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TOWARDS AN AFRICAN HIV/AIDS POLICY: NO MORE BUSINESS AS USUAL?

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I. Introduction

The HIV/AIDS pandemic has been ravaging the world and more specifically, Africa for over two decades. Powerful, 'big picture' lessons have been learned. More importantly, conceptual leaps have been made because of the fight against HIV/AIDS that should enter into mainstream political and socio-economic policy making. Human security is one such conceptual leap. This paper aims to further develop some of the links between HIV/AIDS and human security. The paper returns to a more holistic view of HIV/AIDS, accommodating the many human security causal links and contexts that mark HIV/AIDS. The paper then approaches the problem of devising an African HIV/AIDS policy from an institutional framework – and focuses on the African Union's HIV/AIDS strategic plan.

II. Origins of HIV/AIDS in Southern Africa: A History of *Human Insecurity*

For many years now, experts have speculated that the transmission of HIV is linked to war, and suggested that escalations in violent conflict are often followed by increases in HIV prevalence rates. Yet, southern Africa, the epicenter of the disease, is considered a relatively 'peaceful' subregion. The roots of its HIV/AIDS epidemics are more attributable to low-scale violence, poverty and inequality, and unprecedented levels of mobility amongst migrant workers, miners, and traders. [1]

[1] For example, see Fourie, P and Shonteich, M, "Africa's New Security Threat: HIV/AIDS and Human Security in Southern Africa", *African Security Review*, Vol 10, No4, 2001 and Shonteich, M, "HIV/AIDS and Security", Regional Governance and AIDS Forum, IDASA/UNDP HIV Development Project for Southern Africa, April 2-4 2003.

Trade routes and seasonal and temporary migration in southern Africa have contributed to the spread of HIV, with large numbers of men spending the majority of their lives in temporary hostel areas. Informal sexual relationships and prostitution are rampant in these settings. These same men, upon returning home to their wives, transmit STDs and HIV. Truck drivers and commercial traders also facilitate the spread of HIV. These routes of transmission through population movements are examples of how HIV reflects existing economic, political and social networks. Shula Marks, an eminent South African historian, has remarked that epidemic diseases in general have been borne by mobile men. The soldier, labourer, and trader has helped carry history's greatest plagues from city to port to village:

> *"From earliest times, [epidemic disease] has travelled with merchants and migrants, soldiers and sailors. In South Africa, from the smallpox and measles which decimated the Khoisan population at the Cape in the seventeenth and eighteenth centuries, to the tuberculosis and syphilis that commuted with migrant workers in the twentieth century, epidemic disease has accompanied long-distance movement. But the numbers of people travelling around the world and the speed with which they are doing so today is surely now on a scale beyond the conception of even my parents, let alone my grandparents."* [2]

With the end of apartheid in South Africa in 1994 and the resolution of conflicts in Mozambique and Angola, the subregion had the opportunity to develop stronger democratic governance structures and improve its economies. The first reported cases of HIV outside of the white homosexual community in South Africa were in the early 1990s. But today, it is the worst affected subregion in the world with HIV prevalence rates well above 25 percent and between 4.5 and 6.2 million people living with HIV at the end of 2003 in South Africa alone. Fifty-seven percent of the infected on the continent are African women – in some countries in southern Africa, there are as many as three young HIV positive women for every man between 15 and 24 years. Despite relative peace and a history of stability in countries such as Botswana, 20-35 percent of adults in Southern Africa are estimated to be HIV positive. It is currently estimated that HIV/AIDS is responsible for the deaths of nearly half a million people every year in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe alone.[3] Thirty-eight percent of Botswana's adult population is estimated to be HIV positive; 3,000 Zimbabweans a week die of the disease; while life expectancy will decrease by at least seventeen years in Lesotho, Namibia, Swaziland, South Africa, Zambia and Zimbabwe as a result of AIDS. Overall HIV prevalence amongst pregnant women is very high. In Botswana, Lesotho and Namibia and Swaziland it exceeds 30 percent. Finally, Angola, which is the anomaly in the region with a median HIV prevalence rate of 3 percent, has high levels of HIV amongst sex workers – 33 percent.[4] All indications are that the rapid increases in prevalence of the disease were inevitable. The subregion

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[2] Marks, S, "An Epidemic Waiting to Happen? The spread of HIV/AIDS in South Africa in social and historical perspective," in *African Studies*, Volume 61, Number 1, July 2002.

