Poverty, debt and Africa's HIV/AIDS crisis

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Under intense structural adjustment pressure, African governments have capitulated to the will of the World Bank and International Monetary Fund (IMF) in formulating the continent's health and social policy.[1] Concomitant with this shift has been a dramatic change in the philosophy of health provision away from its traditional emphasis on social justice and equity towards markets and efficiency.[2] Hence, public health services and health care for all are now perceived (in policy-making circles) as the major obstacle threatening public finances and the 'wealth' of African states. Ironically, this is happening at a time when communities and households on the continent are facing a day-to-day experience of declining standards of living, reduced capacities for personal and social achievement, an increasingly uncertain future (with important consequences for what can be achieved today), and a diminished capacity to maintain what has been secured over past decades in terms of social and economic development. The basic facts are well known but bear repeating: 40 per cent of the continent's population live on less than US$1 per day, and surviving on less than US$2 a week is a reality for over half of its people.[3] The resulting inequalities in health outcomes are similarly stark: Africans are five times more likely to die before reaching five years of age than any other people in the world. Moreover, across the continent, health systems are in an advanced state of decline: access is poor, the quality is rudimentary and drugs are not available.[4]

In the midst of this depressing picture of retrogression and decline the Human Immunodeficiency Virus (HIV)—the cause of Acquired Immunodeficiency Syndrome (AIDS)—is eroding fundamentally the continent's already fragile

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[1] N. K. Poku and A. Whiteside, 'Global health and the politics of governance: an introduction', *Third World Quarterly* 23, 2002, pp. 191–5.

[2] B. G. Schoepf, C. Schoepf and J. V. Millen, 'Theoretical therapies, remote remedies: SAPS and the political ecology of poverty and health in Africa', in J. Gershman, ed., *Dying for growth: global inequality and the health of the poor* (Monroe, ME: Common Courage Press, 2000).

[3] World Bank, *Africa Development Indicators 2000* (Washington DC: World Bank, 2000).

[4] N. Namposya-Serpell, 'Social and economic risk factors for HIV/AIDS-affected families in Zambia', paper presented at the AIDS and Economics Symposium, IAEN, 7–8 July 2000.

capacity for development.[5] By any measure, and at all levels, the impact of HIV/AIDS in Africa is staggering. At the continental level, 28 million people are now thought to be living with HIV or AIDS.[6] Most will die in the next five to ten years, joining the 16.7 million Africans already claimed by the pandemic.[7] All but unknown a generation ago, today HIV has become the leading infectious killer on the continent, but its structural impact threatens to be much more devastating than that of Africa's other infectious killers. 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. However, due to the advent of AIDS the figure is set to recede to just 44 years between 2005 and 2010. Moreover, fewer than 50 per cent of Africans currently alive are expected to reach the age of 60, compared with an average of 70 per cent for all developing countries and 90 per cent for industrialized countries.[8]

For some time many observers of this grotesquely pervasive HIV/AIDS pandemic in Africa have taken the view that its dominant feature has been politics, not medicine.[9] Consequently, a solution must be found and applied in the political arena as much as the medical. Beginning from an acknowledgement of the continent's socio-economic retrogression, this article charts the power relations driving the pandemic, frustrating the possibility of alleviation and recovery as well as working to relegate Africa to a bleak and vulnerable future.

A crisis rooted in poverty

President Thabo Mbeki's contextualization of Africa's HIV/AIDS crisis in the continent's ubiquitous poverty generated a tremendous political storm at the opening address to the 13th International AIDS conference in Durban in 2000. Mbeki's 'audacity', as one Western scientist viewed it, was to challenge the established view that Africa's HIV crisis was functionally related to its unusually high rates of sexual partner change. Dr Yuichi Shiokawa from the University of Tokyo put the position this way: 'The AIDS crisis in Africa could be brought under control only if Africans restrained their sexual cravings … it follows that Africans should change their sexual behaviour.'[10] Although this view merely reiterates the central thrust of prevention programmes and strategies over the past two decades—which have been dominated by the advocacy of behavioural

5 J. Collins and B. Rau, *AIDS in the context of development* (Geneva: UNRISD/UNAIDS, 2000). See also N. K. Poku, 'Africa's AIDS crisis in context: how the poor are dying', *Third World Quarterly* 22, 2001, pp. 191–204.

