The Review of African Political Economy (ROAPE) is published quarterly by Carfax Publishing Company for the ROAPE international collective. Now 27 years old, RAOPE is a fully refereed journal covering all aspects of African political economy. RAOPE has always involved the readership in shaping the journal's coverage, welcoming contributions from grass roots organisations, women's organisations, trade unions and political groups. The journal is unique in the comprehensiveness of its bibliographic referencing, information monitoring, statistical documentation and coverage of work-in-progress.

Editorial correspondence, including manuscripts for submission, should be sent to Jan Burgess, RAOPE Publications Ltd, P.O. Box 678, Sheffield S1 1BF, UK. Tel: 44 +(0)1226 74.16.60; Fax 44 +(0)1226 74.16.61; editor@roape.org.

Advertising: USA/Canada: The Advertising Manager, PCG, 875 Massachusetts Avenue, Suite 81, Cambridge MA 02139, USA. EU/Rest of the World: The Advertising Manager, Taylor & Francis, PO Box 25, Abingdon, Oxon OX14 3UE, UK. Tel: +44 (0)1235 401 000; Fax: +44 (0)1235 401 550.

Business correspondence, including orders and remittances relating to subscriptions, back numbers and offprints, should be addressed to the publisher: Taylor & Francis Ltd, Customer Services Department, Rankine Road, Basingstoke, Hants RG24 8PR, UK. Tel: +44 (0)1256 813 002; Fax: +44 (0)1256 330 245

Permission to reprint or translate material from Review of African Political Economy should be sought from ROAPE Publications Ltd. Consent to copy for general distribution, for promotion, for creating new work, or for resale must be specifically obtained in writing from ROAPE Publications Ltd.

ISSN 0305-6244

©2000 ROAPE Publications Ltd
Editorial: Special Issue on AIDS

Carolyn Baylies & Janet Bujra

The spectre of AIDS is haunting Africa. If present trends continue, its impact on development and society will be devastating. This issue of ROAPE looks at some of the graphic realities of the situation as faced by those who must cope. It also explores the struggles and the debates around who might take responsibility – for delivering programmes of prevention and care, for making affordable drugs available to those in need and for dealing with the consequences of loss wreaked by the epidemic. If families bear the heaviest burden, what role do states, NGOs and international agencies have in managing the crisis and in averting the worst scenarios? These questions have to be considered in context. The epidemic comes at the worst possible time for Africa, already facing economic crisis and indebtedness, the deliberate downsizing of national governments through externally-imposed neo-liberal policies, as well as riven by more armed conflicts than any other region of the world.

It is not surprising that African governments have often failed to fully acknowledge the enormity of the challenge which AIDS poses. But it is vital to recognise that this has frequently hampered the effective mobilisation of strategies for prevention, mitigation and support. The most recent example is President Thabo Mbeki's questioning of the link between HIV and AIDS and his thesis that it is poverty which propels the epidemic. Arguments about the linkage between HIV and AIDS are clearly related to the search for a cure or for effective prophylactics, and thereby not unimportant. But they divert attention from dealing with the current realities of a rising number of protracted deaths, particularly amongst the youngest, the fittest and most productive members of society. And whilst poverty may enhance vulnerability in several ways, it is not in itself the cause of the epidemic in Africa. Conversely poverty is everywhere deepened by the impact of AIDS.

AIDS cannot be sidelined. It is not a matter of marginal concern, nor merely a health issue. It is profoundly grounded in social behaviour and underwritten by social relations of inequality. Its impact is wide-ranging, threatening not just economic growth, but its very sustainability; undermining the integrity of affected households; dramatically lowering life expectancy; weakening the very social capital upon which international institutions increasingly place their faith; exposing the lack of government capacity – jeopardising the future.

AIDS is also a crisis reflecting patterns of inequality, both those operating on a global basis, as well as those internal to affected countries. The ‘Statement of Concern on Women and HIV/AIDS', issued at the International Conference on HIV/AIDS in Durban in July 2000, draws particular attention to the significance of gender inequality for the course of the epidemic and its impact. AIDS also feeds on inequalities defined by class, generation, race, ethnicity and political power. It is this same array of factors which must be addressed in strategies aimed at limiting its further spread and fashioning means for social and economic recovery. AIDS is deeply embedded in the dynamics of political economy.
There are many facets to the question of HIV/AIDS in Africa. The articles in this volume touch only on some of them, but individually and collectively they point to the importance of situating the analysis of the epidemic and its effects into a framework of political economy. They thereby address the power relations which drive the epidemic, frustrate the possibility of alleviation, care and recovery – and operate not just to marginalise those with HIV or AIDS, but to relegate entire populations to a position of vulnerability. Unless able to step outside the system as privileged individuals, few have access even to basic care.

Among themes running through the articles in this issue are those relating to the way epidemic falls heavily on households. Rugalema details how many households are devastated by the effects of AIDS, and may disappear or become submerged into other households. AIDS is not like other disasters such as floods or drought, or even war. In these cases recovery can eventually be anticipated. AIDS is cumulative in its effects on households. Heterosexual and mother to child transmission often mean serial deaths within the same family. AIDS compromises future food security through deaths and the time taken up by care for the dying. By virtue of claiming adults in their prime, it leaves orphans stranded, sometimes with few resources to carry through to adulthood, and with elders having to shoulder parenting roles which they had assumed to be well past. The impact on households is all the greater following the collapse of health services and reduced accessibility to them, given the imposition of fees in the wake of structural adjustment conditionalities. As Soori Nnko and colleagues note for Tanzania, care is increasingly concentrated in the home and then made a virtue of through the promotion of home based care initiatives which enlist the compassion of ‘community’ members – in practice, almost invariably women. Women, families and poor people have no choice but to care for the sick, generally without additional resources, and often without the information or counselling which would allow them to extend life and relieve suffering, as well as protecting themselves and others from the further spread of infection. Even in this dire situation, carers do learn from their experience and could be a resource for others, if their knowledge were recognised.

Where medical facilities are more developed, as in the case of South Africa, questions emerge concerning the appropriateness of care. As Seidel shows, discourses around care which in the past represented victories against pressure from the global market, now operate in potentially counterproductive ways. Seidel looks specifically at the case of advice given to mothers about breastfeeding. Noting that health professionals often inhabit different social worlds from their clients and may hold unhelpful stereotypes about them (further distorted by the stigma conferred by AIDS), she analyses their resistance to acknowledging the serious risk which breastfeeding by mothers with HIV or AIDS poses to their children. The dilemma about what advice is appropriate may be even more acute in other countries with more limited access to powdered milk or clean water – or indeed where there is little testing of women and hence limited certainty about their HIV status.

Several of our contributors address the question of how the crisis of AIDS might be managed and who are the appropriate agents in this urgent task. The articles by Scott and Cheru (each with reference to Zambia) address strategies which both engage governments and attempt to fashion a broader, international endeavour in response to AIDS. Cheru discusses an international initiative for combining cancellation of debt with the building of a fund to finance AIDS initiatives. This incorporates means for ensuring that the funds are not hijacked by government and diverted towards other, perhaps more politically attractive (or more private) ends. The dangers of this
in situations where authoritarian state forms persist is evident. Scott is keen to promote the state as the most effective agency in addressing AIDS and delivering recovery plans. He reviews an earlier initiative in Zambia to confront the impact of drought, arguing that the state planning and multisectoral coordination that made this initiative so successful could be harnessed again for confronting AIDS. As Rugalema notes, there may be hazards in drawing parallels between the disasters of drought and AIDS. But the thesis does return us usefully to older debates about the efficacy of the ‘developmental state’, especially at a point when neo-liberalism has rendered such ideas anachronistic. Does AIDS present a challenge which cannot be addressed without rebuilding the state, or at least increasing its capacity to deliver basic health and education services to its citizens?

A third piece, by Gray and Smit, concurs with Cheru and Scott, in noting how initiatives at the national level are tightly constrained by global dynamics, whether operating through markets, donor agendas or the specific rules of engagement negotiated by the WTO or the IMF. Gray and Smit argue powerfully that the threat of AIDS must be addressed at a global level and that it is not unrealistic to demand a global response. However, there is also an underlying frustration detectable through all of this with how power relations, between, within and across nations, prevent the cries of those at the ‘bottom’ being heard and responded to. This is exemplified not just in practice, but also at the level of theoretical discourse.

Rugalema explicitly highlights the way in which the notion of ‘coping’ has been foisted on households and communities in accord with broader neo-liberal ideologies of self-help and individualistic solutions. Households are abandoned to cope, to get on with it, to bundle together their assets in anticipation of future disasters (of whatever sort) and develop effective strategies to deal with them. Nnko et al. describe just such outcomes. In a sense (and despite statistics showing sharp falls in life expectancy and a rising tide of funerals within so many communities) AIDS remains hidden within families and remote rural areas. Nor can it be so easily addressed, as famine might be, through short term deliveries of emergency relief. State aid, even international support, cannot transform behaviour at an intimate level, though it can mitigate the consequences of epidemic.

It is not unreasonable to point out that in Africa the terrain of poverty makes the provision of anti-retrovirals unaffordable, given the market control exerted by multinational drug companies. But it also has to be conceded that in some of the most severely affected countries the medical infrastructure is inadequate to the task of storing, appropriately dispensing and effectively monitoring the use of such drugs. There is also a clear prior need for sufficient testing facilities to diagnose HIV, for basic health care to ameliorate the effects of opportunistic infections, for enough food so that undernourishment does not make for greater vulnerability to infection. AIDS uncovers some very fundamental development issues which have to be tackled locally. Perhaps the task is just too great, and yet, as the contribution of Gray and Smit suggests, AIDS lays bare the need for global solutions – at the same time as disclosing how AIDS is a manifestation of global contradictions. Their query – ‘Is a global welfare system [one which is] powerful enough to counter the oligopolists, any less fanciful than the ideal of ‘Health for All’?’ – deserves serious consideration.

There are other issues on the agenda of AIDS analysis and action that we have not had chance to engage with here – in particular the shift in AIDS discourse from a focus on those seen as vulnerable – especially women and young people, towards the powerful, who might be more effectively targeted as driving the epidemic.
includes not only states, multinational drug companies and international financial
institutions, but also men, whose behaviour is increasingly seen as a contributory
factor in spreading AIDS. It also important to disclose the extent to which people in
Africa are fighting back through organising themselves in the work of prevention and
care. This is not just manifested in the work of indigenous NGOs, though some of
them have developed impressive innovative approaches – it is also to be seen in small
groups of activists in urban neighbourhoods and rural settings, who, despite their
relative poverty, lack of skills and resources, nevertheless throw themselves into the
struggle to avert disaster. We hope to extend our reach in a further issue of ROAPE to
include these other agendas. This is a call for contributions.
Overview: HIV/AIDS in Africa: Global & Local Inequalities & Responsibilities

Carolyn Baylies

This issue of the Review is devoted to an examination of the HIV/AIDS epidemic in Africa, an emergency which compromises the future of so many on the continent, yet is persistently underplayed. The depth of need it has generated has scarcely been measured and not even begun to be met. Although increasingly acknowledged to be grounded in social behaviour and systemic inequalities, HIV/AIDS is still treated predominantly as a health problem. At the same time, far more attention continues to be paid to the (admittedly crucial) issues of prevention and care than to the economic and social impact of AIDS and the ways it can be addressed and mitigated.

This introduction to the issue expands upon general points made in the editorial and reviews some of these issues by exploring two aspects of the multi-layered context of the AIDS epidemic:

• The question of what African governments should and can do in the face of AIDS, and

• The viability and potential of the International Partnership on AIDS in Africa.

The argument here – and running through the contributions to this issue – is that AIDS must be seen within the broad context of political economy. Economic relations involving debt, dependency and external determination of economic policies set the wider framework within which the ‘expendability’ of lives is determined. Social divisions and conflict along lines of gender, generation, class and race describe patterns of vulnerability. Power relations between individuals, groups and nations are critical to the way HIV is spread and to the manner in which responses to the epidemic are fashioned. Political will is crucial to the epidemic being recognised as a social and development issue; to challenging the stigma attached to those who are infected; and to determining priorities for blocking its path and mitigating its impact. But the exercise of political will is constrained by the capacity of governments to respond. Attempts of communities to support those affected and ensure their collective survival are restricted by the resources at their command. The ability of women and young people to protect themselves is frequently affected by their position of economic dependency.

The layers of inequality and of inequitable power relations which set the context of the epidemic are paralleled by layers of differentially circumscribed agency – at global, national and community levels, as well as at the level of the couple and the individual. From the perspective of social justice and human rights, these in turn imply layers of responsibility towards fellow human beings, citizens, neighbours, partners, oneself and one’s children. What is crucial, not just for explaining the course of the epidemic
but also for crafting strategies of intervention, is recognition of the structural connections between these layers of inequality, agency and responsibility. The individual can be exhorted to change his or her behaviour, but may find it difficult to do so in the absence of an enabling environment which not only sets up a moral imperative to change, but also facilitates the process. Access to condoms, elimination of legal discrimination against women, and expansion of economic opportunities may all be instrumental in providing a basis for less ‘risky’ behaviour.

Communities with high rates of HIV and AIDS-related mortality may be exhorted to expend social capital or to fabricate communal safety nets (Donahue, 1998). But the very depth of the impact of HIV/AIDS may prevent successful mobilising of assets and a sustained outpouring of public compassion. The real costs such communities incur need to be fully acknowledged and their efforts facilitated. The emergency they face needs to be treated with the same urgency as drought or floods and with due attention to the need for long term developmental assistance.

Governments may be exhorted to provide public goods and co-ordinate concerted AIDS campaigns (Squire, 1998), but as long as they are burdened with debt servicing, their capacity to expand welfare and health care provision for those in need, or to construct viable means of mitigation and programmes of recovery for affected households and communities, will be restricted. Debt relief and appropriate assistance, at levels consistent with need, are urgent priorities.

What African Governments Should & Can Do

The Joint United Nations Programme on AIDS (UNAIDS) has persistently called for national AIDS programmes to be publicly supported at the highest political level. Instead there has often been a stance of denial or, alternatively, official acknowledgement of the need for an AIDS policy coupled with a persistent failure to accept the depth of the crisis or the urgency of the situation, much less to follow through on construction of a comprehensive policy. It is as if, having officially conceded the presence of AIDS, governments then go about their business – fighting wars, co-opting or undermining opposition elements, issuing statements about ‘development initiatives’ – all with nary a whisper about the impact of AIDS on all aspects of social and economic affairs. They may make gestures on World AIDS Day or when a ‘Partnership group’ visits, but otherwise it is ‘business as usual’ with AIDS barely figuring.

In South Africa, by contrast, AIDS has become a major political preoccupation. But here President Mbeki has maintained a campaign of scepticism, unwilling to acknowledge how far the spread of HIV threatens the future of the nation, unwilling to accept that some interventions could reduce transmission from mothers to their children. His emphasis on poverty raises an important issue. Poverty, deprivation and denial of human rights all figure in the construction of vulnerability to HIV. Ultimately it is these underlying factors which must be addressed. Yet a stance which at the same time denies the virulence of the HIV virus and its link to deaths from AIDS serves – unwittingly or otherwise – to delay a concerted fight against AIDS and prevent support to those living with HIV or AIDS or vulnerable to infection. It is important to call into question the international power relations which contextualise the epidemic and to carefully scrutinise scientific research and medical interventions, but not to the extent that this becomes negligence and allows the epidemic to grow. In
this regard former President Mandela's recent and forthright statement about the need to confront AIDS is a particularly important one (Daily News, 28 September 2000).

On the international stage, consideration of what approach should be taken in the face of the AIDS crisis has seen a gradual shift of emphasis toward what has come to be known as an expanded or enlarged response (Tawil et al., 1999; UNAIDS 1998). Rather than focusing on individual behaviour or on medical interventions, this takes account of the structural context in which AIDS occurs and calls for this context to be addressed in strategies aimed at countering the epidemic and in the design of programmes of care. It challenges the social, economic and cultural circumstances which create vulnerability to HIV. As Topouzis and de Guerny (1999) argue, it may incorporate a human centred approach premised on participation and empowerment and oriented toward development and sustainability. An important example of adherence to this enlarged response is a resolution passed by the World Health Assembly in May 2000, which affirms the need for HIV/AIDS programmes which combat poverty and advocates both the cancellation of debt and reduction of unemployment, alongside improvements in public health (Af-AIDS, 805, 27 May 2000, af-aids@hivnet.ch).

Yet the validity and efficacy of such an approach is not without its critics. A recent article (2000) by M Ainsworh (with the Development Research Group of the World Bank but writing in her personal capacity) and W Teokul (a member of the Thailand's National Economic and Social Development Board) argues that in the context of scarce resources and limited administrative capacity, it is more appropriate – indeed imperative – for governments to prioritise and to undertake fewer initiatives selected on the basis of cost-effectiveness. Advocacy of cost-effectiveness as a criterion for assessing policy and modes of intervention is hardly new, emerging as it has in debates about primary versus selective health care and the appropriate focus of the Safe Motherhood Initiative. Cost-effectiveness is a tried (and tired) principle underlying the World Bank's approach to the relationship between health and development; it underpins the use of the notion of Disability Adjusted Life Years (DALYs) as detailed the 1993 issue of the World Development Report and finds its way into the formulation of 'action plans' at many levels.

Ainsworth and Teokul (2000) recommend that a cost-effective response to AIDS should be built on a small core of objectives, defined in terms of achievable and measurable outcomes. Governments, they say, should address four areas – overall coordination, prevention, care and mitigation – and should 1) monitor national programmes and provide public goods, 2) ensure behaviour change among those with the riskiest behaviours, 3) ensure universal access to treatment for opportunistic infections and 4) integrate AIDS into poverty alleviation strategies. Their position warrants serious consideration given the urgency of the emergency posed by AIDS, 'wastage' caused by the partial activities of NGOs and donors, the ambivalence of governments in acknowledging the depth of need, and the difficulty of designing effective measures for attacking the problem. But it also warrants close critical analysis, not least as regards how far any of these priorities can be defined in respect of 'measurable outcomes and impact', how small a core they really constitute when taken together, and whether cost-effectiveness is the most appropriate measure of interventions aimed at stopping the progress of the epidemic.

Ainsworth and Teokul (2000) allude briefly to the role and responsibility of the international community in three areas:
• assessing the cost-effectiveness of increased availability of drugs for treating opportunistic infections (effectively setting anti-retrovirals aside as beyond the reach of the great majority of those with HIV and AIDS in poor countries);

• promoting private-public partnerships to develop vaccines and microbicides (since low incomes of potential purchasers will again provide little incentive to the private sector);

• ensuring the production of a number of 'global public goods' such as knowledge and technology (without fully addressing the probable complaints from some quarters about patents, profits and intellectual property rights).

But the burden of their paper is to put responsibility squarely on the shoulders of governments. It is governments who must formulate plans, manage programmes and co-ordinate efforts around AIDS. As indicated by the account of Scott (in this issue), there is a clear need to gain control over the myriad and often disconnected activities of players in the field of AIDS work. Governments working responsibly on behalf of their citizens need to rein in the donors and international NGOs which often follow their own agendas, pull together the activities of various ministries, enlist the contribution of the private sector, and channel assistance to the many community based organisations which have arisen to meet local needs.

There is also a need for governments to take charge of providing the sort of public goods referred to by Ainsworth and Teokul (2000) and by Over (1998, 1999) and Squire (1998) (Ainsworth’s colleagues at the World Bank), as being crucial to prevention campaigns. Governments, they argue, have a responsibility to provide information and health education, particularly where asymmetries occur in the distribution of information. They also have a responsibility to provide incentives to change behaviour, by subsidising condoms, for example and, where appropriate, promoting needle exchange programmes. The position of Ainsworth and Teokul (2000) in respect of prevention is upbeat: ‘we already have the tools to prevent HIV infection and AIDS’. The problem, they say, is that such tools – increased condom use, treatment of STDs, reduction in the number of sexual partners, safe injecting behaviour, and drugs for the prevention of mother to child transmission – are not being used.

Why is this so? Why in so many cases are such tools not utilised, or at least not to good effect? Is it because of incompetence or perhaps limited capacity? Lack of political will emerges as a possible explanation, fostered by denial in the face of a highly stigmatising disease. Scott provides a further explanation: that AIDS presents an uncomfortable arena for politicians to enter and one which they calculate is unlikely to gain them popularity and votes. As Ainsworth and Teokul (2000) note, politicians are reluctant to tackle the problem of AIDS, embedded as it is in the realm of sexual behaviour and, moreover, in what many regard as immoral or illegal activity, until a critical mass of ill health or mortality forces their hand, by which time it is too late. Governments generally back off from intrusion into relations of intimacy. Few venture, as has China in its population control programmes, for example, toward making strong prescriptions about the precise number of children couples should have or when they should have them. Yet even that intrusion was premised on private behaviour within the moral confines of marriage, not outside it. AIDS appears to reside in that murky area beyond morally acceptable behaviour, although in reality it quickly exposes the illusory nature of any rigid divide between what is proper and what is not.
But there are other constraints on governments, as is well illustrated in Cheru's account (in this issue) of the grip which debt servicing continues to have on some of those countries worst affected by AIDS. Ainsworth and Teokul (2000) admit that 'severe financial and administrative constraints' often apply, but they, and others, need to couple this admission with identification of the origin of these constraints and recognition of the extent to which they are a function of historical experience and global market forces rather than a given or the consequence of incompetence or 'limited capacity'. The hypocrisy of donors and international organisations must be called into question given their articulation on the one hand of the huge gap in funding measures to combat the AIDS crisis and, on the other, the relative paucity of their own contributions (and beyond this the tendency for what is offered to be bound up in conditionalities or formulae which merely exacerbate the situation). According to James Wolfensohn, President of the World Bank, official assistance stood at some US$160 million in early 2000 as against an estimated need of as much as US$2.3 billion (UNAIDS, 2000a). Although the World Bank has increased the funds it has itself made available, its terms have not always been welcomed. Thus in October 2000 a number of SADC (Southern African Development Community) countries were reported to have rejected a US$3.8 billion World Bank loan to 12 African countries intended to assist with the fight against AIDS, the Health Minister in Zambia arguing that the loan would only deepen the country’s debt burden and sit uneasily alongside calls for debt cancellation (health-l@hivnet.ch, 681, 12 October 2000).

None of this is to deny that governments do have responsibilities in regard of the health of their citizens and that the role of governments is crucial in those countries hard hit by AIDS, with delays or denials having contributed to the depth of the problem. The question is where the emphasis should be placed and the specific modes of intervention which are most effective. Ainsworth's and Teokul's (2000) recommendation regarding prevention - that governments should concentrate on 'ensuring behavior change among those with the riskiest behavior' - has the feel of reasonableness about it. It is not a new suggestion. Over (1998) contends that perhaps the most important lesson for governments to take on board is the need to reduce the impact of AIDS through vigorous attempts to change the behaviour of those most likely to contract and spread the infection. But who are the people with the riskiest behaviour and what sort of behavioural change is envisaged for them?

A focus on those with the riskiest behaviour – via a targeting approach with an eye to cost effectiveness – can entail a sliding away from UNAIDS' emphasis on human rights towards reassertion of the notion of risk group, which early in the epidemic served to demonise and stigmatise certain groups; this need not necessarily follow. Yet a tendency to view those with the riskiest behaviour as socially marginal can often creep in – as when, for example, they are portrayed as difficult to access, already stigmatised, not forming a strong political constituency, or engaged in illegal or immoral behaviour. Sex workers or drug users are obvious cases in point. For countries where transmission is predominantly heterosexual, however, this view about marginality implies an odd notion of who is engaging in risky behaviour. In practice as in the case of Thailand – hailed as having the most successful programme of prevention to date – it was men who frequented brothels who were targeted, as well as sex workers. Not all men visit sex workers, engage in casual sex, have more than one partner, or are promiscuous. Not all women are faithful. But men are more likely than women to have multiple partners. And such men are not marginal, nor is their behaviour necessarily aberrant. The point was acknowledged in a focus group among traditional healers in Kanyama, a neighbourhood of Lusaka, during research on gender and AIDS.
'To make a very honest contribution', said one, 'we the men, are the problem'. Another concurred: 'I am a man, but I cannot shield myself from this blame. Talking about HIV/AIDS infection, the people who are primarily responsible are the men. It is not practicable for me to flirt around with other women hoping that I will use a condom with my wife.' ... 'men are the ones who make propositions to women' (quoted in Baylies and Bujra, 2000).

The recommendation should thus be more emphatic in specifying that it is men, in particular, who should be targeted through prevention campaigns. As Foreman (1999) has forcefully argued, because men constitute a 'core group' in respect of AIDS, by virtue of comprising that group both liable to contract and transmit the virus, they must be recognised as driving the epidemic.

But how should this targeting occur? Only by getting men to use condoms when visiting sex workers? This was a strong element in prevention campaigns in Thailand. Taking up the theme, Over (1999) argues that government intervention which subsidises men's use of condoms with 'outside partners' may have positive effects for the welfare of their wives and may yield more immediate results more effectively, and less controversially, than interventions aimed at improving the bargaining power of wives. Challenging gendered power relations within marriage is more likely to yield resistance. Yet there is a danger that such an approach side-steps the deeper structural relations of inequality which lie at the heart of the epidemic. A stronger argument is that the mutual interest of men and women – in the survival of themselves, their children, their communities – rests on a fundamental transformation of gender relations towards greater equity, openness and autonomy (Baylies and Bujra, 2000). It is this which demands attention.

Ainsworth and Teokul (2000) acknowledge the merit of an expanded response to AIDS in taking fully on board the 'social and contextual factors' which condition individual choices, but contend that these factors can only be addressed in the long run. And yet this is precisely the nub of the problem. If they are not addressed, then behaviour change may only be partial. If they merely 'skim the surface' – addressing the problem at a superficial level – it is questionable whether interventions can be truly cost-effective. In the face of the interlocking structures of inequality which inform the spread of AIDS, there may be a tendency to conclude that not everything can be done at once, and so outcomes which are measurable in terms of cost-effectiveness may seem preferable. Yet the underlying structural contradictions which AIDS exposes – the inequalities which drive the epidemic – must be addressed and challenged, not ignored or papered over.

What is crucial is to ensure that interventions adopted are consistent with and push forward the long term structural changes and transformations required for the epidemic to be truly halted (Baylies and Bujra, 2000). There is need, for example, to focus on masculinity(ies) and its potential harmful effects as played out through HIV infection and deaths of both men and women. It is not just male 'responsibility' in using condoms during their encounters with sex workers which should be promoted, nor yet female condoms which, while apparently empowering women, do so secretly – without effecting a more fundamental change in gender relations. It is greater equality between men and women along all dimensions which is required.

In tackling the epidemic, it is not just prevention which must command attention, of course, but care of those affected with HIV or AIDS, mitigation of the impact of HIV/AIDS and assistance in aid of the recovery of individuals, households and
communities which have been affected. Questions of care relate both to the balance of
provision between households and the public sector and the extent to which medical
assistance should or can be made available. The recommendation of Ainsworth and
Teokul (2000) in this regard is that there should be 'universal access to cost-effective
drugs for palliative care and treatment of opportunistic infections'. The logic of cost-
effectiveness points away from the provision of anti-retrovirals, given the limited
medical infrastructure to ensure their effective use. Clearly there is also an issue of
cost, as detailed by Gray and Smit (in this issue), and the need to interrogate the
operations of pharmaceutical companies and the operation of global mechanisms of
protectionism. The refrain that some forms of medical intervention are 'unaffordable'
cannot be left unchallenged. Yet it is surely true that there is also great need in many
countries for basic health care, the provision of which could extend lives and improve
their quality. So too is there need for proper nutrition. Were universal access to basic
health care, including treatment for STDs to become available, the situation for many
would be markedly improved. But as well as drugs, there is also a need to support
those caring for people living with HIV and AIDS. There is a tendency to assume that
communities and households will 'make do' on this score, but the costs exceeds their
means in many cases.

It is in this area of the cost of AIDS, as measured in expenditure on health care and
support, as well as in the loss of labour and hence of productive output, that
remarkably little attention has been directed. There has been some modelling of
impact on overall output, as well as on the performance of certain industries or
economic sectors. Yet as Rugalema argues (in this issue and 1999), the true costs of the
epidemic may be substantial, and yet partially hidden insofar as they are borne by
households, sometimes to the extent of their dissolution as viable units. Ainsworth
and Teokul (2000) make a gesture towards this issue in calling for the integration of
AIDS into poverty alleviation strategies, but concede at the same time that 'amazingly
little is known' about appropriate strategies for mitigating the impact of AIDS on
poverty or who should be targeted by anti-poverty programmes.

Researchers with UN's Food and Agricultural Organization (FAO) have argued for
the mainstreaming of AIDS in wider programmes of rural development and poverty
alleviation (Topouzis, 1998; Topouzis and de Guerny, 1999). But the special features
of AIDS and the specific nature of its cumulative impact may demand more than this
if there is to be any genuine recovery. Not least, the gender effects of AIDS may need
to be taken into consideration in any realistic strategy. The breadth of need may thus
cast doubt on the claims of Ainsworth and Teokul (2000) that, in the area of
mitigation, they have identified one component of a 'small set of achievable
outcomes' which stands the test of cost-effectiveness. Far too little is known for such a
claim to be justified and the extent of need in many cases is almost certainly greatly
underestimated. Nor is it likely that governments of those countries most severely
affected are likely to have the means to 'cope' with either mitigation or the requisites
of long-term recovery. The agency and the responsibility of global actors must be
invoked towards this end. The initiation of the International Partnership on AIDS in
Africa is an important marker of recognition of this pressing need.

Progress of the International Partnership on AIDS in Africa
International NGOs have been important in promoting innovations in respect of work
around AIDS on the global stage. But a pre-eminent role has been taken by UNAIDS
in assuming responsibility for monitoring the epidemic, disseminating good practice,
and calling for a sustained, indeed increased, global response. The dissolution of the WHO's Global Programme on AIDS in the mid-1990s with the formation of UNAIDS in its place, was aimed at achieving greater co-ordination at the international level by consolidating the disparate initiatives of the UN family and, despite its name, bringing in the World Bank. But it also reflected a view that AIDS is not just a health problem but requires a multi-sectoral and multi-faceted approach. UNAIDS' estimations of the scale of the epidemic have proved to be just that and have been subject to revision. Necessarily they depart very greatly from officially reported cases of HIV or AIDS and their accuracy can be questioned. But, they stand as a stark reminder not just of the overall toll of lives affected and lost, but of the extent to which AIDS is increasingly, predominantly, concentrated on the African continent, with a tendency for the number of new cases among women to increasingly edge above those among men.

In recognition of this changing pattern - whereby AIDS both exposes patterns of inequality and deficits in human rights within countries and reveals similar patterns of inequality, poverty, indebtedness and dependency among nations – particular attention has been focused on Africa. This is signified, among other things, by the formation in early 1999 of the International Partnership on AIDS in Africa by the co-sponsors of UNAIDS (IPAA, 1999a; see Baylies, 1999). It has as its primary goal to 'curtail the spread of HIV, and to reduce sharply the impact of AIDS on human suffering and on the development of human, social and economic capital in Africa' (IPAA, 2000d).

The Partnership initiative purports to put pressure on the global community – not least on the private sector – to take up its moral and material responsibility in respect of AIDS, while at the same time calling for agendas to be set by African governments. It calls for collaboration on a more equal basis, while simultaneously pre-empting this through an insistence that governments should demonstrate political will and develop strategic plans along lines acceptable to the donors and the international financial institutions. It is an initiative steeped in good will, a strong dose of paternalism, and a deep sense of urgency, exposing the contradictions dogging attempts to fashion consensus and the illusion of co-operation out of the stark inequalities that sustain the epidemic. The notion of partnership has important resonance across many of the relationships between donor and recipient countries, reflecting an apparent concern to shift attention away from external control, conditionality and abuse of sovereignty, toward a more amicable notion of collaboration. And yet such partnerships can hardly operate on equal terms, in this case no less than others.

At its launching the objectives of the Partnership included: 1) mobilising political support at the highest level, 2) supporting the work of African governments, 3) strengthening technical resources and services, 4) mobilising financial resources and 5) enlarging itself. Its specific goals and objectives altered slightly after an initial period of consultation. According to the Framework for Action which subsequently emerged, the Partnership was to assist countries through 'collective efforts, promotion and protection of human rights and promotion of poverty alleviation' to:

- substantially reduce new HIV infections;
- provide a continuum of care for those infected and affected by HIV/AIDS;
- mobilise and support communities, NGOs and the private sector, and
individuals to counteract the negative impact of the HIV/AIDS epidemic in Africa (IPAA, 2000d).

In accordance with the broader position of UNAIDS, the Partnership initiative is firmly based on 'an expanded and decentralised response to the epidemic'. This means, at least at the level of rhetoric or aspiration, that national responses should embrace and be built on a 'comprehensive human development agenda' and 'human rights principles' (Ibid.). At the same time, cost-effectiveness notions are incorporated as tools to assist governments in making allocative decisions. Included on the list of anticipated milestones are that strategies should be developed for involving communities, facilitating community action and ensuring rapid resource transfer to district and community levels. But communities are also listed as potential suppliers of additional funds for fighting AIDS, alongside donors, foundations and the private sector.

The precise identity of partners has been somewhat fluid throughout the Partnership's short existence. The initial co-sponsors (members of UNAIDS) indicated the importance of expanding the partnership to include NGOs, the private sector and bilaterals (IPAA, 2000a). A little over a year on, the Partnership's Framework document listed partners as African governments, the UN, donors, the private sector and the community sector (IPAA, 2000d). A further list in the Partnership's bulletins (IPAA, 2000g) comprises African governments, African and international civil society; the United Nations; the donors; NGO networks, the private and corporate sector and foundations. Sometimes the private and corporate sector has expanded to include workers and their unions (IPAA, 2000f). Sometimes civil society extends to community groups. Sometimes it includes people living with HIV and AIDS. It is at least evident, however, that all those affected and liable to assist in the effort against AIDS in Africa have been invited to become partners, hopefully working towards the same goal in a co-ordinated and concerted fashion.

How genuine the nature of partnership is remains a matter of interpretation. Indeed UNAIDS is engaged with a complex mix of partnerships in respect of this initiative – between donors and recipients, the private and public sectors, NGOs and communities, governments and those living with HIV and AIDS. With so amorphous a grouping it is perhaps not surprising that the Partnership should be facing in many directions at once, with the standpoint of the various partners informing what they make of it. And though repeated emphasis is placed on the fact that initiative should be at country level – with each country having its own goals and formulating indicators to measure progress (IPAA, 2000c) – various of its activities and consultation exercises seem almost to sideline Africans. Participants in a London meeting of the 'Corporate, Labour and Foundation Sector' of the Partnership in March 2000, for example, hosted by the Global Business Council on HIV/AIDS and chaired by a representative of Glaxo Wellcome, included representatives from UNAIDS, Bristol-Myers Squibb, InterScience, Rotary International, the Rockefeller Foundation, and some of the larger international AIDS NGOs, with relatively few Africans among them (IPAA, 2000b).

UNAIDS has assumed the role of facilitating the Partnership and nudging African governments to come on board, using the carrot of possible increased funding should they produce plans which suggest the sort of commitment donors feel able to support. In November 2000, for example, a Partnership Bulletin announced that the World Bank had decided to allocate up to US$100 million to Uganda to assist with its anti-AIDS campaign and, moreover, that it was ready to provide finance to countries
whose prevention and awareness campaigns had led to high demand for condoms and medication (IPAA, 2000i). That representatives of UNAIDS found it necessary to ‘explain the importance’ of the Partnership to a conference of the Commonwealth Regional Health Community Secretariat (CRHCS) for East, Central and Southern Africa in October 2000 (IPAA, 2000j), however, suggests the extent to which it remains an external creation outside the awareness of many African officials. It is certainly not ‘owned’ by Africans. Far from acting on the initiative of Africans or African governments, it would appear to be acting on their behalf within a changing donor and market environment, with externally circumscribed agendas. Still UNAIDS’ Executive Director’s reference to the need for South-South co-operation as ‘pre-emminently a 21st century strategy’ suggests that there is a concerted desire to foster local initiatives and to promote horizontal linkages. Indeed he characterised the Partnership itself (more perhaps by way of aspiration than current reality) as the largest example of South-South co-operation in the face of AIDS, as ‘a coalition under the leadership of African governments, bringing them together with the donors, the private sector, the community sector and the UN system around this single issue’ (UNAIDS, 2000b).

