

Debt, adjustment and the politics of effective response to HIV/AIDS in Africa

FANTU CHERU

ABSTRACT Today in much of Africa economic growth has slowed and living standards for the majority have suffered in the face of rising unemployment and mass poverty, resulting in incomes that are presently below the 1970 level. One problem that has been the focus of much attention and contention over the past 20 years is the huge foreign debt owed by African countries to bilateral donors and multilateral institutions. Debt servicing is consuming a disproportionate amount of scarce resources at the expense of the provision of basic services to the poor. In order to receive help in servicing their debts, countries must agree to implement structural economic reforms. This often entails drastic cuts in social expenditures, the privatisation of basic services, and the liberalisation of domestic trade consistent with WTO rules. These policy decisions have had a direct impact on the capacity of African countries to promote, fulfill and protect the right to health of their citizens. This is further compounded by ill-conceived privatisation of basic services such as water and health services, without any regard for the ability of the poor to access these essential services at a cost they can afford. Finally, adherence to WTO trade rules, which often comes as an extension of liberalisation policy, hampers the capacity of African governments to produce or purchase less expensive generic drugs for their citizen without fear of retaliation from the developed countries.

It has become increasingly evident over the past decade that international policies and initiatives, particularly those that drive economic globalisation, have negative implications for the universal enjoyment of human rights. These include trade, investment and financial liberalisation, the international debt regime and structural adjustment programmes. As a result, numerous civil society groups and developing country governments have raised concerns about the need for social and development issues to be taken into account during discussions of any multilateral trade and investment treaty, or in the design of macroeconomic reform programmes. These voices have also spoken out about the need to retain and enhance the ‘regulatory’ role of the state. These calls are reinforced by a growing perception that economic and social rights are increasingly being eroded by the momentous disruptions brought about by economic globalisation. This article explores the impact of debt and the international trade rules of the World

Fantu Cheru is at the American University, Washington, DC 20016, USA.

Trade Organization (WTO) on the realisation of the right to health in sub-Saharan Africa, with an emphasis on the HIV/AIDS pandemic.

HIV/AIDS as a development crisis

Over 36 million people in the world today are HIV/AIDS infected. Of these, some 95% live in the global south. In particular, sub-Saharan Africa is home to over 25 million people suffering from HIV and AIDS. In 16 African countries, more than 10% of adults are now infected, with South Africa having the largest HIV-infected population of any country (4.2 million, 12% of the global total). Each day in Africa more than 5000 people die from AIDS (UNAIDS, 2000a: 26–36). Experts estimate that the world community needs to invest US\$7–10 billion every year to fight HIV/AIDS, as well as other diseases like tuberculosis and malaria. In the face of this humanitarian crisis, however, African countries continue annually to pay \$13.5 billion in debt service payments to creditor countries and institutions, an amount far in excess of the United Nations' proposed global HIV/AIDS trust fund (Drop the Debt, 2001: 4). This massive transfer of resources from poor African countries to wealthy Northern creditors is one of the factors that has critically weakened health care and education in the countries that are now worst affected by the pandemic. Therefore, strategies to tackle the HIV/AIDS epidemic in Africa must take into account the structural context in which AIDS occurs. Turning Africa's towering debt burden into investment to fight the pandemic is one among the many interventions that the international community must act upon without reservation.

Besides being a global public health emergency, the HIV/AIDS epidemic has become the foremost contemporary threat to the development of many African countries. The opportunity cost of the disease to the development prospects of many African countries is enormous (UK House of Commons, 2001). In many countries, rising adult mortality as a result HIV/AIDS 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 private firms. As labour turnover increases because of mortality, the cost of additional training costs rises.

Past achievements in economic growth, improved life expectancy and decreasing child mortality have been reversed by the rapid spread of the HIV virus. In nine countries with an adult prevalence of 10% 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).