6 I use HIV and AIDS interchangeably. Since this chapter focuses on policy rather than medicine, until medication is widely available whether one is HIV-positive or has AIDS is merely a matter of one's place in the inevitable terminal cycle. With the expectation—or possibility—of effective drug treatment, the distinction between HIV-positive status and AIDS will become increasingly meaningful.

7 UNAIDS *Report on the Global HIV/AIDS*, p. 13.

8 UNDP, *Human development report* (Oxford: Oxford University Press, 2000).

9 See R. A. Fredland, 'A sea change in responding to the AIDS epidemic: leadership is awakened', *International Relations* 15, 2001, pp. 89–102.

10 Y. Shiokawa, 'Sex and AIDS in Africa', paper presented at the AIDS and Economics symposium, IAEN, 7–8 July 2000.

modification and the encouragement of condom use—there is no empirical evidence to support it.

The notion that males from any continent or region are more addicted to sex than those from any other is dismissed by scientists because testosterone levels, the measure of sexual vigour in men, never vary by more than a tiny fraction of a percentage point anywhere in the world.[11] Yet the ease with which the image of oversexualized Africans is accepted as a basis for many of the explanations offered for the continent's HIV and AIDS crisis would suggest otherwise. To be clear, what is in contention is not that particular social behaviour is exposing Africans to a greater risk of contracting the HIV virus, but that there is something in the culture of Africa or in the sexual mores of its population which makes them conducive to sexually transmitted diseases. It is important to remind ourselves that significant levels of unprotected multipartnered sex take place in the Western world as well, as is evidenced by serious epidemics of other STDs, such as herpes-2 and chlamydia.[12]

Sexual behaviour is undoubtedly an important factor in the transmission of any sexually based disease. Alone, however, it appears totally inadequate in explaining HIV prevalence as high as 30 per cent of the adult population in some African countries and less than 1 per cent anywhere in the Western world. In this context, Mbeki's proposition echoes Louis Pasteur's comment that 'the microbe is nothing, the terrain everything'[13]—a view also shared by the late Jonathan Mann (the founding director of the WHO's Global Programme on AIDS), who concluded that 'those people who were marginalized, stigmatized and discriminated against—before HIV/AIDS arrived—have later become, over time, those at highest risk of HIV infection.'[14] For Pasteur and Mann, the environment in which any infection is transmitted is bound to be strongly influenced by crucial societal factors such as the levels of poverty, sanitation, malnutrition, environmental degradation, and access to preventive and curative care—to mention but a few. In other words, pre-existing socio-environmental conditions play a key role in people's susceptibility to any disease.

Herein lies Africa's vulnerability to diseases more generally and to HIV in particular. Despite the major advances made by humanity in the fields of commerce, finance and technology over the past three decades, Africa has quite literally been left behind in terms of any of the spoils of globalization. Whatever the causes of this position—about which there is (quite legitimately) a debate—we cannot ignore or deny the magnitude of the continent's predicament. Across the continent, households are attempting to secure their basic 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

[11] See E. Shippen and W. Fryer, *The testosterone syndrome: the critical factor for energy, health, and sexuality—reversing the male menopause* (New York: M. Evans, 2001).

[12] J. S. Nevid, *Choices: sex in the age of STDs* (New York: Viacom, 1999).

[13] E. A. M. Jakab, *Louis Pasteur: hunting killer germs* (London: McGraw-Hill, 2000).

[14] J. Mann, 'Medicine and public health, ethics and human rights', J. Mann, ed., in *Health and human rights: a reader* (London: Routledge, 1999).

their citizens. In general the continent's economic growth has failed to keep up with its population's expansion. Exports have declined in relative and absolute terms. Food production has also declined, while imports of food and other necessities have increased. Similarly, import substitution industries have not lived up to expectations.[15] Industrialization has, with very few exceptions, failed to materialize; borrowing and debt have soared; currencies have weakened or collapsed. State revenues have plummeted. State-controlled economic activities have foundered. State-funded services have declined or disintegrated; official economies have shrunk and parallel economies have grown.