The OAU issued the Lome Declaration on HIV/AIDS in Africa at its meeting in July 2000, updating previous resolutions and committing member governments to keep HIV/AIDS high on their agendas. The declaration called on governments to ‘make it a development issue’, to recognise the sacrifices of African peoples, ‘mainly women’, to cope with the epidemic’s impact and to take personal responsibility and provide leadership in promoting the activities of national AIDS councils. It also endorsed the Framework of the International Partnership on AIDS in Africa, in the process acknowledging its external origins. OAU members’ view of the Partnership and their expectations in regard to it are revealed in the Declaration’s ‘request’ that the Partnership collaborate with the OAU General Secretariat and individual member states to mobilise additional financial resources to fight AIDS and assist them in drawing up appropriate plans of action and establishing research and training centres (OAU, 2000).

So what has the Partnership achieved? In a ‘Progress Report’ (IPAA, 2000e) issued in May 2000, the Partnership is claimed to have heightened awareness of the depth of the emergency of AIDS in Africa, as marked by its being the subject of the first UN Security Council of the new century, by the general enthusiasm of the various partners brought into the initiative and by the political commitment elicited at the highest levels in a range of African countries. Although a major plank in the Partnership’s objectives is to mobilise financial resources, the Progress Report focuses more on country efforts to demonstrate commitment as a prerequisite to gaining further assistance than on recounting achievements, thus continuing to forecast what will be done, rather than describe what has been accomplished. Indeed it provides a stark reminder of the funding gap, with resources reportedly growing at only a third of the rate at which the epidemic is itself increasing (IPAA, 2000e). Even so the progress report provides indications of some success, as in the case of a round table conference convened by Malawi in March 2000 which yielded pledges of over US$100 million in support of the country’s National Strategic Framework. UNAIDS has subsequently assisted Malawi in preparing its poverty reduction strategy paper to be submitted to the World Bank and IMF which includes a case for allocating some debt relief funds to HIV/AIDS programmes (IPAA, 2000h).

The Partnership may have been instrumental in keeping pressure on UNAIDS co-sponsors and donors in ensuring continuing funding for HIV/AIDS in Africa and in
moving towards greater co-ordination of efforts (IPAA, 2000a). But it is difficult to assess how far its networking with private sector bodies has induced more than merely the rhetoric of agreement with the Partnership Framework. Nor is it clear that any of the more high profile donations to work around AIDS – from Ted Turner and the Bill and Melinda Gates Foundation – or initiatives by Chevron Oil in Nigeria and Eskom in South Africa, can be attributed to the Partnership’s work. In terms of the partner referred to as ‘community’ it would appear that relatively little has been done, other than hold a number of conferences devoted to considering progress achieved and possibilities for the future. Yet it is precisely here – in determining how communities can be effectively supported and funds channelled to projects which include them – that much work remains to be done. This may indeed be key to the ultimate effectiveness of the Partnership.

So what has occurred on the ground? Reports of country visits under the Partnership – to Tanzania, Namibia and Ghana – reflect uncertainty about what this partnership actually is, and divergent interpretations of how it can be operationalised and, in particular, how it can assist local programmes. To a certain extent they reflect attempts to ‘speak the language of the donors’, acknowledging the need for local responsibility, recording attempts to get to grips with AIDS, but underneath it all making a plea for external support for research, technical assistance or funds.

The Tanzanian document bears the stamp of an author steeped in the language of participatory development methodologies and places more emphasis on the inclusion of those most at risk rather than on relations between governments and donors. It stresses the need to facilitate and support local response teams, optimistically suggesting that the welling up of grassroots activity will both induce political leaders to realise that ‘the solution to the HIV/AIDS problem lies in the development of social immunity’ (IPAA, 1999d) and alert donors to the need for further assistance. The Namibian report focuses on what the government there has put in place, emphasising the level of political commitment which this implies and noting that the Ministry of Health and Social Services already allocates a significant proportion of its recurrent budget to run the national AIDS programme and provide assistance to those living with AIDS. In this case, relatively little comment is made on what the Partnership might do for Namibia, save for funding studies of the economic impact of the epidemic (IPAA, 1999b).

The visiting mission to Ghana (IPAA, 1999c) was similarly briefed about local activities concerning AIDS and future plans. The report of this visit includes discussion of the potential for taking advantage of the country’s decentralised administrative system in extending the response to AIDS at district and community level. But as a caveat, the report notes that effective expansion will depend on the availability of further funding. The need for further political commitment and the necessity for translating political will into action, not least through strengthening the national AIDS control programme, is noted. But the theme of need for additional resources recurs throughout. A ‘prominent traditional ruler’ told the mission that poverty contributed to the spread of HIV and requested financial and technical assistance. It was suggested that donors should allocate new money or redirect funds remaining at the conclusion of projects and programmes towards the fight against AIDS; more specifically, it was recommended that these monies be placed in a special fund controlled by a supra Ministerial body and earmarked for HIV/AIDS prevention and control. If the Partnership thus means co-ordination and coherent planning from the perspective of UNAIDS and the donors, it implies the prospect of further assistance from the perspective of governments and communities.
It would appear that the Partnership has moved in contradictory ways during its short existence. On the one hand, there has been a transition towards greater inclusiveness with repeated insistence that the initiative should be located in Africa and that those living with HIV/AIDS should be involved in its activities. As indicated in the Partnership Framework approved in May 2000, key principles include African ownership and leadership of the Partnership at all levels: country and community priorities should drive the action, implementation plans should be based on local priorities and contexts; there should be active involvement of people living with AIDS in setting the parameters of the Partnership and its design, implementation and evaluation; and there should be equal access to appropriate treatments and other scientific breakthroughs in prevention and care (IPAA, 2000d). These aspirations are both admirable and necessary.

At the same time, however, the Partnership’s activities have consolidated around assisting countries in formulating national plans to deal with AIDS. As indicated in the Framework document:

The critical first step to co-ordinated working at country level is to develop a shared action plan, which will in most instances be incorporated into the national strategic plan; in others, they will supplement the existing national strategic plan. The key to their value lies in their role as a jointly negotiated and agreed statement of what all partners will do. For the purposes of this framework for action, they are referred to as ‘national action plans’ (IPAA, 2000d).

This is in accordance with what UNAIDS has always done to a greater or lesser extent, as did the Global Programme on AIDS before it. Increasingly, however, such activity has been oriented not just toward achieving greater co-ordination of efforts but also, crucially, towards ensuring that plans and programmes are congruent with the changing rules of debt relief initiatives. Thus the UNAIDS Secretariat has undertaken to act as an ‘informed advocate’ of exchanging debt relief for work around AIDS. It sees this role as assisting countries in putting together their policies and programmes and in drawing up national strategic plans (IPAA, 2000e) to be submitted for consideration under the Heavily Indebted Poor Countries (HIPC) programme (see Cheru in this issue). Thus, just as one set of external actors has changed the rules in response to pressure from indebted nations, another has entered the arena to assist with their compliance.

In the process the Partnership continues to face in a variety of directions at once. If it seeks to embrace civil society and communities on the one hand, it also gives voice to concern (expressed by some participants in a meeting of donors held under the auspices of the Partnership) that efforts to decentralise the response to AIDS might hinder or slow down specific interventions (IPAA, 2000c). As Scott argues, attempts to achieve genuine co-operation, while admirable, may be fraught with difficulties as different actors, operating from different perspectives, seek to shift the terms towards their own interests or perceptions. Here as elsewhere, rhetoric is not always matched by reality. Hence determination of where the locus of initiative and agenda-setting capacities actually lies is likely to correlate more closely with who commands the resources than with who has an expressed and urgent need.

It is important and necessary for African actors to be attuned to and, where possible, to exploit evolving initiatives. To the extent that debt relief is on donor agendas and can be coupled with assistance with AIDS programmes, it makes sense for countries to lodge claims and garner support, as well as to accept expertise from those willing to...
offer it in refining their bids. Yet even if further funding is obtained, questions remain as to how it should be utilised and, more specifically, how far the fight against AIDS should be integrated with broader development efforts (increasingly relabelled now as poverty alleviation). Ainsworth and Teokul (2000) optimistically claim that ‘we already have the tools to stop AIDS’. Peter Piot of UNAIDS has declared more modestly that ‘we now better understand what works’ (IPAA, 2000c). Yet there remain many gaps in our knowledge of the crisis, and real danger that the measures or criteria utilised may not in fact get at the heart of the problem. Acknowledging the burdens placed on women, the importance of bringing men in, and the urgency of supporting community action is crucial. But more important are questions of how these are to be done in ways which advance the transformations (in gender relations, in class inequalities, in global market relations) which are necessary, not just to stem the AIDS epidemic, but to move towards more just and equitable societies on the African continent and elsewhere.

Carolyn Baylies, University of Leeds, UK.

References

Af-AIDS, 805, 27 May 2000, af-aids@hivnet.ch
Gender-aids@hivnet.ch, 690, 7 June 2000.
Health-l@hivnet.ch, 681, 12 October 2000.
(1999b), UNAIDS, Joint Country Mission Report, Namibia, 31 May - 4 June 1999,
(1999d), UNAIDS, Joint Country Mission Report, Tanzania, 8-12 November, 1999
(2000f), UNAIDS, Bulletin No. 26, 1 September.
(2000g) UNAIDS, Bulletin No 27, 11 September.
(2000i), UNAIDS, Bulletin No. 32, 1 November.


Reconceptualising Issues Around HIV & Breastfeeding Advice: Findings from KwaZulu-Natal, South Africa

Gill Seidel

This article is concerned with the dynamics between health care workers and pregnant women, and advice given to women about mother-to-child transmission (MTCT) through breastfeeding in KwaZulu-Natal (KZN). Using ethnographic methods, it explores issues relating to HIV and infant feeding in settings where a period of breastfeeding is expected.

The anti-baby milk action of the 1970s remains an important point of reference, which has profoundly shaped attitudes towards breastfeeding as 'the culture of health'. For many health professionals in KZN, the breastfeeding lobby, on which the authority of many nurses depends, and its successes, are now perceived to be undermined by AIDS and the 'AIDS camp'.

International data that point to the risks attached to any period of breastfeeding have provoked a range of reactions among health workers in KZN, from suspicion attached to information 'from outside', to confusion and outright disbelief. An integral part of this study is the pattern of power relations that pertain between health workers and their patients, and the values they may seek to sustain. Many nurses hold negative attitudes about young, pregnant and largely unmarried mothers, and HIV/AIDS is an additional stigma. Nurses' professional socialisation, influencing how they construct gender, women with HIV, and 'motherhood', has an important bearing on how they interact with vulnerable young women, and on the information and advice they make available to them. These patterns will also shape the ways in which they engage with the new South African and UNAIDS policy guidelines, which emphasise a woman's right to make an informed decision on infant feeding, in what is a rights' culture. These representations, investments, and practices, are also shaped by earlier identity processes, and are shot through with images of gender, class and ethnicity. How to advise and counsel HIV+ women on how best to feed their babies raises some of the most complex and hotly debated issues in health care ethics today. It is imperative that these issues, including the ideologies and discourses that may accompany changes in breastfeeding practices, and the values they underwrite, be explored from new angles, underpinned by social theory.
Introduction

My aim here is three-fold: first, to explore how the question of reducing mother-to-child transmission (MTCT) in South Africa is being debated using the language of rights; second, how competing representations of ‘woman’ and ‘motherhood’ are also shaping responses to MTCT, and, third, what pregnant women are being told about transmission through breastfeeding in a context of high HIV seroprevalence, in a region where breastfeeding is being encouraged.

South Africa’s National AIDS Plan was framed by the language of rights. This impressive plan was drawn up initially by NACOSA (National AIDS Convention of South Africa), and subsequently adopted by the ANC government. Five years down the line, the Treatment Action Campaign (TAC) whose Global March took place during the 13th International AIDS Conference in Durban in July 2000, scheduled to coincide with the controversial opening address delivered by President Thabo Mbeki, demanded that antiretrovirals be made available to women. In early 1999, prior to the second non-racial election in South Africa, People against Women Abuse (POWA) demanded in an open letter to Mbeki that antiretrovirals be provided to all rape victims. While the more public agendas have focused attention on the responsibilities of major pharmaceutical companies, and in medical circles fierce debates have raged around the ‘cost effectiveness’ of treatment that would reduce MTCT, it is as if the right to treatment debate ended there (Endnote 1). The existence of international guidelines on HIV and infant feeding (UNAIDS/UNICEF/WHO, 1998) and, indeed, South African guidelines, both framed within the rights’ discourse, have been brushed under the carpet. Indeed, there is a dearth of information in developing countries about the dangers presented by breastfeeding, whether an HIV+ mother is receiving drug treatment or not. Somehow, this dynamic picture has been frozen, as if access of an HIV+ mother to drugs, and the affordability of such therapies, although crucial, were the only issues. However, in an exceptional move immediately prior to the July 2000 International AIDS Conference, and after a period of virtual silence on the important issue of infant feeding (other than brief references in some NGO AIDS publications), 21 South African NGOs, including the National NGO coalition, issued a significant declaration, ‘Statement of Concern about Women and HIV/AIDS’. While seeking to extend discussions around gender and power relations, they have demanded, inter alia, that formula and breastmilk substitutes be made part of the state free health programme for children (UNAIDS Epidemic Update, June 2000, Maternal and Child Health, University of Cape Town). It remains to be seen if such lobbying will have any effect.

The language of rights is the only currently available language that has popular purchase and depth to articulate the needs of both collectivities and individuals. But there are competing discourses of rights where each signifies different needs, and where a diversity of needs implies some negotiation with the groups involved – in this case the government, and the health care workers. Changing this asymmetrical relationship between health workers and patients, as well as making health care more accessible for the majority, is the political project of primary health care, identified as a government priority. But there are other considerations involved, which make for conflicting priorities. These include representations of history (including the struggle against the multinationals, like Nestlé, in the 1970s), which continue to influence and mobilise particular values supportive of breastfeeding, and which assign value and legitimacy to locally acquired knowledge, at times irrespective of the HIV epidemic. This history and its representations also encompass constructions of ‘motherhood’.
These embraces divergent opinions about women as a resource, their use and their place, all of which shape responses to the MTCT issue.

First, before embarking on a discussion of these various dimensions, it may be helpful to provide a brief outline of MTCT. In South Africa, where HIV is primarily transmitted through heterosexual contact, mother-to-child transmission is now thought to be the second major transmission route. An HIV+ mother may pass on the virus to her baby during pregnancy, during the delivery, or through breastfeeding. In South Africa, transmission through breastfeeding is thought to account for between 12 and 43 per cent of HIV+ babies, with the median risk put at 25 per cent (McIntyre, 1997; Gray et al., 1996). There are no reliable statistics about breastfeeding in South Africa, as few provide a clear definition of 'exclusive breastfeeding' (University of Cape Town, 1997). KwaZulu-Natal (KZN), where the research reported on here was carried out, is the province most severely affected by the epidemic. Approximately a third of women attending ante-natal clinics where HIV surveillance surveys are routinely undertaken are seropositive (Endnote 2). The success of trials in Thailand in 1998, conducted under the auspices of the US Centers for Disease Control (CDC), and which assumed non-breastfeeding populations, triggered demands for greater access to AZT and to combination therapies. This has led to bitter controversies within South Africa, and internationally. The toxicity of AZT in particular has been stressed by government (statement by the ANC, 9 September 1999). This attack on AZT, and especially the denial of the link between HIV and AIDS, provoked an outcry in the international scientific community. The government has created 'confusion' and 'consternation', and in a country in which 'every month 5,000 babies are born, unnecessarily and avoidably, with HIV' (keynote address at the July 2000 Durban International AIDS Conference by Judge Edwin Cameron). Indeed, one well-known militant and lifelong ANC member argued in an interview with the BBC in June 2000 that this is the kind of behaviour one would have expected from the Nationalist Party.

Encouraging if still early news of the use of nevirapine in NIH-HIVNET trials in Uganda (Guay et al., 1999) to reduce MTCT has shifted the parameters of the debate. More trials are to be carried out at the Chris Hani Baragwanath Hospital, Soweto. The interest in nevirapine, not a new drug, is that it costs a matter of pence. This means it is affordable, even to the poorest countries. But in any event, the question of infant feeding must still be addressed – and this question has far from been resolved. Meanwhile, the related question of provision of formula milk for mothers who opt not to breastfeed but who cannot afford formula, generic or otherwise, but who are deemed responsible for the health of their family, has received scant attention. Initially, this seems puzzling, as the idea of supplying generic milk would be in line with the South African government's drive towards the generic medicines route (Daily Mail and Guardian, Johannesburg, 10 February 1999). Indeed, UNICEF-sponsored AZT trials in Abidjan, Côte d'Ivoire, have already taken up this issue (Msellati et al., 2000) (Endnote 3). But not so in South or southern Africa where demand for the provision of formula milk has only exceptionally been an issue. Glenda Gray of Chris Hani Baragwanath Hospital has consistently demanded that UNAIDS and the government supply formula milk to needy mothers and accused UNAIDS of 'a cop-out' ('In War against AIDS, Battle over Infant Formula flares again', New York Times, 8 June 1997:12). But given the influence of the breastfeeding lobby, she has remained almost a lone voice in South Africa.

In 1998, new international policy guidelines and a new South African draft policy guideline, while continuing to stress the overall benefits of breastfeeding, articulated
a new right: that women should be allowed to make an informed choice about how best to feed their new baby, and should be supported in that choice. These guidelines (Evian, 1998) extend the discourse and political platform of 'reproductive rights' and 'reproductive choice', which implies an individual woman's right to self-determination over her reproductive body. Even some clinicians have commented that this rights' discourse is one of the most distinctive features of these policy documents (Pillay, 1999).

This UNAIDS/WHO/UNICEF policy shift constituted a major re-assessment of the WHO's earlier stance, according to which HIV+ mothers in developed countries should no longer breastfeed, while those in LDCs should continue doing so. For its critics, this earlier WHO position was not so much a policy as a dereliction of responsibility (Desclaux, 1994). Key South African texts and a Durban conference had alerted health professionals at an early point to the risks of MTCT (Evian, 1993; Gray et al., 1994, 1996), as had an international meeting on MTCT and infant feeding held in Durban in 1996 (Pillay, 1996). Some years later, a separate but comparable draft policy document, also based on rights, was drawn up on behalf of the STD/AIDS Directorate and the Nutrition Directorate (Evian, 1998). But despite the fact that is was circulated, and comments received, it has not been implemented. On the basis of recent ANC statements it seems now to be largely ignored and is simply gathering dust in what is clearly a policy context bristling with tensions.

Competing Discourses on Rights & Representations of 'Motherhood'

These debates on infant feeding are not simply about bio-medical and nutritional issues, although this is the impression given by conventional health commentaries and, indeed, by most AIDS networks. All kinds of investments are being defended and challenged. There is the celebration, re-enactment and defence of a certain triumphal past, in which breastfeeding constituted a major 'good news story' for developing areas, including the former KwaZulu and Natal. The fight against the multinationals that pitted David against Goliath in the 1970s may be seen as an exemplary political struggle in favour of 'the majority' and the poor, that has shaped health care workers' identities in KZN, many of whom now occupy positions of authority in nutrition and nurse training. It established breastfeeding as 'the culture of health'. Although AIDS was depicted officially as 'the new struggle', for many health care workers in mother and child health, and especially nutritionists, that new challenge is not AIDS, but how to continue to promote breastfeeding. Conflicting priorities may be seen across the breastfeeding vs. the AIDS divide. Whereas international clinical studies hitherto have all emphasised that any period of breastfeeding is risky (Burns & Mofenson, 1999), the drive in KZN has been 'to make breastfeeding safe'.

This position has been championed by Professor Hoosen Coovadia (chair of the 13th International AIDS Conference) and his colleague and trialist, Anna Coutsoudis, both based in the Department of Paediatrics and Child Health at the University of Natal's Medical School in Durban (Coutsoudis et al., 1999; Coovadia et al., 1996). Discussions with them in 1998 suggest they are driven primarily by nutritional priorities. In both public and private, they speak with passion and deep conviction about the unique advantages of breastfeeding in virtually any situation, and adamantly rule out substitutes. Furthermore, these priorities are informed not only by the international literature on breastfeeding (where the general literature makes scant reference to HIV), but have been sharpened by regional history – through first-hand exposure to
extremes of poverty and deprivation, with babies presenting with kwashiorkor and marasmus, or both. While these distressing pictures are by no means simply a snapshot of the past, of the bad old days (there are still ‘kwash’ wards and ‘kwash’ babies in some large hospitals, serving rural areas including Ngwelazane, in northern KZN, and Edendale, outside Pietermaritzburg), this situation has been largely redressed through promoting universal breastfeeding, and by constantly underlining its gains. This priority has not changed. In KZN, with few exceptions, universal breastfeeding is ‘the message’. And despite the AIDS epidemic and the risks of MTCT through breastfeeding, this teaching has been reinforced in both nurse training in the region (as in baby friendly clinics, discussed below), and in the training of doctors at the University of Natal.

What happens at the University’s Medical School, and what is received wisdom there, is significant not only for the region, but for South Africa as a whole, and for some time ahead, as it was the only medical school for many years that accepted black candidates. It was also in Durban that the first major study of the determinants of mother-to-child transmission was carried out (Bobat et al., 1997). The overriding desire of these major Durban-based players to find a way of ‘making breastfeeding safe’ for HIV+ women, and hence to try to conserve these gains, has been characterised by an eminent US correspondent in AIDS network exchanges as ‘the third way’ (Halpern af-aids communication, November 1999). However, on a wider stage, the Durban-based study on vitamin A, published in the Lancet (Coutsoudis et al., 1999) is altogether exceptional and controversial in its conclusion that three months of exclusive breastfeeding is the safest option, capable of reducing the possibility of child infection by 44 per cent. It has attracted a lot of attention, as it is the only study to have arrived at this conclusion. Unfortunately it has nothing to say about a longer period, and no follow-up was planned. It has nevertheless been welcomed in KZN and by the breastfeeding lobby.

The pros and cons of breastfeeding were of course debated at the Durban 2000 Conference (see Coutsoudis, 11 July; and for a summary of the contributions on MTCT from Africa, see Maternal and Child Health News 2000, 15, University of Cape Town). It would be a mistake to assume from the start that this is a largely North-South controversy. The issues are infinitely more complex. Rich ethnographic perspectives were represented in an important paper based on multi-disciplinary work from West Africa (Desclaux, Taverne & Alfieri et al., 2000). One South African contributor to the debate, from the Eastern Cape, argued that exclusive breastfeeding was an elitist position, given that many women who need to work in fields some distance from their homes must leave their babies in the charge of others. Exclusive breastfeeding, she maintained, was impossible under such conditions (see conference programme, breastfeeding debate, http://www.aids.com ). A revealing statement about the priorities of the trialists was made by Coovadia in February 1999 at the Durban HIV Update Conference, just before the results of their Vitamin A study were made public: ‘We have solved the breastfeeding question. Now we need to look at AIDS’.

There is important investment in breastfeeding training, including in the UNICEF baby friendly initiative clinics (WHO/UNICEF, 1992), where bottles are banned from the premises. As the result of extensive lobbying dating from the mid-1970s, breastfeeding itself has been extolled as a right, indeed, as a birthright for children and mothers. It has been promoted in South Africa through multisectoral initiatives, like the Nutrition Strategy and the National Plan of Action for Children. It has further
been reaffirmed as a right within the context of the Convention of Elimination of Discrimination against Women (CEDAW) and the 1995 Beijing Platform of Action.

Apart from the renewed nutritional drive towards breastfeeding, the controversies surrounding HIV and infant feeding also engage with competing discourses about women’s bodies and representations of ‘motherhood’. Discourses promoting universal breastfeeding carry a particular set of meanings and values about what is appropriate behaviour for a woman (Carter, 1995). They tend to be based not on a social construction of gender, but, more ‘traditionally’ on a biological view of woman, restricted to the domestic sphere; nor do they satisfactorily theorise gender dimensions of ethnicities (Mare, 1993). From this perspective, women are ‘natural’ resources. The phenomenon of woman’s depletion is ‘unspeakable’ (Maher, 1996), and ‘needs’, including the nutritional needs of a nursing mother, or her need to seek paid employment away from the home, are always contested concepts (Fraser, 1989). This more ‘traditional’ discourse is at odds with the discourse of reproductive rights and with the debates over gender and citizenship (Lewis, 1999; Walby, 1994; Williams, 1992; McClintock, 1991).

Echoing the more traditional construction, Professor Coovadia (interview, 1998) regrets ongoing trends: ‘Why has breastfeeding declined? – because women say they want to do other things with their time’. Indeed, many women are obliged to seek work in the cash economy, and in the informal sector, where conditions are not always conducive to breastfeeding. Furthermore, our interview data showed that most women are not familiar with the practise of ‘expressing’ milk, and find the idea totally unacceptable, mainly on hygiene grounds. For this reason they are likely to favour formula. This was clear from data generated from our interviews in northern KZN with women attending baby clinics, whose behaviour challenges the hegemonic representations of the ‘use’ and ‘place’ of women, of women’s reproductive bodies, and of ‘motherhood’. Community workers from the Pietermaritzburg region informed us that most schoolgirl mothers who enjoy parental support also prefer formula, not least because this option allows them to continue with their schooling. The interrelated gender issues here have been largely neglected in the literature on MTCT.

One particular dominant representation of traditional ‘motherhood’, which appeals to many different constituencies, is being given a new spin: ‘Breastfeed for a healthy nation’. In KZN, this slogan further enhances the status of local experience in a setting in which nation-building, informed by local experience and knowledge of the kind gained from practice and struggle in favour of ‘the majority’, are valued over knowledge and experiences gained ‘from outside’ (where this ‘outside’ also includes other parts of Africa). But no less significant is the way that motherhood, as constructed by this nationalist and gendered discourse ‘stands in’ for ‘the nation’. In Europe, from the 1970s onwards, there has been a substantial output of critical, scholarly and international studies on representations of gender and nation, including accounts of ‘the political breast’ (see, for example, Macciochi, 1978; Thalmann, 1982; Afshar, 1987; Seidel, 1988; Yuval-Davies & Anthias, 1989; Soiri, 1996; Laloum, 1997; Capitan, 2000). Idealised versions of motherhood and childbirth have also served as strong metaphors for political and ideological shifts in South Africa (see, for example, Gaitskell & Unterhalter, 1989; Gaitskell, 1982; Brink, 1990). Writing on the invention of national discourses and on ideology and politics, the sociologist, Meintjes, made the following observation:
In South Africa, women have been identified as ‘the mothers of the nation’. In this way black and white women have been able to influence the substance of politics within their individual communities. (...) However, the ideological discourse employed by defining the sphere of women’s actions was predominantly around motherhood, and responsibility for children (...) It was a national discourse which existed within the boundaries of different patriarchies. (...) For the success of the national project, whether this was Afrikaner or African nationalism, it was essential that women be drawn into the process. This reflected the significance given to their nurturing role as nurturers of the nation. It was imperative that women be purveyors of this nationalism to keep them within the ‘patrimony’. This gave women a special and revered place, but also allowed for their continued subordination to the broader nationalist project. Recognising and revering mothers was to deny them autonomy and authority beyond the domestic realm (Meintjes, 1998:68-69).

These issues raise more general concerns about dominant representations of the female reproductive body, its uses, abuses, and its regulation in the domestic and public sphere, including under the medical gaze. The decisions and the weighing of advice offered by health professionals to individual women, most of whom are still struggling with what their HIV positive status means to them and their family (Tallis, 1997, 1998) has not been the subject of detailed local studies.

It is true that many rural and peri-urban areas, including fringes of some informal settlements, remain under-resourced. In these settings there is a well-grounded public health rationale for highlighting the greater risks attached to formula feeding, which have been clearly enunciated in the very balanced South African guidelines (Endnote 4). However, other areas – often within the same township or rural district – have been upgraded, allowing access to electricity, and clean water supplies (May et al., 1998). These changes were frequently stressed during our discussions with community workers. However, many nurses lack detailed knowledge of the areas where most of their patients stay; indeed, in some clinics, the nurses rotate. Nonetheless, with few exceptions, as part of the breastfeeding orthodoxy and operating within a static view of their region, they continue to reiterate that ‘our women do not have choices’.

This view expressed by many nurses may be a stereotyped view of their patients and the areas where they live. Even where it is true for many women, it may not apply to all. Teachers, for example, working in poor rural areas, live close to their school. An HIV+ teacher could afford formula. The problem with such stereotyped thinking is that it deprives some women of information that might save their new baby’s life. There are further rights’ implications here, given that many nurses continue to take decisions on behalf of their patients as part of the vertical health paradigm. Vague and at times populist recommendations that ‘we should listen to the community’ fail to problematise these dimensions in that they mask hierarchies of class, age and gender.

The principal focus in what follows is on data derived from observations, interviews and discussions with different categories of health care workers in KZN, primarily in the Pietermaritzburg area. Against this background and troubled policy context, I propose to illustrate that vulnerable and unmarried mothers tend to be judged, at times harshly, by health care workers (Jewkes et al., 1999), irrespective of their HIV status, where nurses’ perceptions of these women have been shaped by a ‘medico-moral discourse’ (Seidel, 1993) which gives positive value to compliance, rather than to individual rights. As Marks’ work (1998) has shown, many nurses have little contact with ‘ordinary women’, given their professional socialisation, status, and place of residence. By virtue of the way identities were framed under apartheid and
the creation and policing of separate ‘racialised’ communities, negative and static representations by certain health care workers of other ‘cultures’ are still being reproduced, reinforcing various hierarchies. These representations impact in turn on the lives of vulnerable young patients (as, for example, the representations of some nurses of Indian origin of Zulu-speaking women, in some Pietermaritzburg city clinics).

In settings where many women are expected to breastfeed at least initially, and where they must supply an explanation if they do not, counselling HIV+ women on how best to feed their babies and informing them clearly of the risks involved must surely rank among the most complex in health care ethics today (Seidel, 1998).

Theoretical Framework & Methods
The theoretical base which grounds this analysis is that of social constructionism informed by discursive theory, especially as formulated by Foucault with regard to multiple sites of power (Foucault, 1973, 1976, 1980, 1989); and by feminist scholarship in anthropology and sociology that has highlighted the persistent dissymmetries of ‘race’, class, and gender (for example, Caplan, 1988; Moore, 1994, 1998 and especially Guillaumin, 1981, 1995) (Endnote 5). A set of basic questions run through this research:

• What images of women, women's place and the female body are in circulation?

• What values are attached to them, how, and by whom (what social actors/networks/institutions control or legitimate what passes for knowledge)?

• How and by whom are these images/representations/discourses challenged, sustained, or renewed?

A range of qualitative methods has been used. These include observation, especially in ante-natal education settings, interviews with key informants and with different categories of health care workers using open-ended and semi-structured interview schedules, elements of life histories, and more innovative techniques with certain subgroups using elements of role play as well as interactive storytelling (Endnote 6). When the constraints on nurses’ time and non-availability of a more private space made open-ended and semi-structured interviews impractical, the focus group was used. The majority of interviews with health care workers were conducted in English by the principal investigator.

Hospital & Clinic Data from Pietermaritzburg
The bulk of the interviews with health care workers were conducted in the Pietermaritzburg region (PMB). PMB, with a large rural hinterland, is the only town of any size in KZN, after Durban, and in the 1980s, and since, the region of PMB has been the site of extreme unrest. It included an important exodus of refugees, mainly women and children (Bekker, 1992; Morell, 1996; Marks, 1970). The data used below draws on interviews and observations conducted in the town clinics in Pietermaritzburg, administered by the Transitional Local Council. Short excerpts from interviews with other nurses, in ante-natal and maternity services, as well as clinic nurses, suggest some of the ways in which they are marginalising and ‘otherising’ women with HIV, as if they were not their legitimate concern. The interview at the Baby Friendly clinic (southern KZN) draws attention to the
phenomenon of suspicion attached to any knowledge 'from outside'. The more extended example illustrates how certain ethnic identities, sustained by apartheid and by certain forms of ethnic nationalism, may be shaping the perceptions of patients from other 'cultures' (Endnote 7).

First, some comments and observations about how the right to confidentiality is practised in care settings, and its effects. In general, only counsellors know the HIV status, but in practice in health settings counsellors are also nurses. The onus in clinics, especially ante-natal units, is on the patient if she asks for, or agrees to submit herself to, an HIV test. This confidentiality code (Seidel, 1996), which leading AIDS activists from legal NGOs, such as the AIDS Law Project, continue to defend, with its public health and human rights' implications (see, for example, Heywood, 2000), is controversial among a number of nurses. As one put it: 'How can we help her if we do not know her status?'

Furthermore, some nurses interviewed in PMB clinics blame the mothers who do not agree to have the test, as if this in itself would provide the total solution to the women's health care.

We offer them a test. It is free. We also give free contraception. But, you see, they still fall pregnant. They do not behave like they are responsible. They know what they are doing. They know about contraception. Now we cannot help them (...) We have these posters. [None mentions MTCT through breastfeeding]. But we cannot give them individual information. We cannot counsel them unless they ask for the test. This is because of this confidentiality thing. If it is HIV, and I think there are many like this, then they must see the counsellor and take the test. Then they will get the information about staying healthy, for them and their baby. We cannot help them.

As Lupton (1993, 1995) has commented in another context, the current popularity of testing and screening procedures is a modernist response to the threat of disease and death. There is a slippage between 'detection' and 'cure' in such circumstances. But that is not all. What is also lacking in this judgmental and bureaucratic attitude are insights into the construction of gender (Varga & Makubalo, 1996), and the role that violence often plays in sexual relationships. This is often overlooked, despite the fact that many of these same nurses will be regularly treating abused women (on violence in sexual relationships, see, for example, Wood, Mafarah & Jewkes, 1996; Wood & Jewkes, 1998; Campbell, 1992; Goldblatt & Meintjes, 1997). And as part of more 'traditional' attitudes to unmarried women who are sexually active, hostility has been shown towards young unmarried people seeking contraception (Karim, 1992; Wood et al., 1997). They are well aware of the stigma attached to HIV, but they still position themselves within a purely medical model of disease, blaming the patient for not collecting the result, or for not disclosing their status to a family member. Elsewhere, following an important Kenyan study (Temmerman et al., 1995), 'not to know' [the HIV result] has itself been proclaimed as a right.

The excerpt that follows, from a PMB clinic, is a one-to-one exchange between a clinic nurse and a first time pregnant woman who wanted to find out about infant feeding. Her HIV status was unknown to the nurse, as is the norm. It illustrates the social as well as 'cultural' distance between nurse and young patient. The nurse, in this town clinic, a health care worker of Indian origin, spoke very fast and used some relatively technical and at times quite formal, even textbook English to the young Zulu-speaking patient (for example, 'womb', 'prone', 'body fluids'). The patient's command of English was quite good, but it is unlikely that she grasped everything
because of the register and the nurse’s rapid speech delivery; and asking questions involves a different set of language skills as well as a particular social relationship. The exchange, recorded with the permission of both parties, is reproduced below.

Nurse: We expect you to breastfeed. We always say that breastfeeding is best. When baby is born, you are immediately bonding by holding your baby – he looks at no-one else. If you compare the cost of formula, breast is cheapest. It is about 20 Rands a tin, or more [weight not given].

If you breastfeed, baby is not prone (sic) to childhood diseases. There is no preparation. The breastmilk has all the right nutrients, and the right proportions. You also regain your figure more quickly. When baby sucks, the womb (sic) contracts. It’s also good against cancer: it helps prevent breast cancer.

It is easier to suck on breast than on bottle. We also say of HIV+ mother that she can pass this on. Do you know about that?

[Patient gives some sign of assent to the questions, as the nurse pauses, but seems hesitant].

Do you know about AIDS?

Patient: No.

Nurse: [explains first how it cannot be transmitted]. You only get it through body fluids [very abstract and medical, especially if the patient genuinely does not know about transmission routes. She then talks about ‘soldiers’ in the blood that protect the blood, but are under attack].

You get it from too many sexual partners. It’s on the increase. But if somebody is HIV+, they can lead a healthy lifestyle, like eat well, if they practise the things I am telling you. You can live for a long time depending on your immune system. If you still want to have sex, safer to use a condom. HIV is on the increase. There are lots of teenagers who are HIV+.