The immediate impact of AIDS is felt most acutely in the households where one or more members are HIV infected. Both household savings and consumption are quickly depleted. According to UNAIDS, households in South Africa, for example, will have on average 13% less to spend per person by 2010 than they would if there had been no HIV epidemic (Piot, 2001). Widespread poverty in turn creates situations of vulnerability to infections—women may have little choice but to enter into prostitution where economic opportunities are lacking. For example, according to a study by Zimbabwe Farmers Union, the AIDS-related reduction in

the production of maize has reached 61%, cotton 47% and groundnuts 37% (ILO, 2000: 21) All these problems are further intensified as sickness reduces the capacity of adults to work or cultivate land. AIDS also generates greater medical, funeral and legal costs, and has a long-term impact on the capacity of households to stay together.

In education AIDS has a negative impact both on the supply of teachers and on the capacity of children to continue in school. As children are orphaned and household poverty deepens, girls are taken out of school, reducing further their chances of receiving an education (ILO, 2000: 13; Hunters & Williamson, 1997). In some countries many more teachers die than retire, and the teaching force is being depleted almost as quickly as new teachers can be trained. In Zambia, for example, it has been estimated that more than 30% of teachers are already infected with the HIV virus (Kelly, 1999; World Bank, 2000: 11). Ministry of Education data show that 680 teachers died in 1996, 624 in 1997 and 1300 in the first 10 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 (Republic of Zambia, 1997: Tables A.25).

The unprecedented scale of HIV/AIDS-related death in Africa and the resulting breakdown of family and social networks have yet to stir the international community to anything near the level of action required. The response of Western governments to the HIV/AIDS crisis in Africa amounts to callous indifference when compared with recent responses to the most widely televised and strategically important trouble spots—the Turkish earthquake, Balkan wars and Middle East peace agreements (Cheru, 2000: 519–535). This double standard must be viewed in the larger context of ‘global apartheid’, where access to lifesaving medicines for Africans infected with the HIV/AIDS virus is largely determined by race, class, gender and geography (Booker & Minter, 2001: 11–17; United Nations, 2000: 276–277).

Freeing Africa from the shackles of debt

The external debt situation of developing countries remains a source of concern. The problems of the heavily indebted poor countries (HIPC), most of whom are in Africa, are far from being resolved, while other poor countries are also facing a mounting debt burden as a result of worsening global economic conditions. A number of middle-income countries in East Asia have overcome the first phase of an acute balance-of-payments crisis, but still have to resolve their debt problems. Other middle-income countries in Latin America are encountering serious payment problems, with Argentina becoming the latest victim.

At the beginning of 1999 the total foreign debt owed by developing countries was \$2.1 trillion. The regional distribution of this debt was as follows: \$792 billion for Latin America; \$340 billion for Africa (of which \$175 billion was owed by sub-Saharan Africa); and \$972 billion for Asia (United Nations, 2000: 279). While most of Latin America’s debt is owed to commercial banks, most of the debt owed by African nations is to official donors and multilateral organisations. Yet, by most conventional indicators, such as the ratio of debt to GNP, sub-Saharan Africa’s debt burden was 123% of its GNP compared with 41.4% for

Latin America and 28.2% for Asia. In terms of ratio of external debt to exports, the figures are striking: 340% for sub-Saharan Africa; 202% for Latin America; and 121% for Asia (United Nations, 2000: 279).

Time and space do not permit delving into the root causes of the Third World debt crisis. There are indeed many reasons for the crisis and it would be wrong to place the blame solely on either the governments of debtor nations or on creditor nations and their commercial banks. It is safe to say, however, that the policies pursued by both creditors and debtors are responsible for accentuating the economic and social crisis; both must share the burden of adjustment equally.

