africa's disheartening reality. Over the past two decades, African governments have had to adopt Structural Adjustment Programmes (SAPs) as a crucial prerequisite to receiving vitally needed loans from these IFIs – particularly International Monetary Fund (IMF) and the World Bank. Today, there are no signs of these programmes achieving their desired objectives: economic stability and growth. Yet, their socio-economic impacts have been particularly devastating. Table 3 shows the knock-on effects of SAPs for essential services on the continent. The cumulative impact has been a severe deterioration in basic services in adjusting countries. Cuts in government expenditure, for example, have forced up the costs of primary education and health care beyond the reach of many ordinary Africans.[32] Similarly, rushed privatisation has resulted in the laying off of tens-of-thousands of workers;[33] the removal of price controls and the devaluation of the national currency have resulted in the cost of living spiralling.[34]

[29] Ibid.
[30] Poku, *Africa's AIDS Crisis.*
[31] Ibid.
[32] L. Wallace (ed.), *Africa: Adjusting to the Challenges of Globalization* (Washington, DC: International Monetary Fund Publication Service, 1999).
[33] R. Tangri and A. Mwenda, 'Corruption and Cronyism in Uganda's Privatization in the 1990s', *African Affairs*, 100/398 (2001), pp. 117–33.
[34] J. F. Bayart, 'Africa in the World: A History of Extraversion', *African Affairs*, 99/395 (2000), pp. 217–67.

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Table 3. *Circle of decline and vulnerability: the impacts of SAP on African societies.*

Policy	Policy response	Domestic impact	Implications for the spread of HIV/AIDS
To reduce government expenditure	Introduce user fee for health services	Reduce access to health services; decline in general health of the population	Reduced awareness of health issues, including HIV/AIDS; poor general health; reduced treatment for opportunistic infections – particularly STDs
	Introduce user fee for education	Children, particularly girls, removed from schools; marginalisation of large section of population to informal sector like prostitution with associated risk	Reduced education; increased illiteracy; increased risk of HIV transmission due to poor educational knowledge. Particular vulnerability of women due to lack of formal education
	Decrease spending on health and education	Reduce quality and quantity of facilities; lack of equipment; fewer and less trained staff	Increased vulnerability to infection
	Public sector redundancies and wage freezes	Unemployment; staff shortages leading to reduced quality and quantity of education and health services	Increased vulnerability to infection
	Removal of price subsidies on food, fuel and other basic commodities	Reduced quality and quantity of food; declining calorie consumption per head	Poor health means greater vulnerability to infection, increased in informal sector activities with increased risk of HIV infection
	Reduced civil services	Reduced administrative capacity	Governments less able to promote AIDS prevention
To increase export earnings	Promote large export-orientated projects	Workers migrate to jobs from home; decreased food production; restructures domestic production patterns leading to decrease in consumable food for domestic societies; rural to urban migration	Workers more likely to engage in risky behaviour with increased risk of HIV/AIDS contraction; spreading of HIV through migration; returning migrants infecting local communities

Perhaps the most insidious aspect of all is the relationship between SAPs, the repayment of Africa's debt and the spread of HIV/AIDS. In aggregate terms, the total long-term debt of the continent stood at US$315 bn in 2000.[35] Although this figure is quite modest by global standards – Brazil, for example, owed more than US$120 bn at the end of 2000 – compared to the continent's ability to repay, the debt is enormous. Africans can pay off the debt only with earnings in foreign currency; that is, they must use money from exports, from aid or from new foreign loans. Take the case of Ethiopia, one of the poorest countries in the world. Its debt of US$10 bn ($179 a person) at the end of 1999 may not seem like much compared to the US$98 bn the American government released for emergency response to ground-zero after the terrorist attack of 2001. But Ethiopia's debt is almost thirteen times the amount the country earned in exports in 1998. Ethiopia used the equivalent of 45 per cent of its US$783 m in export earnings on debt payments. Even after such a crushing payout, Ethiopia's debt is still unsustainable. Or consider the trade-offs with investments in health care. In 2000, 75 per cent of the world's new AIDS infections were in sub-Saharan Africa. So were four-fifths of all deaths from AIDS that year. Yet among all African countries only South Africa was spending more on health care than on debt service. For most African countries, the entire annual health budget is less than US$10 a person. Health care, moreover, is only one of the urgent needs requiring investment. This perverse anomaly is reducing the already limited ability of governments across Africa to provide even the basic levels of health care for their people at a time when the pressures of HIV/AIDS threaten to overwhelm existing health services.[36] For example, in Tanzania – where over half a million children are orphans as a result of AIDS[37] – the government spends only around US$3.20 per person per year on health provision, a quarter of what the World Bank itself estimates is necessary to provide basic care.[38] The Tanzanian government spends in excess of three times more on debt servicing each year than it does on health care – see Table 2. Similarly, in Malawi where nearly 16 per cent of the population are either living with HIV or AIDS, where there is only one doctor for every 50,000 people, government spending on health care was dwarfed by debt repayment by two to one – see Table 2.