Not surprisingly, poverty has increased at a faster rate than anywhere else in the world. Today Africans account for one out of every four poor persons in the world—with four out of every ten Africans living in conditions of absolute poverty.[16] The average gross national product (GNP) per capita for the region is US$492, but in 24 countries it is under US$350, compared to an average of US$880 for all developing countries and US$4,160 for the world as a whole. The percentages of the population having access to health services, safe water and sanitation are 51, 40 and 31, respectively; and average calorie supply per capita is only 92 per cent of requirements.[17] Desperate as these statistics sound, they are even worse for children and women. The mortality rates for infants (under twelve months) and children (under five years) per 1,000 are, at 101 and 160 respectively, again the highest of all regions in the world. The percentages of children who are underweight, malnourished 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 immunized.[18]

Beyond these statistics lie unfolding stories of human desolation. Take the following passage from one woman's experience in South Africa:

> My husband lost his job about five months ago. It was a big shock but we thought we could cope. I was earning a reasonably good wage. We had to cut a few corners though. We had to eat less meat. We had to save on all kinds of things ... Then two months ago I lost my job. We were desperate. There was no money coming in now ... Now they've cut off the electricity and we're two months in arrears with rent. They're going to evict us, I'm sure, we just can't pay though. My husband decided to go to Jo'burg ... I don't know where he is ... Sometimes [the children] lie awake at night crying. I know they are crying because they are hungry. I feel like feeding them Rattex. When your children cry hunger crying, your heart wants to break. It will be better if they were dead. When I think things like that I feel worse ... I'm sick. I'm sick because of the cold. I can't take my children to the doctor when they are sick because there is no money ... What can one do? You must start looking. You can also pray to God that he will keep you from killing your children.[19]

[15] World Bank, *Africa Development Indicators 2000*.
[16] N. van de Walle, *African economies and the politics of permanent crisis* (New York: Cambridge University Press, 2001).
[17] World Bank, *Africa Development Indicators 2000*, p. 23.
[18] Ibid.
[19] N. K. Poku, *AIDS and poverty in Africa* (London: Ashgate, forthcoming 2003).

This woman's experience shows the innumerable mechanisms through which poverty creates a milieu of risk. She knows, even without necessarily being in possession of the relevant statistics, that 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.[20] 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.[21] 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. 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 among many Africans. Data for 2000 indicate that Africa has the highest incidence of curable STDs at 284 cases 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.[22] 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.[23] One study suggests that the presence of an untreated STD can enhance both the acquisition and transmission of HIV by a factor of up to ten.[24] 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.

Aside from STDs, there are many other ways in which poverty exposes the poor to a higher risk of contracting HIV/AIDS. Take the continent's perennial

[20] P. Farmer, M. Connors and J. Simmons, eds, *Women, poverty and AIDS: sex, drugs and structural violence* (Monroe, ME: Common Courage Press, 1996). See also W. H. McNeill, *Plagues and peoples* (New York: Anchor, 1998).

[21] P. Farmer, *Infections and inequalities: the modern plagues* (Berkeley and Los Angeles: University of California Press, 1999).

[22] UNAIDS, *AIDS in Africa, country by country* (Geneva: Joint United Nations Programme on HIV/AIDS, 2000), p. 23.

[23] World Bank, *Intensifying action against HIV/AIDS in Africa: responding to a development crisis* (Washington DC: World Bank, 2000).

[24] See www.medilinks.org/Features/Articles/Statistics.

issue of population mobility in search of work. Mobile workers are defined as those workers who work far away from their permanent places of residence and are usually unable to return home at the end of the working day. They therefore have temporary residences in the vicinity of their work sites and return home at various intervals. Such workers include, for example, truck drivers, road/dam/building construction workers, itinerant traders, soldiers, wildlife officers, seafarers, agricultural workers, miners and commercial sex workers. For these workers, being mobile in and of itself is not a risk factor for HIV/AIDS; it is the situations they encounter and the behaviours in which they may engage while they are travelling around that lead to and increase vulnerability to HIV/AIDS.

The mining community in Carletonville, South Africa, is a tragic and 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.[25] 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 KwaZulu-Natal, for example, showed that 13 per cent of women whose husbands worked away from home two-thirds of the time or over were infected with HIV.[26] Among women who spent two-thirds of their time or more with their husbands, no HIV infection was recorded.[27]

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 less 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

[25] B. G. Williams, D. Gilgen, C. M. Campbell, D. Taljaard and C. MacPhail, *The natural history of HIV/AIDS in South Africa: a biomedical and social survey in Carletonville*, South Africa, Centre for Scientific and Industrial Research, July 2000.