What is important for the purpose of this article, however, is the manner in which the IMF and the World Bank have single-handedly gone about managing the Third World debt crisis since the 1980s, without any regard for the social and economic costs of macroeconomic adjustment, particularly to the health sector. Demand management policies, which are central in structural adjustment programmes, have had a regressive impact by reducing the amount of foreign exchange available to purchase necessary imports, leading to severe import strangulation, depriving industry and agriculture of needed inputs. In the social sector, debt servicing and the adjustment policies pushed to free up foreign exchange needed to service the debt have worsened social welfare in the areas of health, education and poverty reduction (Cheru, 1989; Beckman, 1992: 83–105).

Adjusting markets: whatever happened to the human right to health?

As difficulties servicing huge loans made by Northern banks and the Bretton Woods institutions escalated in the 1980s, pressure to adopt structural adjustment grew stronger as a wide range of bilateral and multilateral donors insisted upon radical economic reform as a condition for the disbursement of donor funds. Co-operation between the World Bank and the IMF was brought to a higher level with the establishment in 1988 of the Structural Adjustment Facility (SAF) to closely co-ordinate surveillance and enforcement activities, particularly in sub-Saharan Africa.

The key objective of adjustment programmes within indebted countries was to reduce consumption of goods and services. The IMF calls this ‘demand management’. It is meant to ensure that more of debtor nations’ resources will be used to produce exports to be sold for dollars that can then be used to pay debts. Among the conditions typically required by the IMF and the World Bank are the following (Kahn, 1990: 2; Mosley *et al*, 1991):

- deep reduction or elimination of subsidies and price controls that distort internal prices for a number of goods and services;
- drastic reduction of trade and exchange controls designed to protect the local economy from foreign competition;
- high interest rates to fight inflation, promote savings and allocate investment capital to the highest bidders;
- privatisation of state-owned firms, including the privatisation of public service (ie health care, education);

- reduction of the role of the state, not only in the economy but also in the provision of social services such as health, education and social security;
- indiscriminate export promotion through devaluation of the currency.

These policies are uniformly applied to all debtor countries requesting assistance from the multilateral financial institutions, regardless of the special circumstances of each country or reasons behind their balance-of-payment difficulties. Between 1985 and 1990, some 38 sub-Saharan countries implemented over 257 adjustment programmes. Most have undertaken multiple programmes, with 14 countries implementing 10 or more. While many elements of macroeconomic adjustment are critically important for promoting economic growth and social development, the context in which these policies have been applied is largely motivated to ensure that debtor nations fulfill their interest and principal payments to creditor institutions. The international financial institutions' single-minded preoccupation with achieving macroeconomic balance and servicing foreign debt has had a regressive impact on human development, and jeopardised the right to food, education and health.

As we come to the end of the second decade of adjustment, the role of the state has been significantly curtailed, the dominance of market forces is set in place, and African economies are wide open to external penetration, thanks not only to adjustment programmes, but also to the continued pressure of globalisation and market integration. While it is generally true that some debtor countries have witnessed varying degrees of growth following reform, there are few countries where macroeconomic stability and policy-induced growth have been consistent over the medium term. Instead, living standards for the majority of Africans have declined and investment in the productive and social sectors of many countries has dwindled. The cuts mandated by structural adjustment have been indiscriminate, thereby jeopardising the following rights:

- *The right to food:* there is convincing evidence demonstrating that nutritional levels decrease among poorer segments of the population as a result of the removal of food subsidies. Growing unemployment has a similar result. The switching effect of agricultural policies, primarily from food production for local consumption to generation of foreign exchange through the production of coffee, tobacco or cotton, has resulted in a drastic decline in food production, reduced nutritional levels and increased malnutrition.
- *The right to education:* Article 26 of the Universal Declaration of Human Rights declares that all people have the right to education. The Convention of the Rights of the Child has also established the right to early development and education. Thanks to extraordinary efforts during the 1960s and 1970s, the percentage of children completing at least four years of primary education reached 50% or more in almost all developing countries. But since the 1980s increasing debt and consequent implementation of structural adjustment programmes has led many governments to freeze or cut educational spending. As UNESCO has noted, primary schooling has often suffered disproportionately, and there was significant slippage in sub-Saharan Africa. The percentage of 6–11 year olds enrolled in school dropped from a high of 55% in 1979 to 45%

