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Africa's AIDS crisis in context: 'how the poor are dying'

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ABSTRACT *The 13th International Conference on AIDS held in Durban, South Africa, highlighted the social catastrophe unfolding on the African continent. The meeting took place in the country with the largest number of people infected by HIV—the virus that causes AIDS—on the continent that is home to 70% of the world's HIV-infected population. The cruel irony of the unfolding human tragedy is that Africa is also the least equipped region in the world to deal with the multiplicity of challenges posed by the HIV virus. Drawn from ongoing research in southern Africa, this article charts the relationship between poverty, HIV prevalence and the politics of global response.*

Of the 30 new viruses that emerged during the last quarter of the 20th century, 20 still remain immune to standard chemotherapeutical control and mutation rates are such that any synthetic antidote rapidly becomes obsolete.[1] With 35 million people infected worldwide, the Human Immunodeficiency Virus (HIV) is by far the most prevalent of these new incurable viruses. Despite two decades of intense research, its origins remain obscure.[2] What is accepted, however, is that HIV is a zoonosis; that is, it is a human disease acquired from animals. The virus evidently evolved from a Simian Immunodeficiency Virus (SIV): a type of slow virus found naturally in monkeys and apes which, while not harming its host, produces diseases in other primates. Amid the usual wild allegations and implicit racism—wide tribal sexual practices with monkeys (the suggestion of a Cambridge virologist) or some magical practices involving blood drinking—how the virus crossed the species barrier remains unclear. Although the historical epidemiology poses 'daunting difficulties', the political ramifications are even more imposing. Identifying an origin automatically means pointing an accusing finger and who would accept being stigmatised as the group or nation that gave HIV—the cause of Acquired Immune Deficiency Syndrome (AIDS)—to the world? As a consequence, the biological and geographical origins of the HIV virus remain obscure. This notwithstanding, the virus now represents the gravest threat to human life in the developing world, where 90% of all infected persons reside.[3]

Nowhere is HIV more firmly established than in sub-Saharan Africa, where an estimated 23.5 million people infected with the virus live (see Table 1). The cruel irony, of course, is that Africa is the least equipped region in the world to deal with the multiplicity of challenges posed by this deadly virus. Infection levels are

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TABLE 1
Regional HIV/AIDS statistics and features, June 2000

Region	*Epidemic started*	*Adults and children living with HIV/AIDS*	*Adults and children newly infected with HIV*	*Adult prevalence rate (%)*[1]	*Percent of HIV-positive adults who are women (%)*	*Main mode(s) of transmission for adults living with HIV/AIDS*[2]
Sub-Saharan Africa	late 1970s–early 1980s	23.3 million	3.8 million	8.0	55	Hetero
North Africa and Middle East	late 1980s	220 000	19 000	0.13	20	IDU, Hetero
South and Southeast Asia	late 1980s	6 million	1.3 million	0.69	30	Hetero
East Asia and Pacific	late 1980s	530 000	120 000	0.068	15	IDU, Hetero, MSM
Latin America	late 1970s–early 1980s	1.3 million	150 000	0.57	20	MSM, IDU, Hetero
Caribbean	late 1970s–early 1980s	360 000	57 000	1.96	35	Hetero, MSM
Eastern Europe and Central Asia	early 1990s	360 000	95 000	0.14	20	IDU, MSM
Western Europe	late 1970s–early 1980s	520 000	30 000	0.25	20	MSM, IDU
North America	late 1970s–early 1980s	920 000	44 000	0.56	20	MSM, IDU, Hetero
Australia and New Zealand	late 1970s–early 1980s	12 000	500	0.1	10	MSM, IDU
TOTAL		**33.6 million**	**5.6 million**	**1.1**	**46**	

Source: WHO/UNAIDS.

