THE LINKS BETWEEN HIV/AIDS AND DEMOCRATIC GOVERNANCE IN AFRICA

Alex de Waal
Justice Africa & GAIN

Adapted from presentations at Justice Africa, 30 October 2003 and Oslo Governance Centre, 3 November 2003

The HIV/AIDS epidemic is the biggest challenge to democratic governance in Africa today. This presentation is going to focus on just one element of that challenge, namely the considerable difficulties we shall face in ensuring that the response to the HIV/AIDS epidemic in Africa is consistent with both the technical requirements of effective public health policy, and also supportive of democratic governance.

Responding to the HIV/AIDS epidemic is technically complex and resource-intensive. It requires lots of money, large numbers of skilled and dedicated people, and commitments to consistent public policy over a decade or longer. Designing and implementing HIV/AIDS policies and programmes of the scale and reach required will be Africa's biggest-ever public service delivery operation. If successful, expanded treatment will not only keep millions of people alive and healthy for longer, but will also help to mitigate many of the more dangerous secondary impacts of widespread adult mortality. For example, by keeping skilled people working longer, it will make it easier to sustain complex institutions. Keeping parents alive longer will reduce the numbers of children orphaned by AIDS. In a world where life-sustaining treatment exists for people living with HIV and AIDS, withholding that treatment simply because people happen to live in poor countries, is simply not an option.

If millions of people living with HIV and AIDS in Africa are to have access to this life-prolonging anti-retroviral treatment (ART), and AIDS education, prevention, care and mitigation programmes are to be mounted at scale, then of necessity there will be enormous shifts in the public policy priorities of African governments and their partners. Scaling up AIDS programmes, especially treatment, will necessarily entail trade-offs and the downgrading or even abandonment of other public priorities. AIDS treatment is welcome, but for poor countries with weak institutions, massive treatment programmes are not a simple and unalloyed benefit. My major point is that responding effectively to the HIV/AIDS epidemic requires major, difficult and controversial public policy choices, at national and international levels.

At present, some of the most important public policy decisions for Africa for the coming decade, or even longer, are being taken with scant public debate. Nobody can disagree with saving lives, and to ask difficult questions about programmes that aim to save lives smacks of cynicism, racism or cruel disregard for human life. But, as with charitable relief in famines, the enticing simplicities of the humanitarian imperative can drown out

the reality that all actions have political and economic consequences, which need not all be beneficial. It is a disservice both to the genuine humanitarian impulse and to the public policy aim of ensuring the best outcome, that all aspects of the policy options be openly debated. But at present, this is not happening—not because of conspiracy or moral intimidation, but largely because of the speed with which decisions are being taken, and the fact that we are in unknown territory with little past experience to guide us. This lack of public debate is very unfortunate. For the necessary choices to be identified and made, and the required policies implemented with sufficient consistency and rigour, will require a very robust political system. This can only be a democratic system, in which citizens and stakeholders can openly discuss the pros and cons of different courses of action, and come to a conclusion acceptable to all.

One important question that needs to be discussed openly is, what is the source of the resources to tackle the HIV/AIDS epidemic? This question must be asked both of national and international resources, and of financial and human resources.

As AIDS advocates we naturally prefer new, additional funding. At present, the reality is that most of the new resources are purloined from elsewhere. Funding for HIV/AIDS is increasing at a time when ODA levels are not increasing. After declining steadily for about a decade, global ODA has slightly increased in the last year. Globally, it is just under $60 billion, of which about $20 billion goes to Africa. Money that is spent on HIV/AIDS programmes cannot be spent on education, poverty reduction – or indeed on other health needs. Equally importantly in the context of African countries, people who are employed in AIDS activities cannot be utilised elsewhere. Whether we like it or not, a decision is being made to devote resources to AIDS at the expense of other social and economic priorities. It is quite possible that within a decade, we could see HIV/AIDS-related funding representing a third or even a half of all assistance to Africa.

The demand to expand AIDS funding has been driven by a powerful and persuasive campaign. That is welcome, not just because the goal is a laudable one – indeed a necessary one – but also because it is an inspiring example of the potential of citizens' action and of international activist coalitions. But it is important that the lessons of decades of aid-assisted public service delivery in Africa are applied to HIV/AIDS programmes and policies. There is a need to apply current best practices in development programming to AIDS policies, if we are to avoid many of the avoidable errors that have meant that so much foreign aid money has been misspent in the past. For example, one of the most important lessons learned has been in the area of policy harmonisation. Aid works best when it is part of an overall, coherent, nationally-owned strategy, designed within a medium and long-term framework. It works least well when it is assigned to projects that are specific to each individual donor, externally designed and poorly harmonised, subject to complex and burdensome reporting and accounting techniques. For a number of understandable reasons, much AIDS funding has to be devoted to pilot projects and sector-specific programmes, and it is very difficult to implement results-based monitoring. But this does not mean jettisoning the aim of making assistance simple, harmonised and subject to mutual accountability.