[3] Irin PlusNews, "Southern Africa: New Research questions link between food crisis and AIDS," IRIN HIV/AIDS News Service for Africa, 12 June 2005, [available from http://www.plusnews.org/pnprint.asp?ReportID=4874]

[4] Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), *AIDS Epidemic Update, December 2003*, Geneva: UNAIDS/WHO, 2003, p.23-25.

had all of the characteristics of a high-risk environment for epidemic diseases – particularly disease transmitted through human hosts.

According to Shula Marks, 'from the late 1950s, South Africa was also the site of some of the most massive population movements in peace-time'. With over three million people uprooted and their communities destroyed under acts of forced removal, the government's policies affected the entire subregion by profoundly transforming the way people lived, worked, and had sex. The mobility of migrant labor produced an impure, constantly fluid and unstable process of urbanisation. In hostels and mining towns, women – who were often living and working illegally outside of government-authorized homelands - were materially and legally dependent on men that, in turn, returned once a year to their wives in the rural areas. Similarly, exaggerated notions of macho masculinity in death-trap working conditions perpetuated the premium on multiple-partner sexuality. The apartheid government's not so silent internal and external war added another element of instability. The low-intensity conflict to free South Africa involved countless men and women throughout the subregion. Anthropologists have suggested that this type of low-scale violence creates a sense of 'unreality' and profoundly fragments social cohesion. Shula Marks writes:

> *It is thus perhaps not entirely surprising that KwaZulu Natal has seen the highest levels of HIV/AIDS infection in South Africa to date. This, after all, was the region which witnessed the most prolonged, bloodiest and dirtiest of the conflicts that marked the last days of the* ancien *regime, as well as some of the most rapid and disorderly urbanisation in the subcontinent.*[5]

AIDS has been the leading cause of death in KwaZulu Natal province at a 48 percent prevalence rate.[6] By the end of apartheid and democratic elections in 1994, these conditions had taken root. Ironically, the end of apartheid has not produced greater social cohesion and stability – but only intensified mobility and dislocation. Urban areas are still flooded with large inflows of people from the rural areas. Despite the relatively peaceful transition to democratic rule, South Africa's HIV/AIDS epidemic has continued to rise to alarming levels. Antenatal HIV prevalence has risen from 0.7 percent in 1990 to 22.8 percent in 1998.[7] It is worth noting that a lack of accurate data on varying prevalence rates forces analysts to rely on approximations of HIV/AIDS trends. In South Africa, prevalence rates and the number of AIDS-related deaths vary greatly in terms of region, race, class, and gender. Variations also exist between rural and urban areas.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation reported in 2004 that the subregion is shifting into the next stage of the pandemic: mortality. Life expectancy has dropped to below 40 years in Botswana, Lesotho, Malawa, Mozambique, Swaziland, Zambia and Zimbabwe. Alex de Waal's article "How will HIV/AIDS Transform African Governance" from 2003 explains that reductions in life expectancy translate into shorter life expectancy at adulthood. In the countries with rapidly decreasing life expectancy, when a person reaches

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[5] Marks, S, op.cit.
[6] UNAIDS/WHO, op.cit.
[7] UNAIDS/United Nations Children's Fund (UNICEF)/WHO, "South Africa, 2002 Update," *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections,* (UNAIDS/UNICEF /WHO, Geneva, Switzerland, December 2002).

adulthood they can expect live another 20 to 30 years.[8] Zimbabwe's life expectancy has fallen from 52 in 1990 to 34 in 2003.

In much of southern Africa, the impact of AIDS on women has been particularly worrying: adult mortality amongst women has increased by 3 times in the last decade in Namibia. South Africa's death registration data shows a 40 percent rise in the total number of adult deaths in the past six years and amongst women between 20 and 49 years, an increase in deaths of 150 percent. These numbers - all of which point to future transformation - will increase as AIDS mortality reflects HIV incidence of *nearly a decade before*.