A child may be taken into foster care, and could be adopted. But his life span would be shortened. When you have sex with too many partners, you get this disease, like your people (emphasis added – author)

AIDS is like a form of cancer. Boys come with lots of STDs; and men also come with ‘cauliflowers’. Some say they have 3 partners. They say it makes them feel like a man to go around with lots of girls. With the people I see here, this is common among your people. Is it a way of life, or what? (emphasis added – author)

Patient: I did not. Now I have one man. But some say condoms do not work.

Nurse: That’s nice. Nice to have one man, and to have a baby from this one man. [turns to author]. You see, this one is a good girl. Not many like this one. She has only one man! (emphasis added – author). If your friends can’t stop having other men, it’s best to use a condom.

About breastfeeding. You asked about that, isn’t it? There is a risk that the baby may get it from the breastmilk. What do YOU think? [addressing author, who responds only with a clear nod]
But we always say that ‘breast is best’. And with this first baby, from birth to 2 years. The first milk is sticky – but it is very nutritious. You must give baby this. You must also massage the nipples, so that the baby can catch on. Baby has less chance of colic if you do that. And with breastmilk, it is easy – there is no preparation! And no germs – not like the bottle which can be dropped on the floor. All you have to do is to wipe the nipple.

**Patient:** Are there any books on breastfeeding?

Nurse: I must look. Am not sure if we still have them. [The Nurse then proceeded to give dietary advice, stressing the importance of protein and fresh fruit and vegetables, all of which are expensive]. Have you any more questions?

**Patient:** No. No more questions.

Even from this single interaction, involving a nurse with community experience, who had a joking manner, as she saw it, and was not coldly aloof, it is clear that some nurses see their role not as supporting vulnerable patients, but as telling them how to behave. The provision of care, the profile of the carer, together with her/his political and professional socialisation, and the discourses and language used, as well as the manner in which information is given, cannot be easily divorced from the act of judging. In this case, what is at issue is a certain stereotyping along ethnic lines of assumed sexual behaviours. These considerations, and the conceptual frameworks from which they derive, have been overlooked in conventional health studies concerned with nurse training and with improving health delivery. The received wisdom seems to be that health workers can be regarded as ‘clean slates’, that is, without any ideological baggage and positions, and can simply be required to undergo further periods of practical training, and all will be well. However, such training normally consists of more learning by rote, based on manuals and checklists to be memorised, as in traditional bio-medical training. Little attention is given to social theory, or its possible relevance. The hegemony of neo-positivism is still largely unchallenged in many health settings (Seidel, 1999b).

**Baby Friendly Clinics**

In KZN, a number of existing clinics are due to be accredited Baby Friendly status with appropriately trained nurses. In clinics studied on the south coast, there was no space for women to make choices about infant feeding, or to be informed about the risks of MTCT through breastfeeding – even though HIV rates in the area were high, and rising. Many nurses did not know their patient’s status, while many patients were likely to be HIV+ but not aware of it either. Notices at every point which set out the various Baby Friendly steps to be adopted set the tone as part of an unquestionable script. An interview with the clinic nurses there proved to be unambiguous and closed. The following extract is representative of the positions expressed:

**Clinic Nurse:** ‘No, I don’t think breastfeeding is a big risk for the baby if the mother is HIV+ maybe just a small risk? I think that is what they are saying – but is that true? Is that so? Who is saying this? People from here?’ (emphasis added – author).

She went on:

‘Why are they saying that? (pause). But in any case it is better that she breastfeeds. This is good and what we do here. People expect it. If she breastfeeds, the baby gets
all the right nutrients in the right proportions. He is protected from so many infections. Everything is just right – even the temperature'.

A lot of this was rote learning being reproduced from textbooks. The rejoinder – ‘the people expect it’ – also underscores the hegemonic, still largely unfractured, script on breastfeeding, and which seems to echo the ANC’s use of ‘people’, represented as a unified and democratic voice. Although problematic when used as an analytical category (as is the much used ‘community’, denoting black citizens, and areas where they live), it may serve to bond rather than to fragment. On one level, she seemed to be arguing that breastfeeding was part of her culture and, at the same time, was ‘natural’ and wholesome; in other words, that there is a synergy between nature and culture. But could it be that in doubting the evidence about MTCT through breastfeeding, and in querying or rejecting this, she was not necessarily rejecting cosmopolitan (‘western’) science, or clinical findings, as such – but, by implication, the status of this knowledge on the grounds that it was not locally produced, and for this reason lacked legitimacy. In her own words, this unwelcome message comes from ‘people not from here’. This was contrasted with her clinic’s practices where both knowledge and practices were of local (KZN) origin, and for this reason were seen as wholly acceptable and legitimate.

In one reading of her response, there appear to be accents of ‘black consciousness’, that is, an affirmation of a distinctive non-European identity. In another reading, particularly in this region, where ‘our people’, or ‘people from here’, often refers to the Zulu-speaking community, the unique value put on local knowledge could also be interpreted as an ethnic-nationalist response (that is, knowledge not originating from KwaZulu is worthless and not to be trusted). Whether or not for some nurses this is akin to an ‘ethnic-nationalist’ response, identities are not fixed, but constantly in flux. Many people have been forced into an ethnic identity by the way violence and conflict have been defined them as belonging to a particular group. Mare (1988) has argued that in these cases, it is more appropriate to speak of being ‘categorised’ into an ethnic identity rather than belonging to a particular group. Furthermore, it is important to differentiate between ‘dominant’ and ‘dominated’ ethnicities. Both, however, may be the sites of other inscriptions of power (class, patriarchal, etc). The nurse’s query and emphasis, ‘people from here?’, does call for some unpacking. In questioning the status and ‘uses’ of knowledge around infant feeding that she assumes come ‘from elsewhere’, that is, from whites, is she both acknowledging the shared experience of black women at the hands of the multi-nationals and re-asserting one of its main outcomes, the promotion of breastfeeding as ‘the culture of health’? By this interpretation she is acting as a ‘cultural broker’.

The difficulty is that it is double-edged. Some representations, involving a certain historical and cultural pride may, at times, be manipulated into making common cause with ethnic nationalism, and in particular forms may be inseparable from repression of ‘difference’, and from xenophobia. Furthermore, negative representations are constructed of women who do not conform in a hierarchical setting where non-conformity, especially by women, is grounds for punishment and exclusion. The murder of the FWA activist, Gugu Dlamini near Kwamashu in KZN, after she ‘went public’ about her HIV status, should not be forgotten. As our interviews with a support group of HIV+ women meeting at King Edward Hospital Durban indicated, some women who do not breastfeed can be beaten and insulted by a male family member to force them to conform (Seidel, Sewpaul & Dano, 2000).
Conclusions

The broader picture in our study region suggests that the slogans 'breast is best' and 'breastfeed for a healthy nation' exemplify an orthodoxy that is widely shared, despite the risks of MTCT. It is as if the breastfeeding, anti-baby milk action of the 1970s has never stopped, and as if AIDS were purely a marginal issue, and something of an irritating and, for some, shameful distraction to the business in hand, that is, universal promotion of breastfeeding. However, there have been occasional indications that some in government do see these contradictions (statement issued by the ANC, Johannesburg, 9 November 1999, af-aids posting, 22 November 1999). The political identities of health workers in KZN, their attitudes to women's sexuality before or outside of marriage, and the information they make available to mothers about MTCT through breastfeeding, are all shaped by the push and pull of earlier conflicts and representations, by their own sense of authority, by institutional investment in breastfeeding, and by certain gender-based continuities in discourse and in practice. It is appropriate, in some instances, to refer to an ideology of breastfeeding. By ideology, I refer not simply to elements in a belief system and a process by which meaning is produced, but to a means by which and within which contradictions and irrationalities are accommodated or rendered unapparent (Barrett, 1980:87; Thompson, 1995). Although social and cultural identities have become more diversified and 'pluralised' in modern society, the ways in which health workers act in respect of vulnerable women have been predominantly shaped by particular sets of hegemonic discourses.

The multiple constraints and stresses on nurses running an overcrowded clinic, the budget restrictions, and the tension this now presents, may have combined to produce a demotivating effect among many health workers. Clearly, more local studies, which elicit women's practices, preferences and constraints, and which are underpinned by social theory, are essential (Endnote 8). The issues involved in HIV prevention as a whole – social, medical, gender and rights' issues – are multi-layered. Whereas gender inscriptions everywhere take female and male bodies as the target and as their vehicle for expression, key targets for women are reproduction and 'motherhood', comprising aspects of 'family ideology', where there is often conflation between biological sex and gender (Guillaumin, 1989). There has been an increasing volume of work by African women on these issues. That this is not simply a concern of 'western feminists' is confirmed by the important South African NGO document referred to earlier, the Statement of Concern about Women and HIV/AIDS. Although uneven, this growing concern with gender is a significant trend over the last 20 years (Baylies and Bujra, 1993). In every culture, the body is not only a 'text', as anthropologists and philosophers have argued – it is also a practical, direct locus of social control. There is need, therefore, to challenge discrimination against those women who choose not to breastfeed (Editorial, 2000, Maternal and Child News 15, University of Cape Town). Such a position inevitably involves competing notions of rights: collective, individual, and gendered, especially where rights associated with citizenship tend to privilege the individual. The power embedded in the various representations of women reviewed here, and the competing discourses which underlie them (Levett et al., 1997), will continue to be fought over (Gouws, 1999; Lewis, 1999; Friedman, 1999; Williams, 1992; Walby, 1994).

Another problem is the vertical health paradigm. Although officially priority has been given to restructuring the health service in South Africa along primary health care lines, and hence toward a more participatory framework, there is still a very long way to go. HIV/AIDS has been said to represent a potent challenge to the ingenuity of
scientists seeking a vaccine, in extending access to care and treatment as a responsibility of global citizenship, and to extending discussions about gender power relationships. In the field of MTCT, there are also challenges to the authority which health professionals have claimed over their patients, to medical ethics as an extension of patients' rights, to certain historical and gender continuities, to the social construction of the sexual and reproductive body, to children's rights, and to the expansion of women's development rights (Kabeer, 1994).

Gill Seidel, e-mail: ssd@u-bordeaux2.fr: Université de Bordeaux 2, France. This project was funded by the ANRS (Agence nationale de recherches contre le Sida), Paris from 1998-9. The work was carried out under the auspices of the Bordeaux team (Uprès A5036, CNRS, Sociétés, Santé et Développement). It was hosted by the Department of Paediatrics and Child Health, University of Natal, Durban. Ethical approval was obtained from the Ethics Committee of the Medical School, University of Natal, Durban. The author would like to thank Medical School colleagues, members of the Centre for Social and Development Studies (CSDS), University of Natal, Durban, for stimulating exchanges; and for the support, guidance, and inputs of countless others, in South Africa and elsewhere. Special thanks are due to Vicci Tallis, University of Natal, Durban, to Clive Evian, consultant, Johannesburg, also, to members of the research team at the Health Systems Trust, and to Gethwana Makhaye of Targeted AIDS Interventions, Pietermaritzburg. This article draws on an earlier version hitherto only available in French, and first published in A Desclaux and B Taverne (eds.), 2000.

Endnotes
1. For differing positions among leading clinicians in South Africa on the feasibility of using AZT for pregnant women, see McIntyre et al. (1998) and Wilkinson et al. (1998), respectively

2. According to the Ninth National Survey of women attending ante-natal clinics, the seroprevalence rate among women in KZN stood at 32.5 per cent for October/November 1998 compared with 26.9 for 1997. The figure was even higher at King Edward Hospital, Durban, among ‘unbooked mothers’ (45 per cent over 6 months in 1998; D Moodley, personal communication, January 1999). It is primarily young women between the ages of 15 and 25 who are affected

3. For an authoritative, multi-disciplinary study with particular reference to West Africa, and which includes specific recommendations that have a far wider application, see Desclaux & Taverne (2000).

4. Indicators would include gastro-intestinal disorders, diarrhoea, and upper respiratory infections

5. The basic assumptions that inform this research are: 1) that all communities have systems of beliefs and knowledge which are inscribed in discourses that carry value, among which are gender constructions and representations; 2) since no cultural products can be investigated from a static perspective, the interpretation of these meanings is essentially dynamic; 3) practices may be 'in tension' with proclaimed beliefs/belief systems/doctrines, hence the importance of investigating actual practices in particular settings, as well as the explanations given for them; 4) these discourses, inscribed with ideologies and values, together with associated practices, construct sets of meanings which can be challenged by a range of competing
discourses and practices operating within multi-layered structures; 5) structural arrangements, including socio-economic status, networks and alliances (not only of biological kin), and the composition and the dynamics of the household are also very important in decisions and practice surrounding pregnancy, infant rearing and ‘mothering’.

6. For a more detailed discussion of the research design, of which the storytelling dimensions were reported elsewhere in an earlier pilot rural study on gender, care and support, see Seidel (1999a); Seidel and Coleman, (1999); and especially Seidel (1999b).

7. ‘Culture’ is a deeply problematic term in democratic, English-speaking South African circles supportive of the new dispensation because of the apartheid legislators’ project to define and separate ‘cultures’ along ethnic and language lines. For this reason, it is usually avoided, as are terms such ‘as ‘Zulu’, or ‘Xhosa’, and ‘black’ or ‘white’, for the same reasons. This makes it difficult and controversial to talk about ethnicity at all in these circles. Conscious of these sensitivities, I refer here instead to Zulu-speakers since the all-embracing term ‘South African’, preferred in ‘PC-Speak’, would not be helpful here.

8. Arguments were put forward in a session co-chaired by Mary Crewe (1992), a South African social scientist, at the Durban AIDS 2000 Conference and in a subsequent interview with her (11 June), underlining the centrality of social theory (http://www.aids.2000.com). However, apart from references to the important work of Paula Treichler and Dennis Altman in particular, undoubtedly landmarks in the first decade of the epidemic, few examples were cited from more recent ethnographic work illuminated by discourse and other social theories. It is as if two international Conferences on Social Sciences and AIDS in Africa, the first held in Côte d’Ivoire in 1993 (Dozon & Vidal (eds.), 1993) and the second, in Senegal in 1996, had never taken place (Becker, Dozon, Obbo & Touré, 1999). Yet the latter was published in a bilingual edition precisely with a view to bridging the language divide. Neither were illustrations of exceptional work carried out in sub-Saharan Africa cited, such as that on the history of sexually transmitted infections and earlier community and policy responses (e.g. Becker, 1995; Becker & Collignon, 1999), on representations of the infection and of gender (e.g. Vidal, 2000; Le Palec, 1999), of different pathways to care (e.g. Vidal, 1996), or in relation to MTCT and infant feeding (Desclaux & Taverne, 2000). So although an input on social theory is, indeed, overdue, it seemed frozen in time, and strictly anglophone.

References


Coovadia, H M et al. (1996), Consequences of maternal HIV-1 infection on ante-natal, perinatal and postnatal outcomes, with specific reference to the effects of breastfeeding on the mothers’ and infants’ health, Wellcome Trust Proposal, No 4, Population Studies and Reproductive Health.


Evian, C et al. (1993), Primary AIDS Care, Johannesburg: Jacana Editions (revised edn. 1999).


Karim, Q A et al. (1992), 'Teenagers seeking condoms at family planning services', *South African Medical Journal*, 82: 356-359.


Lewis, D (1999), 'Gender myths and citizenship in two autobiographies by South African women', *Agenda* 40: 38-44.


(1993), 'The competing discourses of AIDS in Africa', Social Science and Medicine, 26, 3: 175-194;


Temmerman, M et al. (1995), 'The right not to know HIV rest results', Lancet, 345: 969-970.


University of Cape Town (UCT) Child Health Policy Institute (1997), 'A review of the Literature on Breastfeeding: Implications for Policy and Research', Child Health Institute, University of Cape Town.


Wood, K, F Maforah, & R Jewkes (1996), 'Sex, violence and constructions of love among Xhosa adolescents: putting violence on the sexuality education agenda', Tygerberg: CERSA Women’s Health, MRC.

Debt Relief & Social Investment: Linking the HIPC Initiative to the HIV/AIDS Epidemic in Africa: The Case of Zambia

Fantu Cheru

Besides being a global public health emergency, the HIV/AIDS epidemic has become the foremost contemporary threat to the development of many African countries. Past achievements in economic growth, improved life expectancy and decreasing child mortality have been reversed by the rapid spread of the HIV virus. It is estimated that each day in Africa more than 5,000 people die from AIDS or HIV related illness, with the figure expected to climb to almost 13,000 by 2005. In the context of this unfolding humanitarian crisis, creditor nations and institutions should cancel outstanding debt immediately so that resources of affected countries can be directed toward containment of the epidemic, within broader strategies of poverty alleviation. Addressing this crisis should not be construed as an act of charity, but an obligation – and a necessity. Linking debt relief to HIV/AIDS is one small but important step in the long march to eradicate poverty in the poorest developing countries. This article examines a proposal formulated in Zambia to enact such a link.

Introduction

At the G-7 meeting in Cologne in June 1999, the leaders of the industrialised countries announced a major debt reduction initiative that goes far beyond what was discussed during a meeting of the IMF and the World Bank in the spring of that year. The Cologne Initiative proposed incremental, but noteworthy steps toward improving the Heavily Indebted Poor Countries (HIPC) initiative which is administered by the World Bank and the IMF. Chief among these were proposals to grant larger reductions of the total accumulated debt, quicker reductions in debt service payments and, most importantly, to place poverty reduction at the heart of an enhanced HIPC framework. These imply the possibility of a tremendous advance in the tortured history of debt relief for poor countries.

The challenge now is to come up with innovative ideas that link debt relief to critical social problems in the HIPC countries. It is in this context that this article advocates the linking of debt relief to addressing one of the most critical emergencies of this century – the HIV/AIDS pandemic. Given the epidemic's generalised and profound impact on the human rights of millions of destitute Africans, this is a matter of urgency.
African Debt, HIV/AIDS & the Politics of Indifference

For almost 20 years international financial institutions and creditor governments have been engaged in the self-deceptive, and destructive game of managing African economies from afar, by forcing down unpopular economic policies in the belief that the bitter medicine of macro-economic adjustment will ultimately put them on a path toward prosperity and debt-free existence. Yet many countries are in worse condition than when they started implementing IMF/World Bank structural adjustment programmes. The social and ecological costs of these harsh austerity programmes have been far reaching, with many countries experiencing dramatic declines in human development targets.

In the autumn of 1996, the consequence of many years of persistent resistance against the policies of the IMF and the World Bank by a global coalition of NGOs and civil society organisations, the Bretton Woods institutions finally conceded the need to address the issue of poor country debt and approved the Heavily Indebted Poor Country (HIPC) initiative. Under its terms, however, a country only received debt relief after jumping two hurdles. First, it needed to complete six years of structural adjustment under the IMF’s Enhanced Structural Adjustment Facility (ESAF). Second, debt relief itself was a two-step process – a decision would be first taken to grant debt relief after three years of SAP implementation, subject to meeting certain additional conditions. Following three more years of successful SAP implementation, a ‘completion point’ would be reached, whereby debt reduction would be calculated on projections of debt stock.

Initially, 41 countries were identified as possible candidates for debt relief under the HIPC initiative. In total they owed $221 billion in 1998, about $61 billion of which was owed to the multilateral financial institutions (United Nations, 1998). By the spring of 1999, however, only three countries had become eligible for actual debt relief: Uganda and Bolivia, in April and September 1998 respectively, and Mozambique in mid-1999. Although eight others – Mali, Côte d’Ivoire, Benin, Honduras, Senegal, Tanzania, Guyana and Burkina Faso – had reached their decision points and had assistance committed to them by the end of 1999, they represented only a small proportion of the total initially targeted.

Strong criticism of the failure of HIPC I to achieve its goals focused on the stringent qualification criteria that prevented many deserving poor countries from obtaining relief. Nor was the initiative properly targeted to take into account the special circumstances of many heavily indebted poor countries that make it virtually impossible for them to meet debt repayment requirements while simultaneously caring for the needs of their people. To repay their debt, governments are often forced to shift scarce financial resources away from the urgently needed investments in human, social, and physical infrastructure, including schools, health services, roads and agriculture, that lay the foundation for sustainable development. More critically, many developing countries face wide-scale humanitarian crises due to the effects of war and genocide (for example, Sierra Leone, Rwanda); natural disasters (for example, such as Hurricane Mitch in Honduras and Nicaragua); and health emergencies such as HIV/AIDS (Nyamugasira, 1999; Cheru & Figueredo, 2000). These disasters are wiping out decades of development advances.

Under major pressure by a wide network of international actors, the IMF and the World Bank conceded in the spring of 1999 that the HIPC initiative had major shortcomings and that there was a need for more substantive steps to address the debt
problem. Shortly thereafter the original HIPC initiative (HIPC I) was revamped at the meeting of the G-7 in Cologne in an attempt to speed up debt relief by relaxing qualification criteria. The intention was also to link the programme more explicitly to a country’s commitment to poverty alleviation.

Table 1: Comparison of HIPC I & HIPC II

<table>
<thead>
<tr>
<th>Elements</th>
<th>HIPC I</th>
<th>HIPC II (Cologne) and post-Cologne revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Countries benefiting</strong></td>
<td>Poorest countries eligible for highly concessional assistance from IDA and the IMF's ESAF. 26 countries, those with debt-sustainability ratio of 200-240 per cent of exports or 280 per cent of fiscal revenues.</td>
<td>33 countries can qualify. Those with debt-sustainability ratios of 150 per cent of exports and 250 per cent of fiscal revenues.</td>
</tr>
<tr>
<td><strong>Time until actual relief</strong></td>
<td>6 years of SAP implementation. 3 years until a ‘decision point’, followed by 3 more years of implementation until full relief.</td>
<td>Following 3 years of reforms and production of PRSP, arrival at ‘decision point’. After 1 year of further implementation it can move to ‘completion’ or full relief. 'Interim relief' in meantime.</td>
</tr>
<tr>
<td><strong>Conditionality</strong></td>
<td>Fulfilment of SAPs for 6 years, with IMF as gatekeeper.</td>
<td>Production of democratically arrived at PRSP, and some implementation, alongside macro-economic policies (SAPs). Less stringent for “interim relief”</td>
</tr>
<tr>
<td><strong>Eligible debt stock for cancellation</strong></td>
<td>$22 billion HIPC relief, with $30 billion through Paris Club.</td>
<td>$70 Billion of all Third World Debt of $340 Billion. Approx. ½ of the debt of 30 countries.</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>No agreement on financing. Cost is $28 billion. Agreed sale of 10 million ounces of IMF gold. Costs divided 50 per cent bilateral and 50 per cent multilateral creditors.</td>
<td>Strong-in theory. In practice, contentious.</td>
</tr>
<tr>
<td><strong>Link to poverty reduction</strong></td>
<td>Un-articulated.</td>
<td></td>
</tr>
</tbody>
</table>


HIPC II & the Post-Cologne Consensus: Old Wine in a New Bottle?

In launching this enhanced HIPC (HIPC II), a total of $90 billion in debt service was promised for 33 poor countries, with the cost to creditors estimated at just $27 billion, primarily due to heavy discounting of the loans and the advantage of purchasing the debt today as opposed to having it accrue interest over the length of the loan (Endnote 2). However, by the time of the IMF/World Bank annual meeting in Prague in September 2000, there was little progress to report on debt relief under the Cologne initiative. The key impediment has been the failure of the G-7 governments to appropriate sufficient resources to the HIPC Trust Fund.
Moreover, even in its reformulated guise (HIPC II), the HIPC debt relief programme continues to be caught up in a complex web of IMF and World Bank eligibility conditions. Among other factors, eligibility for debt relief under HIPC II is conditioned upon 'good performance' in the implementation of IMF and World Bank policies. While the World Bank and IMF claim that HIPC II links debt relief more firmly and transparently to poverty reduction, the underlying SAP conditionality still remains, inhibiting possibilities of real change. Even so, former requirements have been perceptively eased.

With HIPC II a decision point can now be reached after the first three years of good economic performance in cases where a Poverty Reduction Strategy Paper (PRSP) has also been produced and approved. At this stage, countries become eligible to receive 'interim relief'. The country must then demonstrate that its debt servicing is unsustainable, following designated threshold values with respect to the ratio of debt to exports, and the ratio of debt to fiscal revenues (Endnote 3). If the country finally qualifies for relief, its debt servicing is brought down to what is deemed within the terms of the initiative to be a sustainable level, but only after reaching the 'completion point', or a further three-year waiting period. This less than generous arrangement still leaves the country deflecting a sizeable portion of its scarce foreign exchange earnings into debt servicing for an inordinate period of time. And what of the countries which cannot manage the terms of 'good economic performance'? These may be precisely the countries that need debt relief the most.

Critics have argued that debt relief as envisaged under the Cologne initiative will be neither sufficiently deep nor broad and will not be delivered at the pace required for addressing the pressing development needs of poor countries. Significantly, the HIPC Trust Fund remains under-funded. Although the US Congress authorised a revaluation of approximately 10 million ounces of the IMF's gold reserve, it was stipulated that proceeds should fund new IMF structural adjustment lending under the ESAF programme rather than be used to fund debt relief (Endnote 4). The continuing promises of G-7 governments are therefore in stark contrast to the precarious financial situation of the HIPC Trust Fund.

More importantly, debt relief on its own will not be sufficient to put these broken countries on a path of sustained growth. Other necessary components of a broader strategy include increasing aid flows, mobilising internal savings, improving terms of trade, and increasing and diversifying exports. It is also worth emphasising that discussions of financing debt relief must be placed in a broader context, challenging the legitimacy of the debt and resulting financial responsibility. Jubilee South, for example, comprising a vast network of international civic actors and governmental supporters, places the debate within an even wider context – one where debt cancellation must be considered alongside retribution for colonial wrongs.

**Debt Relief & Poverty Reduction Strategy Papers (PRSP)**

There is, however, one new critical element contained in the Enhanced HIPC initiative that was absent under the old HIPC. Countries wishing support for debt-relief, or from IDA and under the ESAF (now reincarnated as the Poverty Reduction and Growth Facility-PRGF), must prepare Poverty Reduction Strategy Papers (PRSP) (IDA, 1999). The PRSPs are to be country-driven; prepared and developed transparently with the broad participation of civil society, key donors and other
relevant International Financial Institutions (IFIs); and linked clearly with agreed international development goals – specifically with principles embedded in the Comprehensive Development Framework (CDF). The idea, which is a brainchild of Oxfam and UNICEF, is intended to enforce a pro-poor ‘contract’ between debtors and creditor governments. Specifically, the PRSPs are to contain the following key elements (Oxfam/UNICEF, 1999):

- Structural, institutional, social, and macro-economic policies which impact on existing poverty outcomes. Identification of the obstacles to more rapid growth and more extensive poverty reduction. Elaboration of a medium-term macro-economic framework and structural policy matrix which is capable of supporting poverty reduction;

- Consultative processes by which governments can access and incorporate the views of civil society, the private sector and other domestic stakeholders, as well as donors, regional development banks, and other international financial institutions and organisations;

- Intermediate and final outcome indicators which are related to the international development goals of 2015 and which can be monitored by civil society;

- The integration of external finance and resource flows into the strategy;

- Capacity building and technical assistance requirements to support the strategy.

While the responsibility of preparing PRSPs rests first and foremost with the authorities of the countries concerned, the Bank has undertaken to facilitate the consultative process, while the Fund has agreed to assist with macro-economic policies. Governments are also encouraged to seek extensive technical assistance – including from the Bank and Fund – on the elaboration of policies within the PRSP (Endnote 5).

Before proceeding to examine links between debt relief and HIV/AIDS, some reflections on this process to date are in order. To start with, not all HIPC countries have the necessary institutional and intellectual set-up or the database to write their own poverty strategy framework. In consequence, in the short and medium-term, many HIPC countries in Africa are likely to rely on Fund guidance, making ‘national ownership’ of the programme highly unlikely. At the same time, there are serious questions vis-à-vis the Bank and the Fund’s competence in the area of poverty reduction, particularly given a record of poverty induced by the implementation of ESAF. Furthermore, key UN specialised agencies, which do have extensive experience in poverty eradication, such as UNDP, ILO, UNICEF and UNCTAD, have not been brought into the process nor involved in the management of the HIPC initiative. This is a serious omission that must be addressed quickly if the initiative is to bear any fruit and be sustainable.

While the emphasis of HIPC II on strengthening the link between debt relief and poverty reduction represents a tremendous intentional step forward in the tortured history of debt relief for poor countries, it remains to be seen how much weight both the IMF and the World Bank will attach to poverty strategy plans that are an outcome of genuine and broad-based national consultations in determining debt relief to a country. First, there is the question of whether the Fund has the necessary internal capacity to integrate ESAF-macro-economic conditions with broader social develop-
ment goals that are likely to emerge from societal consultations. The potential changes, and even the intention of poverty reduction, are at odds with the Fund’s mandate, requiring a far more comprehensive rethink about how the contradictions will be managed. While expenditures on education and health services are likely to be expanded under the new HIPC, the structural factors that induce poverty are unlikely to be addressed by conventional structural adjustment programmes (Endnote 6).

Most significantly, it is ESAF conditionalities that continue to be predominantly linked to debt relief, rather than a country’s demonstrated effort toward poverty reduction. In the end this is likely to influence the theoretical content of the national Poverty Reduction Strategy Papers, effectively bringing them in line with the theoretical thinking of the IMF and ensuring that the old wine is, in fact, simply in a new bottle. Put simply, HIPC II/ESAF could turn out to be a back-door way for both the IMF and the World Bank to maintain control over the national development policies of poor and indebted countries. That there may be concern on the part of the Bank and the Fund to reassert control by creating procedures ostensibly granting local ‘ownership’ should not be surprising, given evidence that high-levels of ESAF non-compliance have, in part, been a consequence of the top-down approach taken in designing conditionality.

The Enhanced HIPC Initiative will become more meaningful and genuinely poverty oriented only if decisions on conditions and terms of debt relief are left to the countries themselves, and are subject to broad consultation with civil society organisations. This will guarantee that the HIPC Initiative simultaneously addresses both macro-economic objectives and social development goals (Sacks, 1999). National poverty reduction strategy papers (PRSP), if done properly, would become important policy instruments so long as countries have the autonomy to determine their content through broad and transparent consultation with civil society and the private sector. The PRSP, which is to be updated regularly, would in essence then become the basic framework guiding future Bank/Fund lending operations to poor countries. It is expected that other donors would similarly use it for determining their assistance to governments.

In the final analysis, while the HIPC initiative has raised expectations, a great deal of scepticism remains about the willingness of western creditor countries, the multilateral development banks in particular, to break the chain of debt-bondage of the HIPC countries, not to mention doubts about the adequacy of funding for HIPC for wiping the slate clean (Hellinger and Hansen-Khun, 1999). Linking debt relief to successful implementation of ESAF is a major mistake, however, which is bound to delay much needed relief to countries desperately in need of fresh resources to fix broken down social systems (EURODAD, 1999). Past experience shows that many African governments have failed to meet such conditionalities of adjustment and reform. In fact, in recent years, three out of four ESAF programmes have broken down precisely because their conditions were too tough to be fulfilled. They place too great a burden on people living in poverty.

It is for these reasons that the Southern Jubilee 2000 movement continues to insist that debt relief be conditioned on the development and implementation of transparent mechanisms along the lines of Uganda’s Poverty Action Fund which tries to ensure that resources freed up by debt relief go directly to poverty eradication and sustainable human development (Endnote 7). The process of debt cancellation needs to be closely monitored by NGOs and civil society, possibly in collaboration with parliaments. New borrowing and lending must also be monitored by civil society to ensure their relevance to sustainable human development.
Important as it is, debt relief has left its own bitter legacy on future development financing for poor countries. At the moment, donors are replenishing both the HIPC and ESAF Trust Funds by redirecting current bilateral budget allocations instead of mobilising new resources to fund the initiative (Morrison, 1999). In the long run, important sources of development assistance are likely to be at risk. Aid budgets to poor countries, already at the lowest level in decades, may be reduced further due to 'crowding out' by the need to find resources to finance debt reduction. But to provide debt relief while at the same time reducing other resources for development makes little sense. Although it is still too early to pass judgement on HIPC, the initiative may turn out to be a sham if it fails to liberate poor countries from debt bondage, and help them to start the broad process of human development.

For HIPC II to become successful, therefore, it must avoid excessive conditionality, especially so long as little evidence exists of the success of programmatic conditionality in reducing poverty. Most critically, it must give countries facing major humanitarian crises increased flexibility. Such countries are forced to make decisions and allocate resources in ways not consistent with business-as-usual development planning and management, given an urgent need for reallocations of funds towards ensuring as a priority that people stay alive. The time factor is obviously critical. In the face of humanitarian and health emergencies, there is no time to wait for an evaluation of three years implementation of conditionalities. Particularly in these cases, ESAF conditionalities should not remain the sole gatekeeper for determining eligibility for debt relief. To the contrary, debt relief should be part of a much larger humanitarian assistance.

A ‘Silent Emergency in Progress’: The Human & Economic Consequences of HIV/AIDS in Africa

Besides being the foremost contemporary public health problem, the HIV/AIDS epidemic has become the greatest present threat to Africa’s development. Past achievements in economic growth, improved life expectancy and decreasing child mortality have been quickly reversed by the speed with which the HIV virus has spread (World Bank, 2000). It is estimated that there are 23.2 million people living with HIV in sub-Saharan Africa – two thirds of the world’s total. Women account for 55 per cent of HIV-positive adults (UNAIDS/WHO, 1999). In 1998 alone, 5.6 million people were infected with the HIV virus worldwide, 4 million of whom were Africans. More than 5,000 people in Africa are estimated to die from AIDS or HIV related illness each day, and epidemiologists expect that figure to climb to almost 13,000 by 2005. If these projections are correct, more people in sub-Saharan Africa will have died from AIDS by that time than in both world wars combined or from the bubonic plague, which killed 20 million people in the 14th century Europe. In addition, it is believed that more than 8 million children have lost their mother or both parents to AIDS. As UNICEF Executive Director, Ms. Carol Bellamy put it, ‘HIV/AIDS epidemic is the most terrible undeclared war in the world, with the whole of sub-Saharan Africa a killing field’ (Endnote 8).

Of all the regions in Africa, southern Africa has been particularly ravaged by a strand of HIV that is killing more people, more rapidly than in any other part of the continent. Of the 9.6 million people believed to have died in sub-Saharan Africa since the beginning of the epidemic, 9.2 million were from Eastern and Southern Africa. Estimates of the percentage of adults (15 to 49 years old) currently infected with HIV range between 16 and 32 per cent in the sub-region. According to UNICEF, AIDS will
orphan 11 million children in 12 Eastern and Southern African countries by 2010 (McDermott, 1999). Life expectancy, a primary human development indicator, has fallen from 70 years to just under 40 years in Namibia and Zimbabwe, highlighting the degree of crisis for development in the region (Gellman, 2000).

HIV/AIDS & the Indifference of the International Community

The unprecedented scale of HIV/AIDS-related death in Africa and the breakdown of family and social network systems which follow in its wake have yet to stir the international community to anything near the level of action required. This is in stark contrast to the recent Western response to widely televised and strategically important trouble spots, such as Turkish earthquakes, Balkan wars and Middle East peace agreements. What explains the gross indifference by the international community to the widening humanitarian crisis of HIV/AIDS in Africa? Why have so many African leaders also kept ‘silent’ when their citizens are being decimated by the epidemic on a daily basis?

The lack of urgent action from the international community to the HIV/AIDS epidemic in Africa must be viewed in the larger context of ‘donor fatigue’ and ‘Afro-pessimism’ which have prevailed in recent years. Since the end of the cold war, overall donor assistance to Africa has been shrinking. Many UN agencies working in Africa have repeatedly pointed to the unequal treatment of the continent by the donor community in relation to other regions. For example, in 1999, donors provided less than three-fifths of the $800 million the United Nations requested for emergencies in sub-Saharan Africa. Similarly, the World Food Programme announced in September 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 during the summer 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 in the spring of 1999 – brought minimal initial response and predictions of mass starvation. With respect to HIV/AIDS, persistent warnings by WHO and UNAIDS about the impending crisis have been repeatedly ignored by the international community until recently.