in 1995 (UNESCO, 1996). At greatest risk is one of the areas in which sub-Saharan Africa has fared well—the reduction of inequalities between boys and girls in school enrolments. Girls' enrolments grew from 36% in 1960 to 63% in 1980. But in the face of increased fees, families may keep their daughters home from school when forced to choose which children to educate. Given the critical correlation between child welfare and the level of mothers' education, this could have important implications for infant and child health over the long term.

- *The right to health*: health is one of the fundamental human rights embodied in the 1946 constitution of the WHO, as well as in Article 25 of the 1948 Universal Declaration of Human Rights. The goal of 'Health for all by the year 2000' agreed upon in the Alma Ata Declaration has been severely undermined by cutbacks in government health budgets as social and development objectives have been superseded by financial imperatives. The imposition of 'user fees' for primary healthcare drove large numbers away from public health services, contributing to increased rates of sexually transmitted diseases. Moreover, cutbacks in the public sector helped send health professionals to the private sector or abroad and reduced investments in health-care delivery systems.

The inflexibility of the IMF and the World Bank on macroeconomic conditionalities put undue pressure on countries where high HIV/AIDS prevalence is wiping out decades of development (UNAIDS/World Bank, 2001: 10). Debt servicing often absorbs well over a quarter of African countries' limited government revenues, crowding out critical public investment in human development (Cornia *et al*, 1987; Cornia *et al*, 1993). Throughout sub-Saharan Africa health systems are collapsing for lack of medicines, schools have no books, and universities suffer from a debilitating lack of library and laboratory facilities. Even the so-called African 'success' cases, such as Ghana and Uganda, are basically being held afloat for demonstration purposes by continuing aid inflows.

The turning point: the heavily indebted poor countries (HIPC) debt initiative

After decades of persistent criticism by a global coalition of NGOs and civil society organisations, the Bretton Woods institutions were finally pressed to recognise the need to address the issue of poor country debt and subsequently approved the heavily indebted poor country (HIPC) initiative in the autumn of 1996. Under the original HIPC designation a country receives debt relief after jumping two hurdles. First, it must have completed six years of structural adjustment under the IMF's Enhanced Structural Adjustment Facility (ESAF), now renamed the Poverty Reduction and Growth Facility (PRGF). Second, debt relief itself is a two-step process—a decision is taken to grant debt relief, subject to meeting certain additional conditions. When these are met, the debt is actually cancelled.

Less than three years later, however, the limitations of the HIPC initiative to lighten the debt burden of poor countries became clear. Only three countries had been granted actual debt relief—Uganda and Bolivia in April and September

1998, respectively, and Mozambique in mid-1999. The stringent qualification criteria simply excluded many poor indebted countries from requesting debt relief. Consequently, the World Bank and the IMF concluded at their 1999 spring meeting that the HIPC initiative had major shortcomings; there was a need for more substantive steps to address the debt problem. Reacting to this, the G-7 leaders announced from Cologne in June 1999 a major debt reduction initiative aimed at improving the HIPC initiative. The Enhanced HIPC Initiative proposed to grant larger reductions of the total accumulated debt and quick reductions in debt service payments, finally placing poverty reduction at the heart of an enhanced HIPC framework. Unfortunately, the envisioned debt relief would be neither sufficiently deep nor sufficiently broad and would not be delivered at the pace required to address the pressing needs of many African countries with a high-level prevalence of HIV/AIDS (Cheru, 2000: 519–535).

The debt service cuts so far for the 22 HIPCs are releasing \$700 million a year to be ploughed into programmes to benefit the poor, such as rural development and water supply, primary schooling, improving access to health care, road construction and institution building. Debt relief money is also increasingly being used as core funding for HIV/AIDS national strategies in a number of HIPCs. A 100% debt cancellation by creditor governments and institutions could help many African governments solidify these limited efforts that have proven effective (Booker, 2001).