The promotion of exports for debt repayment and the cutting of public expenditure on welfare in a region where 280 million people are undernourished; where there is 1 doctor for nearly 55,000 people, compared with 1 for 400 people in industrial countries; and where nine out of the ten HIV infected people worldwide reside, is a scandal.

The potent mix of debt and adjustment makes it virtually impossible for any African country to treat those with the virus effectively, or to undertake successful campaigns to reduce high-risk behaviour while also providing essential resources in the fight against the pandemic. Peter Piot, the director of the United Nations Programme on HIV/AIDS (UNAIDS), puts the position this way; 'structural adjustment raises particular problems for [African] governments because most of the

[35] World Bank, *Africa Development Indicators 2000* (Washington, DC: World Bank, 2001).
[36] J. D. Sachs, 'Macroeconomic and Health: Investing in Health for Economic Development', Paper presented to Gro Harlem-Bruntland, Director-General of the World Health Organization, Geneva, 2001.
[37] UNAIDS, *Report on the Global HIV/AIDS Epidemic.*
[38] World Bank, *Africa Development Indicators 2002.*

factors which fuel the AIDS pandemic are also those factors that seem to come into play in structural adjustment programmes'.[39] As a result, there is a great tension between what governments want to do and what they are able to afford to do in confronting the pandemic. These tensions are complicated even further by the question of the provision of anti-retroviral therapy, which is seen by some as a major factor in helping to mitigate the impact of HIV/AIDS in Africa. Despite the recent cuts in the prices of anti-retroviral drugs, they still remain way beyond the means of most Africans. For governments, the choice of providing increased access to anti-retroviral therapy might seem to be taking much-needed resources away from other areas of health provision. Hence, some presidents deliver messages which, at the very least, can be characterised as ambiguous. In this vein, the former president Lissouba of Congo-Brazzaville regularly evoked his country's determination to confront the pandemic during interviews with the foreign press, while not hesitating to characterise HIV infection as the primary symbol of social and political disorder in his country in 1993 and 1994. More recently, in July 1999, the president of Kenya declared war on AIDS, while affirming in the same speech his staunch opposition to all initiatives to promote condom use in his country.

To be clear, SAPs do not cause HIV or AIDS, but they do create an extremely fertile environment for the spread of HIV/AIDS – see Table 1. Of particular interest here is the correlation between adjustment programmes and poverty on the one hand, and poverty and vulnerability to HIV/AIDS on the other. Of course, the link between poverty and HIV transmission is not a simple one, but the evidence shows that all of the factors predisposing people in Africa to an increased risk of HIV infection are aggravated by poverty. Africa's experience with SAP shows a strong correlation between their implementation and a rise in poverty.[40] Poverty is closely linked with high unemployment, hunger and malnutrition, lack of basic services, inability to pay for or access health care, disintegration of families, vulnerability, homelessness and often hopelessness. Mainstream biomedical literature has long documented the methods by which this combination of factors can undermine the body's specific and non-specific immune response.[41] Hence, we know that protein-energy malnutrition (general calorie deficit) and specific micronutrient deficiencies, such as vitamin A deficiency, weaken every part of the body's immune system, including the skin and mucous membranes, which are particularly important in protecting the body from STDs, including HIV.[42] Moreover, in an environment of poverty, parasite infestation plays a dual role in suppressing immune response. It aggravates malnutrition by robbing the body of essential nutrients and increasing calorie demand; and in addition, the presence of parasites chronically triggers the immune system, impairing its ability to fight infection from other pathogens.

