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# Overview: HIV/AIDS in Africa: Global & Local Inequalities & Responsibilities

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**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 acknowledgment 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 co-ordination, 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 epidejic 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-eminently 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 Lomé 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 Heavility 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.

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