The enhanced HIPC debt relief, like its predecessor, is also caught up in a complex web of IMF and World Bank eligibility conditions. Among other factors, eligibility for debt relief is conditioned upon 'good performance' in the implementation of an IMF and World Bank ESAF programme for a period of three years. Having reached the decision point after the first three years of good economic performance, each country must then demonstrate that its debt servicing is unsustainable, following designated threshold values with respect to the ratio of debt to exports, as well as debt to fiscal revenues.¹ 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 after 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 indefinite period of time.

In short, the Enhanced HIPC Initiative raised expectations beyond limits. Given the magnitude of the humanitarian crisis unfolding in sub-Saharan Africa as a result of the HIV/AIDS pandemic, an immediate and total cancellation of Africa's debt by creditor institutions could go a long way in assisting impoverished countries to contain the spread of the HIV/AIDS virus and to strengthen care, treatment and social support of orphaned children and those living with HIV/AIDS (Cheru, 2000: 519–535; Booker & Minter, 2001: 11–17).

Debt relief and HIV/AIDS: ensuring financial accountability

Creditors and local civil society organisations alike have expressed considerable concern about the extent to which resources freed through debt relief might be directed towards the emergency posed by AIDS. While this is a valid concern, it

should not be an excuse to deny or delay debt relief to countries that are in need. Already some good cases of ensuring accountability can be found in Africa.

In Zambia, for example, a proposal has been circulating to establish an HIV/AIDS multi-donor debt fund to be managed by a debt relief steering committee, consisting of representatives from major partners in civil society, private and public sectors, creditor countries and multilateral agencies (Republic of Zambia, 1999). Under this proposal, scarce national funds which would otherwise go to service the debt would be set aside in the HIV/AIDS Debt Fund for investment in activities aimed at curtailing the spread of the epidemic. Any additional grant by donors would also be channelled into the debt relief fund. The fund would then be used by civil society groups and public social sector institutions to implement activities nationwide designed to prevent HIV/AIDS, manage existing cases and address the growing orphan crisis (Cheru, 2000: 519–535).

The debt relief committee would be charged with receiving reports periodically from each of the implementing partners and preparing technical summary reports. Each partner organisation would be given an equal say in the development, implementation and evaluation of the programme. 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 intervention on the HIV/AIDS epidemic over time. Mechanisms for reporting and collecting this information must be established before funds could be released. A high premium would be placed on ensuring transparency in respect of the use of resources.

In Uganda, the Poverty Action Fund (PAF) makes monitoring of debt relief funds clearer. In order to maximise the impact of resources directed to poverty programmes and tackle corruption, a transparent budget process with multiple channels of accountability, involving local authorities, the press, community groups, NGOs and donors, has been established. The Ministry of Finance, Planning and Economic Development organises and chairs quarterly meetings involving all stakeholders to discuss the implementation of the PAF, at which line ministries present the reports of disbursements and activities carried out. In an effort to let people know what they should expect, announcements are made through the local media about when new money will be spent. In the education sector, for example, budget allocations for schools are posted on school notice boards. Local governments can only access funds once they have reported on the progress achieved using previous funds remitted to them (Cheru, 2001). At a more micro level, government has started monitoring performance indicators to track the overall progress towards achieving the objectives of the poverty reduction strategy. This type of arrangement should allay the fears of creditor countries and institutions that oppose speeding up debt relief on the grounds that the money will be wasted by unaccountable governments.

HIV/AIDS and the TRIPS agreement: corporate rights or human rights?