[1] The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

[2] MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

highest, access to care is lowest, and social and economic safety nets that might help families cope with the impact of the epidemic are badly frayed—in part because of the epidemic itself. There are already signs that HIV is threatening to wipe out the fragile development gains achieved over many decades. A new measure published by the United Nations Development Programme (UNDP) calculates the percentage of the population currently alive that can expect to live to celebrate their 60th birthday. Fewer than 50% of Africans currently alive are expected to reach the age of 60, compared with an average of 70% for all developing countries and 90% for industrialised countries.[4] Drawn from field research this paper details the impact of the HIV virus on African societies. Specifically, the paper is divided into three sections: the first section draws on community-based research to explore the relationship between poverty and the

high HIV prevalence in Africa. Section two examines the role of the International Monetary Fund and the World Bank, along with the pharmaceutical companies, in shaping the ongoing response to the virus. Following this, the final section maps out the options ahead.

AIDS in Africa

All but unknown a generation ago, today HIV poses the foremost threat to development in Africa.[5] By any measure, and at all levels, its impact is simply staggering; at the continental level, 23 million people are now living with HIV/AIDS—that is two-thirds of all the cases presently on Earth. Most will die in the next 5–10 years, joining the 13.7 million Africans already claimed by the epidemic and leaving behind shattered families and crippled prospects for development. Already the virus has overtaken malaria as the major killer on the continent, but its structural impact threatens to be even more devastating.[6] Across the continent, life expectancy at birth rose by a full 15 years from 44 years in the early 1950s to 59 in the early 1990s; thanks to AIDS the figure is set to recede to just 44 years between 2005 and 2010. By comparison, life expectancy in South Asia, another of the world's poorest regions, is evolving very differently. While South Asians born in 1950 on average could barely survive to their 40th birthday, by 2005 they can expect to live 22 years longer than their counterparts in aids-ravaged Africa.[7]

Recent evidence also suggests that companies doing business in Africa are suffering as a consequence and are bracing themselves for far worse as their workers become sick and eventually die. According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service. On one sugar estate a quarter of the entire workforce was infected with HIV. Direct cash costs related to HIV rose dramatically—company spending on funerals increased five-fold between 1989 and 1997, and direct health expenditure increased ten-fold.[8] In addition, the estate's managers reported greatly increased absenteeism, lower productivity (a 50% drop in the ratio of processed sugar recovered from raw cane between 1993 and 1997), and higher overtime costs as workers were paid to work extra hours to fill in for sick colleagues.[9] This is by no means an isolated case. A flower farm in a different part of the country saw a similar ten-fold rise in spending on employee health costs between 1985 and 1995. The expenditure—estimated at over US$1 million for a company with 700 employees—ate so heavily into profits that the owners sold the company. Indeed, according to the survey's findings, 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% of employee dropout by 1999.

The six countries in southern Africa that now form the global epicentre of the epidemic—Botswana, Namibia, South Africa, Swaziland, Zambia and Zimbabwe—face a particularly bleak future. Within these countries, one in six adults is HIV positive and AIDS is expected to claim the lives of between 8% and 25% of today's practising doctors by the year 2005.[10] In Zimbabwe, by 2001 the likelihood of a 15-year-old woman dying before the end of her reproductive years

will quadruple from around 11% in the early 1980s to over 40%. More than 2000 Zimbabweans die of AIDS each week. In Botswana, a shocking 35.8% of adults are now infected with HIV, while in South Africa, 19.9% are infected, up from 12.9% just two years ago. In Botswana, it is estimated that a total of 4.2 million people are infected and this number is expected to increase dramatically as the adult HIV prevalence rate in Botswana has more than tripled since 1992, when it was an estimated 10%. More than one in more adults living in Zambian cities are HIV-positive, and more than one in seven Zambian adults are infected in the country's rural areas.[11]

Why Africans are disproportionately affected by the HIV virus, is not fully understood. Any account, however, must attempt to unravel what is cause and what is effect, and it is precisely at the level of interpretation that the (implicit or explicit) use of simplistic causalities often reduces the continent's HIV crisis to a series of casual or tautological clichés, most of which carry distinct racist connotations. Two recent examples will perhaps suffice. At the 13th International AIDS conference in Durban (South Africa) in July 2000, Dr Yuichi Shiokawa from the University of Tokyo claimed that the African AIDS crisis could be brought under control only if 'Africans restrained their sexual cravings'. Pursuing the theme further in a recent edition of *Le Monde*, Professor Nathan Clumeck from the Université Libre in Brussels claimed that, 'sex, love and disease do not mean the same thing to Africans as they do to West Europeans because the notion of guilt doesn't exist in the same way as it does in Judeo-Christian cultures of the West'.[12]