[26] N. S. Morar, G. Ramjee and S. S. A. Karim, *Safe sex practices among sex workers at risk of HIV infection* (Geneva: UNAIDS, 1998).

[27] M. Lurie, B. Williams, A. W. Sturm, G. Garnett, D. Mkaya and S. S. A. Karim, *HIV discordance among migrant and non-migrant couples in South Africa* (Geneva: UNAIDS, July 2000).

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.[28]

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.

Fanning a pandemic: debt, SAPs and the HIPC

A note of caution must be entered here: to acknowledge the synergistic relationship between poverty and vulnerability to HIV is not to conclude that AIDS itself is a nutritionally based disease. Equally, it is important not to deny that HIV is sexually transmitted across the African continent and causes AIDS. The argument is rather that any disease in Africa, however transmitted, must be placed in the context of the continent's underdevelopment. This is particularly important because the behavioural change hypothesis, which remains the dominant policy response to the continent's AIDS crisis, has been less than effective. At the crux of this failure is the inability—or unwillingness—to acknowledge the complex but real relationship between the continent's traditional problems and the entrenchment of the HIV/AIDS pandemic.

[28] Cited in Poku, *AIDS and poverty in Africa*, p. 24.

Take, for example, the medium-term plans (MTPs) from the leading multilateral donors—mainly the IMF and the World Bank—which have become the central organizing structures for the design and implementation of domestic response to HIV and AIDS in Africa. At the beginning of the pandemic, MTPs were primarily ways of organizing public health responses to the crisis. Twenty years into the pandemic, MTPs—in their construction and in their core elements—have remained largely focused on public health concerns.

This is particularly perverse given that our knowledge about the pandemic's impact on the continent's fragile development capacity has been sophisticated for at least a decade.[29] We have known for some time, for example, that economic need and dependency lead to activities that magnify the risk of HIV transmission and render many people, particularly women, 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 pandemic. Further, the setting of the HIV pandemic in Africa creates a downward spiral whereby existing social, economic and human deprivation produces a particularly fertile environment for the spread of HIV. In turn, the HIV pandemic compounds and intensifies the deprivation already experienced by people across the continent. In this sense, AIDS is more than a disease. It is also much more than a public health crisis. AIDS in Africa is a development crisis of the highest magnitude. Of course, by treating the pandemic as a health crisis caused by a hypersexualized culture, the World Bank and the IMF can continue to pursue their structural adjustment programmes (SAP) on the continent, uninterrupted.

Yet despite two decades of intense pressure these programmes have not achieved their intended outcomes—Africa's economic stability and growth. What is clear is the adverse impact these programmes have had on the welfare of the poorest members of African societies, especially as they affect food prices, costs of education and payment for medical services.[30] In relation to HIV/AIDS, Peter Piot, the director of UNAIDS, has pointed out that 'structural adjustment raises particular problems for governments because most of the factors which fuel the AIDS pandemic are also those factors that seem to come into play in structural adjustment programmes.'[31] Thus, at a time when up to 70 per cent of adults in some hospitals are suffering from AIDS-related illnesses—placing extreme pressure on health services—many African countries have had to cut their health expenditure in order to satisfy IMF and World Bank conditionalities. Such circumstances make it almost impossible to treat those with the virus effectively, or to undertake effective campaigns to reduce high-risk behaviour

[29] R. Baggaley, P. Godfey-Fausset and R. Msiska, 'Impact of HIV on Zambian business', *British Medical Journal* 309, 1994, pp. 1549–50. See also G. Kambou, S. Devarajan and M. Over, 'The economic impact of AIDS in an African country: simulations with a general equilibrium model of Cameroon', *Journal of African Economies* 1, 1992, pp. 109–85.

[30] Schoepf et al., 'Theoretical therapies, remote remedies', p. 91.