It is true that social transformation can be identified as one destabilizing condition for the human insecurity of HIV/AIDS and other infectious diseases.[9] As Tony Barnett and Alan Whiteside have noted, Africa has experienced a state of 'abnormal normality' that has fed the growth of HIV/AIDS. Dislocation and disorder have produced disease. The colonial and post-colonial structures of inequality have exacerbated material, as well as existential, poverty for the last five centuries. [10] Political disenfranchisement under colonial rule and then autocratic rule has helped to disempower people. Disempowerment impacts states and societies in various ways, including a lack of sense of self- efficacy. Theories of behaviour change – a bourgeoning area in terms of understanding how to prevent or control HIV transmission – show that if people feel trapped in their socio-economic circumstances, they are less likely to feel a personal motivation or sense of efficacy.[11]

However, transformation is not a sufficient explanation for the scale of the epidemic. Various other factors, including weak social infrastructure and health systems are also to blame. Without viable education and health services, sexually transmitted diseases went untreated, and acted as a gate way for HIV.[12] Ultimately, HIV/AIDS is a crisis linked to health, and while there have been various interventions that deal specifically with preventing its transmission, efforts to rebuild health systems in southern Africa are urgently needed.[13] In the immediate post-independence era many African countries have failed to invest in social infrastructure even at the barest of minimums. Following the 1973 oil crisis, African governments wrongly accepted massive loans and adopted policies that undermined social capital.[14] The International Monetary Fund's (IMF) structural adjustment policies also undermined investment in social capital in many African countries. A recent report from Christian Aid estimates that Africa has 'lost $ 272 billion in the past 20 years from being forced to promote trade

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[8] Alex de Waal, (2003), "How will HIV/AIDS Transform African Governance", *African Affairs*, 102, p. 5. See also Alex de Waal (2002), "AIDS-related National Crises" in Africa. Food Security, Governance and Development Partnerships", *IDS Bulletin*, vol. 33, no. 4, pp. 120-26.
[9] Barnett, T., and Whiteside, A., *AIDS in the Twenty-First Century: Disease and Globalization,* Hampshire and New York: Palgrame MacMillan, 2002, p.129.
[10] Ibid.
[11] For coverage of the debate on self-efficacy, see literature on the rates of success of the Love Life Campaign, for example, Harrison, D., "loveLife: Getting them young, keeping them alive," *Mail and Guardian,* Johannesburg, 26 August – 1 September 2005.
[12] Barnett and Whiteside, p.156.
[13] Centre for Conflict Resolution, *A More Secure Continent: African Perspectives on the UN High-Level Panel Report - A More Secure World: Our Shared Responsibility*, Cape Town, South Africa, 23-24 April 2005. (Available at: http://ccrweb.ccr.uct.ac.za).
[14] Centre for Conflict Resolution, *A More Secure Continent: African Perspectives on the UN High-Level Panel Report - A More Secure World: Our Shared Responsibility*, Cape Town, South Africa, 23-24 April 2005. (Available at: http://ccrweb.ccr.uct.ac.za).

liberalisation as the price for receiving World Bank loans and debt relief'.[15] In terms of the apartheid regime, it undoubtedly had very little interest in ensuring health care. In other parts of southern Africa, conflict and autocratic rule eroded health systems out of neglect. Indeed, in most of the world's developing countries, foreign aid covers over half of the costs of healthcare.[16]

Governments have been slow to strengthen their own national health structures. The African Union Commission reported to the Heads of State in 2005 that only 3 in 10 Africans have regular access to essential medicines; and only 1.3 percent of the world's health workforce while it suffers 25 percent of the world's disease burden[17] – with underdeveloped African countries subsidizing the West by an estimated $500 million a year through the migration of health workers.[18] Condom supply is around 3 condoms per year per potential user. It is no wonder that only 42,000 South Africans have access to ARVs through government health clinics and hospitals.[19] In its 2003 report on health services, the World Health Organization stated that:

> *"The ministry of health of Botswana estimated that achieving universal coverage of antiretroviral treatment alone would require doubling the current nurse workforce, tripling the number of physicians, and quintupling the number of pharmacists…Lesotho reported the public sector nurse vacancy rate at 48% in 1998, and Malawi at 50% in 2001."*[20]

The price of weak health infrastructure and lack of human resources has already been very high. HIV/AIDS has orphaned over 12 million children under the age of 15 in sub-Saharan Africa and less than 10 percent of those who need anti-retroviral treatment for HIV infection receive it.