One of the rationales for GAIN is to bring together the treatment activists who have spearheaded the campaign for accessible ARV, and have won an astonishing victory, with the democracy and governance activists. The treatment activists, who have focused single-mindedly on the goal of making ARVs affordable and accessible, are now facing the challenge of what to do, now they have won. The governance and democracy activists can perhaps contribute their skills and experience, while also finding a way of bringing HIV/AIDS into their array of concerns.

As AIDS advocates we also prefer to prioritise AIDS funding, not only over other spending demands, but also over macro-economic management frameworks that include expenditure ceilings. Few activists are friends of the Bretton Woods Institutions and the fiscal constraints they advocate. We tend to argue that the World Bank, IMF and other advocates of structural adjustment bear a measure of responsibility for the crisis of African health systems, and possibly even the spread of HIV/AIDS itself, and so they should not be listened to when it comes to responding. Even those activists who concede that there is a rationale for fiscal discipline, are inclined to the view that HIV/AIDS should be considered an exceptional case, as with national emergencies such as famines and wars. The parallel is of course inexact, not because HIV/AIDS is not an emergency, but because it is not transient. The moral case is persuasive: people are needlessly dying, funds are possibly available, they must be spent! However, we must listen to the other side of the argument.

What are the potential downsides of AIDS exceptionalism? Principal among them is the threat to other social priorities, including poverty reduction. Among the economic impacts of the HIV/AIDS epidemic are reduced saving and investment, and increased expenditure, especially on health care. This leaves AIDS-impacted economies more vulnerable to inflationary pressures, and in need of careful handling. In this context, substantially increasing AIDS spending runs a serious risk of being inflationary. This threat is most pronounced in the poorest countries with the smallest economies. The fear is that fiscal and monetary destabilisation could lead to lowered savings and investment and thus a setback to poverty reduction. Given that economic development is necessary for building society capable of withstanding and overcoming AIDS, and that national resources are the most important in financing any response to HIV/AIDS, this would represent not only an undesirable outcome in its own right but also a setback in the struggle against HIV/AIDS.

The problem is compounded by the limited absorptive capacity of these countries and the scarcity of the trained personnel needed. Countries such as Uganda and Mozambique already have about half of their national budgets supported by international funding. This is probably close to the limit. A higher proportion is politically undesirable, as it lessens local ownership of policies and programmes and intensifies rent-seeking competition among the candidates for receiving the funding. We are already seeing nasty and counter-productive turf wars between different ministries over which one is to receive increased AIDS funding. Very high levels of aid dependency are also economically inefficient.

Turning to human resources, no African country has enough. Even the best-endowed countries, such as South Africa, face scarcities of the skills required. Already, donors to treatment programmes have found themselves facing serious capacity constraints. The World Bank Multi-Country AIDS Programme has had disappointing rates of implementation, leading to the Bank seeking alternative channels for rolling out its programmes. At the moment it is gearing up for the Treatment Acceleration Programme, which seeks to use civil society organisations and associations of PLWHA as the conduit for implementation. This is laudable: we all want to see greater involvement of CSOs and PLWHA. But, given the high levels of funding involved, will we see all CSOs in a country re-inventing themselves as AIDS support organisations? Will all national civil society simply become a conveyer belt for internationally-funded ART? In both governmental and non-governmental sectors, we may find ourselves robbing good programmes in other sectors and undermining sound policies in order to implement poor HIV/AIDS programmes. Moreover, money that is poorly spent is more likely to be inflationary.

There are very difficult decisions to be taken. Given the low and declining capacities of most African states, it will be necessary to abandon valued goals that can no longer be achieved. Policy triage is perhaps the most difficult task to be undertaken.

A separate but similar set of issues arises surrounding the prioritisation of treatment. Universal treatment access is a goal we all share, with provision of ARVs allocated on medical criteria alone. However, the reality is that hard choices will have to be taken about who is at the front of the queue. A number of exceedingly complicated issues of equity arise, which I shall not discuss. However, handling these issues in a transparent and accountable manner will be a challenge to even the best-governed country. Constitutional systems based on the primacy of the rule of law and individual human rights, are intrinsically ill-suited to deciding on matters of life and death. Constitutional liberalism works best when the disagreement between citizens is relatively limited, and those who lose out in a court of law or a popular vote are not sufficiently threatened that they will seek to contest the outcome by extra-legal means. In fact, the necessity of not disagreeing too much may be a precondition for liberal constitutionalism to work in practice. But when we come to rationing the right to life, those who lose out are likely to be bitter. Will we see a kind of political free market, in which those who are powerful enough to veto the political process will have preferential access to treatment? Or will we see a recognition that poor young women are just as entitled to treatment as wealthy middle-aged men?

We are in a situation in which a small and poor country may be faced with different choices that are equally unpalatable. Governments will simply be unable to meet the aspirations of their people. In a mini-scenario exercise conducted by some GAIN members, in a fictional ‘Ruvula Republic’ designed as a typical sub-Saharan African nation, we found that even in the best case scenario, of committed leadership and plentiful resources, the situation worsened before it improved. But, during the ten year time-frame we envisioned, although the handling of the HIV/AIDS epidemic was the prime determinant of how well or badly the country performed, the issue of AIDS was

rarely the citizens' number one concern. Issues such as employment, corruption and crime were usually higher. This made it extremely hard for the government, however committed, to maintain HIV/AIDS as a consistent public policy priority during two five-year electoral cycles.