[31] P. Piot, address given at the United Nations University, Tokyo, 8 Aug. 2001.

and provide essential resources in the fight against the pandemic. For example, in Tanzania—where over half a million children are orphans as a result of AIDS —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. The Tanzanian government spends in excess of three times more on debt servicing each year than it does on health care.[32]

In aggregate terms, the total long-term debt of the continent stood at US$315 billion in 2000.[33] Although this figure is quite modest by global standards—Brazil, for example, owed more than US$120 billion at the end of 2000—compared to the continent's ability to repay it 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 billion ($179 a person) at the end of 1996 may not seem like much compared to the US$11 billion Europe spent on ice-cream in 1997. But it was almost thirteen times the amount the country earned in exports in 1996. Ethiopia used the equivalent of 45 per cent of its US$783 million 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.[34] 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.[35]

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 recognize 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

[32] A-L. Colgan, *Africa's debt*, Africa Action position paper (Washington DC: Africa Action, July 2001), p. 4.
[33] UNAIDS, *AIDS, poverty reduction and debt relief* (Geneva: UNAIDS, 2001).
[34] Colgan, *Africa's debt*, p. 12.
[35] J. D. Sachs, *Macroeconomics and health: investing in health for economic development*, report presented to Gro Harlem Brundtland, Director-General of the World Health Organization, 20 Dec. 2001.

September 1998 only eight countries, including five in Africa, had qualified for debt relief packages adding up to about US$6.5 billion. Uganda was the only African country that had actually reached the 'completion point', receiving about US$650 million in debt reduction.[36] To supplement World Bank and IMF funds, 15 donor countries (not including the United States) had paid or pledged about US$300 million 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 industrialized countries announced the HIPC II initiative. This initiative proposed incremental but noteworthy steps towards the modernization of the original HIPC initiative. Chief among these were 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, was in the detail.[37] 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.[38] 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 after 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 marginalized countries on a path of sustained growth. If one goes by the experience of the recent budget compromises in the US Congress, funding for HIPC is not at all assured. President Clinton sent a request to Congress for

[36] F. Cheru, *Uganda's experience with the PRSP process: what are the secrets of its success?*, report prepared for the UN Economic Commission for Africa, October 2001.

[37] F. Cheru, 'Debt relief and social investment: linking the HIPC initiative to HIV/AIDS in Africa: the case of Zambia', *Review of African Political Economy* 86, 2000, pp. 519–35.

[38] See F. Cheru and R. Figueredo, *Debt relief and social investment: linking the 'HIPC' initiative to HIV/AIDS in Africa, post-Mitch reconstruction in Honduras and Nicaragua, and the Convention on the Worst Forms of Child Labor* (Geneva: United Nations High Commission for Human Rights, April 2000).

US$1 billion in additional funds for debt relief to heavily indebted poor countries, including 100 per cent cancellation for debts owed by 30 of them to the US government. When the final budget deal was completed in late November 2000, Congress had approved only US$130 million for debt relief, and that amount will cover only bilateral debt relief.

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 scepticism about 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.[39] 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 20 per cent among its adult population. The annual number of deaths has been increasing slowly and will reach 127,000 per annum or nearly 350 per day by 2005.[40] 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. 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.[41] As a result, labour productivity has been diminishing and HIV/AIDS is now the central concern of firms. One review of 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

39 K. Hansen-Kuhn and S. Hellinger, 'SAPs link sharpens debt-relief debate', *Third World Network*, July 1999.

40 Zambian Ministry of Health, *HIV/AIDS in Zambia: background, projections, impacts and interventions* (Lusaka: Central Board of Health, 1997).

41 UNESCO, *Trends and projections of enrollment, 1960–2025* (New York: UNESCO, 1996).

HIV/AIDS became recognized 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 billion in 1998.[42] 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 million and were paid to creditors accordingly: US$89 million to multilateral and US$30 million to Paris Club creditors. The US$123 million 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 1992–7, various creditors extended debt relief amounting to a total of US$1.873 billion, of which US$1.44 billion 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 of 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, laid bare the myth of HIPC debt relief.[43] 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

[42] DroptheDebt, 'Reality check: the need for deeper debt cancellation and the fight against HIV/AIDS', 10 April 2001.

[43] S. Booker, 'Africa's aids crisis', *Los Angeles Times*, 25 March 2001, p. 3.

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.'[44] 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.