By contrast, Kosovo and Bosnia have been able to generate one of the biggest international responses in recent memory. The reason for the differing response 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 epidemic in Africa, on the other hand, is a ‘silent emergency’ affecting largely poor black Africans in remote villages and over-crowded shanty towns far away from the nearest CNN camera.

Recently, attacks by western governments have been mounting towards African governments for not doing enough to combat the crisis. Kalumbi Shangula, Permanent Secretary of the Health and Social Services for the Republic of Namibia has emphasised that these accusations are baseless and unfair, ‘born of ignorance of what is happening here on the ground where the epidemic rages.’ Moreover, he raises the critical point that HIV/AIDS is not the only major public health problem in sub-Saharan Africa. Tuberculosis affects millions and malaria kills more children under 5 than any other disease in the world (Shangula, 2000). Some African critics would even argue that the only reason there is any western interest in combating HIV/AIDS is precisely the concern that it is transmittable, and henceforth a threat to western health security (Endnote 9).
While not all have been so vocal, some political leaders, for example in Uganda and Senegal, have taken a proactive role in mobilising the population against the spread of HIV/AIDS, in the process generating positive results. SADC, under the leadership of Namibian President Sam Nujoma, has also placed the issue at the top of its agenda, approving an essential package of HIV/AIDS-related interventions, including joint programmes for prevention, education and patient care and support. At the same time, civic groups are maintaining pressure for rhetoric to become policy and programmatic reality. Despite these positive examples, however, the fight against HIV/AIDS in Africa has been stalled by the cold-blooded abandonment of millions of poor Africans by many governments, whose leaders have become obstacles to any concerted effort by donors, NGOs and civil society groups to mount major campaigns to contain the spread of the epidemic (Mwara, 1999).

At the same time, it is only recently that many donor governments and institutions have begun to recognise the impact of the epidemic on Africa's future development. The HIPC Initiative could be one important source of funding for HIV/AIDS prevention programmes in heavily indebted poor countries. Unfortunately, the web of macro-economics conditionalities which infuse it threaten to delay badly needed debt relief. While creditor governments haggle over the scale of debt reductions that should be granted to poor countries, many of the gains of the 1960s and 1970s in Africa are being wiped out by the HIV/AIDS pandemic at a breakneck pace.

HIV/AIDS & the Cruel Irony of the Market: How WTO's TRIP Regime Costs Lives

A further area of indifference relates to the rules governing global trade and intellectual property rights. The right to health is being jeopardised by the Trade Related Intellectual Property Rights (TRIPS) regime of the WTO which prevents African governments from acquiring or producing affordable drugs to help those infected with the HIV virus. These countries simply do not have access to medical advances and the resources that stalled the AIDS epidemic in the West. In consequence there remains a moral and practical disjuncture between the drug-price structure and the real needs of the majority of poor people in developing countries.

Until the infamous 1999 WTO meeting in Seattle, countries either had to purchase the drug at market prices, which were far beyond their means, or risk trade sanctions by the United States for buying or developing generic drugs at lower prices (Vick, 1999). For example, in 1997 when South Africa passed a law permitting the government to make drugs it deemed too expensive, the US government placed South Africa on the '301 watch list', which is seen as a prelude to trade sanctions. Similarly, Thailand dropped plans to produce the anti-AIDS drug ddI after US officials threatened sanctions on key Thai exports. On 17 September 1999, however, South Africa was taken off the watch list after officials from both sides met and discuss the matter and reached an agreement.

It is only after the 1999 WTO meeting in Seattle that the United States announced a more liberal stance with regard to intellectual property rights relating to public health issues (Endnote 10). Since then, several American pharmaceuticals have agreed to provide drugs at reduced prices to African countries, although still not competitive with generic products produced in Brazil and India. More recently, President Clinton announced a $1 billion loan from the Export-Import Bank to address the HIV/AIDS crisis, with the condition that the drugs must be bought from American pharmaceuti-
cal firms. This has been strongly criticised by NGOs and rejected by several African governments, who argue against the idea of asking African governments to mortgage the future of their peoples by taking on increased debt, at commercial rates, to pay for medicines that they can legally acquire more cost-effectively. The primary beneficiaries of such a plan are US pharmaceutical giants (ADNA, 2000), and the short sightedness of such an offer is astounding, illustrating the total lack of understanding about the causal linkages between HIV/AIDS and other health crises, bound up as they are with poverty and debt. Essentially it invites African governments to go further into debt, compounding their lack of capacity to manage the HIV/AIDS crisis.

**Linking Debt Relief to Combat the HIV/AIDS Epidemic: The Case of Zambia**

In considering how the provisions of the HIPC II might be geared toward grappling with the problem of AIDS, Zambia will be taken as a case study. Zambia is both highly indebted and burdened with high rates of HIV infection. But it has also been characterised by concerted pressure from within civil society, supported by some sections of government, to highlight the way debt servicing requirements restrict the availability of resources for tackling the AIDS crisis. Most importantly a proposal has been put forward explicitly detailing how debt relief can be linked to the funding of AIDS programmes and broader poverty alleviation within the country.

Zambia belongs to the category of the HIPC countries whose debt burdens have been a major contributor to the persistence of underdevelopment. Debt serving has taken a heavy toll on public budgets, severely shrunk the resources available for development and greatly reduced the prospects for economic growth. Even before HIV/AIDS became recognised as the greatest threat to human development in Zambia, debt servicing at the expense of the adequate funding of vital social programmes had already reversed many of the social gains made in the 1960s and 1970s (Henroit, 1999a). Finding lasting solutions to Zambia's debt could release resources for helping to contain the threat of the HIV/AIDS epidemic, while at the same time contributing more broadly to sustainable human development.

The total external debt of Zambia stood at $6.5 billion in 1998, of which 46 per cent was owed to the multilateral institutions, such as the IMF, the World Bank and the African Development Bank. Zambia's current debt crisis stems from the mid-1970s when the country experienced a steep fall in copper prices. The two rounds of oil price hikes in the late 1970s further compounded Zambia's economic difficulties and the balance of payment position continued to worsen. From the mid-1980s, the government relied more and more heavily on external borrowing to finance imports (Government of Zambia, 1999a). Total external debt stood at $3.7 billion in 1992, $4.2 billion in 1994 and $6.4 billion in 1997. The increase in the debt stock over the period was largely a result of increased borrowing from the multilateral soft window. As a result, the share of multilateral debt rose from 39 per cent in 1992 to 52 per cent in 1997. Of the total exposure to multilateral creditors, debt owed to the World Bank group accounted for 43.8 per cent, while IMF debt accounted for 36.4 per cent.

Because multilateral debts are 'preferred and exempt' debts, they cannot be rescheduled or cancelled and take precedence over other debts. Debt service payments falling due in 1998 totalled $123 million, of which $89 million was paid to multilateral and $30 million to Paris Club creditors. The debt service payment was roughly equivalent to 69 per cent of the funds budgeted for the social sectors
The HIV/AIDS Epidemic in Africa: The Case of Zambia

(Kalumba, 1999). It is projected that scheduled debt service will reach $621 million in 2001 (Endnote 11). As indicated by the data in Table 2, this indebtedness is crushing all possibilities for human development by diverting resources away from investment in education and health care.

The Government has pursued a policy of debt cancellation and rescheduling in order to reduce the debt burden. During the period 1992 to 1997, various creditors extended debt relief amounting to a total of $1.873 billion, of which $1.440 billion was provided by the Paris Club creditors and the balance by both non-Paris Club and commercial creditors. So far the multilateral creditors have offered no debt relief (Government of Zambia/UNICEF, 1999). In July/August 2000, however, the boards of the World Bank and the IMF endorsed the preliminary HIPC document and the Interim Poverty Reduction Strategy Paper (I-PRSP), and agreed that Zambia was eligible for HIPC assistance (IMF/IDA, 2000). Even so, the government can expect to get real debt relief no sooner than three years from that date. This is not good news to celebrate when one considers the cataclysmic impact that HIV/AIDS is having on the population of Zambia and on its future development prospects. Nor is it a logical or pragmatic approach, given the disastrous impact of structural adjustment policies.

Table 2: Social Sector Expenditure & Debt Servicing, 1991-96 (US$ million)

<table>
<thead>
<tr>
<th>Year</th>
<th>Education</th>
<th>Health</th>
<th>All Social sectors</th>
<th>Debt Servicing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>107.8</td>
<td>73.6</td>
<td>192.5</td>
<td>565.0</td>
</tr>
<tr>
<td>1992</td>
<td>78.6</td>
<td>46.8</td>
<td>137.1</td>
<td>275.8</td>
</tr>
<tr>
<td>1993</td>
<td>72.0</td>
<td>44.7</td>
<td>145.3</td>
<td>315.9</td>
</tr>
<tr>
<td>1994</td>
<td>76.0</td>
<td>74.1</td>
<td>176.7</td>
<td>324.4</td>
</tr>
<tr>
<td>1995</td>
<td>91.6</td>
<td>72.4</td>
<td>191.8</td>
<td>348.7</td>
</tr>
<tr>
<td>1996</td>
<td>88.4</td>
<td>67.7</td>
<td>176.1</td>
<td>256.4</td>
</tr>
<tr>
<td>As per cent of GDP, 1993-96</td>
<td>2.5</td>
<td>2.0</td>
<td>5.3</td>
<td>10.3</td>
</tr>
</tbody>
</table>


The Impact of the HIV/AIDS on Zambia's Development

It is estimated that 20 per cent of the adult population between ages of 15 and 49 years in Zambia is currently HIV positive (Ministry of Health, 1997) and that some 500 new infections occur each day (UNAIDS, 1997). The opportunity cost of HIV/AIDS on Zambia's development prospect is enormous. This is particularly troubling since nearly 70 per cent of the households in the country already live below the poverty line (Endnote 12). Widespread poverty creates situations of vulnerability to infections - women may have little choice but to enter into sexual relationships where there are no economic opportunities. Lack of education and low literacy rates make information less accessible. Once HIV becomes established, all these problems are intensified as sickness reduces the capacity of adults to work or to cultivate what land they have. As household poverty deepened, girls are taken out of school, women are forced into prostitution, and children are orphaned, reducing further their chances for education (Lucas, 1999).

Rising adult mortality due to HIV/AIDS in Zambia is reducing the number of people with essential development skills. As a result, labour productivity is affected and
HIV/AIDS has become a 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 (Baggaley et al., 1994). On a large sugar estate, 755 of the deaths between 1992 and 1993 were believed to be HIV related (Halswimmer, 1994). Additional training costs will be incurred as labour turnover increases. In addition, businesses have to pay out more in medical care, salary compensation for deceased families and funeral grants. HIV/AIDS is also having a severe impact on the productivity of the agricultural sector (Drinkwater, 1993), in consequence of absenteeism due to sickness and loss of agricultural knowledge and management skills. Families are often forced to sell livestock and other assets to cover the cost of caring for the sick, further exposing themselves to poverty.

The burden of HIV/AIDS on the health care system of Zambia has been enormous. HIV/AIDS is already absorbing a large share of hospital resources and a substantial share of health sector budgets and human resources. Since most households and communities are living in poverty, there are few options whereby the burden of care can be shifted from the public health services to households and communities (World Bank, 2000; Malawi, 1999). The repercussions of HIV/AIDS can also be seen in the education sector. As more and more children become orphans due to loss of both parents for HIV/AIDS, schooling takes a back seat since there is no one to pay school fees and meet their daily subsistence requirements. The educational system has also been dealt a heavy blow by a high level of mortality among teachers. It has been estimated that more than 30 per cent of teachers in Zambia are already infected with the HIV virus (World Bank, 2000:11). Ministry of Education data show that 680 teachers died in 1996, 624 in 1997, and 1,300 in the first ten months of 1998. Deaths in 1998 were equivalent to the loss of about two-thirds of the annual output of the newly trained teachers from all training institutions combined (Ministry of Health, 1997).

HIV/AIDS is dramatically decreasing life expectancy. In Zambia's case, life expectancy, which stood at 54 years only a few years ago, has plummeted to 37 and is expected to decline in the coming decade to 30 years. In nine countries in Africa with an adult prevalence of 10 per cent or more (Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe), life expectancy in the first two decades of the next century is projected to decrease to 47 years instead of rising in accord with pre-HIV projections to 64 years (World Bank, 2000:7). Declining life expectancy is further aggravated by rising child mortality rates. According to UNAIDS, 25 per cent more infants are already dying in Zambia and Zimbabwe than would have been the case in the absence of HIV.

There has been a considerable increase in the number of orphans in Zambia in the wake of the epidemic. In the late 1990s it was estimated that the number of orphans would reach 1.66 million by 2000, of whom 910,000 would have lost their fathers and 750,000 either their mother alone or both parents. By 2005, it was anticipated that there would be 2 million orphans, representing 38 per cent of the total number of children under the age of fifteen years (Hunter and Fall, 1998).

The overall impact of HIV/AIDS on Zambia's development prospects is, therefore, significant and the cost of delaying an intensified response, monumental. Debt relief is a critical resource that must be made available without delay. In its absence, the need to strengthen care, treatment, and social support will be severely hampered.
The Proposed Zambian HIV/AIDS Multi-Donor Debt Fund

Since the establishment of the HIPC initiative in 1996, both government and civil society have focused their attention both on how to access debt relief and how to mount a more effective assault on HIV/AIDS. At the same time, creditors and citizens alike have expressed considerable concern about the extent to which resources freed through debt relief might be directed toward the emergency posed by AIDS. In response to this concern, the government working jointly with several local NGOs and church organisations has proposed a multi-donor debt relief programme to accelerate the national response to HIV/AIDS. Under this proposal, scarce national funds which would otherwise go to service the debt would be set aside in a Multi-Donor HIV/AIDS Debt Fund for investment in activities aimed at curtailing the spread of HIV/AIDS. Any grant by donors would also be channelled into the debt fund. The funds would then be used by both civil sector groups and public social sector institutions to implement activities nationwide, which would be designed to prevent HIV/AIDS, manage existing cases, and address the growing orphans crisis. The proposal has the following components:

Multi-sectoral Approach to HIV/AIDS

The ‘Debt for Development’ and HIV/AIDS proposal moves away from viewing the epidemic in clinical terms to an approach that embraces a multi-sectoral poverty eradication strategy, in recognition that HIV/AIDS is a crosscutting issue that requires multi-sectoral strategies. For example, any intervention to promote behaviour change must go beyond seminars and provide people job opportunities and recreational facilities. Similarly, the education of the girl child should not be in prevention of HIV but in literacy that enhances dignity and empowers choices (Henriot, 1999b).

Financial Accountability

Debt relief funds, to be held by an independent non-government body, would be deposited at the Bank of Zambia, with money channelled directly from this non-government body to civil and private sectors (NGOs, churches and networks such as the Zambia Federation of Employers and Traditional Healers Association) as well as to public sector implementing institutions. This body would follow general accounting principles and issue regular financial reports to civil, private and public sector implementing institutions. Funds would be audited by an independent, external firm approved by creditors. The Bank of Zambia would be required to report quarterly to the Secretary of the Treasury on movements and balances of the account. Such monitoring documents would then form part of the larger financial report prepared for submission to the National HIV/AIDS Council.

Programme Accountability

The proposal stipulates that all parties should agree upon a set of technical evaluation indicators which would be used to monitor programme progress and measure the impact of the interventions on the HIV/AIDS epidemic over time. All parties would be required to agree upon the mechanisms for reporting and collecting this information before the debt relief funding could be released.
Multi-sectoral Partnerships

A Debt Relief Steering Committee would be formed, consisting of representatives from major partners in civil society, private and public sectors, creditor countries and multilateral agencies, to ensure that the debt relief programme does not become a government-controlled effort, but rather one owned and nurtured by civil society. The Committee would be charged with receiving reports periodically from each of the implementing partners and with preparing technical summary reports. Each partner organisation would be given an equal say in the development, implementation and evaluation of the programme. A monitoring and evaluation system would be developed to track implementation and progress. A high premium would be put on ensuring transparency in respect of the use of resources.

The combined civil and public sector response would be part of the overall National HIV/AIDS Strategy developed by the multi-sectoral HIV/AIDS Council and Secretariat. The estimated amount channelled into HIV/AIDS prevention and impact mitigation programmes, as a result of debt relief, is estimated at $89 million over a five-year period (Government of Zambia, 1999b). This averages to about $18 million per year for covering all programmes in both public sector and civil society – small change when compared with the $2.5 billion spent in Kosovo by NATO during the first month of the air war.

Conclusion

The HIV/AIDS pandemic in Africa is the most serious present threat to human development there. In depleting the most educated, energetic and productive segment of African societies, it is draining human capital. In addition, the crisis exerts heavy pressure on limited infrastructure and resources, negatively impacting on productivity and overall economic growth. This is true not only for Zambia, but for many other African countries which are saddled with huge amounts of unpayable debt. The servicing of this debt is diverting scarce resources away from vital social services, and constraining the capacity of governments to respond to the HIV/AIDS crisis in a constructive way.

While the Zambian ‘debt for development’ and HIV/AIDS proposal is innovative and deserves international support, its prospects for being accepted may ironically be limited by the poor democratic credentials of the government of President Fredrick Chiluba. Even with financial controls, donors may prove reluctant to put resources near the hands of a government that has yet to fully acknowledge the problem of HIV/AIDS in the country.

The insistence by donors that the Government of Zambia institute fundamental political reforms, the rule of law, and practice transparent decision-making ought to be commended and must be continued. At the same time, however, the granting of debt relief specifically targeted to the prevention of the HIV/AIDS epidemic should not be held hostage to progress on governance reform. Given the magnitude of the unfolding humanitarian crisis at the present moment, ‘health emergency’ criteria should be the sole determining factor for granting debt relief to Zambia as quickly as possible. Donor governments must come to grips with the cold reality that HIV/AIDS cannot wait until national budgets are balanced, the inflation rate is brought down to reasonable levels, and a democratic government is installed. Action is needed now, and not three years down the road by which time millions more Africans would have been infected or died of the HIV virus. That would be a great humanitarian tragedy for which the international community would ultimately be held responsible.
Fantu Cheru is with the UN High Commission for Human Rights, Geneva and a Professor at the American University, Washington, DC.

Endnotes


3. The enhanced HIPC stipulates that in order to qualify for relief, a country must have a debt/exports ratio of 150 per cent and debt/tax ratio of 250 per cent or more combined with tax/GDP and exports/GDP ratios of at least 15 per cent and 30 per cent.


5. IMF and World Bank (undated).


7. See for example, the recent Lusaka Declaration, 'Towards an African Consensus on Sustainable Solutions to the Debt Problem', endorsed by around fifty African NGO representatives, 19-21 May 1999.

8. Brief on the 11th International Conference on AIDS and STDs in Africa (ICASA), 12-16 September 1999, p.2.

9. Others document the rise and relative fall of interest within WHO programmes. Michael Merson of WHO notes, 'In the 90’s it became clear that we were not going to have a major heterosexual epidemic in the States ... [AIDs] was no longer a threat to the West', Gellman, Barton, 5 July 2000, p. A12.

10. President Clinton’s address to WTO in Seattle.

11. Interview at Ministry of Finance, Debt Management Unit, 19 October 1999.


Bibliography


EURODAD (1999), 'Towards a Comprehensive Solution to the Debt Problem', contribution toward the HIPC Review, Phase II, August.


Hansen-Kuhn, Karen & Steve Hellinger (1999), 'SAPs Link Sharpens Debt-Relief Debate', Third World Network.


Mwaura, Peter (1999), 'Pioneers in the Control of HIV/AIDS: Uganda and Senegal show that Infection Rates can be Reduced', Africa Recovery, Vol.12, No.4, pp.8-9.

Nyamugasira, Warren (1999), 'Rwanda and the Impact of Debt Relief on the Poor: Reconciliation can't Wait; Children Headed Households can't Wait', an NGO input to the HIPC Review Seminar, Addis Ababa: 29 July.


Sachs, Jeffrey et al. (1999), 'Implementing Debt Relief for the HIPCs', submission to the HIPC Review Phase II, August.


Coping or Struggling? A Journey into the Impact of HIV/AIDS in Southern Africa

Gabriel Rugalema

Analysis of the effects of AIDS-induced morbidity and mortality on rural livelihoods, particularly in east and southern Africa, has gathered pace in the last two decades. An understanding of the interaction between ill health and rural livelihoods is essential both at policy and theoretical levels. However, the tendency to analyse many of the effects of the AIDS epidemic under the rubric of coping strategies needs critical appraisal. In this article the question is posed as a basis for exploring whether the concept of ‘coping strategies’ is capable of explaining reality on the ground or has merely become a convenient escape route for academics and policy-makers. It is argued that in areas hard hit by AIDS, the concept of coping strategies is of limited value in explaining household experience and may divert policymakers from the enormity of the emergency.

Introduction

It is sometimes helpful to stand back from a subject and try to pull together the various strands of knowledge that have accumulated around it; this is the purpose of this article -- to analyse the impact of AIDS on rural livelihoods. Despite a late start, data concerning the effects of AIDS on African rural livelihoods has gradually accumulated. The fact that many tropical diseases are endemic in Africa (malaria, sleeping sickness, schistosomiasis, river blindness) adds to the urgency posed by the impact of AIDS to look more closely at the relationship between ill health and the sustainability of rural livelihoods.

Use of the notion of coping strategies in attempting to explain household responses to disasters gained currency in the 1970s and 1980s, when famine threatened and claimed lives of hundreds of thousands, if not millions, of people, particularly in north-east Africa and the Sahel region. Since then the concept has been widely used to explain household responses to famines (among others see: Corbett, 1988; De Waal, 1989; Rahmato, 1991; Devereux, 1993). Use of the term ‘coping’ in medical literature is not widespread except in mental health (McCubbin, 1979; Hodgkinson and Stewart, 1998). The advent of HIV/AIDS, however, has given the concept of coping strategies a new lease of life, as it has now become widely employed in analysis of the impact of the disease on households (see for example, Topouzis, 1999; UNAIDS, 1999). In this article I question the wisdom of employing the notion of coping strategies to analyse the effects of morbidity and mortality associated with HIV/AIDS in rural Africa.

I begin with a review of research on the impact of HIV/AIDS on rural livelihoods in various countries in the region. As will be seen, the concept of coping strategies features frequently in these studies. I then delve into the analysis of the applicability
of the concept in light of the evidence generated by this very research and consider how far the data reflect coping or, alternatively, a struggle to survive which is not always successful. Finally I argue that the conceptual framework employed is unrealistic and insufficient to explain the effects of the epidemic on rural households.

'Coping' with HIV/AIDS at Household Level

Studies increasingly show that the HIV/AIDS epidemic has had a significant impact on rural households and communities (Kwaramba, 1998). Household responses to HIV/AIDS-induced illness and to the death of adult members of households has attracted a fair share of academic attention, leaving little doubt that HIV/AIDS is having significant adverse effects on household composition, labour, and income (Barnett and Blaikie, 1992; Rugalema, 1999b). These in turn are having knock-on effects on the ability to produce food, schooling of children, cropping patterns, livestock production, labour allocation, access to productive assets and consumption of goods and services essential for household maintenance and reproduction. Numerous studies, including those of Gillespie (1989), Barnett and Blaikie (1992), Hunter et al. (1993), Barnett and Haslwimmer (1995), Kwaramba (1998) and Rugalema (1998, 1999a, 1999b) have clearly shown the extent and type of effects of HIV/AIDS-induced adult morbidity and mortality on rural households (see Table 1). The question is, how far can or should the observed effects be seen as coping strategies?

In its present form the conceptual framework built around the notion of coping strategies owes much to the work of Michael Watts (see Watts, 1983) on famine survival strategies of rural households in northern Nigeria (see Aho et al, 1998:191). The conventional conceptual framework is depicted in Figure 1 (p. 540). According to Curtis (1995):

> famine coping strategies are a set of activities taken by a household in a particular sequence in response to external shocks that lead to the declining availability of basic needs. The long-term objective of these strategies is for the household to maintain its economic and social viability after the crisis has passed.

While the concept has been widely used to explain household responses to famines (among others see: Corbett, 1988; De Waal, 1989; Rahmato, 1991; Devereux, 1993), it has also come to feature routinely in literature examining the impact of HIV/AIDS (UNAIDS, 1999). But how appropriate is this borrowing of a conceptual framework developed elsewhere? How suitable or useful is the notion of coping to analysis of household responses to morbidity and mortality associated with HIV/AIDS?

In order to address these questions, it may be useful to begin with another question: what is coping? In everyday English to cope is to deal successfully with a difficult situation. This means that to cope is to overcome a difficult situation so that, for example, after a disaster or other major setback, a household is able to regain its former living standard, or even surpass it. This implies that households and communities are able to rebuild their lives or to rebound from the nadir of the disaster. In other words, assets disposed of are recovered, food production restored, etc.

It is also assumed that the coping process is achieved through a strategy. What then is a strategy? In proper English a strategy is a general plan or set of plans intended to achieve something, especially over a long period of time. It is assumed therefore that all households have plans of some sort which are designed to cope with adversity.
Table 1: Summary of Household Coping Strategies in Respect to HIV/AIDS

<table>
<thead>
<tr>
<th>Effects of HIV/AIDS at household level</th>
<th>Coping Strategy</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of labour</td>
<td>sale of labour</td>
<td>SAI AIDS (1999)</td>
</tr>
<tr>
<td></td>
<td>co-operative labour</td>
<td>Mtika (1998)</td>
</tr>
<tr>
<td></td>
<td>decrease acreage</td>
<td>Barnett &amp; Blaikie (1992),</td>
</tr>
<tr>
<td></td>
<td>neglect cash crops</td>
<td>Kwaramba (1998)</td>
</tr>
<tr>
<td></td>
<td>destock</td>
<td>Barnett &amp; Blaikie (1992),</td>
</tr>
<tr>
<td></td>
<td>intensify use of child labour</td>
<td>Page &amp; Davies (1999)</td>
</tr>
<tr>
<td></td>
<td>(including withdrawal from school)</td>
<td>Gandiya (1998)</td>
</tr>
<tr>
<td></td>
<td>work long hours</td>
<td>SAI AIDS (1998)</td>
</tr>
<tr>
<td></td>
<td>decrease consumption</td>
<td>Kaijage (1994)</td>
</tr>
<tr>
<td></td>
<td>and/or dissolution</td>
<td>Barnett &amp; Haslummer</td>
</tr>
<tr>
<td></td>
<td>smooth consumption</td>
<td></td>
</tr>
<tr>
<td></td>
<td>decrease household size</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(other members fostered out)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>eat less and low quality food</td>
<td></td>
</tr>
<tr>
<td></td>
<td>work for food (casual labour)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>casual labour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>petty trade</td>
<td></td>
</tr>
<tr>
<td></td>
<td>withdraw children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(especially girls) from school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>decrease consumption</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of purchased foodstuffs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>forego essential services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(school, medical care, clothing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>disposal of productive and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>non-productive assets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dependency on credit and loans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>begging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>immigration/escape</td>
<td></td>
</tr>
<tr>
<td>Shortage of food</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>decrease household size</td>
<td>Kezaliaa and Bataringaya</td>
</tr>
<tr>
<td></td>
<td>(other members fostered out)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>smooth consumption</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(eat less and low quality food)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>work for food (casual labour)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>casual labour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>petty trade</td>
<td></td>
</tr>
<tr>
<td></td>
<td>withdraw children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(especially girls) from school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>decrease consumption</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of purchased foodstuffs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>forego essential services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(school, medical care, clothing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>disposal of productive and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>non-productive assets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dependency on credit and loans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>begging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>immigration/escape</td>
<td></td>
</tr>
<tr>
<td>Loss of income</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>casual labour</td>
<td>Tibaijuka (1997)</td>
</tr>
<tr>
<td></td>
<td>petty trade</td>
<td>Barnett &amp; Blaikie (1992)</td>
</tr>
<tr>
<td></td>
<td>withdraw children</td>
<td>UNAIDS (1999)</td>
</tr>
<tr>
<td></td>
<td>(especially girls) from school</td>
<td>Barnett &amp; Blaikie (1992)</td>
</tr>
<tr>
<td></td>
<td>decrease consumption</td>
<td>UNAIDS (1999)</td>
</tr>
<tr>
<td></td>
<td>of purchased foodstuffs</td>
<td>TANESA (1999)</td>
</tr>
<tr>
<td></td>
<td>forego essential services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(school, medical care, clothing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>disposal of productive and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>non-productive assets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dependency on credit and loans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>begging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>immigration/escape</td>
<td></td>
</tr>
</tbody>
</table>

The ubiquity of the concept of coping strategies in disaster research is hardly a matter of semantics or mere arrangement of words. The evolution of the concept and its widespread use can be traced in the ascendancy of neo-liberal free-market ideology that was resurrected from near oblivion in the 1970s. In the neo-liberal worldview, households as economic agents will be able to cope with adversity on the basis of the knowledge of they have of their specific environment. It is further assumed that households exist in an institutional framework within which the market is the prime mover, and that its role is to facilitate household involvement in economic activity whereby resources to cope will be secured. The bedrock of the argument is that when confronted with difficulty, economic units (individuals, households, or firms) make rational decisions to overcome the situation. It is also assumed that the market facilitates the process of coping. For example, a household short of money to buy food during lean seasons or periods of hunger may sell livestock or exchange it for food. The argument embodies the view that households can cope by drawing on their own assets rather than through reliance on state provision. Thus in order to cope, households will engage with the market and make rational choices about which assets to dispose of and which to retain (Devereux, 1993). Households thus juggle with their portfolio of activities to achieve the balance between needs and resources. The market, it is argued, will react to supply and demand signals to give a fair deal to buyers and sellers.
As advocates of free-market policies worked hard to disengage the state from economic activity and provision of welfare for the poor, the concept of coping was nurtured and slowly pushed onto development research and policy agendas (T. Barnett, personal communication, 8 June 2000). Advocates of free-market, however, rarely mention that perfect markets are more of an abstract construct than an objective reality. In practice, when communities are faced with adversity, market distortions are likely to be high. As observed in Darfur, Sudan, by Alex De Waal, ‘the most remarkable thing is not how many animals die during famines but how few are sold’ (De Waal, 1990:475 cited in Wuyts et al., 1992). What is implied in De Waal’s observation is that in poor peasant societies, market failure in times of adversity is the rule rather than the exception. But even if markets were well developed and functioned well, the fact that poor people are forced by circumstances to dispose of their assets in order to ‘cope’, means that the market plays a significant part in exacerbating vulnerability of the poor.

Theoretically, the framework predicts that the process of coping would be, more or less, as depicted in Figure 1 where A is the pre-disaster point, B is the nadir of the disaster, and C the recovery.

Coping Strategies: In Theory & Practice
Researchers are increasingly employing the concept of coping strategies to analyse household response to adversity ranging from famine, war, accidents, disease and hurricanes to widowhood. At the same time, such strategies are cited as attributes by NGOs and international agencies on the basis of which programmes of mitigation can be constructed. Our argument is that the euphoria over coping strategies obscures the real experience and suffering of individuals, households and communities. Critical reflection and field experience calls into question the utility of the notion for explaining the livelihood crisis induced by AIDS-related morbidity and mortality in rural Africa or for shaping policies on intervention. Our disquiet hinges on a number of points.

The first, as I have argued elsewhere (Rugalema, 1998), relates to the fact that the term ‘coping strategies’ is essentially concerned with analysis of success rather than with failure. It thus has limited capacity to explain ‘failure in coping’ or even ‘failure of coping strategies’. To say that households are coping implies they are managing well or at least persevering. A field based observation (Rugalema, 1999b) shows, however, that in more than a few instances, adult mortality results in household dissolution. Survivors leave the household and join (an)other household(s) largely due to economic and social insecurities resulting from loss of a key household member. This is indeed a failure to cope (point D in Figure 1). It is also in sharp contrast to the presumption that when faced with illness and death of adult members households institute coping strategies in order to ‘avert the breakdown of the household as an economic and social entity’ (Sauerbon, Adams and Hien, 1996).

Dissolution of a household is a clear indication of failure to cope with the effects of morbidity and mortality. It is
doubtful whether such households have the potential to regroup as viable social and economic entities. Coping strategies are, so say the proponents, about long-term viability of a household. In the face of an AIDS-induced dissolution of households following the death(s) of key adult members, it is difficult to see how long-term viability can be regained.

A second issue concerns whether households routinely devise and do have strategies designed to cope with disasters, especially novel disasters such as AIDS. Evidence from my own research suggests that, far from households acting in accord with a previously formulated plan or strategy, they react to the immediacy of need, disposing of their assets when no other alternatives present themselves. Decisions are not based on the importance/usefulness of the asset to the household. Nor is there a discernible pattern in the process of 'coping' across households or over time. Rather, households react according to the demands placed to them by illness/death. For example, if the hospitalisation of the sick person demands more money than available cash reserves, cattle are sold regardless of the importance of the beast in the overall household economy. In this respect saving life is deemed more important than preserving assets. This is surely contrary to observations in famine situations in which, we are told, a household would choose to starve in order to preserve their way of life (De Waal, 1989; Devereux, 1993). The framework of coping strategies predicts that households will spare their land and migrate in search of 'external' support or emergency aid. In the case of HIV/AIDS, households often seem to be determined to save life at whatever cost. More evidence is emerging that even land, the most important agrarian asset, may not be spared in the quest to 'cope' with illness (Corbett, 1989; Kaijage, 1994).

In addition, it is important to note that decisions about how to deploy assets in the face of illness can straddle households and individuals, sometimes involving kinship-based ‘therapy-managing groups’. Such decisions are therefore not always contained within the ‘walls’ of the household. In some situations, individuals (mostly males, including those sick from AIDS) may make decisions about what assets should be disposed of and what kind of treatment should be sought – regardless of the short or long-term costs to the rest of the household members. In others, husbands and wives may consult on the best course of action. In yet others, it is the wider therapy-managing group that manages the resource utilisation of the afflicted households, sometimes without even consulting household members. Rugalema (1999b), for example, reports a case where a therapy-managing group disagreed with the decision of the sick man to sell his land to cover his medical bills. This calls into question whether something like ‘household coping strategies’, formulated at the level of the household and by its members, really exist at all. Should we talk of households, individuals, therapy-managing groups, or even community with reference to strategies invoked in confronting illness? Isn’t it necessary to disaggregate ‘coping’ behaviour rather than bundle together decisions/actions that occur at various levels and take a variety of forms under the single term ‘household coping strategies?’

A third point of contention is that coping strategies tend to be defined as short-term responses to entitlement failure in a way which obscures the true cost of coping. Those who use the concept of coping strategies to analyse responses to disaster have hardly, if ever, discussed the costs of ‘coping’. Indeed they often tend to give the impression that coping strategies are invariably a good thing and involve few if any additional costs (Over et al., 1992). But when we look at the ‘coping strategies’ in relation to HIV/AIDS, we find both short and long-term costs. Examples include curtailing the number and quality of meals, with the short-term consequence of
survivors suffering poor nutrition. Nutritional experts have long demonstrated that long-term consequences of malnourished children (Endnote 1) include perennial underachievement, children of underachievers are also likely to be underachievers. This means that coping by curtailing food consumption has implications for future generations of afflicted and affected households. A second example is withdrawing children (mostly girls) from school in order to overcome labour bottlenecks. Although this 'strategy' beefs up household labour and saves money (in terms of school fees and educational materials) it forecloses the participation of the young generation in the modern economy and plays a role in the increasing illiteracy levels. To sum up this point I would argue that the positive gloss accorded coping invariably ignores long-term costs which fundamentally jeopardise recovery, let alone sustainability. In my view, any meaningful analysis of coping behaviour must include the real and full costs of coping.

A fourth shortcoming that I want to discuss concerns the time span invoked in the analysis of coping behaviour. Most analyses focus on households and communities during disaster, but also, as noted above, frequently incorporate an assumption that households will emerge from a disaster with more secure livelihoods than previously applied. Remember the very definition of coping strategies emphasises the maintenance of household 'social and economic viability' in the post disaster period. Evidence to support this assumption, however, is scanty. My own research suggests, to the contrary, that households emerging from the effects of morbidity and mortality are far more insecure than they were before AIDS. This is partly due to the devastating effects of the epidemic on household 'demographics' and assets. However, this long-term reality is only imperfectly captured, if at all, by a framework employing a short-term focus.