In truth, such myths about the sexual excesses of Africans are not new. Early European travellers returned from Africa bringing tales of black men allegedly performing carnal athletic feats with black women who were themselves sexually insatiable. The affront to Victorian sensibilities was cited alongside tribal conflicts and other 'uncivilised' behaviour to justify the need for colonial social control. In this context, Dr Yuichi and Professor Clumeck are adding new and undocumented twists to an old repertoire. In fact, there is little evidence to support Western perceptions of African sexual promiscuity. Widespread modesty codes for women, whose sexuality is considered a gift to be used for procreation, make many African societies seem chaste compared with the West. For example, the Somalis, Afars, Oromos and Amharas of northwest Africa think that public display of sexual feelings damages a woman's 'gift'. As a result, sexual contacts are restricted to ceremonial touching or dancing. Initial sexual relationships are geared to the beginnings of making a family. The notion of 'boyfriend' and 'girlfriend', virtually universal in the West, has no parallel in most traditional African cultures. Moreover, no one has ever shown that people from Botswana, Namibia, South Africa, Swaziland, Zambia and Zimbabwe are more sexually active than people from France, the UK, Germany, the US or Japan. Indeed, scientists dismiss the notion that males from any continent or region are more addicted to sex than those from another because testosterone levels, the measure of sexual vigour in men, never vary more than a tiny fraction of a per-centage anywhere in the world. What is in contention here, is not that particular sexual behaviour is exposing Africans to a greater risk of contracting the HIV virus (a point to which we shall return), but that there is something in the culture of Africa or in the sexual mores of its population which is conducive to sexually transmitted

diseases. It is perhaps enough to remind ourselves that, in the absence of penicillin, the war-ravaged Europe of the late 1940s would have been devastated by epidemics of syphilis and gonorrhea. That threat was the natural outcome of the combination of men without social constraints and women without any means of support for themselves and their families except prostitution or something close to it. Rape would have played a significant part as well.

The socioeconomic conditions that prevailed in Europe after the second world war are not too dissimilar to the position confronting contemporary Africans. Despite two decades of Structural Adjustment Programmes, the promised advantages of economic restructuring, as hailed by the various lending bodies, have not been borne out in Africa. Foreign investments have failed to flow in, the debt burdens have continued and commodity prices continue to fluctuate amid declining industries. The human cost has been enormous. If we remove territorial boundaries from our cognitive map, we are very much left with a picture similar to that of postwar Europe; of a people across the continent attempting to pursue basic needs within the hostile and unpredictable environment of the global economy. Households are striving to secure these needs in conditions of extreme adversity, as governments and state managers either fail to, or are unable to, pursue policies which will increase the human security of their citizens. Not surprisingly, poverty has been increasing at a faster rate than anywhere else in the world—hence, Africans account for one out of every four poor persons in the world.[13] Within the continent, four of every 10 Africans live in conditions of absolute poverty.[14] More worryingly, recent evidence also suggests that 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.[15]

Poverty is associated with weak endowments of human and financial resources, such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status and low labour productivity as a result. An aspect of the poor health status of Africans is the existence of undiagnosed and untreated sexually transmitted diseases (STDs)—which is now recognised as a significant co-factor in the transmission of HIV.[16] Poor households typically have few—if any—financial or other assets and are often politically and socially marginalised. It is not at all surprising in these circumstances that the poor often adopt coping mechanisms which inadvertently expose them to a higher risk of contracting the HIV virus. Two examples of this state of affairs will perhaps suffices to indicate how poverty leads to outcomes which expose the poor to HIV. First, poverty—especially rural poverty, and the absence of access to sustainable livelihoods—is a factor in labour mobility. Mobile populations, which often consist of large numbers of young men and women, are isolated from traditional cultural and social networks and in the new conditions will often engage in risky sexual behaviours, with obvious consequences in terms of HIV infection.