Allowing the ravages of HIV/AIDS to continue is not an option: it will inexorably lead to the paralysis of institutions and the intensification of poverty, to the point at which states as we know them will collapse. On the other hand, responding to the epidemic may require institutional capacities and human resources that surpass what is available, and attempting to institute and implement the required policies and programmes may undermine or even destroy the possibility of maintaining governance and poverty reduction. A large country and economy may be able to weather the storm. A small one may have no possible route that avoids collapse.

The recent World Bank modelling exercise of the impact of HIV/AIDS on the South African economy by Clive Bell and his colleagues, underlines this. There is a vigorous debate around this model and its application to South Africa which I will not enter into. Rather, I want to ask, what might the results have looked like if the model had been applied to a much smaller and poorer economy such as Zambia or Malawi? The policy options open to South Africa for mitigating the impact of the epidemic might simply not be there because of lack of resources and weak institutions.

If the national government of an affected country does grind to a standstill, what can be done? Where does sovereignty go if it cannot be exercised any longer? Who implements basic governance including the deliver of public services? The international community has devised means of quarantining collapsed states such as Somalia, and sanctioning those that misbehave. But such measures are possible because we assume that these countries can bounce back when conditions are right. With HIV/AIDS in the picture this is no longer the case. The irreversibility of the impacts of AIDS (at least over several generations) creates a wholly different context. Should we begin to look at the challenge of sustaining community governance, alongside relegation of powers to regional entities such as the African Union? Half a century ago, Kwame Nkrumah insisted that if each colonial territory were to achieve separate independence as an independent state, they would simply be too small to be viable. HIV/AIDS is reminding us of this, reviving a pan-Africanism of necessity.

Before addressing these issues, let me digress slightly. What does democratic governance mean in Africa? Following the work of a colleague at Justice Africa, Aziz Rana, let me identify three principal components: material welfare, constitutional proceduralism, and autonomy from external control. All of them threatened by HIV/AIDS. It is clear that HIV/AIDS threatens material progress. It also jeopardises institutional functioning, and thus the smooth and credible operation of key democratic institutions such as parliaments, judiciaries and civil society organisations. But on the third axis of democracy—freedom from external control—that we must exercise special vigilance. Given the colonial history in Africa, this has special salience. For small and poor countries, which are already highly dependant upon donor funding, HIV/AIDS resources

and particularly funding for ART, threaten to create even higher levels of dependency. Can a country which relies on long-term donor generosity dictate policies to its donors? Can it throw them out? Surely not. Botswana cannot expel Merck. Still less can a cash-strapped country like Mozambique or Tanzania expel a donor that has taken the role, in an international division of labour, as the country's leading funder of national ART.

Nor is this is short-term compromise, in the way that African governments in the past explained their humbling climbdowns to accept humanitarian assistance. Whatever donor-recipient relationships are established in the next 12-18 months may well last for a generation. This protracted dependency implies a shrinking space for democratic governance. Voters will simply have no say over the most important activity in their country. Can democracy survive with such an absence of substantive autonomy?

Here, surely, is a major role for the United Nations. One of the main lessons of both development and humanitarian aid is that when it is delivered in 'charitable' mode, the recipient's discomfort with its portrayal as supplicant, creates a residue of resentment and bitterness, which in time comes to act like acid and corrode the assistance programme. When there are mechanisms for local and national ownership, and the programme is seen as an embodiment of solidarity, then it is more robust. The United Nations, as the repository of principled multilateralism, and as an organisation that represents African member states as much as wealthy western ones, could have a historic role to play in mediating the imminent abject dependency of many African countries. Rather than focusing its energies on programmes and projects, the unique role of the UN could be providing for accountable and (in an sense) democratic governance of the responses to the epidemic. If national governments begin to fail, then there is a safety net which can catch the orphaned 'sovereignty'.

In this context, the importance of multiple layers of governance increases. Communities will continue, and it is their governance and livelihoods that will provide the foundation for societies that continue to function. Meanwhile, the regional (African Union) level of governance can provide for an authentically African political oversight. That in turn requires well-functioning executive and representative institutions at the AU. It's tempting to stick with the national governments we know, and cling on in the hope that they will retain sufficient legitimacy and effectiveness to deliver, rather than investing in building a regional institution to replace one that was not, to put it mildly, well-known for its effectiveness. But questions of scale are important: we may need to embrace a pan-Africanism of necessity, recognising that the continent may be stronger than the sum of its parts.

Conclusion

Identifying the dilemmas and options, taking the decisions, policy triage, and implementing the policies consistently and effectively over a sustained period, requires a robust democratic consensus. In fact, it requires a new social contract for the era of AIDS. This in turn requires informed public discussion and democratic decision making. Without this, policies will be imposed and seen as such, and will therefore not be

properly implemented, and will be liable to reversal when the political climate changes. But, given the extraordinary constraints on the functioning of national institutions, we may have to reinvent democracy itself for the age of AIDS.