Insecurity and vulnerability do not only emanate from disposal of assets and loss of labour, but also from the systemic effects of the epidemic on communities and local economies. The social and structural effects of the epidemic combine to intensify livelihood insecurity of HIV affected communities. But more importantly, these are further complicated by other forces such as structural adjustment programmes, droughts, pest attack on crops, lack of credit, etc. In the end, the success or failure of any household coping process is dependent on wider structural forces obtaining in the society. These must also be brought to bear in assessing the dynamics and outcomes of households responses to HIV.

A fifth issue concerns how far famine and HIV/AIDS can be regarded as similar types of disaster. Use of the concept of coping strategies to analyse the morbidity/mortality effects of HIV/AIDS on households would appear to be premised on the view that the two disasters are similar in their effects and their impact on behaviour. But a critical look at famine and HIV/AIDS reveals that the two disasters are not similar and, moreover, that the assumption that households adopt patterns of coping strategies that can be generalised across disasters is, at best, tenuous. Barnett and Blaikie (1992) show that HIV/AIDS differs from many other disasters in being a long-wave phenomenon. This means that, unlike drought, it is difficult to predict and prepare for HIV/AIDS. When rains fail in two or three consecutive years, affected communities know that famine is around the corner. With HIV/AIDS the earliest signal is when the victim begins to weaken due to opportunistic infections. By then it may be too late for a household to undertake the so-called first stage of coping (insurance mechanisms) or to plan in a rational way. Rugalema (1999b) has argued that another dimension that distinguishes HIV/AIDS from other disasters relates to the specific way in which the
disaster affects household demography and assets. The very fact that AIDS kills strong people and leaves behind the weak undermines the capacity of households and communities to cope, especially in the long term. In other words, AIDS renders households more vulnerable to future shocks than, say, famine. Unless the fundamental differences between HIV/AIDS and other disasters are factored in, wholesale adoption of the coping framework in analysis of the effects of the epidemic will remain problematic.

A final point of debate concerns the utility of the framework of coping strategies for shaping policy. As mentioned earlier, the term coping strategies, generally implies that ‘things are fine’ or that the ‘situation is under control’. Policy makers may assume that they need not intervene since households and communities will soon surmount the problem. In the case of HIV/AIDS, the rhetoric of coping strategies has become an excuse (especially for African governments) for doing nothing or too little to alleviate the effects of the epidemic on communities. Communities are increasingly forced to take the larger share of providing care for people living with AIDS through ‘home and community-based care programmes’. In these ‘programmes’ what is emphasised is for households and communities to take a lion’s share of the caring burden. Yet issues of resource allocation between governments and communities are side-stepped. A similar pattern applies in respect of caring for AIDS orphans. The emphasis is on relatives and communities caring for the orphans while support from governments and other state agencies remains scanty, if present at all. No wonder there are voices claiming that home care has become home neglect for people and households affected by HIV and AIDS (Etta, 1997).

Conclusion
When drought hits a community, however deep its short-term impact, the return of rain allows an ecological, social and economic recovery. In these circumstances, reference to coping strategies may make some sense. AIDS on the other hand, not only changes demographic patterns of communities, it also changes the agro-ecological landscape with long-term implications for recovery. It may perhaps be useful to end with two questions.

1) When a disaster brings fundamental change in the agro-ecological, social and economic landscapes, can we still talk about coping?

2) When households and communities are barely able to respond to unremitting pressure on livelihoods, is this coping or struggling to survive?

In my view, it is a struggle that is being lost. This implies that there is need to move beyond the narrow confines of the concept of ‘coping strategies’ in order to address the situation of HIV/AIDS with the urgency it deserves including provision of [external] support to alleviate suffering among affected individuals and households.

Gabriel Rugalema, Research Fellow, Technology and Agrarian Development, Wageningen University, The Netherlands.

Endnote
The World Bank study ‘Confronting AIDS’ (World Bank, 1997) indicates that over 50% of the AIDS orphans in the Kagera region of NW Tanzania are malnourished.
References


Given heterosexual transmission and mother to child transmission, AIDS often strikes more than once within the same family. This is debilitating but can also be a learning experience for carers whose knowledge might then be a resource for the community. This article describes a pilot study into the experience of 21 main care providers in families with chronically ill people suffering mainly from AIDS, each one having cared for and supported more than one patient. During the study 46 out of 51 patients who were cared by these 21 care providers had already died. Respondents provided information on care and support given to the first patient and how much they were prepared and experienced at giving quality care to the next patient. This study provides data from in-depth interviews conducted between April and June 1999 in a suburb of Mwanza, a city in northwestern Tanzania.

Care and support for terminally ill people such as AIDS patients is particularly difficult in resource-poor countries (Shepard, 1997). Terminally ill patients would like to die with dignity and in peace, but care providers often lack the support they need to relieve the pain and distress of people who are nearing death (Ng’weshemi et al., 1997). The main expressed needs of people living with HIV/AIDS (PLWHA) are for palliative and terminal care which includes access to common drugs and emotional support, positive consideration by their families, household help, financial assistance and empathy from health staff. For such care to be comprehensive, it must involve multi-sector inputs such as clinical attention, nursing care, social welfare and the help of religious or community groups. Outcomes will also depend on the economic support available for health care in the country. In the 1990s, Tanzania was forced to reduce health spending in accordance with structural adjustment programmes and subsequently introduced cost-sharing policies whereby even the very poor have to pay for medical care. Bugando Medical Centre, a referral health facility for the Lake zone in northwest Tanzania, where this study was conducted, had 45 per cent of its beds in medical wards occupied by HIV+ patients. This figure is estimated to be much higher today with health facilities being overstretched owing to the increasing case load. In a 1996 study, Tanzania was reported to be devoting 13.7 per cent of its health expenditure to HIV. A high share of the budget allocation went to impressive preventive effort leaving little for curative care (Woelk et al., 1995). The burden of care for PLWHA has therefore fallen on families – stretching family resources to the limits.

Given that families have to bear the main burden of AIDS care, the objective of this pilot study was to assess whether the quality of care of subsequent AIDS patients improves as a result of previous experience, even in the absence of professional
counselling. This might then inform the development of care and support interventions. It also illustrates the resourceful ways in which families learn to cope.

Methods

The research was carried out in Igoma, a suburb of Mwanza located along the Mwanza to Musoma road. Igoma is about 10 km. from Mwanza town centre. Its population is estimated at 19,000 people. Igoma is a trading post with a daily cattle market. There is also a lively market for agricultural products brought in from neighbouring rural areas and from Magu district and beyond. Besides this, Igoma is an industrial area with more than fifteen factories. To cater for the needs of its many traders, a considerable number of hotels, bars, groceries, guest houses, halls for video shows and discos and local brew shops have been established. As far as HIV/STD transmission is concerned, Igoma is classified as a high risk/transmission area, given that it attracts those who are highly mobile and sexually active. HIV prevalence is estimated at 10-12 per cent, which is the overall average for Mwanza region.

The research participants were identified through a resident woman who is a member of a local non-governmental organisation which provides voluntary home visiting services for chronically ill people. She revisited all local families who had nursed more than one dying family member. Those interviewed were the main care providers in families. All the families were living in poverty-stricken circumstances in mud-built thatched roof houses. An in-depth interview schedule was developed and used. It contained guidelines on collecting information on the background of the person cared for (age, sex, marital status, number of children) as well as other variables such as duration of illness and visits to traditional healers and formal health facilities. Number and duration of hospital admissions were also noted.

Interviews addressed the experience of both the patients and their carers. The main complaints of the patient were recorded as well as the nature of the relationship with the caregiver. Information was obtained to see if and when the main care provider knew of the HIV sero status of the patient and the source of that information. The patient’s special needs were recorded as well as the extent of support requested and/or received from outside the family. Information on patient care in terms of drugs, food and clothes and any other specific needs was sought. Particular problems experienced by the care provider were explored. The total time spent in giving care was estimated.

When discussing the next patient the care provider had cared for, the respondent was asked whether the experience gained (with the first patient) had led to changes in their care practice for the second patient. Finally the care provider was asked if they had any advice to offer to other families in similar situations.

Families Facing AIDS

Twenty-one main care providers who had cared for two or more chronically ill/AIDS or suspected AIDS patients were identified in Igoma centre. Cumulatively, these 21 care providers (15 females and 6 males) had cared for 51 patients. One of these 21 care providers was a woman aged between 75 and 80 years who had lost five out of her seven children. The characteristics of the care providers and their relationship with their patients are summarised in Figure 1. We defined as main care providers those who spent most time with the patient, especially giving all-night care. Other family
members and neighbours often provided additional care and support, fetching water and firewood, cooking, offering money to buy medicines, clothes or other requirements as well as psycho-social support.

---

**Figure 1: A Summary of the Details of the 51 Cases**

<table>
<thead>
<tr>
<th>Provider No.</th>
<th>Patient No.</th>
<th>Sex</th>
<th>Death</th>
<th>Marital Status</th>
<th>Illness Duration</th>
<th>Death</th>
<th>Caregiver/Patient Spouse</th>
<th>Spouse Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>F</td>
<td>28</td>
<td>M</td>
<td>1 year 1999</td>
<td>Mother</td>
<td>Alive</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>F</td>
<td>24</td>
<td>S</td>
<td>2 years 1996</td>
<td>Mother</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>F</td>
<td>30</td>
<td>M</td>
<td>1 yr 1997</td>
<td>Mother</td>
<td>No Info</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>F</td>
<td>21</td>
<td>S</td>
<td>1.5 yrs 1994</td>
<td>Sister</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>F</td>
<td>30</td>
<td>M</td>
<td>1 yr 1989</td>
<td>Mother</td>
<td>Sick</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>8</td>
<td>M</td>
<td>35</td>
<td>M</td>
<td>2 yrs 1994</td>
<td>Mother</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>F</td>
<td>22</td>
<td>M</td>
<td>7/12 1994</td>
<td>Mother</td>
<td>Sick</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>M</td>
<td>35</td>
<td>M</td>
<td>1 yr 1995</td>
<td>Brother in law</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>12</td>
<td>F</td>
<td>25</td>
<td>W</td>
<td>2/12 1996</td>
<td>Aunt</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>F</td>
<td>32</td>
<td>W</td>
<td>2 yrs 1999</td>
<td>Mother</td>
<td>Alive</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>15</td>
<td>M</td>
<td>22</td>
<td>M</td>
<td>1 1/2 yrs 1998</td>
<td>Mother</td>
<td>No Info</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>16</td>
<td>F</td>
<td>45</td>
<td>Sep</td>
<td>2 yrs 1998</td>
<td>Mother</td>
<td>No Info</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>18</td>
<td>F</td>
<td>38</td>
<td>M</td>
<td>NK 1988</td>
<td>Mother</td>
<td>No Info</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>19</td>
<td>F</td>
<td>35</td>
<td>M</td>
<td>NK 1991</td>
<td>Mother</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>21</td>
<td>F</td>
<td>25</td>
<td>S</td>
<td>1 yr 1997</td>
<td>Sister</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>22</td>
<td>F</td>
<td>21</td>
<td>S</td>
<td>6 mos 1998</td>
<td>Sister</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>24</td>
<td>F</td>
<td>24</td>
<td>M</td>
<td>3 yrs 1991</td>
<td>Mother</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>26</td>
<td>M</td>
<td>23</td>
<td>M</td>
<td>3 yrs 1993</td>
<td>Mother</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>28</td>
<td>F</td>
<td>38</td>
<td>W</td>
<td>1 yr 1999</td>
<td>Sister</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>29</td>
<td>M</td>
<td>38</td>
<td>M</td>
<td>1 yr 1994</td>
<td>Sister</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>33</td>
<td>F</td>
<td>26</td>
<td>M</td>
<td>4 yrs 1989</td>
<td>Sister</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>34</td>
<td>M</td>
<td>36</td>
<td>M</td>
<td>6 mos 1998</td>
<td>Wife</td>
<td>Alive</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>35</td>
<td>F</td>
<td>50</td>
<td>M</td>
<td>3 yrs 1999</td>
<td>Daughter</td>
<td>Sister Dead</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>37</td>
<td>F</td>
<td>34</td>
<td>M</td>
<td>3 yrs 1995</td>
<td>Mother &amp; sister</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>39</td>
<td>F</td>
<td>41</td>
<td>M</td>
<td>3 yrs 1993</td>
<td>Daughter</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>41</td>
<td>F</td>
<td>13</td>
<td>S</td>
<td>10 yrs 1998</td>
<td>Sister</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>42</td>
<td>F</td>
<td>26</td>
<td>M</td>
<td>2 yrs 1999</td>
<td>Sister</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>44</td>
<td>M</td>
<td>40</td>
<td>M</td>
<td>2 yrs 1992</td>
<td>Wife</td>
<td>Sick</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>46</td>
<td>F</td>
<td>32</td>
<td>M</td>
<td>1 yr 1994</td>
<td>Husband</td>
<td>Sick</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>48</td>
<td>M</td>
<td>48</td>
<td>M</td>
<td>1 yr 1998</td>
<td>Daughter &amp; Son</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>49</td>
<td>F</td>
<td>36</td>
<td>M</td>
<td>6 yrs 1996</td>
<td>Brother</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>50</td>
<td>M</td>
<td>40</td>
<td>M</td>
<td>2 yrs 1997</td>
<td>Wife &amp; son</td>
<td>Dead</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>51</td>
<td>F</td>
<td>36</td>
<td>M</td>
<td>1 yr 1998</td>
<td>Son</td>
<td>Dead</td>
<td></td>
</tr>
</tbody>
</table>

---

Tanzania: AIDS Care – Learning from Experience 549
Limited facilities for testing, and the symptomatic diagnosis of AIDS by ordinary people, explain why some of the AIDS cases were suspected rather than certain. As reported by their care providers, many patients had a combination of several complaints which might indicate AIDS. These included diarrhoea (16), fever (15), chest pain/tightness of chest (9), coughing (9), genital ulcers (9), body aches/weakness (8), sores in the mouth (7) and stomachache (6). Other complaints which were reported include leg pains, abdominal pains, vomiting, skin rash, loss of appetite, pneumonia, boils, hair loss, missing menstrual periods, swollen legs, herpes zoster and fainting. AIDS was assumed also where a patient was discharged from hospital whilst still very ill, but people may be mistaken in making such an assumption. One of the 51 patients who was sick for a year, later recovered and is still alive. His main complaint was backache and loss of power in his legs due to partial paralysis. Most likely he was not a case of syndromic HIV/AIDS. Although the purpose of this study was to address care and support of AIDS patients, information data on all 51 patients has been analysed.

Out of fifty one patients studied, 34 were females (67 per cent) and seventeen were males (33 per cent). The age range was from 13 to 64 years, but the majority (39 patients) were aged 21 to 40 years. Only two patients were above 50 years and two others were below 20 years (Figure 2). A pattern of women being affected in younger age groups is very noticeable here, as in Tanzania more generally (NACP, 1999).

The duration of illness varied. Out of 51 patients, 8 were sick for less than a year, 26 became sick for a period ranging between one to three years, and 12 were sick for more than three years with a maximum of 6 years. One patient, a girl who died at the age of 13, was sick for about 10 years. This underlines the long term toll which AIDS can exact on families. The marital status of patients is shown in Table 1.

**Figure 2: Age Range of Patients**

<table>
<thead>
<tr>
<th>AGE GROUPS</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-20</td>
<td>2</td>
</tr>
<tr>
<td>21-30</td>
<td>10</td>
</tr>
<tr>
<td>31-40</td>
<td>2</td>
</tr>
<tr>
<td>41-50</td>
<td>10</td>
</tr>
<tr>
<td>51-60</td>
<td>2</td>
</tr>
<tr>
<td>61-70</td>
<td>2</td>
</tr>
</tbody>
</table>

**AGE OF PATIENTS (IN YEARS)**

- **Females**
- **Males**
- **Total**
In this study, 34 patients (66 per cent) were married but 20 of the spouses had already died. Ten spouses were alive though five of those spouses were very sick during the study. The survivor status of the remaining four was not known to the care providers. This illustrates the way in which heterosexual transmission of HIV normally leads to serial deaths within families. In this case those most at risk are not the young unmarried or divorced, but those ‘safely’ married. Care providers were asked to describe their relationship to the patients they cared for (Table 2). Out of the 51 cases, 19 were cared for by their mothers. Nine patients were cared for by sisters, six by their wives and four by their daughters. Some of the mothers who were the main care providers were assisted by other family members – sister-in-law, grandmother, daughter, husband, sister or brother. In two cases, wives were assisted by their husband’s friends. In this study, it was very notable that only six out of the 51 cases were taken care of by a male member of household, that is, father (2), son (1), brother-in-law (2), brother (1). The remaining eight patients were tended by distant relatives such as aunts, cousins etc. The burden on women as the major carers of the sick needs to be taken on board in any subsequent interventions. And it is also worth emphasising that with the earlier deaths of spouses, many of the sick are being care for in their natal families, by older women.

Not all carers knew with certainty of the sero status of their relatives. In 19 cases, the main care providers had been told by medical personnel about the HIV status of the patient they were caring for. In 21 cases, main care providers suspected that the patient had AIDS through experience of caring for a previous patient, especially when the patient had similar signs and symptoms as those of the previous patient. Also care providers suspected AIDS when the patient was discharged from hospital while her/his condition was still poor. One care provider stated:

I knew that my daughter was suffering from AIDS because she had similar signs and symptoms as my grand daughter whom we cared for before and also from experience of caring for my four other children who died before this one.

Another care provider suspected that her mother was suffering from AIDS because her father had already died.

Care providers thought that they should be informed well in advance of the HIV status of their sick relatives so that they could take the necessary precautions while caring for the patient and that the family could direct its limited resources towards palliative treatment and improving the quality of food for the patient. Lack of information on the HIV status of the patient encourages care providers to waste time, money and emotional energy uselessly seeking treatment.
The most common needs expressed by the patients were to get special food, which for them included cooked green bananas, potatoes and milk. They also needed medicines, including intravenous drips, to increase their strength, and moral support in the form of compassion and encouragement, as well as nursing care such as help in changing their sleeping position (particularly for bedridden patients). One patient who believed that she was bewitched wished to be taken to a traditional healer for reassurance. Another patient, a female who had three children, requested assurance of future support for them to relieve her constant anxiety. Care providers were unable to satisfy all these needs and often felt overwhelmed. These were families who reported to the woman in the home-based care group that it was normal for them to take only one meal a day, consisting of ugali (stiff porridge) with spinach or occasionally beans or sardines. They had few clothes and little bedding, none of good quality.

As reported by care providers, around half of the patients (24) received some support from outside the family. Eighteen patients had received help from neighbours and friends with money, fruits, vegetables, milk and soap. Neighbours also assisted families with patients in terms of labour, to fetch water and firewood, cooking, cleaning clothes and helping the patient in personal cleanliness. In two cases, relatives who lived far away and could not provide financial support due to their poor economic status, sent their wives for short periods to care for the sick, thus illustrating the disposal of women’s labour by men and the taken-for-granted assumption that such caring is women’s work.

Women here are dealing with extremely needy and sometimes difficult patients. Amongst the kind of problems they have to manage, cleaning and changing soiled bedding after excessive vomiting and diarrhoea is particularly time consuming and tiresome. Some patients had diarrhoea 15 to 20 times a day. Handling severe diarrhoea was reported as one of the most difficult things to deal with, especially in situations where water for washing clothes has to be carried, often from a distance, and where bed linen is a luxury. At the terminal stage, caring for a patient becomes a full-time job for the care provider, so that she is unable to give time to any other activity. On average at this stage, the time spent every day doing nothing else but patient care-related activities was 3 to 7 hours. Women cannot at the same time do their essential domestic tasks of cooking and cleaning or cultivation, which then throws the burden onto men or children in the family. Male carers are in a particularly difficult position, as men do not generally spend time in the house and need to give their attention to income earning. The men involved here were forced into the care-giving role as the only ones available. Cultural inhibitions prevent them from offering intimate care to anyone except a wife, and they are often forced to call in female neighbours or other relatives to help. In general, whether the carer is male or female, time given to nursing is likely to affect other productive activities in the affected household, especially where farming is the main source of livelihood. Food security thus becomes compromised.

Care providers reported having difficulty in fulfilling the food demands of their sick relatives due to economic constraints. Patients demanded special foods which were very expensive, so that no one was able to maintain the purchase of such a diet for long periods of time. Sometimes even if the demanded food was prepared, the patient might not be able to eat due to loss of appetite. Again, given that women generally have less access to a cash income than men, such provision is often beyond their means.
Care providers stated that caring for a family member who has AIDS needed patience, love and commitment. As one care provider remarked in Swahili:

*Kama siyo ndugu yako, huwezi ... Inataka moyo ... Jirani tu hivi hivi hawezi kukubali* (literally implying *If it is not your relative you can’t do it ... It needs courage ... A mere neighbour will not agree to care*).

Another care provider observed that her patient was very abusive to the point that other relatives advised her to abandon the patient. Some patients did not want to be visited hence it became difficult to request support from outside the family. It was reported that some patients were selective in terms of the people they wanted to care for them. One woman did not want her mother to take care of her, she wanted her friend.

**Community-based Support Systems**

In Igoma ward, there were several community-based support structures. They included the Pambana Women’s Association and religious groups. Religious organisations provided spiritual support, money, medicines and protective gloves and sometimes assisted the family with domestic work. The Roman Catholic church was reported to have carried out regular visits to patients, provided drugs and given spiritual support. Three patients reported that they had received support from religious organisations. Pambana Women’s Centre also supported three cases by setting up a drip, offering free treatment, drugs and protective gloves.

A common feature of most of these organisations is that they are self-supporting. Their strength was that they were there and were relevant to the local scene and easily understood and identified with the families. Only one, the Seventh Day Adventist church, was known to obtain external funding. Beyond the family then, limited help may be forthcoming, but it is limited and dependent on voluntary effort and the pooling of what are limited resources in such poor neighbourhoods.

**Treatment-seeking**

There is considerable pragmatism shown by those seeking medical help for the sick in Tanzania. With the exception of one patient (a religious fundamentalist) who did not want to go either to a traditional healer or to a modern health facility, all the other patients had sought modern treatment or traditional treatment or both. Twenty-seven patients who sought hospital treatment were admitted at least once. Nineteen patients went to traditional healers at least once. Since such services have to be paid for, the families of AIDS patients suffer a depletion of their reserves or the diminishing goodwill of relatives called on to help.

Caring for patients admitted to hospital was considered by families to be very time consuming and more costly than provision of care and support at home. Most care providers preferred to take care of their patients at home. One care provider stated that:

*It is less expensive caring for a patient at home. Although caring is always time consuming, at home you still can do other activities. The only problem is getting the drugs needed to treat conditions like fever, cough, skin conditions and dehydration. Most of the drugs are expensive. Travelling to and from the hospital is very disturbing.*
Care providers preferred home-based care to hospitals, as long as drugs were available for the patients and doctors/medical personnel were willing to visit patients at home. This latter condition could never be satisfied as there is no funded hospital-run home visiting programme available here. Indeed there are less than 70 doctors in Mwanza serving a population of two million people. When patients become seriously sick, there should be somebody present all the time. Care providers who preferred home-based care stated that when patients are cared for at home, they are able to see their children and other relatives and receive more compassionate care. In addition this is less expensive as the care provider doesn’t need to travel to and from the hospital. At home, it is easier to maintain cleanliness and to prepare the food needed so as to make the patient more comfortable. Besides that, caring for patients at home becomes a shared responsibility among family members. In hospitals, nurses have many patients to look after and hence may not have time to give proper care to each patient.

A few care providers preferred hospital-based care, insisting that in hospital patients more easily get advice and medical services including drips and drugs for their complaints. Protective gloves are also available for those who care for patients in hospital. When patients are discharged, the doctor may inform the patient and relatives about the HIV status so that they use their resources carefully. When asked about counselling, however, the main care providers stated that they had not received counselling on how to care for their sick.

Advice to Other Care Providers
The care providers who were interviewed offered useful advice to other care providers. They advised them to cooperate well with other relatives, neighbours and other members of the community so that they get support to care for patients. Besides that, care providers were advised to be kind to patients, treat them with respect, encourage and comfort them and be close to them. Care providers were also advised to take their patients to hospital to get treatment for their complaints rather than taking them to traditional healers. In retrospect they perceived taking AIDS patients to a traditional healer as a waste of time and money.

Learning From Sad Experience
Due to their experience of caring for someone who was dying, most care providers suspected much earlier that subsequent patient(s) had AIDS. Where symptoms were closely similar to the first patient and from earlier hearsay and impressions from health workers and other community members, they were quicker to conclude that the disease was AIDS. Care providers reported that they had gained experience on handling frequent diarrhoea better than with the first patient. Some reported to have learnt to use gloves and wash hands with warm water after cleaning the patient. They claimed to have looked after the second patient much better than the first, for instance, making sure that the required food was ready whenever needed and showing more patience and sympathy. Care providers reported to have practiced more patience with dying relatives and provided encouragement to them to eat more and to sleep and generally to make them happy. One care provider stated that:

If I knew what I now know of this disease, my first child would not have died so quickly.

Where the first patient was taken to traditional healer(s), either in the belief that they were bewitched or as an alternative to modern treatment after being discharged from
the hospital, most subsequent patients were not taken to traditional healers. While 11 out of 21 first patients visited traditional healers, only eight out of the 30 subsequent patients visited traditional healers. Two among the first cared-for patients had visited traditional healers up to seven and nine times respectively. Faith in the efficacy of either traditional healers or modern medicine was eroded by the death of the first patient. Where previous patients were frequently taken to hospital including private hospitals for treatment and/or admission, subsequent patients were mostly attended to at home by setting up a drip or buying pain killers.

Conclusion

The Igoma study confirms that the burden of caring for AIDS patient remains with the family itself. Many of those who die lost their spouses a few years before, putting a heavy burden of care on other relatives. This study also confirms the general pattern in Africa, that the burden of care and support for patients is normally taken by close female members of the family especially mothers, sisters, wives and daughters (Bos and Leutscher, 1995). Women perform all caring tasks except washing a male patient or undressing him if she is not his wife (Ibid.). In this study, males played only a minor role in the care of patients; only six patients were cared for by men. Care of AIDS patients, especially at the terminal stage, when diarrhoea becomes severe in many patients, is a full-time job, hence an added responsibility for women.

There is some support from outside the family and this comes from neighbours and friends, but it depends on the relationship the patient had with neighbours and his/her friends and family members before falling sick. Besides financial and material support, visits from friends, relatives or members of religious groups can make people who are sick feel less isolated. The area has several community-based organisations. However, support from organisations such as religious groups is minimal, uncoordinated, believer-specific and reaches only a few individuals. To be effective any community aspect of the care and support process will need coordination.

This study has documented several needs of the patients and their care providers as reported by their main carers. Economic support is one of the major felt needs of AIDS patients and their families. Bos and Leutscher (1995) reported that the main problem expressed by patients, their caregivers and other household members in general is poverty. Due to the long duration of the disease and the fact that many affected families have economic constraints contributed by loss or reduced labour in productive work, fulfilling a patient’s needs in terms of food requirements was difficult for many care providers. This remains an unsolved problem for many families. Patients need (but often cannot get) support for their children, special food and more frequent food as well as transport and treatment. Besides this, it was reported from this study that patients need compassionate attention. These findings are similar to those reported by Colebundres (1995) and colleagues that patients need to feel that they are still loved by their partners and family.

Findings from this study indicate that the majority of AIDS patients are sick for at least one year before they die. During illness, AIDS patients often visited several health facilities – including traditional healers – looking for treatment. Elderly people in Igoma view the recent increase in the number of traditional healers along the Mwanza-Musoma main road as a reflection of increased demand for their services, particularly for AIDS patients. But we found that first-hand knowledge of AIDS patients diminished faith in traditional healing. Similarly with hospital care; fewer
used it extensively the second time around. With the recent practice of cost sharing in public health facilities, only families with money can afford to pay for hospital care. Poor families find it hard to pay and find transport costs, especially where their resources are already depleted by death in the family.

In several African countries, home care programmes for AIDS patient have been shown to be very well accepted by patients and their families (Chela and Siankanga, 1991). However, in Tanzania, the policy that HIV status is confidential between the patient and her/his doctor means that relatives may not be told about the HIV status of their patient unless permission is obtained from the patient. Not knowing the HIV status of a patient one is taking care of has consequences. One of the most serious repercussions is that the care providers will not take protective measures while caring for the patient, hence the risk of spreading HIV infection is increased. The other problem is that care providers may spend their limited resources shopping around for treatment hoping that their patient will be cured. If family carers are to substitute for public health provision, then they must be supported by resources and provision of information and counselling.

In the two years prior to the study, there had been no home-based counselling by HIV/AIDS counsellors in this area. The budget which had supported a programme from Bugando Medical Centre was cut, thus halting out-reach services for HIV/AIDS counsellors. Only one of the caregivers had been counselled on how to give care and support to HIV/AIDS patients. No training on the need for gloves, the use of disinfectant to soak dirty linen, or how to feed and clean a bedridden patient had been given to carers. Most disappointing was their lack of training in pain control. Even provided with training, the cost of such simple measures may be beyond the resources of many.

However, the care providers studied here did have something to offer. Our focus has been on their experience of caring for at least two successive patients. Due to knowledge gained from caring for the first patient, the care of the following patient was better in terms of handling diarrhoea, treatment-seeking behaviour, provision of psychological support and food preparation. From this study, it can be argued that caring for an AIDS patient for the first time is difficult and possibly more risky than caring for the next patient with experience obtained from the previous patient(s). An important observation is that care providers more quickly suspect AIDS in the second patient from experience of the first patient even if the doctor does not disclose their sero status. They are then more likely to take precautions to protect themselves and others.

Formal training in HIV/AIDS counselling is time-consuming, taking at least three months. The few nurses who have been trained in counselling have sometimes performed poorly due to lack of motivation. Therefore, alternative methods need to be considered, such as those adopted by the Traditional Birth Attendant Programme which trains community members themselves. ‘Community HIV/AIDS Counsellors’ could be taught basic counselling skills and refer patients to health facilities for further help where necessary. Carers who have already nursed AIDS patients have experience which could be a valuable resource in such work. For in the end it is clear that families cannot cope alone and that communities need to be resourced to take up and sustain the burden of caring for those with AIDS.
Soori Nnko is a research scientist in the National Institute for Medical Research, Mwanza Centre, currently attached to the TANESA Project as a coordinator of social behavioural research and development care services; Betty Chiduo, Research Scientist, TANESA; Flora Wilson, Research Assistant, TANESA; Wences Msuya, Community Intervention Development Officer & Gabriel Mwaluko, Royal Tropical Institute, The Netherlands, attached to the TANESA Project as Technical Advisor for Research.

TANESA (Tanzania/Netherlands Project to Support Sexual and Reproductive Health and HIV/AIDS Control in Tanzania). This bilateral project aims to study and develop community-based interventions within the context of sexual and reproductive health in order to prevent HIV/STD transmission and to mitigate the impact of the AIDS epidemic. Their address is TANESA, P.O. Box 434, Mwanza, Tanzania.

Bibliography


The Uncertain Future of Bilateralism or, ‘it takes two fingers to kill a louse’*

Sarah Bracking

Economic and political accounts of events often exist as distinct texts which can obscure the political economy of the subject under discussion. In the analysis of bilateral relations this is particularly evident in the new orthodoxy which takes as given that there is a necessary accommodation which must be made with the requirements of ‘modern’ globalisation to ensure international competitiveness. This has caused many economic policy issues to be regarded as a closed box, as a given, not open to discussion. Debates about them have disappeared from view. As a consequence, it is possible for bilateral development finance organisations to maintain a political and, more importantly, moral agenda of poverty reduction, human rights, good governance and a crusade against corruption without questions of political economy or the more specifically economic relationships between states impinging on considerations of the ‘donor’ state’s behaviour.

This article argues that the radical agenda of Britain’s Department for International Development (DfID) and the political interventions of international NGOs are often undermined in practice (whatever their good intentions) by bilateral economic and trade relations which are in desperate need of regulation and reform. If there were some concept of international solidarity and true co-operation, it might be possible to shape the reforms required. Instead, international fora – generally characterised by a democratic deficit themselves – become immersed in a quagmire of hypothetical, even arbitrary, ‘good practice’ codes while developing a blindspot concerning the underlying inequities of bilateral economic relations between North and South.

This paper argues that there are two contradictions at the heart of the current British ‘donor’ agenda: first, that political development policy fails to take into account adequately the economic relationships between states and the ways in which these can undermine even the best intentioned political reform interventions and partnerships; and, second, that policy reforms aimed at helping the poor remain country-based, without the scope to include the interstate economic relations which undermine poverty reduction initiatives. The failure to combine the economic and political agendas, or to consider those political economy relations which exist between and beyond the boundaries of the state, militates against the success of radical bilateral policy in practice.

* This quotation is taken from a Kenyan proverb
If the potential for bilateral political interventions can be legitimate where interstate exchanges are based on universal principles of solidarity, in practice these are undermined by economic arrangements which lack such principles and which remain hidden and unquestioned. The institutions which manage such financial and economic arrangements in the case of the UK remain outside even domestic (much less international) accountability. The paper concludes that increased regulation of those UK government institutions which have a global scope is urgent and necessary if political reform and poverty reduction in the South are to succeed. Moreover, for such reform programmes to be legitimised for all parties requires first the reform of the totality of bilateral interstate relationships.

In making this case, this paper ultimately rejects two opposing types of argument. First, it does not accept the validity of liberal assumptions that interventions by the North in the countries of the South are legitimate on the grounds that liberal values are universal and therefore everywhere legitimate. As we will see, such assumptions rest on premises which are unsustainable. Second, however, it also rejects post-modernist criticism of liberal interventions which are advanced on the grounds that there are no universal values and that universalism is itself a threat to local self-realisation. Instead it proceeds from the premise that universal principles of solidarity, equality and democracy do exist, even if presently they lie outside the boundaries of the liberal developmental discourse. It is the construction of relations and institutions on the basis of such universal principles that is essential to the construction of a legitimate international political economy.

Hidden Agendas: Political 'Good Practice' & Economic Restructuring

Recent events in Zimbabwe illustrate the non-intersection of the political and economic agendas of reform and the analytical dislocation which occurs where political economy should lie. First, policy debates within Zimbabwe had distinct fault-lines which ran along the boundaries of the two agendas. And second, the bilateral relationship between Britain and Zimbabwe was demonstrated to be one in which the UK government employed a thin veneer of moral justification in its efforts to enforce economic conditionality, raising clear questions about whether or not such tactics constituted a legitimate bilateral dialogue between two states and, if they did not, what did.

Within Zimbabwe, and reflected in British media coverage of events, was a particular political debate about the need for constitutional reform and democratisation. The main constituency for this was broadly based within the MDC (though elements of ZANU-PF also embraced it) but demands for change were also made during the 1999 public consultation, conducted by the National Constitutional Assembly, which took evidence in every province. The people's will expressed through the consultation was clearly for curbing executive power and strengthening parliament. However, Commission members loyal to the President and government ensured the production of a more executive-friendly report which became the basis for the referendum in early 2000 that the government eventually lost. Despite such government pressures, demands for democratisation were expressed constantly during the referendum and subsequent parliamentary election campaigns. For instance, the editor of Zimbabwe's largest independent newspaper wrote:

*If I were President Robert Mugabe: I would abolish the word Comrade; I would immediately withdraw Zimbabwean troops from the Congo; I would use my law degree to stop*
lawlessness; and I would stop the ‘government process’ of printing money since this is the main cause of inflation. I would also use my degree in economics to stop scaring investors away through unwarranted racial attacks. And through my broadcasting company ZBC, I would give an actual date for elections and promise the electorate that the elections will be free and fair and whoever wins will smoothly take over.... I would also assure the people that Tobaiwa Mudede is not going to rig elections to help Mugabe win (Pasval Mukuwerere, Financial Gazette, 21 April 2000).

There were also calls for the state to end the intimidation of the opposition, to stop subverting the independence of the judiciary and to restore suspended constitutional and human rights.