Take the case of South Africa. Throughout the past century, men from around the southern African region were drawn or conscripted to work in South African gold, mineral and diamond mines. They left their families behind in rural villages, lived in squalid all-male labour camps, and returned home maybe once a year. Lacking education and recreation, the men relied on little else but home-

brewed alcohol and sex for leisure. A man who makes his living deep inside a South African gold mine has a one in 40 chance of being crushed by falling rock, so the delayed risks of HIV seem comparatively remote. Mining companies pay out $18 million a year in wages to 88 000 workers in the pits of Carletonville, the centre of South Africa's gold industry. The wages buy, among other things, sex. Some 22% of adults in Carletonville were HIV-positive in 1999, according to United Nations Programme on HIV/AIDS (UNAIDS), a rate two-thirds higher than the national average. When these men return to their families, they often carry the virus into their rural communities. A study in a rural area in the South African province of KwaZulunatal, for example, showed that 13% of women whose husbands worked away from home two-thirds of the time or over were infected with HIV. Among women who spent two-thirds of their time or more with their husbands, no HIV infection was recorded.[17]

Second, it is a feature of HIV infection that it clusters in families, with often both parents HIV positive (who in time experience morbidity and mortality).[18] 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 thus are also unable to deal with the consequent health and other costs. These include the costs of drugs when available to treat opportunistic infections, transport costs to health centres, reduced household productivity through illness and diversion of labour to caring roles, losses 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 as their capacity is reduced by the losses of productive family members through death and through 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.[19]

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.[20] Even where they do not, by eliminating the breadwinners—the 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 true of young women, who will often be forced to engage in commercial sexual transactions, sometimes as casual sex workers (CSW) but more often on an occasional basis, as survival strategies for themselves and their dependants. 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. In the western Kenyan city of Kismusu, for example, 23% of girls aged between 15 and 19 are infected with HIV, as compared with only 8% of boys.[21] This difference persists among men and women in their 20s also, although it narrows somewhat with age. Some 38% of women aged 20–25 tested positive for HIV in Kismusu, against 12% of men of the same age.[22]

A note of caution, however, must be entered here because there are many

reasons why women are at a higher risk of contracting the HIV virus than men. Although much research remains to be done about this phenomenon, recent community-based studies have taught us a great deal. First, they tell us that African women are having unprotected sex from very young ages. Although this is no surprise to anyone who keeps track of teenage pregnancies, it is a fact often wilfully ignored by most governments in Africa when it comes to sex education in schools. Kenya, for example, still has no 'family life' education in schools despite nearly two decades of glaring evidence that young Kenyan women are some three to four times more likely to be infected with HIV than young Kenyan men of comparable age. Recent attempts to introduce such education in Kenya, as elsewhere on the continent, have been met with intense opposition from conservative and religious groups.[23]

Second, the age disparity in HIV infection rates indicates that young women must be having sex with men much older than themselves—a point confirmed by, among others, our ongoing studies in Botswana and Zambia.[24] One particular response which emerged time and time again from our questionnaires was that older men selected young girls for sex because they were perceived to be 'clean': ie unlikely to be infected with HIV or STDs. In reality, this belief is misplaced. The high prevalence rates recorded among teenagers mask the fact that in most African societies a significant proportion of the vulnerable age group, that is between 14–19, is not sexually active. Out of 2400 teenagers interviewed in Botswana and Zambia, for example, nearly 48% had never had sex, with only 25% admitting to being sexually active. These results are not too dissimilar to studies from other parts of Africa. In Kisumu, HIV prevalence among 15–19-year-old girls is 23%, but 29.9% of this age group have never had sex.[25] These figures tell us that those girls who are already sexually active are even more likely to be infected with HIV than the high prevalence rate suggests. Moreover, given that they are close to the start of their sexual lives, these younger girls have probably been infected with HIV relatively recently. This further increases their contagious rates because the virus replicates very quickly at the start of an infection, only gradually being brought under temporary control as antibodies are produced. Having unprotected sex with young women may therefore actually represent a higher risk of acquiring HIV for older men than selecting a partner their own age.