III. A pan-African response to HIV/AIDS

[15] Mark, C, "Commentary: How the G8 Lied to the World on Aid: The Truth about Gleneagles Puts a Cloud Over the New York Summit," *The Guardian,* London, 24 August 2005.

[16] International Peace Academy (IPA), "Global Public Health and Biological Security: Complementary Approaches", *Meeting Note: Support for the Follow-up to the High-level Panel*, IPA: New York, April 2005.

[17] African Union Commission, Department of Social Affairs, "Consideration of an Interim Situational Report on HIV/AIDS, Tuberculosis, Malaria, and Polio: Framework on Action to Accelerate Health Improvement in Africa," Fourth Ordinary Session of the Assembly of the African Union, Abuja, Nigeria, 30 -31 2005.

[18] Dugger, C. "Africa Needs a Million More Health Care Workers, Report Says," *The New York Times,* New York, NY, 26 November 2004.

[19] Henk Rossouw, "The Truth Needs Time," he Ruth First Memorial Lecture, *Mail and Guardian*, Johannesburg, 26 August – 1 September 2005.

[20] MOH Botswana, McKinsey & Co. Increasing Access to ARV Treatment, MOH: Gaborone, 2002 and Liese B, Blanchet N, Dussault G. The Human Resource Crisis in Health Services in Sub-Saharan Africa, Washington: The World Bank, 2003, in World Health Organisation and World Bank, "Improving Health Workforce Performance, Issues for Discussion: Session 4," *High Level Forum on the Health Millennium Development Goals,* Geneva and Washington: WHO/The World Bank, December 2003, pp.2.

African governments have enthusiastically vowed – repeatedly - to address HIV/AIDS. They have been less efficient – particularly at the subregional and continental levels – when it comes to implementing their numerous pledges, declarations and promises. In 2001 the Heads of State signed the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases and promised to commit 15 percent of their national budgets to health. They subsequently signed the 2003 Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and other related infectious diseases. The AU Commission's Strategic Plan for 2005-2007 includes HIV/AIDS as priority programme. The time is fast approaching for action that is more concrete. During the AU summit in Sirte, Libya in July 2005, President Obasanjo announced that the AU will convene a summit on HIV/AIDS, Malaria, Tuberculosis and related infectious diseases, in 2006, to review progress made in the last five years.

Africa's response to HIV/AIDS has been uneven. Even its success stories are being contested. Uganda's rapid decrease of HIV prevalence from national prevalence falling from 13 percent in the early 1990s to 4.1 percent by the end of 2003 is radically different from previous estimates.[21] South Africa, where the government's rampant AIDS denialism in the guise of scientific skepticism about HIV's causal link to AIDS, has only just begun responding to its epidemic. Still, the bulk of an African HIV/AIDS response has been at the country-level, and while this is as it should be, successful control of the pandemic remains elusive. All of the declarations and promises were designed to mobilize an *African* response to the scourge that is handicapping the continent's efforts to eradicate poverty and move beyond underdevelopment. But how have these *African* promises translated into *African action?* As the continent moves toward integration, a continental response that scales up the HIV/AIDS response as well as strengthens Africa's ability to respond to future health crises is urgently needed.

Under the rubric of the UN Declaration of Commitment on HIV/AIDS, member countries, including African governments, agreed to time-bound concrete targets for fighting HIV/AIDS. In 2003, UNAIDS reviewed progress made toward achieving these goals and found four critical challenges that explained why inroads in the fight against AIDS had not been achieved. These were: insufficient financial resources; lack of human resources and technical capacity; HIV/AIDS stigma and discrimination; weak monitoring and evaluation capacity. Even though there was some increased financial commitment on the part of bilateral and multilateral donors, 50 percent of the countries reported to UNAIDS that they had insufficient resources for scaling up their HIV/AIDS programmes.

If the hindrances to mobilizing an adequate response went beyond resources from outsiders – that was not captured in the assessment of the performance of African governments. Africa reported that it has been unable to deliver on its promises, without really accentuating the hardships, the continent faces in securing sustainable financing and moving out from under its staggering external debt. Ironically, global as well as African civil society actors have been more vocal in this respect, making radical and important links between deficits in aid and inequities in the international economic infrastructure and Africa's poor response to AIDS. But strong gestures and arguments from African states that support these arguments have been slow,

[21] Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), *AIDS Epidemic Update, December 2003*, Geneva: UNAIDS/WHO, 2003.

convoluted and have failed to support civil society's moral outrage. Indeed, the cry of 'shame' from our leaders has been more of a quiet murmur.