Behind this discourse, however, remained the central economic issues of severe inequality, unemployment, rampant inflation and the question of land distribution. From another Zimbabwe newspaper we are reminded that:

The real land grabbing of the white settler colonial era has bequeathed a situation wherein about 4,000 white farmers own 12m hectares — more than 50 per cent of Zimbabwe's prime agricultural land — while about 2m black peasants occupy 16m hectares, 'often in drought-prone regions', acknowledges a BBC reporter; ... this 'land question' was glossed over at Lancaster House 20 years ago, with neither the EU, Britain nor any significant factor in the northern hemisphere making the kind of noises that would be expected of champions of 'democracy' and 'justice', about this historical and socio-economic obscenity. Yes, it is a complete picture only if the observer is also able to see, behind the white faces that face the TV camera, the many angry ex-combatants and landless peasants who now wish to capitalise on a rare opportunity to have the historical injustice rectified. For all those who believe that the land question should have been resolved at independence in 1980, it is no longer possible for anyone to use the issue as merely a vote-catching gimmick. It is equally disgraceful for any black Zimbabwean to suggest that the land issue is not contentious, if only because two decades of post-independence have caused the obvious amnesia on the part of those few blacks who have benefited most from the 'fruits of independence (Zimbabwe Mirror, accessed www.africaonline.com, April 2000, now http://allafrica.com/zimbabwe/).

These two comments illustrate the separation of the ‘political’ and the ‘economic’ in the Zimbabwean debates, a separation which illustrates wider issues of theory and political economy.

The relationship between a country’s political and economic structures is a highly complex theoretical problem. Broadly speaking, the issue of redistributive politics and the more equitable distribution of economic resources has become a weaker political language since the implosion of the former Soviet Union. It is also a politics whose advocates are uncomfortable about relating it to the conceptual nexus of liberal and democratic texts and policy demands. Meanwhile, for its part, the democratic discourse only touches such economic issues tangentially, through the prism of the economic and social rights agenda. Thus, the fault-lines in Zimbabwe’s debates illustrate the more general pattern of this unhappy coexistence. However, this paper is not concerned with ‘high theory’ but, rather, with how various forms of bilateral intervention try to deal with the complexity. During the period of hegemonic neo-liberalism in the 1990s, there existed a denial that economic class structure could undermine political reform. In fact, economic and political liberalisation were supposed to be purely complimentary. More recently, however, increasing income inequalities are cited — even by the IMF — as obstacles to good governance and
democracy. A new hegemony has developed around the ‘pro-poor’ and anti-poverty agenda. In turn, this shift affects political and economic relationships and interventions between states. It opens up the possibility that economic relationships will again be given analytic primacy and be seen as significant to development prospects.

At first sight, it seems that much is as it was before. In Zimbabwe, both categories of economic and political intervention, and the bilateral dialogue between the UK and Zimbabwe, still resemble and reflect older global power structures. For example, President Mugabe stated that Britain has a moral responsibility because of its colonial history to pay for land transfers. The British foreign secretary, Robin Cook insisted in turn that 20 years of independence means Britain cannot be held wholly responsible for the present malaise. However, he could not resist the post-colonial high ground: there would be economic ‘aid’, but only with political conditionality. This political intervention is not authorised by treaty or by an international representative institution like the UN; instead, it verges on the personal. More money requires the ‘good behaviour’ of Mugabe’s government. As The Guardian observed:

Zimbabwe will receive £12m from the Department of International Development this year and £10m next year. Mr Cook described this as the ‘low scenario’, the money that Zimbabwe would receive even if Mr Mugabe’s government did not cooperate. But he held out the carrot of a ‘high scenario’ if Mr Mugabe was ‘willing to behave reasonably’: this would see the package increased to £28m this year and £30m next year (‘Cook warns Zimbabwean mission he is offering help, not appeasement’, Ewen MacAskill, diplomatic editor, The Guardian, London, 27 April 2000, http://www.guardianunlimited.co.uk/Archive/Article/0,4273,4012203,00.html).

In his turn, Mugabe takes the position that the British government ‘ha(s) no right to comment’. What the scenario does illustrate though is that traditional forms of bilateral intervention are increasingly drained of legitimacy. It is a discourse which does not feel the need for international validation or authorisation. There is no expression of international solidarity, only a reflection of national interest. In what follows, this paper suggests that without a reintegration of the ‘economic’ and the political through a political economy of interstate affairs – and without a concerted effort by the rich countries to mend the democratic deficit in the international system – such exchanges can only remain antagonistic.

Political Interventions: The Context

The prospects for political reform at a national level in the South were seen as positive through most of the 1990s. Following Huntington (1996) many commentators spoke of events as reflecting a ‘third wave of democratisation’ (Szeftel, 1999:5-7). The political interventionism of good governance programmes reflected the optimism of the time. Yet they relied on institutional state reform and were divorced from more radical demands for redistributive politics and social and economic equity through their association with structural adjustment programmes. Meanwhile, the material economic conditions of life in poor countries remained largely unimproved (in some cases even deteriorating) and constantly militated against political reform.

The emergence of a new regulatory regime, or ‘partnership’ between ‘donors’ and ‘clients’ comfortably reflects these contradictions. Currently, the production of a Poverty Strategy Reduction Paper (PSRP) regulates a country’s access to the extended debt relief available though the Highly Indebted Poor Country Initiative. Issues of
governance are part of the dialogue between donors and clients over lending and reform and are included in the demands of donor organisations. In contrast, the demands made by poor countries of donors are limited to negotiating access to money, denominated in debt relief and development funding, to the virtual exclusion of a more extended agenda which would cover the donor country's responsibilities in regard to its multinationals resident in the recipient country, or its trade regime. Thus the dialogue remains one in which the partners reflect the unequal power relations in the economic hierarchy of rich and poor countries.

If there is to be another, different future, one in which a broader process of authorisation is required for political intervention to be defined as legitimate, the question of what is a common political good for humanity must be considered. The current understanding of what is and what is not political good practice rests on the hegemony of liberal ideals of democratic organisation. This, in turn, gives rise to questions about the applicability of western forms of organisation for the African countries on which they are imposed. Are such ideas alien or do they have the longest history in Africa? How mutable are such concepts to local conditions? Is liberalism a legitimate ideology on which to hang infringements of sovereignty?

Two related propositions challenge the hegemony of 'democracy' in its liberal form. The first is that democratic political life as understood in development discourse is not a universal human good. The human values on which it is based reflect instead a more contradictory historical compromise between the owners and non-owners of capital in Europe. Here, the extension of representative democracy and the construction of the citizen (in the political realm) removed the economic class struggle (within the social relations of production) from view, ameliorating the risk of social revolution and a more radical redistribution of wealth. In other words, liberal democracy's claim to be underpinned by universal human values is part of a legitimising ideology of capitalist social relations, rather than the reality of each individual's wellbeing in terms of those values.

This argument has another variant, one derived from the critique of universalism by radical anthropology and post-modernism. As Paul Richards eloquently summarises it, 'universalisms' can close off the space available for radical transformation:

Destructive critique by purveyors of various 'universal' modernisms (whether from the stand-point of neo-liberal market economic or standard theories of human rights) tends to threaten the space in which citizen action might otherwise flourish. Anthropological analysis is useful, I believe, in holding open that space for its rightful tenants ...Citizens of weak but modern states in Africa need and deserve room for creative manoeuvre if they are successfully to build islands of security and archipelagos of peace with the limited material resources at their disposal (Richards, 1996:163).

In other words, the argument can be made that the human rights agenda and the individualism embedded in liberalism just 'don't fit' – or at least may restrict such rights – in other contexts. As President Gadaffi noted at the European-Africa conference in Egypt in April 2000: 'In Africa we need water pumps, not democracy'. For some time, similarly, the Asian model of development, was often said to rightly emphasise economic development over the niceties of (foreign) democratic political form.

The second proposition which challenges the hegemony of liberal democracy as the basis for political intervention can be broadly termed the problem of efficacy. It
criticises the assumption that democracy can be operationalised in any country in the world using this singular set of values, practices and institutions. This view derives from arguments about the efficacy of political intervention *per se* and is perhaps the stronger of the two poles of criticism levelled at advocates of democracy. This critique regards the democratic project in developing countries as 'naive' in that democracy is held not to be possible in *structure adjusted* (Fergany, 1999) poor countries. It also posits that when we see governance structures that seem to indicate the presence of democratic process, we are in fact misled or guilty of misinterpretation.

In the next section I shall discuss further these two poles of criticism of democracy as the legitimating ideology of political interventionism. So far we have assumed that political intervention is legitimate behaviour, in and of itself. In the first proposition above we questioned whether 'democracy' was enough to sanction intervention. But there are more fundamental issues concerning the authorisation, validation and legitimacy of bilateral relations, whatever their ideological basis. The first is that such intervention rides roughshod over the sensitivities of the post-colonial age – an unintended but unavoidable result of the policies of those in the North who advocate political reform. This has led to the explicit or implicit advocacy of eurocentric institutional forms of government, and to the evaluation of other systems against this model. In opposition to this orthodoxy, the post-colonial context produces many objections to such judgements of other political systems being made at all by anyone from the North. As President Mugabe put it: 'you have no right to comment'.

A second, related, argument is that the northern proclivity for intervention demonstrates an indifference to the *unequal power relations* inherent in the development discourse, where the international division of labour pits an advanced North against a backward South (Crush, 1997; Rahnema and Bawtree, 1997; Ferguson, 1994). In this discourse, the 'other', the majority non-Western world remains associated with lack of competence, corruption, and inefficiency, whilst Western supremacy is expressed as technical expertise, managerial know-how and economic efficiency (Benuri, 1990). In this reading, the apparent benevolence of aid and assistance relationships obscures continuing exploitation in economic relations. Carried to its logical extreme, it can be argued that the hegemony of democracy as a universal human good serves a functional purpose for global capital (see, for instance, Claude Ake, 1995). It is the contemporary justification of a history of conditionality and illegitimate leverage exercised by donors on poorer countries in the name of political reform. It thus extends the financial and knowledge-based complex of interstate political patronage and state-endorsed intervention, for the benefit of rich and powerful political and economic agents and firms.

However, and whatever its merits, this critical functional reading does not help us understand how the politics of contemporary bilateral relations, through the activities of many, often well-intentioned people, could be reformed on a more legitimate basis. Thus, we will leave aside the question of who has weight in the legitimate advocacy of political change, although we will return to it later. In the absence of another, more radically distributive politics, democratic protection from more authoritarian and brutal political behaviour is just about the best many people can hope for. The assumption here, is that liberal democratic process has a wide currency, or even a claim to be a universal good. We need to examine further its prospects.
Is Democracy Possible Anywhere?

It has been suggested that we only find what we are expecting to see and that, in the case of North-South relations, what we see are fundamental differences and inequalities. The most obvious difference relates to state capacity and the funding of democratic government. Fergany, citing World Bank (1997:2) figures, observes that, measured in terms of the ratio of government expenditure to GDP, 'government spending in OECD countries was in 1990 about twice as large as in developing countries' and had been steadily rising between 1960 and 1995 (1999:3,4). By contrast, the share of GDP appropriated to government spending in poorer countries had declined in 1990 to its 1980 level as a consequence of the savage capitalism of structural adjustment. When the size of GDP and population factored in together, government spending in OECD countries dwarfs that in the poorer countries. In the historical context of debt and crisis, this means that social investment funds dried up in the South before minimum social and economic rights were in place. The task of social development in richer states, at least in terms of minimum primary health and education had been mostly achieved, essentially under the leadership of the state, before 'neo-liberalism' demanded that the state be 'rolled back' in accordance with its new governance regime of 'policy-making without politics' (Kazancigil, 1998: 71-2). Significantly, the responsibility of the state for distributive justice as the basis for social development had already been established before that in the North. This is not the case in most of the South where poverty prevails, big capital has free reign, and repressive state apparatuses are used to silence criticism, criminalise activists and subject public life to secrecy (Fergany, 1999:5).

In response to such concerns, it is appropriate, in particular, to ask how democracy can grow in very poor or conflict ridden societies. Is it possible to implant liberal institutions in what Holloway has called the 'hollowed out' state, or what Richards (1996) calls 'the mere façade of a state' in Sierra Leone? This 'façade' has often been erected for the benefit of the external, donor gaze or, more particularly, for the governance assessors. Its existence points to the very real gap between the formally-apparent institutional structures of liberal democracy (which are drained of any real power) on the one hand, and the hidden class processes and informal power relations (which determine actual political process in the 'shadow state'), on the other (Richards, 1996). In its extreme form, Fergany identifies

one especially deceitful form of bad governance [which] flaunts the institutional framework but ensures that the institutions do not function effectively (Fergany, 1999:11).

Moreover, argues Fergany, this political shell is tightly managed by those who control it:

It is [now] well known that elections are largely 'managed' by the dominant powers in underdeveloped societies. The executive authority, in conjunction with the security forces, normally decides, at the outset, on who is to run for office. Access to wealth and power significantly influences the conduct of such elections, as do the violation of human rights, the manipulation of results, and sometimes the non-enforcement of judicial decisions to declare results null and void (Ibid.: 26-7). Most importantly for our purposes, the perception of the widespread abuse of state power is itself framed and expressed from the perspective of an implicit model of 'good' democratic behaviour. As a result, such abuses are not considered, in themselves, to disprove assumptions about the universal validity and desirability of democratic practice, they may even reinforce them.
Yet experience on the ground points also to a different and parallel reality, one which suggests that democracy and the degenerative forms of liberal governance can be universal competitors. In cases of state collapse or civil war (Allen, 1999) the central government, the pivotal institution of liberal democratic reform, obviously disappears. However, and here begins an interesting contradiction, in such cases grassroots organisations often reflect more democratic content than the collapsed central state did, as village committees, representative structures, and processes of authorisation spring up in the wreckage. For example, in war-torn Sierra Leone Richards found an educated population committed to political ‘modernity’ as they saw it, desiring transparent and accountable institutions of state and civil society, in order to remove the causes of war and effect environmental management (1996:xxvii). Richards suggested that within the collapse of specific governance regimes, the seeds of renewed demands for human rights, effective bureaucratic and democratically accountable states could be found. In such conditions, for instance, as resources decreased, patrimonialism came to be regarded less as legitimate ‘sponsorship’ and more as illegitimate patronage (Ibid.162). Thus, it might be that the collapse of the post-colonial state is encouraging Africans to look back, as well as forward, at reinstating traditions of democratic process, of checks and balances and government accountability to the community. Democracy may well have a universal validity even where its liberal model does not. Democracy, according to this reading, was not invented by the North – though many of its competitors were.

Thus, if patrimonialism, clientelism, paternalism, authoritarianism and the exploitation of economic groups can be seen as universal experiences, so too can demands for democracy. And this leads us to the next line of our defence against the criticism of universalism: namely, that it is not institutional forms which define democracy but mediating values. Beetham et al. (2000) have recently schematised these mediating values as participation, authorisation, representation, accountability, transparency, responsiveness and, in recognition of the international context, solidarity. These, in turn, can be aggregated into two summary requirements which underpin the construction and maintenance of democratic processes and institutions – those of ‘popular control’ and ‘political equality’ (Beetham, 1999:5). In terms of our underlying concern about the basis on which legitimate interstate relations could be constructed, it is the last of these values – international solidarity – which needs to be regenerated. The post-modern rejection of universalisms, which stems from attempts to incorporate differences between the apparent and the real, and to look beyond the façade of institutional forms constructed for the benefit of periodic donor inspections, ends up (as a corollary) with the rejection of this earlier twentieth century notion of international solidarity found within socialist discourse.

From a more philosophical-historical perspective, the case for defending universal values from post-modernist relativism is equally strong. Sardar (1998) has pointed out that the post-modern rejection of universal moral forms can be timed from the moment when the West could no longer, by any stretch of the imagination, claim the moral high-ground. Everything was to become relative, so that nothing had to really matter. Thus, to operationalise relativism is often to allow, by omission or commission, the most tragic of human events to unfold, to regard them as allowable since to do otherwise would be an infringement of sovereignty, an illegitimate interference in the local customs and practices of a sovereign people. Thus, to those who would say that democracy cannot be a universal concept there are, therefore, two counter-arguments. The first is that the arrogance of modernity, of progress and of western dominance should not be replaced by an equal arrogance of ‘it’s nothing to do
with us'. Geras problematised this form of post-modern morality in the idea that 'if you don't have to help me, then I have no responsibility for you either', what he termed the 'contract of mutual indifference' (1998). This represents a zero-sum option for human aspiration and progress. The second counter-argument is that this claim to relativism often serves an age-old process of modernity, one witnessed in Africa's experiences of slavery and colonialism: it denies the actual history of the participants themselves. If democracy cannot be a universal concept, then what of the myriad groups advocating democracy, the human rights monitors and the courageous efforts of millions of political participants in the South to forge a better life? We risk losing or ignoring these experiences and voices from the transcript of history.

Values, Bilateral Relations & the Policy Context

Assuming that we can decant various values from the overall concept of democracy, and in the process lose its more normal association with particular institutions and practices, does this mean that the concept can be used to validate foreign policy and political intervention? Does it complement the other economic discourse of poverty reduction? Most significantly, are donors as well as clients observing the values to which we have referred above? The problem here, is that richer countries do not observe the norms of their own avowed good practice urged on others, and economic relations are often not considered at all. This behaviour infringes the principle of solidarity as isolated above, and undermines the concept of 'partnership' which now pervades policy-based development literature. A short review of UK policy can illustrate this.

The dominant policy commitment made by the UK government is primarily an economic one: to halve the proportion of the world's population living in absolute poverty by the year 2015 (House of Commons (HC), 1997:6). Official UK sources suggest that nearly a quarter of the world's population, some 1.3 billion people globally, almost 70 per cent of whom are women, live on less than the equivalent of $1 per day (HC, 1997:10). The proper implementation of the UK government's commitment would represent an increase in social wellbeing for some of the poorest citizens of the global community and would raise over a billion people from absolute poverty. This is a commendable policy commitment.

In order to put into effect its poverty reduction strategy, the Department for International Development (DfID) set out seven policy priorities in 2000. These are:

- to operate political systems which provide opportunities for all people, including the poor and disadvantaged, to organise and influence state policy and practice;
- to provide macro-economic stability and to facilitate private sector investment and trade;
- to develop a policy framework which can meet the poverty eradication targets and to raise, allocate and account for resources in accordance with those pro-poor policies;
- to guarantee the equitable and universal provision of effective basic services;
- to ensure personal safety and security in communities with access to justice for all;
• to manage national security accountably and to resolve differences between communities before they develop into violent conflicts;

• to develop honest and accountable government that can combat corruption.

Elements of political reform have been incorporated within this overall strategy framework, such that in effect, the economics is leading the politics. However, the policy framework centres on the national space so the impact of international relations and power structures is removed from the dialogue. Furthermore, the claim that ‘pro-poor’ policies structure policy is contradicted by competing requirements. Thus, the requirement that all should have the right to work and have an adequate entitlement to services exists alongside the right of firms to operate in a competitive, unregulated marketplace. Class-based arguments about the economic distribution of resources are thus not anticipated. In the recognition that development is not merely conditioned by the national, and that DFID is not the only department of state with influence over the totality of bilateral relations, can we contextualise whether this radical departure constitutes an adequate legitimacy and authorisation for either political or economic interventionism?

Economic Intervention
Since debt peonage became the defining system for structuring interstate relations, three broad forms of economic relationship between North and South can be identified. The first is policy-driven, and consists of the programmatic packages of the IMF and World Bank, until recently termed structural adjustment (and now arguably termed country strategies or poverty reduction strategy papers). These are country-level ‘solutions’ flown in, most often by briefcase or laptop from the international development banks. The second set of economic relations is between states and involves the semi-public interventions made by the development ministries, development finance institutions and export credit departments of the rich countries. The third form of relationship consists of the general relations of private economic power as structured by the capitalist world system which, in the case of the South, amounts to debt peonage. Although termed ‘private’, this mode of intervention is included here in recognition of the fact that any system has agents. The global economy exists as the multiple interactions of firms, and is regulated by trade, insurance and financial regimes which involve the agency of national and international organisations authorised by states. I will discuss these three schematised relationships, as modes of economic intervention, in turn.

I have previously argued that progressive forces lost the ideological debate over structural adjustment by failing adequately to question its assumed necessity and rationality (Bracking, 1999). Economic interventionism in this form was falsely justified by what were portrayed as fundamental and unavoidable economic laws. Instead, I argued, adjustment could alternatively be viewed as only one of a number of alternative political and economic strategies and that, in practice, it introduced a re-regulation of dependency relationships through the extended management of southern markets, rather than increasing openness or real competition. Without repeating these arguments here, it was the role of institutions authorised by northern states which led to these conclusions, and which is now pertinent to this article.

Under structural adjustment, the domestic market for finance was constructed by a financial and political elite whose agency derived from their membership or
involvement with development finance institutions. This represented an integration of political and economic power constructed under the auspices of what was depicted as a purely economic intervention. This had a number of effects pertinent to current interventions. First, it increased the power of international financiers, both public and private, to use access to money (or denial of it) as a primary mechanism in the governance of the South - a condition which remains in place, since few countries have subsequently reduced the liabilities acquired. This represents a significant leverage and creates the possibility that further economic conditionalities, imposed in the interests of the banks, could yet undermine the more redistributive pro-poor and good governance agendas. Second, the private and public financiers currently regulating markets are consequently not subject to any remotely democratic requirements of accountability to the mass of southern populations whose livelihoods they now increasingly shape. None of the current political interventions seek to impose or achieve such accountability and so leave market-regulating global institutions as the preserve of representatives of the richer states. Third, the enrichment of a small domestic elite by its association with international money-holders within the structural adjustment process has created a legacy in which the ‘poor’, now ostensibly the key targets of British development policy, have even fewer effective claims over national resources than they once had.

The Role of Nationally-authorised, but Internationally Active Institutions

These conclusions mean that within the second mode of economic intervention identified above - the activities of development ministries, development finance institutions and export credit departments - national interest reference systems for determining policy remain focused on bilateral state relations. They need to be replaced by broader participant reference systems which recognise the constituency beyond the state if policies are ever to reflect a political agenda of 'good governance' which is addressed to the poor. Furthermore, whilst these institutions were all intricately bound up in the country-level 'structure adjustments', the justification for advocating political reforms in other peoples' countries does not seem to have impacted on the values of accountability or transparency 'back home'. Instead, such institutions still resist growing demands for ethical regulation, despite the UK policy commitments to poverty alleviation and an elusive 'ethical dimension' in foreign policy. So, how have the bilateral aid and finance departments responded to such a new challenge in government policy?

Both the Commonwealth Development Corporation (CDC) and the Export Credit Guarantee Department (ECGD) can be regarded as bilateral institutions of economic intervention. While DFID is the lead department for development issues there are complex and overlapping relationships and institutional structures within the British state, involving other departments and organisations. In particular, both CDC and ECGD disburse development finance and export credits which are larger than the sums managed by DFID (Endnote 1). And, since both the CDC and ECGD have been the subject of recent parliamentary Select Committee reviews, we can see how the change in economic and political agendas have been domestically addressed. The reviews identified the future ownership structures and operational criteria of both CDC and ECGD as a contentious issue (HC (1998a); HC (1998b); HC (1999a); HC (1999b); HC (2000) but, thus far, they have been able to avoid ethical regulation and increased transparency.
CDC changed its constitution from a statutory corporation to that of a public limited company on 8 December 1999. However, DfID continues to hold 100 per cent of its shares, the Treasury underwrites its portfolio and no private capital has yet been introduced. It therefore exists as a hybrid case within the category of a Public-Private Partnership (PPP). Established in 1948 as the Colonial Development Corporation with a developmental objective, its new status leaves it open to criticism for the lack of transparency in the public monitoring of this role. CDC itself has given the assurance that it has adopted a Code of Business Principles (http://www.cdc.co.uk/_index.html) and claims a ‘commitment to be a leading ethical and socially responsible investor’ (HC, 1998a:5). DfID, who have some managerial responsibility for the CDC, write that it is making progress on the requirement ‘to implement and report on a code of ethical policy and practice which meets international best practice’ (HC, 1998a:3). However, these assurances remain beyond public scrutiny because the Code of Business Principles is not in public view.

In the case of the ECGD, the power of its larger clients has successfully been used to rule out any unilateral regulation on the basis of ‘best practice’. The ECGD is a department enjoying the sovereign guarantee of the Treasury for its investment portfolio, and supports ‘long and large’ business and the provision of export credit to the poorest countries where the private market is unwilling to participate. The ECGD has been criticised recently in the International Development Committee (HC, 1999a) for failing to explain adequately its support for contentious projects without proper environmental and developmental assessment, and is under review. Within this review, it was proposed by the government that

trade arrangements with developing countries should be used to promote sustainable development in developing countries, in a way that does not discriminate against their exports (HC, 1999a, citing HMSO, 1997:92).

The qualification concerning exports was subsequently taken by firms interviewed in the consultation exercise to mean that any regulation would lead to an unacceptable, and potentially disastrous uncompetitiveness.

During the review, the International Development Committee announced that it was concerned that the development community should be asked to contribute to the ECGD’s review and invited Memoranda on how the ECGD could contribute towards wider government objectives of eliminating poverty in the developing world as set out in the Development White Paper (HC, 1999a:vi). The subsequent discussion centred around the inclusion of a reference to developmental objectives in ECGD’s Mission Statement, with a number of NGOs proposing mandatory social and environmental standards to ensure coherence between ECGD behaviour and government policies on debt relief and poverty alleviation. The Corner House termed this type of mandatory developmental responsibility an ‘Ethical Guarantees Policy’ (HC, 2000:64).

However, in response (and using the caveat of export competitiveness) the exporting community argued that unilateral action would compromise them too much in relation to competitors such as French and German firms. In recognition of the collective, but competitive, interests of the firms of the richer states and the transnational regulatory framework in which they operate, the International Development Committee deferred a decision and recommended that any changes should be internationally agreed with other Export Credit Authorities (ECAs) in the OECD Consensus Group. As a palliative, after this rejection of firmer controls, the
ECGD was asked by the Committee to take a proactive stance in institutionalising its commitment to poverty reduction in dialogue with the other ECAs. Such deferment to an international frame of reference has the potential of abdicating the responsibility of each state in favour of international collective agreements which might or might not be achieved. It also creates the possibility of avoidance of transparency and accountability.

Thus the UK policy of poverty alleviation, or indeed transparent economic governance, does not seem to have been operationalised by all stakeholder departments, particularly those economic institutions with a global role. Promoting integrated political and economic reform would mean changing the roles of institutions which help to define global relationships, are involved in international legal commitments and voluntary unions, and often operate alongside such global assistance institutions as the World Bank and UNDP, in which the UK has institutional membership (Endnote 2). As we have seen, it is the argument against unilateral change, and the correspondent loss of competitiveness, which militates against such an outcome. So what are the prospects of change at an international level?

**Current Prospects for Political & Economic Reform**

The human rights agenda and discourse has taken its place at the centre of international politics since the end of the cold war. There has been a growth in global civil society and with it an increase in lobbying and campaigns to establish minimum standards for the world's peoples in terms of their fundamental rights. At a global level there is a great deal of campaigning for poverty relief, economic and social rights and reform of key institutions in general. These campaigns are mirrored by a plethora of national groups. Globally, initiatives such as the UN 2000 Global Compact (www.unglobalcompact.org; www.unhchr.ch/business.htm) are providing the first international efforts to harmonise standards of economic and social rights. This follows the G7 agreement of 30 October 1998 for Reform of the Financial System; the assertion in 1995 by the Commission on Global Governance of the need for a 'global civic ethic'; the demand by Kaul and colleagues at UNDP for a concept of 'global public goods' (Kaul et al., 1999; arguments developed in the UNDP's Human Development Report 1999); and Kofi Annan's reform plan set out in 'Renewing the United Nations: A programme for reform' (1997, cited in ODI, 1999). Meanwhile, the growing number of poverty-oriented civil society groups and campaigns attest to the increasing public concern about global poverty and welfare (Endnote 3).

The democratisation agenda also has a strong basis of validation at the international level since its incorporation into the Copenhagen Declaration at the Social Development Summit of the UN in 1995. In the 'Principles and Goals' of the Declaration, the heads of state committed themselves to promoting democracy and 'universal respect for, and observance and protection of, all human rights and fundamental freedoms for all' and pledged to promote the effective exercise of rights at all levels of society (http://www.un.org/esa/socdev/wssd/index.html). They underlined 'the importance of transparent and accountable governance and administration in all public and private national and international institutions' (Fergany, 1999:15). Since the UK has an extensive commitment of representation and involvement within global organisations and, as we has seen, also a few bilateral institutions with global reach, it could play a leading role in the current discussions over reform and capability. The critical role played by development finance institutions in the post-colonial global economy
should be used to provide a lead in instigating economic policies based on ethical principles, environmental protection and local ownership.

From a research perspective this means developing the normative aspects of development policy, within the context of foreign policy in general; the modelling of a democratic foreign policy in the post-war and post-colonial era is required. What would a democratic foreign policy look like? How could such a policy be implemented? Can we be assured that it would mean a reduction in global poverty and an enhancement in social wellbeing? This could be so only, I suggest, if it is based in universal ideas of solidarity and codified in international democratic institutions. To map a consistent framework for UK relations abroad is, ironically perhaps, already being demanded by international institutions charged with particular developmental responsibilities. As the OECD has stated:

owe should aim for nothing less than to ensure that the entire range of relevant industrialised country policies are consistent with and do not undermine development objectives (OECD, 1996:18)

To meet such an ambitious objective requires consideration of two aspects. First, it requires that the procedures by which policy is decided need to be reviewed, particularly in terms of the relative influence of economic and political actors and their accountability. In institutional terms this means assessing the relative weight of the Foreign and Commonwealth Office (FCO), DfID, the Department for Trade and Industry (DTI) and the ECGD in the making and implementation of development policy and, in turn, the role and influence of other pressure groups and the public at large. Second, it requires that the content and effects of such policy needs assessing in practice, in the light of international obligations and domestic policy goals.

DfID themselves have seen the need for reform. The International Economic Policy Department (IEPD) was established in December 1997 to take forward the Government's White Paper commitments on policy consistency on trade, agriculture and investment issues as they affect developing countries. As DfID summarise:

DfID does not lead in any of the policy areas on which IEPD works. The lead department is usually DTI or MAFF. A great deal of IEPD work involves influencing and working in collaboration with other Whitehall Departments to ensure that the Government's International policies take account of, and where possible, promote development objectives. (http://www.DfID.gov.uk/public/what/what_frame.html).

Institutional change within the British state would need to change the balance of power between departments in order to downgrade the fear of uncompetitiveness which remains as a consequence of neo-liberal ideas of the necessity for unfettered markets. The consequences of operationalising ethical, sustainable and environmental regulation of agents operating overseas would not be as economically catastrophic as the populace have been encouraged to believe. It is also the only option which could restore some legitimacy to policies of bilateralism and to international relationships between North and South.

Conclusion

There are continuities in the expert, technical managerialism on offer from European countries and ‘international’ institutions in relations of ‘assistance’ to southern countries. There are also emerging forms of inter-continental exchange which are
justified on the basis of globalised universal human aspiration. But, has there really been a paradigm shift, or merely a reworking of an ancient discourse of African subordination to a confident and hegemonic West? Do African charges of western hypocrisy, the apparent crisis of development, and the post-modern rejection of the idea of progress demand an absolute withdrawal of (at least) bilateral interference? And what of the avowedly 'international' organisations? Can these restore the legitimacy required to promote human development in the face of the democratic deficit which characterises their current constitution? For this to take place, it is necessary for four basic essential changes to occur.

First, the argument here has been that under the auspices of a legitimate representative body (as yet hypothetical), political interventions could be made accountable, transparent and perhaps efficacious. However, at present such a legitimising organisation does not exist, given the subordination of the UN to western policy demands. Thus, reform of the United Nations is urgently required to provide a moral foundation for processes of political and humanitarian intervention, particularly since bilateral political intervention without the authorisation of a more representative international body has lost much of its legitimacy. To create an international polity of such a calibre requires a renaissance of the concept of international solidarity, the second basic requirement. This is a difficult project since it must rise like a phoenix from the ashes of post-colonialism and from within the economic inequalities by which global capital divides the populace. Third, alongside such a project, there is a need for advocates of democracy – to redirect themselves in the North to the practices of home governments abroad and to reforming the international institutions through which these states exert illegitimate power. And fourth, it is essential that economic and social rights (within the democracy discourse) or basic needs (from a prior development age) need to be accorded the same weight and effort as their civil and political rights 'sisters'. No politics is worth its salt without the economic means to be empowered as a human being to fully exercise ones humanity. This basic plank of historical political struggle seems to have disappeared with socialist discourse and its emphasis on redistributional politics and economic equity. Ironically, it might be in the early history of the labour movement and in the genesis of socialist ideas that we will find forms of international solidarity better than our current ones.

Endnotes
1. Currently the CDC portfolio consists of US$2.5 billion (on a portfolio valuation which underestimates working funds) directly invested in over 400 businesses, and US$230 million third party funds under management http://www.cdc.co.uk The ECGD issued 167 guarantees to a value of over £3.7 billion during 1998-99 while total ECGD exposure was £23.4 billion at the end of 1998-99 (HC52, 2000, xii); DfID disbursed a total of £2.37 billion in 1998-9 http://www.DfID.gov.uk/public/what/what_frame.html

2. The CDC and ECGD are both members of regional and international groupings. The CDC is a member of the European Economic Interest Grouping (EEIG), made up of 12 Development Finance Institutions of European Union Member States: Portugal, United Kingdom, Spain, Germany, Austria, Finland, Netherlands, Denmark, France, Belgium, Italy, and Sweden found at http://www.edfi.be/index3.htm; while the ECGD is a member of the OECD Consensus group of ECAs (HCS2, p.xxix).

Sarah Bracking is in the Institute for Politics and International Studies, Leeds. This is a revised version of a paper presented to the ROAPE Millennium Conference: Africa – Capturing the Future held at the University of Leeds, 28-30 April 2000.

Bibliographic Note


This brief article outlines an approach to analysing the effectiveness of public health interventions in the third world, specifically in regard to HIV/AIDS. Its purpose is not to be the definitive last word but to float certain ideas consistent with the precepts of political economy, with a view to inviting criticism, commentary and contributions to future publications.

Objective

When the combination of western know-how and western money fails to curb the AIDS epidemic in a third world country, 'lack of political will' is almost routinely adduced as the leading reason. But what is this magical, missing ingredient? How do we know it when we see it? And how does it, or should it, enhance the effectiveness of AIDS prevention, control and amelioration initiatives? In this paper I explore the answers to these questions by comparing the political response in Zambia to two different emergencies. The first is the drought of 1991/92, the response to which was undoubtedly driven by political will on any definition of the term. The other is the HIV/AIDS epidemic to which, it is argued, the response has been characterised by lack of political will.

My analysis leans heavily on concepts of political economy – as involving assessment of the direction of, and competition for, economic resources within society taken as a whole. Classical 20th century (Endnote 1) economics emphasises the competition that takes place in the market-place between commercially motivated producers of goods and services for the custom of consumers. It strives to rigorously show (given certain definitions and restrictive assumptions concerning monopolies, information etc.) that the 'hidden hand' of the free market brings about the most efficient application of resources. Political economy, however, emphasises the broader truth that all entities and institutions – commercial or otherwise – are obliged to compete for resources, often from positions of structured inequality. Government departments, for example, compete amongst themselves for funding from the Treasury and (in the case of a country like Zambia) from the foreign aid donors. Charitable non-governmental organisations also compete – with each other and with government – for donor funding. The profit motive may be absent but not-for-profit organisations, private as well as public, require money to conduct their operations and even the purest doer of good requires to eat, sleep in security and in warmth, and generally keep body together with benevolent soul.