Finally, a comparison of the role of women from West and Southern Africa also offers an insight into how poverty exposes women to the HIV virus. With the exception of Côte d'Ivoire, where infection rates are comparable to those in southern Africa, the general rates of infection in West Africa have been consistently lower than in any other region on the continent, with countries registering up to 5% prevalence rates among adults.[26] One reason for this is that women are generally better-integrated into economic life in West Africa than in any other part of the continent. Being less dependent on men for survival than their counterparts in East and Southern Africa, they are therefore better able to negotiate the terms of sex, insisting on condom use when having sex with men who have other partners. Indeed, a generally more realistic attitude to sex in many West African societies has helped greatly in establishing successful HIV prevention programmes. In Senegal, for example, sex work was a legalised profession long before the advent of HIV/AIDS. When HIV loomed and the link with other

STDs became known, the country was easily able to strengthen STD screening among licensed sex workers, which also provided an easy access point for condom promotion and other prevention initiatives. Following prevention initiatives in Senegal, STDs among sex workers have dropped, and over two-thirds of men who said in a survey that they have casual sex reported using a condom with their most recent casual partner.[27] Partly in consequence of this success, HIV in the general Senegalese population has remained low, with fewer than 2% of pregnant women testing positive for HIV in major urban areas.[28]

Responding to AIDS in Africa: the battle for drugs and money

Over two decades of experience have identified the essential elements of an effective strategy against the HIV virus: visibility and open-mindedness in countering the stigma associated with the disease; addressing core vulnerability through social policies; addressing the synergy between prevention and care; and targeting medical resources to those most vulnerable—particularly young people. Thailand is the clearest case: after an intense national campaign to increase condom use in commercial sex, the condom-use rate for brothel-based sex workers reached more than 90%, STD cases declined precipitously and HIV prevalence among army conscripts dropped by more than half.[29] Unfortunately, the delivery of similar strategies in Africa is being hampered by the actions of three powerful forces: (i) African governments who have dithered in prioritising an effective response to the virus; (ii) the pharmaceutical companies who hide behind unfair patent laws to set exorbitant prices for essential drugs; and (iii) the Bretton Woods institutions of global governance (particularly the IMF and the World Bank) whose conditionalities decide public policy in Africa.

Governments in denial

While it is inevitable that massive rises in death among young, economically active adults will affect economies, it is not easy to isolate or measure that effect. In many of the countries worst affected by HIV, poor economic management, high inflation, rampant corruption and deteriorating infrastructure are commonplace, and conflicts and population displacement are far from rare. Military spending often far outpaces spending on health and education, and inequitable distribution of resources is the rule. The contribution of AIDS to this generally grim picture is hard to pinpoint, but clearly the epidemic can only exacerbate the already precarious situation faced by many countries. A degraded macroeconomic situation inevitably influences priorities at every level from the national down to the individual. In South Africa, for example, a 1996 study estimated that 52% of the 11 million people aged 16–30 were unemployed, and half of those unemployed people were classified as marginalised, with few prospects of formal sector employment. Hardly surprising, then, that young people think of short-term survival before long-term well-being. Short-term survival strategies often include exchanging sex for schooling, a job, money or a roof over one's head. On a continent where so much of the population is already infected with HIV, such strategies are a recipe not for survival but for premature death.

Faced with this developmental challenge, not only must the epidemic itself be directly addressed in programmes of assistance but, as its consequences will affect all existing development initiatives, these will need to be reformulated in order to encompass the real threat of the HIV virus. The role of government in this process is crucial for several reasons. First, only governments can put AIDS at the centre of the national agenda—and not just on the health agenda. Second, only governments can create more favourable conditions for others to play their role. Since the 1980s civil society, non-governmental organisations (NGOs) and some religious groups have taken the lead against the epidemic. They continue to work hard in difficult circumstances. Governments can create the policy and legal environment to enable them to be more effective. Third, only governments can adequately protect the poor and those who are especially vulnerable to the HIV virus by breaking the silence, eliminating discrimination and providing adequate protection; by reducing household poverty to keep women out of the sex trade, while improving access to information, condom and STD care.