More importantly, very little reference is made about the poor state of existing health infrastructure in sub-Saharan countries, or how cultures of denial maintain a deadly silence on the causes of HIV. Constructive self-criticism has not prevailed: little is said about the lack of coordination between ministries of health, finance, development and gender and how this cripples effective management of resources. Only this year has the issue of health capacities been articulated and raised at the highest levels of African governments. Notably, national treasuries continue to cap resources for the health sector, even when those resources would not be diverted from existing national budgets. Finally governance has not been articulated as an important element in combating AIDS - governance deficits such as limits on political participation and marginalisation of community-based initiatives, civil society organizations, and the private sector limit options for public-private partnerships that could mobilize and popularise national HIV/AIDS programmes.

Beginning in December 2004, the AU Commissioner of Social Affairs, Adv. Bience Gawanas, together with civil society, governments and partners, began developing a continental strategy for the African Union on HIV/AIDS. The Commissioner convened a technical consultation in Addis Ababa in December 2004 and a second follow up meeting in May 2005. The product of these deliberations is the AU's HIV/AIDS Continental Strategic Plan, which aims to heighten and enhance Africa's response to the HIV/AIDS pandemic.[22] The Commission's HIV/AIDS Continental Strategic Plan positions the AU as an advocate and coordinator of a continental response to the emergency posed by HIV/AIDS. Its six objectives focus on:

1) Building and projecting leadership and advocacy;
2) Fostering African and external stakeholder accountability to mitigating HIV/AIDS;
3) Harmonizing HIV/AIDS policies in Africa;
4) Mobilising human resources;
5) Mobilising financial resources; and
6) Accelerating the HIV/AIDS response from the Commission and regional initiatives.

The strategy focuses on developing good practices, advocacy and resource mobilization and harmonization. It does not seek to provide treatment, design new strategies or augment existing ones. A more focused advocacy campaign will be incorporated in AIDS Watch Africa (AWA), which has been mandated to mobilse African Heads of State and Governments to prioritise the control of HIV/AIDS, mobilize resources, monitor progress through the African Peer Review Mechanism (APRM) and to sustain the necessary dialogue on the pandemic at meetings of the AU Assembly, and in global arenas. AWA is headed by Nigerian president Olusegun Obasanjo, and is composed of presidents Festus Mogae, (Botswana); Mwai Kibaki (Kenya); Amadou Toumani Toure (Mali); Paul Kagame, (Rwanda); Thabo Mbeki (South Africa); Yoweri Museveni, (Uganda); prime minister Meles Zenawi, (Ethiopia); and the Chairperson of the AU Commission, Alpha Oumar Konaré. AWA is now instituted within the Commission. AWA's immediate advocacy objectives are to push African governments

[22] African Union, *The AU Commission HIV/AIDS Strategic Plan 2005 – 2007; and AIDS Watch Africa (AWA) Strategic Plan*, 28 June – 2 July 2005, Sirte, Libya, Executive Council Document EX.CL/194 (VII).

to meet the Abuja declaration commitments; pursue 100% debt cancellation for highly indebted poor countries; and to promote full funding of the Global Fund to Fight AIDS, TB, and Malaria (GFATM).[23]

Finally, the strategic plan is holistic in its approach to HIV/AIDS. There are undercurrents of a *human security* perspective in both the conceptualisation and possible future implementation of the strategy. The strategy seeks to integrate HIV/AIDS into all aspects of the African Union. The AU's Department of Social Affairs has been mandated to collaborate with other relevant Departments of the African Union Commission (Peace and Security; Political Affairs; the Women, Gender and Development Directorate; Human Resources; Science and Technology; Agriculture and Rural Economy; and NEPAD) as well as with regional economic communities (RECs); and continental, regional, and international stakeholders.

Human security emphasises freedom from fear and from want. The term was first used in a 1994 UN Human Development Report, and encompasses economic, food, health, environmental, personal, community, and political security. The concept of human security is holistic, people-centred, focused on good governance practices, and ideal for influencing new policy approaches that foster renewed focus on the well-being of citizens. Moreover, human security is in many ways a new vocabulary that makes broad linkages between development, security and governance. It is predicated on the view that military structures should be at the service of people-centred development and stability. Traditional security technocrats who were alarmed by the impact of HIV/AIDS on militaries first 'securitised' HI/AIDS. Reports of UN peacekeepers spreading the virus in Thailand and other parts of the globe; the virus' historic mobility; and the role of soldiers in spreading infectious diseases, have led many to believe that the first line of a nation's defence was being decimated by HIV/AIDS.