There is no theorem, so far as I am aware, suggesting that competition between not-for-profit entities results in the optimum allocation and utilisation of resources. In fact the bulk of writing in political economy is devoted to narrating how, in a wide variety of specific contexts, the competitive 'rent seeking' behaviour of non-commercial individuals or institutions results in the seriously inefficient distribution of resources.
Response to the HIV/AIDS Epidemic

The occurrence of deaths in Zambia of individuals who had contracted the HIV virus locally was firmly established by 1985. Shortly thereafter it became clear from ELISA (enzyme linked immunosorbant assays) and Western Blot testing that HIV seroprevalence, though still in single figures percentage-wise, was growing explosively amongst certain categories of people (for example, teachers, nurses, bank workers). The course of the epidemic amongst homosexual and bisexual men in the United States had already given some indication of the magnitude of the crisis that Zambia was facing, with various initiatives in health education, condom promotion, home care, counselling and orphan support quickly springing up in response to the threat. By 1990, a good number of NGOs (funded almost entirely by foreign aid donors) had been established in the country. Throughout the nineties the ‘AIDS industry’ continued to expand and diversify. Fully fledged multi-million dollar aid projects were established (for example, the USAID Morehouse Project), innovative approaches were promoted (for example, the ‘multisectoral’ approach), CBOs were encouraged, religious organisations became increasingly vocal (to diverse effect), and social and medical research projects found their home in Zambia. Sentinel surveys continued to paint a bleak picture, however. By the time of the Xlth International Conference on AIDS and STDs in Africa (ICASA) in Lusaka in 1999, Zambian seroprevalence had risen to the point where more than half the urban adult population was predicted to die of AIDS unless something changed radically and for the better.

While steering clear of the admission that intervention had proved an unmitigated failure, the consensus of those attending ICASA was that much more needed to be done. A senior official of the World Bank had told me only two years previously that ‘we can only look and pass on by’ when it comes to HIV/AIDS. But at ICASA the Bank suddenly displayed a born-again awareness that AIDS is an economic and social disaster, not merely a health problem. Addressing the conference, C Madavo, vice president of the Bank for the Africa region conceded that

the damage AIDS has done in the present in incalculable ... it threatens millions of futures.

And while claiming that AIDS was ‘atop the agenda of most bilateral and multilateral and development institutions’, he further allowed that

nowhere is the effort big enough, broad enough, or well-resourced enough to turn the epidemic back (Endnote 2).

Having been among the early purveyors of the ‘malaria causes more deaths than AIDS’ myth, WHO, and the UN system more generally, have now begun to talk as if AIDS were their number one priority in south-central Africa. Bilateral donors – the Americans, the British, the Nordics, etc. – are turning increasingly heavy guns (or at least increasingly large amounts of cash) onto the problem. It remains to be seen how the greatly increased quantum of resources (if it actually materialises) will be deployed, and now is a good time to harvest the lessons of the past.

The ‘Famine That Never Was’

In January 1992, at the time of maize pollination, the rains suddenly and spectacularly failed over southern Africa below the 14 S parallel. Temperatures soared into the 40s and the entire maize crop was effectively sterilised – doomed to complete crop failure despite the return of rains in the second half of February. Stocks of grain in the region were already low and it became clear that millions of tons of maize would have to cross the
Atlantic from the Americas to stave off famine.

Although parts of northern Zambia had escaped the worst of the drought, these were not the major surplus producing areas of the country. Some 650,000 tonnes of imported maize were needed to keep the 5 million urban population alive until the arrival of the 1993 harvest. In addition some 2 million rural people in the south of the country would need some 250,000 tonnes of relief food. To this second problem was added the complication that, because these people were mostly dependent on maize growing for their annual income, the commodity would need to be distributed freely on some well-managed equitable basis, rather than be simply delivered and sold.

The Government acted swiftly, first using its own financial resources and then some US$350 million of donor aid that was easily elicited once credible procurement, logistics, and distribution systems were in place. As regards the rural relief part of the exercise, at no stage were NGOs or donor projects outside the Government orbit encouraged or enabled to ‘do their own thing’. Instead, southern rural Zambia was divided into some 30 sections and NGOs were co-opted to the newly created ‘Programme to Prevent Malnutrition’ (PPM) as sole administrators for one or more of these. Resources – including maize itself and funds to cover transportation costs – were channelled through Government, specifically the ministries responsible for Health, Agriculture and Finance. A monthly PPM meeting, which participating NGOs were obliged to attend, was always chaired by a Cabinet Minister (usually the Minister of Health) who made all necessary policy decisions before the close of business. The World Food Programme (WFP), whose Resident Representative had designed the programme in consultation with a group of ministers, acted as the secretariat for the PPM – allowing for much speedier execution of decisions than was possible under normal governmental procedures. It cannot be said that the freer spirits amongst the NGO community enjoyed their subservience to the Government/WFP authoritarianism. Friction – usually in the form of differences of opinion over allocations and distribution procedures – was common. Where this could not be resolved, the NGO in question was simply replaced by another. Some organisations, notably the church-based and international NGOs, succeeded in raising some of their own resources, but they were obliged to declare these and thus effectively enter them into the ‘pool’. Furthermore, in order to minimise the scale of independent resource flows, the Government created its own ‘phony’ NGO – the Programme Against Malnutrition (the confusion with the PPM was deliberate) – in order to intercept donations that were not targeted directly at government.

By such means the Governmental/WFP ‘axis’ succeeded in keeping NGO activities in line with the ‘big picture’, achieving the even, timely and life-saving distribution of food across the affected parts of the country. Apart from keeping the NGOs in co-ordinated order, the PPM system, as tenets of political economy would predict, also had to resist attempts from within Government and the donor community to ‘hijack’ it, or at any rate to muscle in on the action. At least two ministries and three UN agencies had to be pacified in order to prevent sudden changes in management and direction disrupting the smooth flow of relief.

Comparison of the Two Responses

Towards the end of the famine period, when it became clear that the crop would not fail in the 1992/93 season, the suggestion was raised that the PPM should remain in existence, modified as necessary, and turn its attention to the HIV/AIDS epidemic. This was strongly resisted by some NGOs, however, and aid donors were similarly less than enthusi-
The not-for-profits were anxious to return to their traditional independent *modus operandi*. Given strong advocacy by the Government, this attitude could probably have been overcome. However, the signal came down from ‘on high’ that AIDS was not a political priority in the same league as famine relief, to be handled via the same high profile, unified and strongly managed way. The reasons for the difference in government attitude are various, but two especially stand out. First, there are votes to be gained from dramatically feeding people who are in danger of starving, while there are no votes to be gained from constantly reminding people that certain enjoyable private activities are eroding their life-expectancy. Second, the presence of a fundamentalist religious element in the Zambian political leadership meant that the condom issue was controversial and consequently that different groups within the cabinet could not be reconciled. It was simpler to sweep the whole issue under the carpet and focus on other important matters of state.

So the ‘free market’ for NGOs, donor agencies and government departments in the AIDS sector continued. True, a national co-ordination committee was established – in fact a series of them – but this was keyed down to civil service level and was given little control over resources. To reduce its profile, and that of AIDS even further, it was given the additional responsibility of controlling leprosy – as if the two diseases were remotely comparable in significance! (More recently an 8-minister task force has been set up but this is in response to pressure from donors and not an expression of political will).

Perhaps the clearest illustration of the difference in political response to the two crises is that AIDS – having already killed more Zambians that any drought could – has still not been declared a national emergency. The drought was declared an emergency within a few days of the full extent of the damage being assessed. The Zambian Government is still being lobbied by donors and NGOs to classify the epidemic as an emergency in order to facilitate fund raising.

Does the failure of political will matter? Would the degree of success of the anti-AIDS endeavour have been enhanced if a PPM type structure had been imposed upon it? I believe the answer to both questions is ‘Yes’.

The most obvious drawback of the absence of political will is that it dilutes the message of health educators. How do you persuade people to award the avoidance of HIV a high priority in their personal lives if the government awards it a low priority nationally? This ‘downgrading’ of the threat is what comes to most peoples’ minds when arguing the necessity of political will. However, there are less obvious but probably more important negative effects. These relate to such matters as the following:

1) Difficulty in obtaining adequate financial resources

In the absence of a unified system and a clear target level of effort and consequential funding needs, the quantum of finance available is determined by the summation of individual contributions from diverse sources with their own diverse agendas. There is no overarching requirement for the sum to match the needs of the country as a whole. Many enthusiastic initiatives are under-funded – for example several district task forces are unable to travel outside district centres. Annual spending on AIDS and its consequences is estimated at around US$50 million at present. Rule of thumb calculations based on comparisons with other health expenditure or the economic costs of sickness and death suggest the figure should be around three times this.
2) Uneven disposition of effort and resources

There is a heavy concentration of effort around Lusaka and around urban centres more generally. It is cheaper and easier to operate in the cities, which also happen to be where the donors are found. The rural areas are very unevenly covered - essentially as a function of the distribution of mission and government hospitals. Gaps in coverage in many rural areas are not filled by allocation to NGOs co-opted to a national programme. Some places are only served by Government clinics or social welfare services that are patently inadequate to the scale of the problem.

3) Duplication of effort

The absence of an effective PPM-style ‘institutional memory’ and ‘clearing house’ means that the same clients (whether individuals or intermediaries such as commercial firms) are covered repeatedly. The wheel is also frequently re-invented. I am aware of at least four separate ‘national’ forums of commercial enterprises against AIDS (existing on paper at least!).

4) Disincentives to expand coverage

The magnitude and nature of the epidemic demands that everyone is targeted with a similar level of per capita resources. In practice interventions select targets that are ‘comfortable’ to the institution in question. In terms of door-to-door fundraising from donors, for example, it makes little difference to the released resources whether 500 clients or 50,000 clients are being reached. There is accordingly little impetus to expansion of service provision. Donors tend to add to this weakness – by showing a bias towards ‘pilot projects’ whose avowed aim is to establish replicable models rather that reach a significant percentage of the population.

5) Neglect of politically weak but potentially effective agents

Because the allocation of money to fight AIDS is seen ‘political economically’ to some extent as the distribution of largesse (to the executing agencies), there is a strong tendency to exclude groups that have little clout with Government or donors. A striking case in point concerns traditional rulers – chiefs and headmen – who have enormous influence over deep rural populations in all aspects of life. The fear, it would seem, is that this ‘politically incorrect’ layer of Zambian governance might personally gain – rather than extend the wide range of virtually free social services that it routinely provides.

6) Distortions in allocation between types of agency

Certain donors prefer to give money to the civil service, while others prefer to work through NGOs and other voluntary associations. In the absence of any agreed division of labour, it is this donor preference, rather than any system of principles, that determines who gets to use what money in what way. For example, despite a careful study that showed that the most effective way to reach the rural farmers was through commercial farmers and traditional leaders, and despite the fact that this study formed part of its own base documentation, the World Bank recently allocated funds for AIDS prevention through the Government’s agricultural extension service, which has been shown to be an ineffective tool for this purpose.

7) Ideological conflict

In the absence of strong leadership and integration, the full range of attitudes and beliefs regarding the causes of AIDS, the morality of condom use, etc. rampages unchecked. In mission hospital ‘X’ they burn the condoms when they arrive each month, in church ‘Y’ they blame HIV on
divine retribution, in CBO 'Z' they have decided that HIV does not cause AIDS are have abandoned their therapy.

Conclusions
I have painted with a broad brush and neglected many subtleties, but some equally broad-brush conclusions seem evident. Governments should govern, most particularly when the whole fabric of society is threatened by an abnormal externality like AIDS. Governing requires much more than the vocal adoption of AIDS as a 'priority'. It also requires the consequential exercise of the authority that only Government has. The demand is not administrative and cannot be met by the popular resort to 'capacity building'. Government did not have the capacity to administer food distribution in 1992 – but it outsourced administration to the WFP, other donors and to NGOs while retaining overall control.

Even saints have to first raise a dollar before they can spend one and competition for resources therefore naturally arises amongst saints as well as sinners. This elementary consideration predicts many things, including frequent outbreaks of personal hostility between those who would do good to their fellow humans. Many attempts at third world development are implicitly based on what I will call 'the Woodstock Principle' – governance is not needed if only we all agree to make love and not war. Experience with interventions in the third world should by now have reinforced the old saying about good intentions – the road to the nearest hospice (if there is one) is paved with 'em.

Endnotes
1. Prior to the publication of Marshall's *Principles* in 1890, economics – as taught by such as Hume, Smith, Ricardo, Mill and Marx – was intrinsically 'political'. With Marshall the focus began to be narrowed to matters such as growth, trade and productivity and the subject to be accordingly 'depoliticised'. In the past decade or so, however, political economy has made something of a resurgence, particularly in the effort to understand why developing countries are not performing well under adjustment programmes designed by apolitical economists.


*Guy Scott* was Minister of Agriculture, Food and Fisheries in the Zambian Government during the drought crisis of 1992. He was also a founder of the Family Health Trust, the first Zambian NGO specialising in Aids, in 1987.
Improving Access to HIV-related Drugs in South Africa: A Case of Colliding Interests

Andy Gray & Jenni Smit

One of the few things that all South African health workers, administrators, policy-makers and politicians can agree upon is that HIV/AIDS is the predominant health problem facing the evolving national health system. Beyond that, however, the consensus rapidly evaporates. Much of that contestation rests on differing world views of the relationship between health and society, between health as a consequence of economic and social factors and health as a biomedical phenomenon, between health as a right and health as a commodity. In the classic words of Lesley Doyal (1979:44):

"patterns of health and illness are to a considerable extent determined by a particular mode of social and economic organisation, and under capitalism there is often a contradiction between the pursuit of health and the pursuit of profit."

Perhaps nowhere are those conflicts more keenly debated than in the campaigns to improve access to HIV-related drugs. This Briefing will explore the extent to which the issue of access to HIV-related drugs is but a manifestation of that contradiction, a case of colliding interests. It shall do so by first considering which drugs are the subjects of contention and how they are selected. Second, factors limiting access to those drugs in the South African context are considered. Finally, attention is directed at the extent to which the means being employed to improve access reflect the fundamental politico-economic collision of interests.

Which Drugs?

HIV-related drugs fall broadly into two categories: those directed at the virus responsible for initiating the immune system collapse (anti-retrovirals), and those directed at the diseases to which the HIV-positive individual becomes prey as his/her immune system becomes compromised (such as antibiotics directed against so-called ‘opportunistic’ infections). In addition, patients with full-blown AIDS require palliative therapy, such as pain-killers and anti-nauseants.

Many developing countries – South Africa included – have based their drug selection process on the essential drugs concept promoted by the World Health Organisation (WHO) (Endnote 1). The aim of the essential drugs concept is to:

"reduce morbidity and mortality from common illnesses by closing the huge gap between the potential which essential drugs have to offer and the reality of need on the part of millions of people – particularly those in developing countries and disadvantaged areas."

The Essential Drugs and Medicines Policy (EDM) component of the WHO claims that

"the concept of essential drugs is forward-looking. It incorporates the need to regularly update drug selections to reflect new therapeutic options and changing therapeutic needs; the need to ensure drug quality; and the need for continued..."
development of better drugs, drugs for emerging diseases, and drugs to meet changing resistance patterns.

The list is claimed to contain ‘safe, effective treatments for the infectious and chronic diseases which affect the vast majority of the world’s population’. It would therefore be expected that the Model Essential Drugs List prepared by the WHO would address the needs of AIDS patients in terms of anti-retroviral drugs as well as those needed for the prevention and treatment of opportunistic infections. After all, while clearly a ‘changing therapeutic need’, and one demanding ‘better drugs’, AIDS could hardly be regarded as a minor health challenge. Instead, however, debate continues on the appropriate use of the essential drugs concept and list in dealing with HIV/AIDS. Two issues predominate. The first is about whether or not HIV/AIDS related drugs should appear on the List itself. The second revolves around the use of the essential drugs concept in improving access to such drugs, particularly in developing countries.

The WHO periodically prepares a Model List of Essential Drugs (EDL), which is used as the basis for producing country-specific lists. The general criteria for inclusion on the List are four-fold:

• safety (the drug must have an acceptable toxicity profile);

• affordability (access to the drug must be feasible, especially for developing countries);

• necessity (the drug must be relevant to the health needs of the majority of patients); and

• efficacy (the drug must be effective against the target disease).

As can be seen, these criteria, (usually abbreviated as SANE), are an uncomfortable mix of the clinical and the economic. The 11th Model List was released in December 1999. In terms of HIV, the List includes two specific agents – zidovudine (AZT) and nevirapine. However, both are listed only for the prevention of mother-to-child transmission (MTCT). The List includes the warning that this:

is the only indication for which they are included here. Single drug use with zidovudine, except in pregnancy, is now regarded as obsolete because of the development of resistance. Triple therapy is beyond the budgets of most national drug programmes and therefore HIV/AIDS treatment policies must be decided at country or institutional level (Endnote 2).

The South African country-specific List was published in 1998. While it lists an ‘ideal’ treatment approach for HIV and opportunistic infections, it adds a blocked warning:

It is recognised that various drugs and therapeutic modalities are very costly and cannot be provided on a mass scale by the public health services. Where therapy is very costly it may only be provided on a limited and selective basis or for academic and research purposes only. A decision on drug treatment shall await a directive from the DOH (Endnote 3).

Accordingly, it lists both zidovudine and lamivudine, but only for post-exposure prophylaxis for health workers. Cotrimoxazole, dapsone, pentamidine and prednisone are listed for the management of pneumocystis. While other agents are included, such as fluconazole and aciclovir, which can be used to treat opportunistic infections, specific guidelines are lacking.

The 11th WHO Model List was greeted with dismay by AIDS activists. Pierre Chirac, of Médecins Sans Frontières (MSF) asked, with obvious exasperation,
What is the problem with AIDS drugs for WHO? (Endnote 4).

In answering him on the E-DRUG discussion list, Professor Richard Laing of the Boston University School of Public Health proposed new criteria for essential drug status. He wished to include

- ease of use without difficult monitoring systems, relative efficacy in terms of whether these drugs cure or alleviate a condition and some assessment of relative cost (Endnote 5).

If AIDS may in time become regarded as a chronic manageable disease, then the issue of cure or alleviation might become less relevant. However, the capacity of the health system to use complex regimens that demand expensive immunological and virological monitoring is a real issue. But as pointed out by Khalil Elouardighi of Act Up-Paris, while

- successful anti-retroviral therapy requires a lot more than just drugs ... the challenge has to be to find the resources, the humanist will, to beef up healthcare systems and treat PHAs (people living with HIV/AIDS) (Endnote 6).

In addition, Jamie Love of the Washington-based Center for Study of Responsive Law has pointed out that the question of the necessary infrastructure to use anti-retroviral drugs is too often used as an 'excuse to oppose compulsory licensing laws in developing countries' as well as to delay access to ancillary agents, such as fluconazole. As Love notes, to

- the infected persons, drugs that prevent death, if taken properly, obviously seem essential.

Thus there is a real danger that failure to designate such a drug as 'essential' implies 'a political statement that the life isn't essential' (Endnote 7).

What Limits Access to These Drugs?

Rhetoric does not buy drugs, however, and as Bernhard Pacoul and colleagues point out in the 27 January 1999 edition of the Journal of the American Medical Association (1999:281), the problem lies with 'the fundamental nature of the pharmaceutical market and the way it is regulated'. Their paper, entitled 'Access to Essential Drugs in Poor Countries; A Lost Battle?', points to 'the potential consequences of recent World Trade Organization agreements on the availability of old and new drugs'. South Africa faces a treble set of hurdles: high prices of anti-retrovirals and drugs in general, an underdeveloped infrastructure, and opposition to all attempts to use the few levers at its disposal.

One measure of access to drugs is the degree to which they are affordable, either to patients who purchase them directly (or are covered by some form of medical insurance) or to the health system itself. Pricing behaviour by drug manufacturers is complex. Prices are related less to the costs of production than to the ongoing costs of the company (such as research into new agents, but also marketing expenses for currently available drugs and to the ability of the particular market to pay for drugs) (Tarabusi & Vickery, 1998). That newer agents, and in particular many of those needed for a comprehensive care programme for patients with HIV, are expensive is well established. Whether they should be purchased by individuals, or provided by the State (as would be case for 80 per cent of South African patients, the balance having private medical insurance) high acquisition costs are a potent barrier to access. A joint UNAIDS-UNICEF-WHO Project released an interim report in December 1999, entitled 'Essential drugs used in the care of people living with HIV: sources and prices', which summarises the problem:
Treatment for HIV-related conditions is limited in developing countries. Explanations include limitations in their diagnostic and treatment infrastructure, lack of epidemiological data on the patterns of opportunistic diseases that is necessary to plan treatment interventions, gaps in their supply system, and the high cost and poor ability to finance the purchase of drugs (Blanco, Renaud-Thery & Perrien, 1999).

As already noted, the capacity of the health system to use complex regimens that demand expensive immunological and virological monitoring is a real issue. It should not, though, be considered as an excuse for inaction on the fundamental economic and political choices surrounding the issue of drug pricing. The 19 January 2000 issue of the Journal of the American Medical Association (JAMA) contains the latest American consensus statement on HIV drug management. Its basic message is encapsulated in bland statements that appear to place optimal care far beyond the capacity of a developing country’s health system:

The availability of new antiretroviral drugs has expanded treatment choices. The importance of adherence, emerging long-term complications of therapy, recognition and management of antiretroviral failure, and new monitoring tools are addressed. Optimal care requires individualized management and ongoing attention to relevant scientific and clinical information in the field (Carpenter, Cooper et al., 2000).

Addressing access therefore requires a two-pronged attack to simultaneously boost infrastructural capacity while bringing prices closer to affordable levels for both patients and the health system.

How Can Drug Prices be Lowered?

Medicines are not ordinary articles of trade. Specifically, their demand and supply characteristics do not follow classic market principles. First, there is a three-tiered demand structure – with the prescribers (physicians and others) as the actual demanders, the patients as the consumers and the health care system frequently the payer. There is often limited competition between suppliers, especially in the case of patented products, which are more characteristic of oligopolistic markets. Drugs also have both positive and negative externalities (for example, through the prevention or non-prevention of infectious diseases). Information available to prescribers and consumers is often selective, unbalanced or incomplete, further demonstrating the supply-driven nature of trade in medicines. Finally, market forces rarely reflect true social costs and benefits, and cannot meet social objectives such as equity. The factors mentioned above, together with the apparent inability of the industry to develop and provide needed drugs for tropical diseases in poor countries, have been called ‘market failure’. Drugs can therefore be considered to be ‘meritorious’ goods, worthy of government intervention.

This contention is not, however, shared by the pharmaceutical industry. Industry groups claim that ‘the market is working’, and that interventionist policies ‘don’t work, may actually increase healthcare expenditures, and stifle innovation’. A June 1999 position paper by a European grouping called for ‘market pricing for all medicines’, ‘less dependence on national social security systems’, ‘more private/insured purchase’, and ‘competitive purchasing systems operating in a price-deregulated environment’ (Endnote 8).

The options open to governments that do chose to intervene can be characterised in a number of ways. They can be either direct (primarily legal measures that have an immediate effect on suppliers or consumers) or indirect (usually market-related measures, which entail financial
implications for the various actors). They may either target prices themselves (supply side measures such as price controls, positive or negative lists, or promotion of generics) or consumption (demand side measures such as exclusion from positive lists, recategorisation to over-the-counter status, introduction of patient co-payments, or caps on pharmaceutical budgets). Policy options have been described as resulting in either a total control situation (as in Ecuador and Honduras), a mixed system (as in Canada), a situation of monitored freedom (as in Brazil) or total freedom (as in the United States). Significantly, resorting to price control is more common in developed than in developing countries, even though price sensitivity might be greater in countries with poorer social security systems.

While South African policy commitment to some form of intervention is evident, the exact mechanics of the proposed system have yet to be revealed (Endnote 9). However, a number of mechanisms have been proposed internationally for reducing the cost of drugs. These include:

- producer price control measures (direct price controls, reference pricing systems, equity pricing or policies that promote the use of off-patent generic medicines);
- distribution chain cost controls (reduced mark-ups and moves to introduce fixed professional fees or reductions in value-added tax);
- bulk purchase measures (improved tender and negotiation strategies or regional initiatives);
- international trade agreement relief measures (such as the use compulsory licensing and parallel importing, as provided for in the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS));
- demand side measures (improving rational drug use or introducing patient co-payments).

However, with regard to HIV-related drugs, the major focus has been on three areas:

- tiered or equity pricing (getting manufacturers to charge less in poor countries);
- parallel importation (buying drugs from countries where prices are already lower); and
- compulsory licensing (getting a local firm to make a copy of an expensive patented drug at a lower price, while compensating the patent holder).

In other words, instead of targeting local cost drivers or the means to address them, attention has focused on fundamentally altering the power of the pharmaceutical industry. This would entail either moral pressure to provide equity pricing or weakening of the monopoly powers afforded the manufacturers by the patent system. The latter are particularly important in the case of the antiretrovirals, most of which were developed in the last decade.

Prior to the 1999 Ministerial Conference of the World Trade Organisation in Seattle, various options were explored. American attempts to strengthen the TRIPS Agreement were expected. In anticipation, Venezuela proposed extending the list of products that could not be patented to include all items on the WHO Model EDL.

A European Commission proposal, developed together with Hungary, Japan, Korea, Switzerland and Turkey called for all EDL medicines to be made subject to compulsory licensing. Both proposals were criticized as flawed, but neither was needed. As Ellen 't Hoen of Health Action International has pointed out, only 11 of the 306 medicines on the 10th WHO
Model List were still patented (Endnote 10). Instead, President Clinton announced that the US would in future not oppose legal attempts by other countries to improve access by using TRIPS-compliant measures such as parallel importation and compulsory licensing. Critically, in a US presidential election year, the issue of drug costs has become an issue. A Bill to allow parallel re-importation of American manufactured drugs is presently being considered and enjoys bi-partisan support. However, this emphasis on US prices has raised the possibility of world price convergence at higher levels.

Where does that leave South Africa in its quest to improve access? In 1997 the South African parliament passed an Act enabling the Minister of Health to issue compulsory licenses. It would also have enabled parallel importation and international tendering. However, this legislation is still the subject of a court action brought by the transnational pharmaceutical manufacturers, and has therefore not been promulgated. Attempts to use existing patent legislation have been signalled, for example at the Durban International AIDS Conference (2000), but have yet to be actioned. The earlier legislative moves also resulted in South Africa's listing by the United States Trade Representatives as a potential intellectual property rights violator ('special 301' status).

While such direct pressure has subsequently been lifted, attempts by countries with substantial pharmaceutical interests to prevent developing countries and activists groupings from addressing the fundamental nature of the problem continue. For example, the recent announcement by the WHO of its 'Massive Effort' to address HIV/AIDS, tuberculosis and malaria was greeted with some incredulity by Médecins Sans Frontières. In their 4 October 2000 press release they noted that MSF disagreed with WHO's claim that:

\[
\text{each death [from these three diseases] can be avoided with low cost technologies that are available today.}
\]

James Orbinski, President of MSF's International Council, stressed the point:

\[
\text{In fact, many effective medicines are either too expensive or don't exist. We think WHO's emerging plan fails to challenge the status quo (Endnote 11).}
\]

That remains the ultimate problem – to what extent will the need to adequately address the HIV pandemic require governments to fundamentally address the status quo. The imposition of direct price control would seem to be in conflict with South Africa's national trade and industrial practices, which are informed to a large extent by global trends and are usually referred to as 'neo-liberal'. Aggressive targeting of industry might also be in conflict with the desire to empower and nurture a local manufacturing base. This area of policy has also been seen as a part of a greater struggle, one that pits the health and economic interests of the South against those of global free trade (Bond, 1999).

To return to Lesley Doyal (1979):

\[
\text{health policies and medical care systems in capitalist countries therefore represent the outcome at any particular moment of the struggle between all these conflicting forces. They are not the rational policies of a benevolent state ensuring healthy lives and scientific medicine for all its people, nor are they the manipulative policies of an all-seeing state controlling every aspect of the daily lives of its members.}
\]

Doyal concludes that 'the demand for health is in itself a revolutionary demand'. Improving access to HIV-related drugs has become the vanguard of that struggle. It has raised world consciousness of the fundamental contradictions
between the interests of people in both developed and developing countries, and those of the transnational drug manufacturers, between the goals of health and profits. National policies seem impotent – while meekly accepting the result of market failure helps no-one, raising additional taxes to pay for drugs or using interventionist policies to reduce prices runs counter to the prevailing economic orthodoxies to which the many governments subscribe. Shifting resources from other social programmes, such as housing or education, is a politically unattractive way to ration scarce resources. While nations might wish to tackle the issue head-on, for example by issuing compulsory licenses and facing the wrath of the industrialised North, any truly meaningful longer-term interventions may need to use, rather than reject, the notion of globalisation.

Is a global welfare system, powerful enough to counter the oligopolists, any less fanciful than the ideal of ‘Health for All’?

Andy Gray & Jenni Smit, Pharmaceutical Policy Practice Group, School of Pharmacy and Pharmacology, University of Durban-Westville, South Africa.

Endnotes

1. The role of the WHO in promoting the Essential Drugs concept has been comprehensively reviewed in N Kani, A Hardon, J W Harnmeijer, M Mamdani & G Walt (1992), Drugs Policy in Developing Countries, London: Zed Books.

2. Both the 10th and 11th WHO Model Lists of Essential Drugs http://www.who.int/medicines/edl.html


Bibliography

Introduction

As the world’s experts on HIV/AIDS gather in Durban to deliberate on one of the worst global pandemics in living memory, the global social and economic inequalities of HIV/AIDS are starkly apparent, especially for South African women who constitute one of the highest risk groups in the world.

HIV/AIDS is a life-threatening but preventable disease affecting millions of women and men in mainstream society; it is a social catastrophe of genocidal proportion that has the capacity to roll back the gains of our democracy and to make our democratic rights meaningless. Already, HIV/AIDS is impacting negatively on development. As women, we recognise HIV/AIDS as a disease of inequality and marginalisation. Our vulnerability arises out of a combination of poverty, unequal access to basic needs and resources, oppressive cultures and traditions, the denial of sexual and reproductive choices and the absence of adequate health-care and information.

The context of increasing poverty in the South, and especially Africa, places an imperative on governments in Africa and the world to act to ensure ethical and moral choices are made to reduce women’s higher risk of HIV infection and mortality. While governments ask women to bear the heavy social burden of nursing the sick and dying, we ask governments to support policy and decisions which include the gender interests and concerns of women and men. Building responsibility for HIV/AIDS, not as a private concern but as a political and social concern, must draw together all our collective strengths. HIV/AIDS research, health-care and prevention budgets should reflect women’s gender needs and demands as an urgent priority.

Global inequalities dictate who can access affordable AIDS treatment. It is the responsibility of governments, the United

Statement of Concern on Women & HIV/AIDS

The following ‘Statement of Concern on Women and HIV/AIDS’ was issued to coincide with the XIIIth International AIDS Conference held in Durban, South Africa, in July 2000. We are reprinting it here with the permission of Agenda, a feminist journal initially established in 1987 by a small group of students and academics from the University of Natal. Agenda is committed to providing a forum for women in the interests of transforming unequal gender relations in South Africa. Among its objectives are to question and challenge the understanding of gender relations and to contribute to women’s capacity to organise, reflect on their experiences and write about them.
Statement of Concern on Women & HIV/AIDS

The following 'Statement of Concern on Women and HIV/AIDS' was issued to coincide with the XIIIth International AIDS Conference held in Durban, South Africa, in July 2000. We are reprinting it here with the permission of Agenda, a feminist journal initially established in 1987 by a small group of students and academics from the University of Natal. Agenda is committed to providing a forum for women in the interests of transforming unequal gender relations in South Africa. Among its objectives are to question and challenge the understanding of gender relations and to contribute to women’s capacity to organise, reflect on their experiences and write about them.

Introduction

As the world’s experts on HIV/AIDS gather in Durban to deliberate on one of the worst global pandemics in living memory, the global social and economic inequalities of HIV/AIDS are starkly apparent, especially for South African women who constitute one of the highest risk groups in the world.

HIV/AIDS is a life-threatening but preventable disease affecting millions of women and men in mainstream society; it is a social catastrophe of genocidal proportion that has the capacity to roll back the gains of our democracy and to make our democratic rights meaningless. Already, HIV/AIDS is impacting negatively on development. As women, we recognise HIV/AIDS as a disease of inequality and marginalisation. Our vulnerability arises out of a combination of poverty, unequal access to basic needs and resources, oppressive cultures and traditions, the denial of sexual and reproductive choices and the absence of adequate health-care and information.

The context of increasing poverty in the South, and especially Africa, places an imperative on governments in Africa and the world to act to ensure ethical and moral choices are made to reduce women’s higher risk of HIV infection and mortality. While governments ask women to bear the heavy social burden of nursing the sick and dying, we ask governments to support policy and decisions which include the gender interests and concerns of women and men. Building responsibility for HIV/AIDS, not as a private concern but as a political and social concern, must draw together all our collective strengths. HIV/AIDS research, health-care and prevention budgets should reflect women’s gender needs and demands as an urgent priority.

Global inequalities dictate who can access affordable AIDS treatment. It is the responsibility of governments, the United
Briefing: Statement of Concern on Women & HIV/AIDS

Nations, the global economy and pharmaceutical companies to ensure that affordable access to HIV/AIDS treatment is extended to all HIV positive men and women.

We demand the Government and President Mbeki to act to ensure that women's concerns are recognised in HIV/AIDS prevention, treatment and care by:

• backing and advancing women-controlled prevention methods for women in the south who are most at risk. Microbicide (a vaginal gel which acts as a spermicide) development and research must be prioritised by the global AIDS industry over more profitable but less urgent research, and the female condom must be made accessible and affordable for all women;

• advancing trials and appropriate research on post-exposure prophylaxis (PEP) and ensuring that the availability of PEP by national and provincial government for rape survivors and women at high risk (that is, in the instance where male condoms fail) is supported;

• providing retroviral drugs for pregnant women after speedy, appropriate and well-funded trials;

• meeting its obligation to children by making formula/breast-milk substitutes available to HIV positive mothers as part of the state free health programme for children;

• providing free access to HIV testing and pre and post-counselling and ensuring there is treatment for all symptomatic illnesses experienced by women;

• adopting effective strategies for caring for people living with HIV/AIDS, in a manner that ensures that women do not bear a disproportionate burden of caring for those who are HIV positive, neglecting their own health and becoming further economically marginalised;

• ensuring that the many laws put in place by government to strengthen and expand women's democratic rights are fully implemented to raise their status in reality and not just on paper.

We extend the call to AIDS Service Organisations, NGOs, industry and civil society to challenge unequal gender relations and the gender subordination of women in all institutions and encourage open discussions about gender power relations and HIV/AIDS. We call for measures to:

• ensure that cultural practices to prevent HIV/AIDS such as virginity testing and circumcision are not oppressive, life-threatening or in any way infringe the right to bodily integrity of the girl and boy child and women and men;

• encourage society, particularly men who are the dominant sexual partner and condom users, to see it as both men and women's mutual responsibility to demand condom use and protection;

• promote the message that only safe sex is good sex;

• counter the belief that AIDS is a 'women's disease' by including men in reproductive health programmes and by encouraging all men to assume mutual collective responsibility for the spread of the disease and to see the urgency of its prevention for their families, their communities and their country;
• ensure that policy-makers and donor organisations do not siphon scarce resources allocated to women’s HIV/AIDS programmes into programmes targeting men, and that gender-balanced policies be prioritised.

We call on women’s organisations, men, government, the donor sector, AIDS Service Organisations and NGOs to work together to create a compassionate and enabling society in which women and men assert their equal right to life by freely exercising responsible choices for prevention and treatment. The imperative to treat HIV/AIDS as a collective social responsibility requires action and decisions from the whole of society and government to bring the pandemic under control and to ensure the survival and longevity of all women, men and children.

By promoting a culture of rights and gender equality, responsibility and in relation to HIV/AIDS we believe we can end women’s overwhelming, biological, social and economic susceptibility to HIV and affirm the right of all people to life and dignity.

Endorsed by AIDS Law Project, AIDS Legal Network, Agenda, Black Sash, Beatrice Ngcobo on behalf of the Commission on Gender Equality, Capacity Building in AIDS for NGOs (CABANGO), Centre for Applied Legal Studies (CALS) Gender Research Project, Gender AIDS Forum (GAF), Gender Advocacy Programme (GAP), Hlomelikusasa, KwaZulu Natal Coalition for Gay and Lesbian Equality, National Network on Violence Against Women, Provincial Parliamentary Programme (PPP), South Africa National NGO Coalition (SANGOCO), Sex Workers Education Training and Advocacy Taskforce (SWEAT), Tshwaranang Legal Advocacy Centre, Treatment Action Campaign (TAC), Vuka Uzithathe Institute for Gender and Economic Development, Women’s Legal Centre, Women’s Health Project.