Unfortunately, African leaders have, until recently, adopted a rather indifferent approach to the epidemic—the only exception other than Senegal being Uganda. An early response to the HIV virus in Uganda has resulted in a dramatic decline in HIV prevalence among pregnant women and young people.[30] In Kampala, for example, HIV prevalence among antenatal clinic attendees tested increased from 11% in 1985 to 31% in 1990. Since 1993, however, HIV prevalence among antenatal clinic attendees has been on the decline, reaching 14% in 1999. Similarly, the percentage of young pregnant women—that is those aged under 20—who tested positive has declined from 28% in 1991 to 6% in 1999.[31] These declining figures are replicated across the country. Median HIV prevalence of antenatal clinic attendees outside Kampala has declined from 13% of antenatal clinic women attendees tested in 1992 to 8% in 1999. HIV prevalence information by age is available from one or two sites over the years since 1990. In 1990, 21% of antenatal clinic women under 20 years of age tested outside Kampala were HIV positive.[32] This rate declined to 8% of antenatal clinic attendees under 20 years of age tested in 1998. In 1989, 42% of male STD clinic patients tested in Kampala were HIV positive. By 1992, HIV prevalence had increased to 46%. In 1998, 30% of male STD clinic patients tested were HIV positive. In 1989, 62% of female STD clinic patients tested in Kampala were HIV positive; by 1997 HIV prevalence among female STD clinic patients tested had declined to 37%.[33]

With the exception of Uganda and Senegal, African leaders are engaged in denial, typically asserting that the moral values of their societies would not permit transmission of an agent such as HIV that is associated with risky sexual behaviour, homosexuality and injecting drug use. President Thabo Mbeki of South Africa has even gone as far as questioning the scientific link between the HIV virus and the cause of AIDS. Even where denial is conquered, the type of intervention proposed and pursued by governments often exacerbates the problem. Malawi is a clear case in point. As recently as 15 August 2000 (some 15 years since the first reported HIV case in his country) President Bakili Muluzi of Malawi was calling on his police force to intensify swoops on known brothels to slow down the spread of AIDS. So convinced was the president of the relationship between high prevalence and the sex industry that he proposed to give police

greater powers to restrict the 'civil liberties' of known prostitutes and their clients. Similarly, in Swaziland, Tfohlongwane Dlamini, the chairman of the powerful Swaziland National Council Standing Committee, told delegates at a recent conference that HIV-afflicted people 'should be kept in their own special place if we want to curb the spread of the disease'. The statement followed earlier parliamentary debate where Swazi King Mswati III called for HIV-positive citizens to be 'sterilised and branded'.[34] By stigmatising the carriers of the virus, African leaders are making the struggle against HIV that much harder. As a result, people are less likely to get tested as those who are HIV positive live in fear of their lives. The chilling story of Gugu Dhlamini, beaten to death in South Africa because she admitted to being HIV positive, is one case in point.[35]

SAPs are hampering the fight against HIV/AIDS

The anticipated economic burden on African economies might well explain why African leaders are so reluctant to engage more effectively in the struggle against the HIV virus. Across the continent, governments are under intense pressures from the IMF and the World Bank to maintain fiscal discipline under the various Structural Adjustment Programmes (SAPs). Over the years, two broad policy components have come to characterise SAPs: short–medium term macroeconomic stabilisation measures to restore internal and external balances, which fall within the province of the IMF; and SAPs proper, which are designed to 'unleash market forces so that competition can help improve the allocation of resources … getting price signals right and creating a climate that allows business to respond to those signals in ways that increase the returns to investment'.[36] In the process, SAPs lead to a radical rationalisation of recipient governments' expenditure commitments mainly—but not exclusively—in areas concerned with the provisions of welfare (ie health, education and basic sustenance, such as food subsidies).