One of the key societal legacies of poverty in Africa is the existence of undiagnosed and untreated sexually transmitted diseases (STDs) among many Africans. Data for 2000 indicate that Africa has the highest incidence of curable STDs at 284 cases

[39] P. Piot, 'AIDS and Human Security', Address given at the United Nations University, 2001.
[40] N. Van de Walle, *African Economies and the Politics of Permanent Crisis* (New York: Cambridge University Press, 2001).
[41] P. Farmer, *Infections and Inequalities: The Modern Plagues* (California: University of California Press, 1999); J. Y. Kim, J. V. Millen et al. (eds.), *Dying for Growth: Global Inequality and the Health of the Poor* (Monroe, ME: Common Courage Press, 2000).
[42] E. A. M. Jakab, *Louis Pasteur: Hunting Killer Germs* (London: McGrew-Hill, 2000).

per 1,000 people aged 15–49 years, compared to the second highest of 160 cases per 1,000 people in South and South-East Asia. There is now growing recognition of the public health implications of curable STDs (especially those causing genital ulcers) by virtue of their frequency of occurrence as well as their ability, when present, to facilitate the transmission of HIV.[43] Such painful bacterial STDs are relatively uncommon in rich countries because of the availability of antibiotics. Yet, in Africa, even when the poor have access to health care, the clinics may have no antibiotics to treat those bacterial STDs that act as cofactors for AIDS. Sub-Saharan Africa is not the only region where malnutrition is associated with HIV/AIDS. Among all low- and middle-income countries, HIV prevalence is strongly correlated with falling protein and calorie consumption.

Alongside STDs is the perennial issue of poverty-induced migration. A by-product of commodity specialisation – a central facet of SAPs – is the focusing of African economies on the production of specific products. The plantations, mines and industries, though development enclaves from one point of view, have required and attracted massive quantities of labour not only from the traditional rural areas, but also from neighbouring and regional states. The development of these economic activities has also involved the recruitment of large numbers of truck drivers to transport these products. The dislocation of so many millions of people from their traditional places of residence significantly increases their probability of contracting HIV or indeed, passing the virus on. Decosas and Adrien note that migrants have higher infection rates than those who do not migrate, independent of the HIV prevalence at the site of departure or the site of destination.[44]

The mining community in Carletonville, South Africa, is a tragic but powerful reminder of how mobility provides an environment of extraordinary risk for HIV contraction. With a mine-working population of 85,000 people, of whom 95 per cent are migrant workers, Carletonville is the biggest gold-mining complex in the world. These migrant workers leave their families behind in rural villages, live in squalid all-male labour hostels and return home maybe once a year. Lacking formal education and recreation, these hardworking men rely on little else but home-brewed alcohol and sex for leisure. For these men, there is a 1 in 40 chance of being crushed by falling rock, so the delayed risk of HIV seems comparatively remote. Astonishingly, some 65 per cent of adults in Carletonville were HIV-positive in 1999, a rate higher than any region in the world.[45] When these men return back to their families, they often carry the virus into their rural communities. A study in a rural area in the South African province of KwaZulu-Natal, for example, showed that 13 per cent of women whose husbands worked away from home two-thirds of the time were infected with HIV.[46] Among women who spent two-thirds of their time or more with their husbands, no HIV infection was recorded.[47]

[43] World Bank, *Intensifying Action Against HIV/AIDS in Africa. Responding to a Development Crisis* (Washington, DC: World Bank, 2000).
[44] J. Decosas and A. Adrien, 'Migration and HIV', *AIDS*, 11: supplement A (1997).
[45] B. G. Williams, D. Gilgen, et al., *The Natural History of HIV/AIDS in South Africa: A Biomedical and Social Survey in Carletonville* (Johannesburg: Centre for Scientific and Industrial Research, 2000).
[46] N. S. Morar, G. Ramjee, et al., 'Safe Sex Practices Among Sex Workers at Risk of HIV Infection', Poster 33287, 12th World AIDS Conference, Geneva, 1998.
[47] M. Lurie, B. Williams, et al., 'HIV Discordance Among Migrant and Non-Migrant Couples in South Africa', Paper presented at 13th International AIDS Conference, Durban, 2000.