Issues of Concern

South African women are among the most vulnerable to HIV/AIDS globally – among all countries in the world we have the greatest number of people living with HIV (2.3 million women; 1.8 million men) (UNAIDS Epidemic Update, June 2000);

• The main reasons for women’s vulnerability (namely the intersection of biology with sexual, social and economic inequality) are not reflected in HIV/AIDS policy which has so far failed to recognise the different gender impacts of the epidemic for women and men;

• As South African women we have recently obtained the right to equality. At the same time, as a group, women experience the worst levels of poverty in both urban and rural areas and face further marginalisation and social isolation on a growing scale as a result of HIV/AIDS;

• The absence of information and policy on treatment of HIV/AIDS is resulting in destructive mythologies which result in unacceptable human rights abuses against women on an increasing scale and reinforce harmful and oppressive social prejudices;

• It is a political issue that the unacceptable level of gender violence in South Africa (with among the highest reported rape rates in the world) serves to put women at further risk of HIV infection;

• The stigma that only ‘bad girls’ get AIDS is misleading and dangerous when those among the groups most at risk are married women who have lifelong single partners and adolescent girls;

• The failure of the ABC campaign (Abstain, Be faithful, Condomise) for women is evidence that while women want protection against HIV infection,
unequal gender relations make sexual negotiation a no-go for marginalised women.

To endorse this statement of concern contact the Gender AIDS Forum c/o Agenda. Telephone 031-304 7001 Fax 031-304 7018; e-mail director@agenda.org.za

© Agenda

Violence in Mozambique: In Whose Interests?

Joe Hanlon

Renamo's failure to turn itself into a party and Frelimo's refusal to make any concessions to the opposition finally led to a violent confrontation on 9 November 2000 in which at least 40 people were killed. It is the first break in the remarkable peace that has held since the end of the war on 4 October 1992. But it also reflects the stagnation in Mozambican politics.

The 3-5 December 1999 election was closer than expected, with Frelimo head Joaquim Chissano being re-elected president with 52.3 per cent of the vote against Renamo head Afonso Dhlakama. The election was approved and generally praised by international and domestic observers, but there was a very high error rate in the filling out of forms by polling station staff, which led to thousands of votes being excluded. Private estimates and extrapolations suggest that Chissano would have probably gained about 51.3 per cent and Dhlakama 48.7 per cent, if there had been a full national recount (Mozambique Peace Process Bulletin, Maputo & Amsterdam, January 2000).

Dhlakama declared that he had won and called for a national boycott of the 'self-appointed, illegitimate Frelimo government'. His claim won no international backing. Indeed, the United States embassy in Maputo - Renamo's long term friend - finally withdrew informal support for Renamo. The US also cut support for the democratisation process as a whole, because it sees no chance of Renamo winning and forming an effective government, but also sees no possibility of a 'third force' or serious alternative party that could win popular support and beat both Renamo and Frelimo. For its part, the US State Department seems to still be divided, with the old Cold Warriors still hostile to Frelimo, but with another group supporting Frelimo because of its wholehearted adoption of capitalism and IMF structural adjustment policies.

Renamo has always seen the boycott as the only option for a smaller and weaker group, created by outside forces and without much of a local base. Boycotts give it a veto and force concessions. This was used effectively in the 1990-92 peace talks and the 1992-94 UN-monitored peace process. Renamo even boycotted the first day of the 1994 elections, forcing an extra day of voting.

At first, the international community backed Renamo and pressed Frelimo to make concessions to Renamo boycotts. But when Renamo boycotted the 1998 local elections, the government called its bluff - it went ahead with the elections and won general support of the donor community. A new bipartisan election law was passed for the 1999 national elections and Renamo's demand for a totally new registration was granted - because the European Union was prepared to pay the cost. But Renamo members of the National Election Commission still walked out on the last night of counting.

Renamo then boycotted the first session of the new parliament and refused to appoint new members to the National
violence in Mozambique: in whose interests?

Joe Hanlon

Renamo’s failure to turn itself into a party and Frelimo’s refusal to make any concessions to the opposition finally led to a violent confrontation on 9 November 2000 in which at least 40 people were killed. It is the first break in the remarkable peace that has held since the end of the war on 4 October 1992. But it also reflects the stagnation in Mozambican politics.

The 3-5 December 1999 election was closer than expected, with Frelimo head Joaquim Chissano being re-elected president with 52.3 per cent of the vote against Renamo head Afonso Dhlakama. The election was approved and generally praised by international and domestic observers, but there was a very high error rate in the filling out of forms by polling station staff, which led to thousands of votes being excluded. Private estimates and extrapolations suggest that Chissano would have probably gained about 51.3 per cent and Dhlakama 48.7 per cent, if there had been a full national recount (Mozambique Peace Process Bulletin, Maputo & Amsterdam, January 2000).

Dhlakama declared that he had won and called for a national boycott of the ‘self-appointed, illegitimate Frelimo government’. His claim won no international backing. Indeed, the United States embassy in Maputo – Renamo’s long term friend – finally withdrew informal support for Renamo. The US also cut support for the democratisation process as a whole, because it sees no chance of Renamo winning and forming an effective government, but also sees no possibility of a ‘third force’ or serious alternative party that could win popular support and beat both Renamo and Frelimo. For its part, the US State Department seems to still be divided, with the old Cold Warriors still hostile to Frelimo, but with another group supporting Frelimo because of its wholehearted adoption of capitalism and IMF structural adjustment policies.

Renamo has always seen the boycott as the only option for a smaller and weaker group, created by outside forces and without much of a local base. Boycotts give it a veto and force concessions. This was used effectively in the 1990-92 peace talks and the 1992-94 UN-monitored peace process. Renamo even boycotted the first day of the 1994 elections, forcing an extra day of voting.

At first, the international community backed Renamo and pressed Frelimo to make concessions to Renamo boycotts. But when Renamo boycotted the 1998 local elections, the government called its bluff – it went ahead with the elections and won general support of the donor community. A new bipartisan election law was passed for the 1999 national elections and Renamo’s demand for a totally new registration was granted – because the European Union was prepared to pay the cost. But Renamo members of the National Election Commission still walked out on the last night of counting.

Renamo then boycotted the first session of the new parliament and refused to appoint new members to the National
Election Commission (which must be reappointed after a national election) on the grounds that Dhlakama and Renamo had really won the election. Dhlakama variously demanded a recount of the votes and a power-sharing government.

During 1994-99, Renamo never moved to create more than a rudimentary party machine. This seemed to reflect two factors. First, party machines were seen as a hangover of the old socialist days and Frelimo, while in the new era parties were to be donor funded and Maputo-based. Second, Dhlakama was afraid of any potential challengers building up a local base.

For the 1999 election, Renamo was joined by 10 small parties (also without a base) and stood as the Renamo Electoral Union (Renamo UE). Chissano lost relatively few votes compared to 1994, but there were only two candidates in the 1999 election and Dhlakama won all the votes that had gone to independents five years earlier. Clearly, Dhlakama and Renamo UE were winning the anti-Frelimo vote.

Dhlakama’s fear of internal opposition has been shown by his unwillingness to hold a party Congress, by the exclusion of several higher profile people from the Renamo electoral lists, and by the decision to appoint total unknowns to head the party bench in parliament.

Early in 2000, Dhlakama’s unexpectedly good showing in the elections meant that he could have held a party congress and triumphantly done anything he wanted. Instead, he continued to refuse to hold a congress and opted for a total boycott position. The final straw for the international community was probably when Renamo called on donors at the 3-4 May conference in Rome not to give money to the government for reconstruction after serious floods earlier in the year; this backfired, and donors actually pledged more than the $450 million asked for.

On one hand, Dhlakama probably is convinced that he really did win (despite being repeatedly told by the international community that he did not). On the other, he genuinely hoped to gain some concessions from Frelimo, particularly some involvement in the choice of governors in the provinces where Renamo did well in the election. Secret negotiations were opened between Raul Domingos, who had been the chief Renamo negotiator in the 1990-92 peace talks, and Tomás Salomão, former finance minister and newly appointed transport minister, and a trusted figure in Frelimo. Talks revolved around financial support for Renamo, giving a bigger piece of the economic cake to Renamo leaders, and governorships. Pointedly, new governors were not named.

As well as boycotting parliament, Renamo began to organise a tax boycott, particularly calling on market traders not to pay the market fees that are an importance source of revenue for local government. This led to the first deaths, on 5 May, when the police in Aube, Nampula province, arrested a Renamo organiser promoting the fee boycott. Renamo supporters stormed the police station to free their man, and the police opened fire, killing between four and eight Renamo supporters.

Chissano and Frelimo gave no ground. It would have been painless for Chissano to invite in his ‘brother’ Dhlakama for consultations after the elections; perhaps a few Renamo advisors might have been appointed in provinces where Renamo had done well in the elections. Instead, Chissano offered Dhlakama nothing, and in May the strategy hardened even further... Talks with Renamo were broken off. In June, Chissano said in a speech that Raul Domingos had been asking for $500,000 for himself to pay off business debt, $1 million a month for Renamo, and $10,000 a month for Dhlakama. Domingos denied the allegations. But Domingos is already engaged in a series of business
ventures with Frelimo leaders. He seemed the one person in Renamo who had some standing and might be acceptable to the new Mozambican elite. Thus he was the most serious threat to Dhlakama, and he was expelled from the party in July.

On 14 July Chissano announced new governors for all 10 provinces, making no concessions to Renamo. On 26 July, Frelimo appointed its members to the national election commission, which meant it could begin work setting up an important by-election, despite the Renamo boycott.

Savana, an independent weekly newspaper that had been sympathetic to Renamo, said on 21 July that ‘Dhlakama has lost everything’ that it had been demanding—no governors, no recount, no early election. The boycott strategy had proved ineffective, ‘like trying to stop wind with your hands’. The newspaper asked: ‘Why has Renamo lost everything?’ and it answered that ‘it is not organised to win anything’. It has wasted an entire year without ‘preparing for municipal elections in 2003 or general elections in 2004’.

In October, the police unexpectedly raided Renamo houses in Beira, including one of Dhlakama’s own houses, and confiscated guns. Renamo argued that it had the right to guns under the 1992 peace accord, while the government said that peace accord extra guarantees finished with the 1994 elections. But the move was widely criticised, because everyone knew the guns had been there since 1994, there were only a small number, and they had never been used. Thus the raid seemed a provocation.

Dhlakama had repeatedly promised national anti-government demonstrations and several times threatened to set up parallel governments in the provinces where it won majorities, but it never succeeded in doing any of this. Thus, when Dhlakama called demonstrations for November to protest the elections that had taken place nearly a year before, few took the call seriously. Again, the government raised the ante, by calling on people not to take part in what it called anti-government demonstrations.

Small and not very well publicised demonstrations took place in more than 30 cities on 9 November. The demonstrations were technically illegal, because four days notice must be given and because demonstrations cannot be held during the working day. Three very different things happened in different places:

- In Maputo and a number of other towns, police either turned a blind eye or actually cooperated with Renamo to work out a route for a march. These demonstrations were all peaceful.
- In a number of cities, police decided to stop the ‘illegal’ demonstrations at all cost. They used tear gas, dogs, batons and, most seriously, live ammunition. An estimated 8 people were killed by the police, and hundreds arrested—many before they even started to march.
- In several places, former Renamo guerrillas and the local leadership organised what seemed like a military assault on local government facilities.

The worst occurred in Montepuez, Cabo Delgado, where independent sources confirm that a group including former guerrillas attached the town centre, looting shops and damaging the telephone exchange, then attacking the police station where they stole weapons and freed prisoners, then attacked the district administration office where they destroyed all the files. In the raid, seven policemen were killed (at least one-third of the entire police force) and 18 attackers died.

In Nametil, Nampula province, armed Renamo people entered the town and six people were killed. In Caia, Sofala, an armed man was shot inside the administration offices. In Pemba, Cabo Delgado,
demonstrators badly beat a woman election official. In all, more than 40 people were killed.

The very different nature of the demonstrations and the responses in different places suggests that neither Renamo nor the government had a consistent policy, but that hard-liners on both sides were active in a number of places.

Frelimo's hard line against Renamo comes in part due to its shock at having done worse than expected in the 1999 elections. The voters seems to be reacting to two related economic issues. First, people do not feel that the quality of their lives has improved much since the end of the war. The UNDP's 'Mozambique National Human Development Report 1999' (UNDP, Maputo, 2000) shows that 34 per cent of the entire country's GDP is generated in Maputo city, where per capita GDP in 1998 was $1426 compared to just $134 the most populous province, Zambezia. Between 1996 and 1998, Maputo city per capita income jumped $354 while Zambezia per capita income rose only $32. People see that Maputo is a prosperous and expanding city, and they also see how rapidly the gaps between rich and poor are increasing.

Widespread corruption also brought a major backlash against Frelimo. There are complaints about petty corruption, such as teachers and nurses demanding small bribes, and there has been a very public crackdown since the election. But nothing has been done about grand corruption. The court system is massively corrupt and does not function, which means corruption and other cases are not prosecuted. President Chissano confirmed that model after his re-election by reappointing a weak justice minister but removing a strong and reforming deputy minister. Corruption has been particularly common in the privatisation process, especially of the banks, and in government contracts. Many government ministers and their families, and President Chissano's family, are involved in businesses which now dominate the local economic scene. Renamo figures such as Raul Domingos are being incorporated into this new politico-economic elite.

The Frelimo government has done nothing to tackle either grand corruption or to develop strategies that will being real gains to the areas outside Maputo. Renamo has no policies at all; it just wants more of the cake. It is in this context that the increasing tensions must be seen. Both parties are badly fractured, and there are clearly conflicting lines in both. But there seem to be two lines at work, probably with a substantial overlap.

First is the group that did not want to settle the war in 1992. Some of the old guard in Frelimo feel that when Renamo is weakest, it should be smashed once and for all. Each time Dhlakama is weakened, he is kicked again. But this actually feeds what Carlos Cardoso, editor of the independent daily Metical, calls 'the bellicose faction of Renamo that wants total ostracism', because it can argue that there is no point in working with the government. It argues, like the opposition in Zimbabwe, that the government is illegitimate and must be overthrown.

But there is a second group which actually finds the tension and violence useful. Carlos Cardoso talks of the 'gangster faction' in both parties, who want to divert attention away from their own greed and their own lack of policies and actions to help the poor. No one will notice that bank fraud cases do not come to trial if attention is focused on interparty warfare.

One question remains. In January Dhlakama had substantial prestige, at least within his own party, and could have used it to build a party that would have been loyal to him. Instead, he frittered away that prestige by demand-
ing recounts and revotes, so that by May he had lost much of his enhanced standing. It was at this point that Frelimo moved onto the offensive. But why? Frelimo could have simply allowed Renamo to whither away. In advance of the 9 November demonstrations, if it had said nothing (or said, flippantly, ‘demonstrations are normal in a democratic society’) and told the police to ignore technical law violations, then 9 November would have passed off more peacefully, and Renamo taken the blame for any violence. Instead, with its arms raids and bellicose statements, Frelimo provoked a Renamo response.

Is it possible that Frelimo realises it needs Renamo, but also needs to keep Renamo weak. Renamo occupies the opposition space; an independent third force has failed to arise anywhere except in the Maputo city assembly. But in Maputo, an opposition built mainly from the old-Frelimo left challenges Frelimo on economic, development and corruption issues. Are there some in Frelimo who feel that Renamo can be kept in the boycott box and made to boycott the 2003 local elections and lose the 2004 national elections, but that a real opposition would have a chance of winning? In that case, the only choice is to prop up Renamo and keep it from collapsing. And if Dhlakama cannot motivate his supporters into action, then Frelimo has to.

Thus the conclusion must be that in the absence of political and development strategies, and where self-interest dominates, inter-party tensions and some limited amounts of violence seem in the interest of leaders of both parties.


The Murder of Carlos Cardoso

Carlos Cardoso, editor of the independent Maputo paper, Metical, was murdered in Maputo on Wednesday 22 November 2000. His funeral was held on Friday 24 November in Maputo. A fearless campaigner for freedom and a lifelong socialist who committed his life to the African revolution and the struggle against imperialism, Cardoso was gunned down in what appears to have been a planned and professional assassination. Here we reproduce two items published by AIM, the Mozambique news agency. The first is a report published the day after the killing. The second is an edited obituary and appreciation written by Paul Fauvet as a tribute to our fallen comrade.

The Murder Of Carlos Cardoso,
Maputo, 23 November 2000

The Mozambican government has instructed the police to work with Interpol and with the police forces of the neighbouring countries to hunt down the killers of Carlos Cardoso, editor of the daily newsheet, Metical, who was murdered on Wednesday evening in Maputo. Prime Minister Pascoal Mocumbi told a Maputo press briefing on Thursday that the government ‘will spare no effort so that the moral and material authors of this crime will be arrested, tried and sentenced’.

Since all the indications are that this was a highly organised crime, and the murderers might have tried to flee the country, the police had been instructed to make this a regional investigation. South African High Commissioner Jessie Duarte confirmed to AIM that the South African government has offered ‘expert help’ to the Mozambican authorities to track down the assassins.

Mocumbi paid warm tribute to Cardoso, praising him for ‘his unceasing fight for
truth, for justice, and for the well-being of his fellow citizens. Carlos Cardoso was a man of integrity, a combative and consistent journalist, who held strong convictions, and who defended his ideas persistently and tenaciously’, said the Prime Minister. ‘The brutal and cruel murder of our fellow citizen is an act of cowardice’, he stressed. ‘It is an assault against freedom, an attempt to silence the voices who fight for honesty and for the progress of our country’. Mocumbi reiterated the government’s commitment ‘to do all in our power so that the Mozambican media is truly free and independent, and committed to our people’.

In the Mozambican parliament, the Assembly of the Republic, deputy Luis Videira read out a declaration on behalf of the parliamentary group of the ruling Frelimo Party, expressing condolences to Cardoso’s family and to the country’s journalists. He called on the authorities ‘to ensure that this heinous crime is fully investigated and that the murderers are severely punished. We have lost a fighter for the construction of the Mozambican motherland’, Videira declared.

The circumstances of Cardoso’s murder, from eye-witness accounts of passers-by and from the lacerated state of his body, are now fairly clear. The attack occurred at about 18.40 on Wednesday evening as a Metical driver, Carlos Manjate, was driving Cardoso from the paper’s offices to his home. On a central Maputo street, Avenida Martires da Machava, in front of a local park, a car suddenly pulled in front of the Metical vehicle, a Toyota Corolla, forcing it to stop. A second car drew up alongside, and a gunman opened fire with an AK-47 assault rifle at point blank range. Cardoso was hit several times in the head, dying almost instantly. The shooting was over in a matter of seconds, and the two cars used in the ambush then drove off into the night. Manjate was also hit in the hail of bullets, but he survived, and is currently in the intensive care unit in Maputo Central Hospital.

The site of the murder has become an impromptu shrine. At the spot where the Toyota was forced to halt, and where shattered glass from its windows can still be seen in the road, there is the stump of a dead tree. On top of this stump, friends and passers-by have left flowers, and messages of sorrow and outrage. When AIM visited the spot on Thursday morning, two women [with] tears in their eyes were lighting candles there in memory of one of Mozambique’s most outspoken and courageous journalists.

Carlos Cardoso: An Appreciation
Paul Fauvet

Carlos Alberto Cardoso, editor of the independent news-sheet, Metical, who was murdered on Wednesday, was born of Portuguese parents in the central Mozambican city of Beira in 1952. He studied in South Africa where he became involved in radical, anti-apartheid student politics, leading to his expulsion from the country. In Maputo, he identified with the revolution against Portuguese colonial rule, although he never became a member of the Mozambique Liberation Front (Frelimo).

The revolution split the Cardoso family. Carlos considered himself a Mozambican and stayed to help build the new, independent state, while his parents returned to Portugal. His exceptional talents as a writer ensured a rapid rise in the world of journalism. He worked first on the weekly magazine Tempo, then briefly on Radio Mozambique, before he was appointed chief news editor of the Mozambique News Agency (AIM) in 1980. At the time, AIM did not, strictly speaking, have a director. Cardoso was usually treated as the director, though he did not formally acquire this title for several years.
ing recounts and votes, so that by May he had lost much of his enhanced standing. It was at this point that Frelimo moved onto the offensive. But why? Frelimo could have simply allowed Renamo to wither away. In advance of the 9 November demonstrations, if it had said nothing (or said, flippantly, ‘demonstrations are normal in a democratic society’) and told the police to ignore technical law violations, then 9 November would have passed off more peacefully, and Renamo taken the blame for any violence. Instead, with its arms raids and bellicose statements, Frelimo provoked a Renamo response.

Is it possible that Frelimo realises it needs Renamo, but also needs to keep Renamo weak. Renamo occupies the opposition space; an independent third force has failed to arise anywhere except in the Maputo city assembly. But in Maputo, an opposition built mainly from the old-Frelimo left challenges Frelimo on economic, development and corruption issues. Are there some in Frelimo who feel that Renamo can be kept in the boycott box and made to boycott the 2003 local elections and lose the 2004 national elections, but that a real opposition would have a chance of winning? In that case, the only choice is to prop up Renamo and keep it from collapsing. And if Dh lakama cannot motivate his supporters into action, then Frelimo has to.

Thus the conclusion must be that in the absence of political and development strategies, and where self-interest dominates, inter-party tensions and some limited amounts of violence seem in the interest of leaders of both parties.


The Murder of Carlos Cardoso
Cardoso: Report & Obituary

Carlos Cardoso, editor of the independent Maputo paper, Metical, was murdered in Maputo on Wednesday 22 November 2000. His funeral was held on Friday 24 November in Maputo. A fearless campaigner for freedom and a lifelong socialist who committed his life to the African revolution and the struggle against imperialism, Cardoso was gunned down in what appears to have been a planned and professional assassination. Here we reproduce two items published by AIM, the Mozambique news agency. The first is a report published the day after the killing. The second is an edited obituary and appreciation written by Paul Fauvet as a tribute to our fallen comrade.

The Murder Of Carlos Cardoso, Maputo, 23 November 2000

The Mozambican government has instructed the police to work with Interpol and with the police forces of the neighbouring countries to hunt down the killers of Carlos Cardoso, editor of the daily newsheet, Metical, who was murdered on Wednesday evening in Maputo. Prime Minister Pascoal Mocumbi told a Maputo press briefing on Thursday that the government ‘will spare no effort so that the moral and material authors of this crime will be arrested, tried and sentenced’.

Since all the indications are that this was a highly organised crime, and the murderers might have tried to flee the country, the police had been instructed to make this a regional investigation. South African High Commissioner Jessie Duarte confirmed to AIM that the South African government has offered ‘expert help’ to the Mozambican authorities to track down the assassins.

Mocumbi paid warm tribute to Cardoso, praising him for ‘his unceasing fight for
truth, for justice, and for the well-being of his fellow citizens. Carlos Cardoso was a man of integrity, a combative and consistent journalist, who held strong convictions, and who defended his ideas persistently and tenaciously, said the Prime Minister. 'The brutal and cruel murder of our fellow citizen is an act of cowardice', he stressed. 'It is an assault against freedom, an attempt to silence the voices who fight for honesty and for the progress of our country'. Mocumbi reiterated the government's commitment 'to do all in our power so that the Mozambican media is truly free and independent, and committed to our people'.

In the Mozambican parliament, the Assembly of the Republic, deputy Luis Videira read out a declaration on behalf of the parliamentary group of the ruling Frelimo Party, expressing condolences to Cardoso's family and to the country's journalists. He called on the authorities 'to ensure that this heinous crime is fully investigated and that the murderers are severely punished. We have lost a fighter for the construction of the Mozambican motherland', Videira declared.

The circumstances of Cardoso's murder, from eye-witness accounts of passers-by and from the lacerated state of his body, are now fairly clear. The attack occurred at about 18.40 on Wednesday evening as a Metical driver, Carlos Manjate, was driving Cardoso from the paper's offices to his home. On a central Maputo street, Avenida Martires da Machava, in front of a local park, a car suddenly pulled in front of the Metical vehicle, a Toyota Corolla, forcing it to stop. A second car drew up alongside, and a gunman opened fire with an AK-47 assault rifle at point blank range. Cardoso was hit several times in the head, dying almost instantly. The shooting was over in a matter of seconds, and the two cars used in the ambush then drove off into the night. Manjate was also hit in the hail of bullets, but he survived, and is currently in the intensive care unit in Maputo Central Hospital.

The site of the murder has become an impromptu shrine. At the spot where the Toyota was forced to halt, and where shattered glass from its windows can still be seen in the road, there is the stump of a dead tree. On top of this stump, friends and passers-by have left flowers, and messages of sorrow and outrage. When AIM visited the spot on Thursday morning, two women [with] tears in their eyes were lighting candles there in memory of one of Mozambique's most outspoken and courageous journalists.

Carlos Cardoso: An Appreciation
Paul Fauvet

Carlos Alberto Cardoso, editor of the independent news-sheet, Metical, who was murdered on Wednesday, was born of Portuguese parents in the central Mozambican city of Beira in 1952. He studied in South Africa where he became involved in radical, anti-apartheid student politics, leading to his expulsion from the country. In Maputo, he identified with the revolution against Portuguese colonial rule, although he never became a member of the Mozambique Liberation Front (Frelimo).

The revolution split the Cardoso family. Carlos considered himself a Mozambican and stayed to help build the new, independent state, while his parents returned to Portugal. His exceptional talents as a writer ensured a rapid rise in the world of journalism. He worked first on the weekly magazine Tempo, then briefly on Radio Mozambique, before he was appointed chief news editor of the Mozambique News Agency (AIM) in 1980. At the time, AIM did not, strictly speaking, have a director. Cardoso was usually treated as the director, though he did not formally acquire this title for several years.
truth, for justice, and for the well-being of his fellow citizens. Carlos Cardoso was a man of integrity, a combative and consistent journalist, who held strong convictions, and who defended his ideas persistently and tenaciously’, said the Prime Minister. ‘The brutal and cruel murder of our fellow citizen is an act of cowardice’, he stressed. ‘It is an assault against freedom, an attempt to silence the voices who fight for honesty and for the progress of our country’. Mocumbi reiterated the government’s commitment ‘to do all in our power so that the Mozambican media is truly free and independent, and committed to our people’.

In the Mozambican parliament, the Assembly of the Republic, deputy Luis Videira read out a declaration on behalf of the parliamentary group of the ruling Frelimo Party, expressing condolences to Cardoso’s family and to the country’s journalists. He called on the authorities ‘to ensure that this heinous crime is fully investigated and that the murderers are severely punished. We have lost a fighter for the construction of the Mozambican motherland’, Videira declared.

The circumstances of Cardoso’s murder, from eye-witness accounts of passers-by and from the lacerated state of his body, are now fairly clear. The attack occurred at about 18.40 on Wednesday evening as a Metical driver, Carlos Manjate, was driving Cardoso from the paper’s offices to his home. On a central Maputo street, Avenida Martires da Machava, in front of a local park, a car suddenly pulled in front of the Metical vehicle, a Toyota Corolla, forcing it to stop. A second car drew up alongside, and a gunman opened fire with an AK-47 assault rifle at point blank range. Cardoso was hit several times in the head, dying almost instantly. The shooting was over in a matter of seconds, and the two cars used in the ambush then drove off into the night. Manjate was also hit in the hail of bullets, but he survived, and is currently in the intensive care unit in Maputo Central Hospital.

The site of the murder has become an impromptu shrine. At the spot where the Toyota was forced to halt, and where shattered glass from its windows can still be seen in the road, there is the stump of a dead tree. On top of this stump, friends and passers-by have left flowers, and messages of sorrow and outrage. When AIM visited the spot on Thursday morning, two women [with] tears in their eyes were lighting candles there in memory of one of Mozambique’s most outspoken and courageous journalists.

Carlos Cardoso: An Appreciation
Paul Fauvet

Carlos Alberto Cardoso, editor of the independent news-sheet, Metical, who was murdered on Wednesday, was born of Portuguese parents in the central Mozambican city of Beira in 1952. He studied in South Africa where he became involved in radical, anti-apartheid student politics, leading to his expulsion from the country. In Maputo, he identified with the revolution against Portuguese colonial rule, although he never became a member of the Mozambique Liberation Front (Frelimo).

The revolution split the Cardoso family. Carlos considered himself a Mozambican and stayed to help build the new, independent state, while his parents returned to Portugal. His exceptional talents as a writer ensured a rapid rise in the world of journalism. He worked first on the weekly magazine Tempo, then briefly on Radio Mozambique, before he was appointed chief news editor of the Mozambique News Agency (AIM) in 1980. At the time, AIM did not, strictly speaking, have a director. Cardoso was usually treated as the director, though he did not formally acquire this title for several years.
Under Cardoso's leadership, AIM achieved fame in the country and in the region for its campaigning coverage of the apartheid regime's war of destabilisation against Mozambique. So persistent was AIM's work in this field that, according to Mozambican security sources, Cardoso's name was on a list of potential targets drawn up by South African Military Intelligence.

Cardoso's commitment to the Mozambique revolution did not stop him from having a number of disputes with the leadership. There were often tensions between the open and outspoken brand of journalism practiced by Cardoso and the altogether more cautious approach followed by the Frelimo leadership and by the Ministry of Information. In 1982 a clash even resulted in the sudden imprisonment of Cardoso, apparently because an article he wrote in the daily paper Notícias which violated a government guideline on covering the war of which he was not aware. Other journalists and intellectuals protested at the jailing, insisting to government members, including President Samora Machel, that Cardoso was no enemy of the country. Six days after his arrest he was released and though there was no government apology for the arrest, he was reinstated as the head of AIM.

Cardoso's outspoken approach also led to a public clash with the then head of the Frelimo Ideology Department, Jorge Rebelo, at the Second Congress of the National Journalists' Organisation (ONJ) in 1986, when Cardoso suggested that Frelimo could not rely on the loyalty of journalists forever. Despite this, Cardoso was one of a select group of journalists invited for private briefings with Samora Machel in the last months of the President's life. Cardoso was deeply affected by the death of Machel in a plane crash at Mbuzini, just inside South Africa, on 19 October 1986. He investigated the crash with tenacity and built up a picture of the likely cause of the crash — deliberate electronic interference by the apartheid military machine to lure the plane away from its correct flight path.

In the late 1980s, Cardoso found himself in conflict, this time with Information Minister Teodato Hunguana. He offered his resignation as AIM director and, although Hunguana initially refused to accept it, he finally agreed when it became clear that Cardoso was determined to concentrate full-time on journalistic work. Despite these political differences, Hunguana publicly praised Cardoso's work at AIM, saying that it was thanks to Cardoso's leadership that the agency had won 'prestige and credibility' in the outside world.

In 1990, Cardoso was among a core group of journalists campaigning for the inclusion of a specific commitment to press freedom in the new Mozambican constitution. This campaign, including a petition to President Joaquim Chissano, entitled 'The Right Of The People To Information', and signed by over 160 media professionals, was entirely successful. The clauses on the media in the 1990 constitution, and the follow-up Press Law of 1991, are among the most liberal in Africa.

In 1992, Cardoso and others founded a journalists' co-operative, Mediacoop. In May of that year, the co-operative launched a new independent daily paper, Mediafax, to produce investigative journalism and in-depth articles on issues not normally touched by the other media. Edited by Cardoso, Mediafax reached its subscribers by fax, thus avoiding problems of distribution and paper supplies. In 1992 this was an entirely novel way of proceeding, though one soon imitated by other publications.

A dispute in Mediacoop in 1997 led to Cardoso leaving the co-operative. Taking most of the Mediafax staff with him, he set up his own paper Metical, to continue his brand of investigative journalism, par-
particularly on economic matters. Just as in the 1980s Cardoso had campaigned tirelessly against the South African destabilisation of Mozambique, so now he campaigned against what he regarded as the disastrous recipes for the Mozambican economy imposed by the World Bank and the IMF. He championed the fight, first of the cashew processing industry and later of the sugar industry, against liberalisation measures that would shut down factories and cost thousands of jobs. Cardoso took up the cause of environmentalists protesting at government plans to incinerate obsolete pesticides in the cement factory in the densely populated city of Matola. It was in no small measure due to Cardoso’s work that this became a public issue, and the government eventually beat a retreat and decided to re-export the pesticides instead.

In 1998, angered by the Frelimo government’s handling of the economy, and seeing no future in any of the existing right-wing opposition parties, Cardoso stood as an independent candidate for the Maputo municipal assembly. The independent grouping, known as ‘Juntos pela Cidade’ (Together for the City) won 26 per cent of the vote, and became the opposition in the city assembly. Cardoso then threw himself into municipal politics with the same enthusiasm and commitment he had shown in his journalism.

Among the scandals Cardoso had been investigating in the last months of his life one stands out above all others. This was the largest banking fraud in the country’s history. In 1996, on the eve of the privatisation of the country’s largest bank, the BCM, a well-organised criminal network siphoned the equivalent of US$14 million out of the bank. Although the names of the main suspects were known, and repeatedly published, there was no prosecution and no trial. *Metical* has covered the BCM affair persistently, calling for an end to the culture of impunity, and for the culprits to be brought to justice. That this was dangerous territory became clear in November 1999, when the BCM’s lawyer, Albano Silva, narrowly escaped an assassination attempt. One cannot help but wonder whether the attacks on Silva and Cardoso are linked – and whether, having failed to silence their main judicial opponent, the criminal sector of the Mozambican economy has succeeded in eliminating its main enemy in the media.

© (AIM), Maputo, 23 November 2000

Books Received
*Afriche e Orienti*, University of Bologne, vol 2-4 1999, 88 86051 85 9.


Bowen, Merle L, *The State against the Peasantry: Rural Struggles in Colonial and Postcolonial Mozambique*, The University Press of Virginia, 0-8139-1917-7
particularly on economic matters. Just as in the 1980s Cardoso had campaigned tirelessly against the South African destabilisation of Mozambique, so now he campaigned against what he regarded as the disastrous recipes for the Mozambican economy imposed by the World Bank and the IMF. He championed the fight, first of the cashew processing industry and later of the sugar industry, against liberalisation measures that would shut down factories and cost thousands of jobs. Cardoso took up the cause of environmentalists protesting at government plans to incinerate obsolete pesticides in the cement factory in the densely populated city of Matola. It was in no small measure due to Cardoso’s work that this became a public issue, and the government eventually beat a retreat and decided to re-export the pesticides instead.

In 1998, angered by the Frelimo government’s handling of the economy, and seeing no future in any of the existing right-wing opposition parties, Cardoso stood as an independent candidate for the Maputo municipal assembly. The independent grouping, known as ‘Juntos pela Cidade’ (Together for the City) won 26 per cent of the vote, and became the opposition in the city assembly. Cardoso then threw himself into municipal politics with the same enthusiasm and commitment he had shown in his journalism.

Among the scandals Cardoso had been investigating in the last months of his life one stands out above all others. This was the largest banking fraud in the country’s history. In 1996, on the eve of the privatisation of the country’s largest bank, the BCM, a well-organised criminal network siphoned the equivalent of US$14 million out of the bank. Although the names of the main suspects were known, and repeatedly published, there was no prosecution and no trial. *Metical* has covered the BCM affair persistently, calling for an end to the culture of impunity, and for the culprits to be brought to justice. That this was dangerous territory became clear in November 1999, when the BCM’s lawyer, Albano Silva, narrowly escaped an assassination attempt. One cannot help but wonder whether the attacks on Silva and Cardoso are linked – and whether, having failed to silence their main judicial opponent, the criminal sector of the Mozambican economy has succeeded in eliminating its main enemy in the media.

© (AIM), Maputo, 23 November 2000

Books Received

*Afriche e Orienti*, University of Bologne, vol 2-4 1999, 88 86051 85 9.


Bowen, Merle L, *The State against the Peasantry: Rural Struggles in Colonial and Postcolonial Mozambique*, The University Press of Virginia, 0-8139-1917-7


May, Julian (ed.), *Poverty and Inequality in South Africa: Meeting the Challenge*, Zed Books, 2000, 1 85649 656 2, £16.95.


Toulmin, Camilla & Julian Quan (eds.), *Evolving Land Rights, Policy and Tenure in Africa*, IIED, 1 899825 51 7.


UNCTAD (ed.), *African Development in a Comparative Perspective*, James Currey, 0-85255-165-7, £12.95.


Verney, Peter, *Raising the Steaks – Oil and Conflict in Sudan*, A Sudan Update Report, Sudan Update, 1999, 0 9537678 0 9.