GFA: Annan's 'big' challenge

Annan's 'bolder approach' came in June 2001 when he called on the international community to create a Global Fund for AIDS (GFA; hereafter referred to as 'the Fund'. According to Annan, it will seek annual contributions of between US$7 billion and US$10 billion to support its work on five critical HIV-related issues: prevention of new infections; ending mother-to-child transmission; providing affordable and accessible treatment; accelerating scientific breakthroughs; and providing social support to those infected and affected by the pandemic (particularly AIDS orphans). So far, the opaque and ad hoc process by which the Fund is being negotiated into existence—with a swirl of rumours, whispers and backroom intrigue driving the process forward—makes the final outcome uncertain. Yet it has the potential to transform the seemingly unstoppable march of the AIDS pandemic in the developing world, where the economic costs of a massive treatment programme remain a daunting challenge. Moreover, its existence could offer a number of significant opportunities, including, first, the chance to focus attention on the wider crisis in global health provision and to kick-start a coordinated response involving both developed and developing countries in increased efforts to meet the human right to health, and second to provide an incentive to developing countries' governments, daunted by budgetary constraints, to prioritize poverty-focused health programmes.

In real terms, the US$7–10 billion requested by Annan to operationalize the Fund is equivalent to a little more than 1 per cent of global annual military spending and a fraction of the estimated US$400 billion price tag for developing the new fighter aircraft for the American and British forces. Yet there are already signs that the campaign to raise the cash is stalling. Thus far, the combined contribution from the United States, Britain, France, the Gates Foundation and other private donations (mainly the Credit Suisse Bank) amount to less than US$1 billion. The United States was first to announce its contribution: US$200 million (later revised to US$400 million) for the Fund's first year (a level of funding, if maintained for ten years, equivalent to less than 0.2 per cent of the Bush tax cut). Unfortunately, in the rush to be first, the American government set the donor bar too low, and even this measly sum has been enveloped in a tissue of

[44] Cited in *New York Times*, 28 June 2001.

conditionalities. President Bush, in announcing the initial US donation of US$200 million, stated that the Fund should respect intellectual property rights and provide incentives for pharmaceutical research. The European Union's development commissioner, Poul Nielson, suggested that the EU would back the Fund only if other donated funds are indeed new funds—not recycled prior commitments.[45]

Herein lies the real challenge facing Annan in his quest to operationalize the Fund. Improved prevention, awareness and access to better drugs in the more advanced countries have meant that the scourge of AIDS has largely slipped from public consciousness; the little attention still given to it there is dominated by the view that AIDS is an African problem. Sadly, since the end of the Cold War, overall donor assistance to Africa has been shrinking and its pattern has been highly selective. This is true for both foreign direct investment (FDI) and official aid. Hence, of the US$2.52 billion FDI that flowed into Africa during the 1990s, just three countries (Angola, Nigeria and Lesotho) accounted for US$1.672 billion—all of them lucrative mining or oil-producing countries. If South Africa is excluded (both as a recipient and a source of FDI), five other countries accounted for another US$576 million—Republic of Congo, Côte d'Ivoire, Equatorial Guinea, Namibia and Sudan—leaving the remaining 40 countries of the continent to compete for just US$275 million in annual FDI flows. According to African Development Indicators 2001, 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 billion compared to US$17.9 billion in 1992, when development assistance to Africa reached its highest ever levels.[46]

Not surprisingly, many organizations—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 US$800 million 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 ago—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 million to take care of nearly 4 million people crowded into 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.

[45] www.fpif.org.

[46] African Development Bank, African Development Indicators, 2001 (Nairobi: African Development Bank, 2002), p. 45.

The reason for the differing responses by the international community is simple: Kosovo and Bosnia were 'loud emergencies' 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 emergency' 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.[47] 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 summarized 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.'[48] 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.'[49]

The moral calculus of inactivity

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 socio-economic 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 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

[47] Cheru, 'Debt relief and social investment'.
[48] Booker, *Los Angeles Times*, p. 3
[49] Lead editorial, *Washington Post*, 28 Dec. 2000, p. 3

these activities are programmes that address poverty today so as to facilitate socio-economic 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 globalization can indeed work to the benefit of all humankind.'[50] 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. Yet unless these dominant players mobilize quickly and effectively, the future prospects for Africa looks decidedly gloomy. In this sense the moral calculus of inactivity could be beyond computation.

[50] Sachs, *Macroeconomics and health*, p. 21.