The realisation of the risks of HIV infection associated with this type of migrant work, is a stark reminder of the complexities of poverty reduction in countries heavily affected by HIV/AIDS. Both miners and truck drivers are examples of groups at high risk of HIV infection, and yet the development of such economic activities as mining and transport might be seen as vital to a country's further economic development.

The link between HIV/AIDS and poverty also has a clearly gendered dimension. Many of the poorest in Africa are women who often head the poorest of households. Inevitably such women will often engage in commercial sexual transactions, sometimes as commercial sex workers, but more often on an occasional basis, as survival strategies for themselves and their dependents. The effects of these behaviours on HIV infection in women are only too evident, and in part account for the much higher infection rates in young women who are increasingly unable to sustain themselves by other work in either the formal or informal sectors. Even those who do not engage in commercial sexual transactions are less likely to be able to dictate the terms of sexual relationships, and are more likely to engage in risky sexual behaviour. A study in South Africa showed that women in poor households had less access to knowledge about HIV/AIDS and that there was a small but statistically significant relationship between poverty and risky sexual behaviour for women.[48]

Poverty structures not only the contours of the pandemic but also the outcome once an individual is sick with complications of HIV infection. A strong feature of HIV infection is that it clusters within families, often resulting in both parents being HIV-positive – and in time falling sick and dying. Poor families have a reduced capacity to deal with the effects of morbidity and mortality than do richer ones, for very obvious reasons. These include the absence of savings and other assets that can cushion the impact of illness and death. The poor are already on the margins of survival, and are unable to deal with the costs associated with HIV/AIDS. These include the cost of drugs – when available – to treat opportunistic infections, the cost of transport to health centres, reduced household productivity through illness and diversion of labour to caring roles, loss of employment through illness and job discrimination, funeral and related costs, and so on. In the longer term such poor households never recover even their initial level of living, since their capacity is reduced through the loss of productive family members through death and migration, and through the sales of any productive assets they once possessed. As a result, a true process of immiseration is now observable in many parts of Africa, particularly southern Africa.

Take this powerful image from a field worker in Zambia:

> In the field you are often led into somebody's home. The first thing that hits you is that the patient will be on the floor. If that household was not poor before HIV/AIDS infected somebody, then by the end of the first few years, poverty will come to the household as all of their assets are sold off to pay for healthcare. Children have been taken out of school – daughters, particularly – to become caregivers. Invariably, the person you have come to see will be on the floor without a blanket or a pillow. If you look around that mud hut for food, you won't see it, and you won't smell people cooking. There is no food.[49]

[48] F. Booysen and J. Summerton, *Are Poor South African Women More Likely to Have Risky Sex than Women from More Affluent Households?* (University of the Free State, South Africa: Centre for Health Systems Research and Development, 2002).

[49] Poku, *Africa's AIDS Crisis.*

There is thus enormous strain on the capacity of families to cope with the psychosocial and economic consequences of illness, such that many families experience great distress and often disintegrate as social and economic units. Even where they do not, by eliminating the breadwinners – often both parents – the process further exposes the rest of the family members to poverty, which then increases their chances of contracting the virus. This is particularly so for young women, who will often be forced to engage in commercial sexual transactions, sometimes as casual sex workers, as a survival strategy for themselves and their dependants. The effects of these behavioural patterns on HIV infection in women are only too evident. In part, this also accounts for the much higher infection rates in young women, who are increasingly unable to sustain themselves by other work in either the formal or informal sectors.