While the debt burden affects the capacity of African governments to expand health services to their poor citizens, the rules governing international trade have become the second most important obstacle to the promotion of the right to health in poor countries. In the midst of today's spectacular technological and

scientific advances, global pandemics such as HIV/AIDS continue to kill millions of people in the developing world each year. These avoidable deaths are perpetuated, in large measure, by WTO patent rules codified as the agreement on Trade Related Intellectual Property Rights (TRIPS) that puts life saving medicines far beyond the reach of poor people (Chirac *et al*, 1999). The TRIPS agreement guarantees a minimum of 20 years of patent protection within and between the WTO's 142 member countries. It safeguards patents for corporations that create innovations in all fields of technology including microbiology. Northern corporations own 97% of all patents. When developing countries' governments attempt to produce or acquire cheaper drugs for their people during times of 'national health emergency', they are likely to be hauled before costly WTO dispute panels or face bilateral trade sanctions. Consequently, 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 (Oxfam America, 2001).

Recent events in the nations of Brazil, Thailand and South Africa illustrate the extent of this problem. On 5 March 2001, a lawsuit was opened in Pretoria by 39 pharmaceutical transnationals against a 1997 South African law favouring the importing of generic drugs and price controls on these generics in the fight against HIV/AIDS. The US government placed South Africa on the 'Special 301 watch list' as a potential intellectual property rights violator—a prelude to trade sanctions (Gray & Smit, 2000: 583–589). Similarly, Thailand dropped plans to produce the anti-AIDS drug DDI after US officials threatened sanctions on key Thai exports. And in early February 2001 the USA filed a complaint with the WTO over a Brazilian law that permits a local company to manufacture a product made by a foreign company if that company fails to initiate production within Brazil within three years (Palmer *et al*, 1999: 8).

In the case of the US complaint against South Africa, it took numerous demonstration and lobbying efforts by a broad range of AIDS activist organisations for the Clinton Administration to remove South Africa from the watch list in September 1999 (US Department of State, 1999). As a result of growing public criticism surrounding the South African case, President Clinton signed an executive order directing the USA to take a more liberal stance with regard to intellectual property rights relating to public health emergencies. Sensing negative publicity, several US pharmaceutical companies, such as Pfizer, Bristol-Myers Squibb, Boehringer Ingleheim and Merck, agreed to provide drugs at reduced prices to African countries, although still not competitive with generic drugs produced in Brazil and India (IMF & World Bank, 2001: Agenda Item II.C). They were driven not by altruism, but by the threat by countries to use compulsory licences to produce cheap generic drugs at home (Geffen, 2001). Few African countries have taken up the offer since they can still procure generic drugs from Brazil, India and Thailand at prices much lower than what these giant pharmaceuticals have been able to offer.

Brazil is the only country in the developing world that provides free universal treatment for all HIV and AIDS sufferers and allows the production of cheap generic drugs. As a result, mortality from AIDS has dropped by more than 50% in that country (UNAIDS, 2000b). Brazil came to a decision to produce generic drugs

at home after a long and protracted negotiation with the patent-holder pharmaceutical company, Roche, which was the main provider of an anti-AIDS drug to the country. Because of the drug-price structure that the corporation had implemented, more than a quarter of Brazil's spending on AIDS treatment went to purchasing the drug from Roche. After spending six months negotiating for a price cut without success, Brazil decided to go ahead and produce the drug at home even if that meant breaking WTO rules (Bloomer & Pecoul, 2001).

This commendable action to provide affordable drugs to Brazilians afflicted with HIV/AIDS is not viewed favourably by the US government. As the USA was preparing to bring a case against Brazil at the WTO early this year for ignoring international patent rules, the UN Human Rights Commission overwhelmingly voted in April 2001 in support of a Brazilian resolution calling for universal medical treatment for people with HIV and AIDS. The resolution specifically calls for countries to adopt legislation similar to that which is in place in Brazil. The UN vote came after 39 multinational pharmaceutical companies dropped their court case to stop South Africa buying or producing cheaper versions of patented AIDS drugs. In the aftermath of the vote by the Human Rights Commission, the new Bush administration dropped its complaint against Brazil after both countries agreed to establish a new mechanism to address the dispute, which centres on where certain AIDS drugs will be manufactured.