In spite of two decades of adjustment programmes, no African country has achieved a sound macroeconomic policy stance. In truth, it is not clear whether the lack of success is a result of unwillingness of African countries to follow the adjustment policies correctly (as the World Bank claims) or from the policies being inherently non-implementable. After so many years of adjustment policies, this debate remains largely unresolved. The one certainty, however, is that SAPs often have an immediate impact on the welfare of the poorest members of society, especially as they affect food prices, costs of education, and payment for medical services. The dominant 'opinion among African intellectuals is that the structural programmes are part of the problem rather than part of the solution'.[37] Across the continent SAPs have done little to foster the social, political and economic conditions that could contribute towards an effective strategy against the HIV virus. Indeed, the promotion of exports for debt repayment and the cutting of public expenditure on welfare in a region where 100 million people are undernourished; where there is one doctor for 36 000 people, compared with one for 400 people in the developed world; and where the HIV virus is killing people at a rate of 6000 people per day is a scandal. One author has even referred to SAPs as a form of 'economic genocide'.[38]

To offset such criticisms the World Bank recently (1999) launched a document

titled: *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis.* In this document the Bank proposed to mobilise development partners to 'address the compelling and evolving implications of the HIV/AIDS epidemic in order to halt further reversal of human, social, and economic development in Africa'.[39] This noble objective is to be achieved through five main policy initiatives:

- advocacy to position HIV/AIDS as a central development issue and to increase and sustain an intensified response;
- increased resources and technical support for African partners;
- prevention efforts targeted to both general and specific audiences, and activities to enhance HIV/AIDS care;
- expanded knowledge-base to help countries design and manage prevention, care and treatment programmes based on epidemic trends, impact forecasts and identified best practices.

In truth, it is too early to judge the effectiveness of this new initiative. It is ominous to note, however, that SAPs are not mentioned even as a possible problem in the fight against the HIV virus. This omission is tragic for at least two reasons: first, in formulating its new initiative, the Bank seems to have completely overlooked the demonstrable links between SAPs and high HIV prevalence. From the growing literature, it is clear that SAPs, with their emphasis on fiscal discipline and restrictions on government health expenditures, contribute to the high prevalence of HIV infections in at least two ways: (1) less funding for the treatment of STDs and blood screening increases the risk of transmitting HIV; (2) less funding to support good hygiene practices in clinics (eg sterilisation of equipment) is also a major factor in HIV transmission. Second, in a situation where up to 50% of Africa's government revenues are directed towards servicing a total debt of $350 billion, it is highly unlikely that, without substantial debt relief and payment rescheduling, any effective strategy that relies on government intervention will succeed. In short, this initiative from the Bank appears to be at best ill-conceived and at worse a meaningless, cruel deception.

The battle for affordable drugs

Although there is no cure for the HIV virus, over the past decade many breakthroughs have been made in anti-retroviral (drugs that slow down the course of HIV infection) treatment for those infected. Tragically the fruits of this common effort have landed in the hands of powerful pharmaceutical companies, who now use their ownership of these life-sustaining drugs to make huge profits. As a result, the people that need the latest anti-retroviral drugs in Africa cannot afford them. The multibillion-dollar pharmaceutical corporations of the USA and Europe have spent millions of dollars testing and manufacturing HIV-inhibiting drugs. They are bitter rivals in the market place, but on one key issue they have long had a common interest—using international copyright law to maintain their grip on the manufacture, distribution and pricing of AIDS drugs—such as AZT—worldwide. Throughout the 1990s the drug companies fought vigorously to protect their privileges. Their argument was simple: infringement of intellectual

copyright laws to allow poor countries cheap access to AIDS drugs would be the thin end of a dangerous wedge. Pirating would run riot across the world—and global (read US) business would suffer. If copyright is not protected, said representatives of the pharmaceutical giants, who will bother investing in the research and development necessary to continue the fight against AIDS?