HIPC and HIV/AIDS

Against this background, the introduction of the Heavily Indebted Poor Countries (HIPC) initiative in 1996 by the World Bank and IMF appeared as a step in the right direction – not least because it seemed to recognise the impossibility of resolving the continent's debt crisis by simply postponing payments (the now infamous rescheduling policies of the late 1980s and early 1990s). Some debt, creditors acknowledged, would have to be cancelled, including debt owed to the multilateral institutions themselves (which accounts for almost one-third of Africa's total debt). Creditors agreed that, in principle, as much as 80 per cent of external debt could be cancelled. The unanswered questions, however, were under what conditions, how much, how fast and who would pay for it. Typically, the international financial institutions imposed rigid economic adjustment programmes as a condition for participation in HIPC. By September 1998 only eight countries, including five in Africa, had qualified for debt relief packages adding up to about US$6.5 bn. Uganda was the only African country that had actually reached the 'completion point', receiving about US$650 m in debt reduction.[50] To supplement World Bank and IMF funds, 15 donor countries (not including the United States) had paid or pledged about US$300 m for the initiative by late 1998.

In view of the challenges facing Africa, it was clear by the end of 1998 that the HIPC initiative was not even close to meeting the continent's needs for debt cancellation. It was in this context – not to mention intense NGO pressure – that at the G7 meeting in Cologne in June 1999 the leaders of the industrialised countries announced the HIPC II initiative. This initiative proposed incremental, but noteworthy steps towards the modernisation of the original HIPC initiative. Chief among these was the proposal to grant larger reductions of the total accumulated debt (the 'debt overhang'), quicker reductions in debt service payments, and finally placing poverty reduction at the heart of the enhanced new framework. The devil, however,

[50] F. Cheru, *Uganda's Experience with the PRSP Process: What Are the Secrets of its Success?* (Addis Ababa: UNECA, 2001).

was in the detail.[51] Eligibility for debt relief under the enhanced HIPC initiative was made conditional upon 'good performance' in the implementation of an enhanced structural adjustment programme (to be renamed the poverty reduction and growth facility – PRGF) for a period of three years instead of six years under the original HIPC.[52] Having reached the decision point after the first three years of good economic performance, the country must then demonstrate that its debt-servicing requirement is unsustainable, following designated threshold values with respect to the ratio of debt to exports, and the ratio of debt to fiscal revenues. If the country finally qualifies for relief, its debt-servicing payment is brought down to what is deemed within the terms of the initiative to be a sustainable level, only after reaching the completion point, or a further three-year waiting period.

This less than generous arrangement would still leave the qualifying country diverting a sizeable portion of its scarce foreign exchange earnings towards debt servicing for an indefinite period of time. Moreover, while expenditures on education and health services will be expanded under the new HIPC, the structural factors that induced poverty were not addressed by conventional structural adjustment programmes. More worryingly, while debt relief is important in the short run, the extent to which additional fresh resources would be available for HIPC countries is not certain. Debt relief alone is not going to be enough to put these marginalised countries on a path of sustained growth.

Not surprisingly, there exists a great deal of scepticism about the willingness of Western creditors, in particular the multilateral development banks, to break the chain of debt-bondage of the HIPC countries, not to mention the adequacy of funding for HIPC to wipe the slate clean. Conditionality and external control remain the core guiding principles of the enhanced HIPC initiative, despite the claims of the architect of the plan that poverty eradication is its real objective. Moreover, linking debt relief to successful implementation of 'good governance' is a major mistake and is bound to delay much-needed relief to countries desperately in need of fresh resources to fix collapsed social systems.

Zambia is a clear case in point. It is one of the worst HIV-infected countries in the world, with a prevalence rate of 21.5 per cent among its adult population – see Table 2. The annual number of deaths has been increasing slowly and will reach 127,000 per annum or nearly 350 per day by 2005.[53] This means that one in five of Zambians now over the age of 15 will die at a young age from this disease, mostly over the next five to ten years. The overall impact of the virus on life expectancy is particularly noteworthy: life expectancy, which stood at 54 years a few years ago, has plummeted to 37 and is expected to decline in the coming decade to 30 years. As adult mortality from AIDS rises, people with essential skills account for a significant percentage of HIV/AIDS-related deaths. Teachers, accountants, civil servants and other professionals are dying in large numbers.[54] As a result, labour productivity has been diminishing and HIV/AIDS is now the central concern of firms. One review of

[51] F. Cheru, 'Debt Relief and Social Investment: Linking the HIPC Initiative to the HIV/AIDS Epidemic in Africa: The Case of Zambia', *Review of African Political Economy*, 86 (2000), pp. 519–35.