The capitulation by the US government in both the Brazilian and the South African cases has strengthened the resolve of developing countries to challenge the TRIPS agreement. Between 9 and 13 November 2001, the WTO was to have to take a position on access to drugs for people in developing countries. The group of 50-odd developing countries that had been spearheading efforts in the WTO to address concerns relating to TRIPS, patents and access to medicines prepared a draft text they wanted to see endorsed by ministers at the Ministerial Conference in Doha, Qatar (Ministerial Declaration on the TRIPS Agreement, 2001). The proposal elaborates on some of these public health measures, including parallel imports, compulsory licenses for production and exports, establishment of easier marketing approval procedures for generic products, and authorisation of production and export of medicines without consent of patent holders. In addition, these governments are asking for a moratorium on legal actions before the WTO against poor countries that use cheap drug copies to treat their sick.

A US- and Swiss-led coalition of countries has also circulated a paper that outlines a counter-proposal that rejects the developing countries' call for a separate Ministerial Declaration on TRIPS and public health. The US statement seemed furthest away from the general line taken by the majority of countries. In taking the position that strong patent regimes can produce benefits for countries, whether developing or developed, the USA refused to acknowledge the concerns of developing countries that TRIPS implementation would have a negative effect on access to affordable medicines (US Statement, 2001). If the WTO refuses the request made by the developing countries, it will have chosen its side: the side of the rich countries. By strengthening the monopoly of giant drug companies, it will continue to block access to treatment.

Regardless of the outcome of the talks in Qatar, African countries should follow Brazil and South Africa's example and be able to turn to measures to

resolve market failure by allowing generic competition. When a patent monopoly is against the public interest, governments have the right to free themselves from that monopoly. This is an inherent and necessary component of any patent system and is recognised by Article 31 of the TRIPS Agreement, which allows parallel imports and compulsory licensing. The move by Brazil and South Africa does not threaten hopes of finding new drugs and vaccines as suggested by the pharmaceutical industries and their government supporters. In fact, the global patent system will avoid attack if countries are allowed to exercise their legal rights within a system that ensures that the resultant benefits are shared with those most in need.

Conclusion

Poverty, marginalisation and widespread alienation remain the most significant and pervasive problems facing many indebted countries in the Third World. These problems cannot be adequately addressed until the current approach to macroeconomic adjustment and rules governing international trade are fundamentally altered. The Copenhagen Declaration on Social Development, for example, called on governments to ensure that social development goals are included in structural adjustment programmes and basic social programmes and expenditures are protected from budget reduction (para 9). Structural adjustment programmes should be reviewed and altered to reduce their negative effects and improve their positive impacts. The emphasis of structural adjustment should no longer be on how to achieve economic growth, but rather on what kind of growth is being achieved, by whom and to what end. Effective responses to the HIV/AIDS pandemic should include, among others, the following measures.

Changing the terms and conditions of adjustment programmes

An alternative 'adjustment with transformation' should emphasise sustainable economic growth combined with social justice. This would entail adjusting economies to meet human needs and not vice versa. Adjustment that is 'transformative' must place the emphasis on alleviating poverty and meeting the basic needs of poor people, who are the principal resources to build upon. The provision of healthcare, basic nutrition and education are the building blocks of a human-centred transformation strategy (UNECA, 1991). Malnourished people unable to receive health and educational services are in no position to improve their own well-being or contribute productively to the nation. Nutritional imbalances are, therefore, as crucial as trade imbalances, and high infant mortality rates require the same immediate action as high rates of inflation. A concrete plan to incorporate human concerns should be an integral part of adjustment programmes.