The logic of this neoliberal argument has given rise to a perverse position whereby all AIDS related drugs are more expensive in Africa—where they are needed most—than anywhere else in the world. At the June 2000 intergovernmental conference held in Nairobi (Kenya) on 'Improving Access to Essential Medicines', delegates were told that the potent antibiotic, ciprofloxacin (one of the most successful anti-retroviral drugs available on the market), was twice as expensive in Uganda as in Norway. An equally disturbing example is the case of fluconazole, a treatment for AIDS-related meningitis. In Thailand, where generic competition has lowered prices, fluconazole costs only US$0.30. However, this same drug costs US$18.00 in Kenya, where it is patent protected. Similarly, it was noted that comparing retail prices of other essential drugs showed the same disturbing pattern: 10 out of 13 commonly used drugs are more expensive in Tanzania than in Canada. The huge disparity in average income between the two countries means that a Tanzanian would have to work 215 days (assuming he/she is lucky enough to be in employment) to buy these 13 drugs, while a Canadian would only have to work eight days.

Confronted with this absurd reality, in July 2000 five of the largest international pharmaceutical companies agreed to slash the cost of their AIDS treatment drugs for Africa. At first glance, this much-needed concession is cause for celebration. But a closer look at the agreement suggests that it is premature to break open the champagne. The accord simply provides a framework for how the drug companies might proceed, and leaves a host of questions unanswered. For instance, it is far from clear just what has been agreed to. A UNAIDS press release described what occurred in Geneva as simply the beginning of 'a new dialogue', and that companies have agreed to offer 'to improve significantly access to and availability of a range of medicines'.[40] The drug companies themselves—Bristol-Meyer Squibb, Merck, Glaxo Wellcome, Hoffmann-La Roche and Boehringer Ingelheim—issued a flurry of press releases, but provided few details of how much they will charge for the drugs. Only Glaxo Wellcome said it might sell Combivir, a combination of AZT and 3TC, for $2, instead of the average price of $16 it has been charging worldwide. In the wider context of poverty and the marginality of Africa, there is some question whether this proposed reduction will be big enough.

It is also far from clear whether the move by the drug companies reflects a genuine desire to make their drugs available to the largest number of people, or a rearguard effort to protect their virtual worldwide monopoly on the manufacture and distribution of these essential drugs. It may have just been a coincidence that the Geneva announcement came two days after President Clinton issued an executive order which represented a frontal challenge on a company's patent rights over anti-AIDS drugs in poor countries. The pharmaceutical companies may now feel they have grounds to argue that, if they offer the drugs at lower prices, there is no reason for any country to force them to grant foreign licences to

companies that can produce the drugs more cheaply, as allowed under the executive order. That would leave developing countries with less flexibility in securing drugs at the best possible prices than they currently have.

Looking to the future

Already the HIV epidemic is posing an unprecedented challenge to communities and societies across the continent: a challenge to human survival, human rights and human development. It is difficult to visualise the devastating effect of the HIV epidemic within our lifetime and beyond. The challenge facing national and international communities is to act speedily and effectively to limit the further spread of the epidemic, and to minimise its impact. In the case of Africa, this impact must be understood in the context of the critical social and economic problems already experienced by countries on the continent: poverty, famine and food shortage; inadequate sanitation and health care; the subordination of women, and adjustment policies that allocate insufficient resources to the social sectors. These factors create a particular vulnerability to the devastating consequences of the epidemic. Economic need and dependency lead to activities that magnify the risk of HIV transmission and mean that many people, particularly women, are powerless to protect themselves against infection. Inequitable power structures, a lack of legal protection and inadequate standards of health and nutrition all further exacerbate the spread of the virus, accelerate progression from HIV infection to AIDS, and aggravate the plight of those affected by the epidemic. Further, the setting of the HIV epidemic in Africa creates a downward spiral whereby existing social, economic and human deprivation produces a particularly fertile environment for the spread of HIV and, in turn, the HIV epidemic compounds and intensifies the deprivation already experienced by people across the continent.

Notes

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