[52] F. Cheru and R. Figueredo, *Debt Relief and Social Investment: Linking the HIPC Initiative to HIV/AIDS Epidemic in Africa* (Geneva: UNHCR, 2000).

[53] Ministry of Health, *HIV/AIDS in Zambia: Background, Projections, Impacts and Interventions* (Lusaka: Central Board of Health).

[54] UNAIDS, *Report on the Global HIV/AIDS Epidemic.*

33 businesses in Zambia showed a dramatic increase in average annual mortality from 0.25 per cent in 1987 to 1.6 per cent by 1992. Barclays Bank of Zambia has lost more than a quarter of its senior managers to AIDS. On a large sugar estate, 755 of the deaths between 1992 and 1993 were HIV-related. Part of the reason for increased absenteeism is the time employees spend attending funerals. Additional training costs will be incurred as labour turnover increases and businesses will have to pay out more in medical care, salary compensation for the families of the deceased, and funeral grants.

Zambia belongs to the category of the HIPC zone wherein the debt burden has been a major contributor to the persistence of underdevelopment. It has taken a heavy toll on public budgets, severely shrunk the resources available for development and greatly reduced the prospects for growth. Even before HIV/AIDS became recognised as the greatest threat to human development in Zambia, the country's external debt was regularly serviced at the expense of vital social programmes. Thus, finding lasting solutions to Zambia's debt can open up a strategic opportunity to contain the threat of the HIV/AIDS pandemic to sustainable human development. The total external debt of Zambia stood at US$6.5 bn in 1998. Of this, 46 per cent is owed to the multilateral institutions, such as the IMF, the World Bank and the African Development Bank. Because multilateral debts are 'preferred and exempt' debts, they cannot be rescheduled or cancelled, and they take precedence over other debts. Debt service payments falling due in 1998 amounted to US$123 m and were paid to creditors accordingly: US$89 m to multilateral and US$30 m to Paris Club creditors – composed largely of Western governments. The US$123 m in debt service payment was about 69 per cent of the funds budgeted for the social sectors. Yet no nation can develop without educated and healthy citizens, no matter how faithfully it may meet its debt-servicing requirements.

The Zambian government has pursued a policy of debt forgiveness and rescheduling in order to reduce the country's debt burden. During the period 1992–97, various creditors extended debt relief amounting to a total of US$1.873 bn, of which US$1.44 bn was provided by the Paris Club creditors and the balance by both non-Paris Club and commercial creditors. The multilateral creditors have offered no debt relief. It is possible now that Zambia can qualify for debt relief under the enhanced HIPC initiative, if the government successfully fulfils numerous macroeconomic and governance conditionalities that creditor countries are demanding. At the earliest, the government can hope for real debt relief three years from now. Like many other countries on the continent, Zambia's progress towards qualification for debt relief under the enhanced HIPC initiative hinges largely on the government's capacity to show real and tangible progress on the promise it made during the last consultative group meeting to institute fundamental governance reform. While there is little wrong with this in principle, the fear is that the critical resources needed to tackle the AIDS pandemic might be held up indefinitely if progress on governance reform falters. As a consequence, the excellent work that NGOs and civil society are doing with meagre resources to prevent the spread of HIV/AIDS will be completely wiped out. In the context of the pandemic, action is needed now; not three years down the road, by which time millions more Africans will have been infected with, or died from, the HIV virus.

As other highly indebted countries struggle to meet the criteria for HIPC relief, it is time to face the facts. The case of Zambia has, perhaps more clearly than any other,

Table 4. *Foreign directed investment (as percentage of global FDI flows), 1997–2002.*

Indicators	1997	1998	1999	2000	2001	2002
Developed countries	56.8	69.8	77.2	79.1	80.1	
Developing countries and economies	39.2	27.2	20.7	18.9	18.0	
Asia	22.4	13.8	9.3	11.3	11.2	
Latin America	14.9	12.0	10.3	6.8	6.8	
Africa	2.3	1.2	1.0	0.7	0.7	
Africa (as a percentage of developing countries)	5.88	4.63	4.72	3.78	3.87**	3.11**