An alternative 'adjustment with transformation' must ensure that people have a significant voice in shaping how development policies in general are formulated and implemented. There is rarely commitment by the people to any policy which is either imposed from above or put in place from outside by those who assert that they have the knowledge and authority to decide for others. Participation in

policy formation is a human right. People should be enabled to reflect on their own problems and to articulate their own ideas for solutions to such problems. Only if this is done can development be seen as a liberating process, one that creates conditions for people and societies to identify their own needs, mobilise resources and collectively shape their future.

Total cancellation of poor countries debt

The Africa Development Forum of December 2000, organised by the UN Economic Commission for Africa in Addis Ababa, culminated in a consensus statement declaring a 'watershed in national leaders' readiness' to address AIDS and announced a joint commitment to marshalling all national resources against the epidemic. During the Abuja meeting of the heads of states in April 2001, African leaders agreed on a target of spending at least 15% of their national budgets, two or three times the current levels, on health. But the chances of meeting this target are slim if governments are forced to give priority to paying illegitimate foreign debts over making investment in public health. The existing debt reduction programme for African countries, as designed by the creditors, has proven woefully inadequate. The 22 poor countries receiving debt relief under the HIPC programme have thus far only realised a 27% reduction in payments. After qualifying for debt relief, these same countries now spend more on debt payment than on health care. Without debt cancellation, African countries have little hope of treating the more than 25 million Africans living with AIDS or caring for the 13 million African AIDS orphans already in need of support.

If the richest creditor nations and institutions are serious about confronting the worst plague in human history, they must stop the charade, cancel Africa's debt and remove the major economic obstacle to African efforts to fight AIDS (Booker & Minter, 2001: 11–17; Dakar Manifesto, 2000). Despite claims to the contrary by the World Bank and the IMF, complete debt cancellation is affordable. One dollar for each G-7 citizen per year would cover the cost of cancelling the debts owed by HIPC countries to the World Bank and the IMF. According to an independent audit by two leading British accounting firms, the IMF and the World Bank could afford 100% cancellation of HIPC debt without negatively affecting their own credit ratings (Drop the Debt, 2001: 4).

Ensuring consistency between trade agreements and human rights

Trade rules that uphold corporate rights and devalue the human rights of people are morally and economically indefensible. Strict enforcement of the spirit of the current TRIPS agreement goes against the basic principles of international human rights treaties. The realm of trade, finance and investment are not exempt from general human rights obligations, particularly in situations where millions of people are at risk. States have, therefore, an obligation to fulfil the rights to life and health care even if that means going against trade agreements. The G-7 governments should uphold the rights of African nations to ensure access to life-saving medications at the lowest cost for their citizens. Ensuring the right of countries to produce generic compounds is consistent with Article 30 of the TRIPS

Agreement, which permits member states to authorise production and export of medicines by persons other than holders of patents on those medicines to address public health needs in importing members.

Supporting the global trust fund for HIV/AIDS and other diseases

Debt relief alone is not going to place desperate African countries on a sound enough economic footing to enable them effectively to address the debilitating effect of the HIV/AIDS pandemic. Adequate and predictable funding from the international community is critical to expanding treatment and prevention programmes over the long term. During the UN Special Session on HIV/AIDS in summer 2001, UN Secretary-General Kofi Annan proposed the establishment of a global HIV/AIDS trust fund of \$7–10 billion a year to assist in the struggle against HIV/AIDS worldwide. So far, the response from the international community has been very disappointing when compared with the international response against terrorism following the tragic events of 11 September, which killed innocent citizens in New York and Washington, DC. The indifference towards African lives, which is rooted in Western racism, must be challenged and exposed if we are to create a just world order where human rights and human dignity take precedent over corporate rights and creditors' greed.

Notes

- ¹ The enhanced HIPC stipulates that, in order to qualify for relief, a country must have a debt:exports ratio of 150% and debt:tax ratio of 250% or more combined with tax:GDP and exports:GDP ratios of at least 15% and 30% respectively.

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