Note: *UCTAD data 2002; **UNDP 2002.
Source: ADB Statistics Division and IMF.

laid bare the myth of HIPC debt relief. Even with the full application of the HIPC initiative, Zambia's debt crisis will not be lessened, its government will be no more able to address the national health emergency and its people will be no less tied into a cycle of deprivation. On average, countries that receive HIPC relief see reductions of only about one-third in their debt service payments. As Kofi Annan, Secretary-General of the United Nations, concluded in a September 2000 report, 'the enhanced HIPC Initiative does not provide an adequate response to HIPCs' debt problems', and therefore 'a bolder approach will have to be taken'. The current debt relief framework has failed Zambia, just as it has failed other highly indebted poor countries across Africa and throughout the developing world.

The moral calculus of inactivity

Table 4 illustrates the magnitude of Africa's economic challenge. Other regions of the world have demonstrated a much greater ability to attract FDI over the past few years (arguably over the past two decades) than Africa. The Table does not fully reveal the highly selective patterns of FDIs. Of the US$18.52 bn FDI that flowed into Africa during the 1990s, just three countries (Angola, Nigeria and Lesotho) accounted for US$11.672 bn – all of them lucrative mining or oil-producing countries.[55] If South Africa is excluded (both as a recipient and a source of FDI), five other countries accounted for another US$4 bn – Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Namibia and Sudan – leaving the remaining 40 countries of the continent to compete for just US$3.275 bn in FDI flows over the decade.[56] According to African Development Indicators 2002, official aid has followed a similar selective trend over the past decade and is falling in terms of total volume. Aid levels in 1999, for example, were US$10.8 bn compared to US$17.9 bn in 1992, when development assistance to Africa reached its highest ever levels.

Not surprisingly, many organisations – particularly UN agencies working in Africa, such as the United Nations High Commission for Refugees (UNCHR) – have repeatedly pointed to the unequal treatment of Africa by the donor community. For example, in 1999 donors provided less than three-fifths of the

[55] ADB, *African Development Report 2002.*
[56] UNDP, *Human Development Report.*

US$800 m the UN requested for emergencies in sub-Saharan Africa. Similarly, the World Food Programme announced in September 2000 that it would curtail its feeding programme for nearly 2 million refugees in Sierra Leone, Liberia and Guinea after receiving less than 20 per cent of requested funding. An emergency appeal in the summer of that same year to feed and shelter at least 600,000 Angolans who had been displaced in that country's long-standing civil war – a number nearly equal to Kosovo's refugees of three Springs previously – brought minimal initial response and predictions of mass starvation. In the Great Lakes region of Congo, Burundi and Rwanda, the UN estimated it would need US$278 m to take care of nearly 4 million people crowded in refugee camps. By late October 2000, only 45 per cent of that amount had been donated. By contrast, Kosovo and Bosnia have been able to generate one of the biggest international responses in recent memory.

The reason for the differing responses by the international community is simple: Kosovo and Bosnia were a 'loud crisis' unfolding in front of television cameras and affecting largely people of European descent; the HIV/AIDS pandemic in Africa and the developing world is a 'silent crisis' affecting largely poor black people (mainly Africans), who, in the eyes of the Western media, are constantly portrayed as being in a state of permanent crisis. Indeed, racism must not be underestimated in any analysis of why the Western nations have responded so half-heartedly to the AIDS pandemic. The position is perfectly summarised by Salih Booker, director of the Africa Fund/American Committee on Africa, when he concludes that 'AIDS is a black plague; it is mainly killing black people . . . And that is the cruel truth about why the world had failed to respond with dispatch.'[57] Consider this cruel irony: the World Bank – as a sponsor of UNAIDS – is charged with funding strategies to alleviate poverty and to reduce HIV infectivity in the developing world. Yet it could write concerning the pandemic that 'if the only effect of the AIDS pandemic were to reduce the population growth rate [in developing countries], it would increase the growth rate of per capita income in any plausible economic model'. Moreover, the Bank has developed the idea of 'disability-adjusted life year', or DALY, to measure the number of years lost to illness and death. 'By this calculation,' reported the *Washington Post*, 'a country that spent US$1,000 a year to save the life of someone earning US$500 a year would suffer a net economic loss'.

Conclusion

Although the proximate cause of Africa's AIDS crisis is HIV, the underlining societal causes are much broader and more familiar. Across the continent, poverty structures not only the contours of the pandemic but also the outcome once an individual is infected with HIV. Thus, until poverty is reduced there will be little progress with either reducing transmission of the virus or creating an enhanced capacity to cope with its socioeconomic consequences. It follows that sustained human development is an essential precondition for any effective response to the pandemic in Africa. Herein lies Africa's predicament: how to achieve the sustainable development essential for an effective response to the pandemic under conditions where the

[57] S. Booker, 'Global Apartheid', *The Nation*, 2001, pp. 11–17.

pandemic is destructive of the capacities essential for the response – namely, killing the most economically productive members of the continent's people. Simple answers to this problem do not exist, but recognition of its nature is a step towards its solution. The next step has to be the development of policies and programmes that address the interrelationships between poverty and development and actually to put in place those activities that can make a difference for development outcomes. Central to these activities are programmes that address poverty today so as to facilitate socioeconomic development tomorrow.

The recent Sachs Report puts the position this way: 'With bold decisions in 2002, the world could initiate a partnership between rich and poor [countries] of unrivalled significance, offering the gift of life itself to millions of the world's dispossessed and proving to all doubters that globalisation can indeed work to the benefit of all humankind'.[58] Central here is the perennial problem of Africa's overwhelming debt and the necessity of its unequivocal cancellation. To be sure, debt cancellation is not a panacea for Africa's AIDS crisis, but it is a hugely important step in enabling the continent's states to engage more effectively with the challenges posed by HIV/AIDS. With the best will in the world, no country can physically afford to make the investments necessary in social services while being forced to give priority to debt repayments. The argument that cancelling the debt of African countries would foster financial irresponsibility by debtors does not hold up. On the contrary, it is necessary for countries on the edge of economic marginality to take responsibility for the use of future resources – however limited – in the fight against HIV/AIDS.

Moreover, a mechanism could be devised whereby the conditions of debt cancellation would be determined by a governance structure that incorporated civil society and elected governments in the affected states. This would be a particularly powerful safeguard against corruption and would expose domestic strategies to public scrutiny in both debtor and creditor countries. Clearly, any such strategy must be driven by political will, within both lender states and their omnipresent institutions of economic governance – mainly the IMF and the World Bank. Ominously, the rhetoric of political will on the part of these bodies has not been supported by context-relevant strategic initiatives – such as total debt cancellation for the heavily indebted countries confronting the modern incarnation of Dante's inferno that is AIDS.

In addition to debt-relief, a key aspect of the poverty/HIV nexus which should be addressed by the institutions of global governance is that of access to AIDS medicines and treatment. The need for increased access to anti-retroviral therapy for those living with HIV/AIDS in Africa can be supported not only on human rights grounds but also on an economic basis. Increases in longevity that are the result of anti-retroviral treatment may be extremely valuable, particularly in productive groups of people, and in those who have families and dependents to support. Economically, widening access to ART could be a good investment as it has the potential in the long-term to reduce costs of hospitalisation and treating people with HIV-related illnesses, and will also reduce the strain on the economy due to loss of productivity because of HIV-related illness and absenteeism of workers. However despite progress in the reduction of prices of anti-retroviral medicines and the achievement of the Doha agreement, there is still a long way to go before treatment

[58] J. D. Sachs, *Macroeconomics and Health.*

is widely affordable in Africa. In the post-Doha period, the US Government has tried to narrow the interpretation of the agreement announced there, by opposing efforts to clarify the right of poor nations without a domestic pharmaceutical industry to import generics from other countries. And the pharmaceutical industry itself has attached numerous conditions to their offers to reduce the price of HIV/AIDS drugs. In these conditions, and with the seeming unwillingness of the US and the other G8 countries to provide adequate funding for comprehensive treatment programmes, it seems unlikely that the four million people estimated to require anti-retroviral therapy in Africa will receive it in the short term.

Unless the dominant players mobilise quickly and effectively, the future prospects for Africa looks decidedly gloomy. In this sense the moral calculus of inactivity could be beyond computation.