Many experts focus on the military's vulnerability to HIV/AIDS, framing the issue from what appears to be a state-centric model. However, a real analysis of the impact of HIV/AIDS on militaries inevitably takes on an approach that focuses more on people: the human resource toll on the men and women serving in the uniformed services. First, HIV-related illness and high death rates can potentially lead to the depletion of skills in all ranks, undermining a military's morale, cohesion, and capacity to build and sustain its institutional capacity. Second, AIDS deaths, especially in militaries, which are responsible for caring for service men and women *as well as* their dependents are serious cause for alarm. Militaries will be expected to care for increasing rises in the numbers of orphans. Third, hierarchy and unequal distribution of power and prestige will also play a role in the way AIDS is treated. Militaries that are under resourced are more likely to provide expensive ARV to senior officers or those with strong political ties – leaving younger soldiers and new recruits to fend for themselves. Lastly, expensive costs of treating HIV- particularly where civil-military relations are shrouded in power-struggles, secrecy, and overt coercion - can lead to resource competition between elites in defence ministries, the armed forces, and civilian authorities. The truth is that attempting to address HIV/AIDS in militaries is a human security issue.

However, going further, HIV/AIDS is transforming states and societies. Existing research speculates that states and societies will be profoundly changed by HIV/AIDS

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[23] African Union, *The AU Commission HIV/AIDS Strategic Plan 2005 – 2007; and AIDS Watch Africa (AWA) Strategic Plan,* op.cit.

as it interacts with economic development and democratisation processes – possibly hindering efforts to reduce poverty, manage conflicts, and democratise political participation across religion, gender, ethnicity, and class. HIV/AIDS raises the question of whether or not Africans will be able to contribute to, or enjoy, freedom from fear, want, and hunger. In effect, this question influences state-centric as well as human security.[24] The transformative factors that have helped fuel HIV/AIDS are still prevalent in southern Africa. The pandemic continues to unfold against a backdrop of inequality, poverty, weak governance structures, poor health infrastructure, and low-intensity conflict. Ultimately efforts to control HIV/AIDS must be linked to a broader and deeper policy agenda.

As the African Union begins to actualise the strategic plan for HIV/AIDS two key issues will have to be addressed. First, the Commission's department of Social Affairs, which is solely mandated to lead on the AIDS issue, has a professional staff of six and is under-resourced. The department is also expected to deal with population and development; migration issues; all health and nutrition; the social welfare of vulnerable or disadvantaged groups; children; adolescents; the disabled, and the aged; the promotion of sports, scouting and family life; drug control and crime prevention; and promotion of African art and culture. How will the department implement a continental HIV/AIDS strategy given these other pressing areas of application? What sort of capacity, external linkages, and partnerships are needed to support the department and ensure that HIV/AIDS is addressed? Is it possible for the department to utilize initiatives in these other priority areas to also promote the harmonization of AIDS policies, strengthening Africa's health capacities; and advocating for other policies that will build the continent's social welfare infrastructure? Can HIV/AIDS then, act as the lit fuse that leads to a new explosion of action around social welfare issues? Indeed, using HIV/AIDS as the driver for these other strategies might allow this small department to succeed: reasons of capacity should be enough to encourage further pruning and synthesis of the social affairs agenda.

Second, the department must take its cue from the AU Member States. The Commissioner of Social Affairs is expected to 'coordinate, intensify and monitor efforts in Member States to promote the social well-being of all Africans while retaining cultural values and knowledge'. The African Union is, after all, an organisation of states. AU organs, such as the Economic, Social and Cultural Council (ECOSOCC) and the Pan-African Parliament (PAP) aim to infuse the new Union with the voice of people, either through peoples' institutions and civil society, or through parliaments. Nevertheless, the Assembly of Heads of State and Government is the only legislative body of the Union. The Commission is merely an executor.

Consequently, true implementation of HIV/AIDS advocacy and harmonisation of continental efforts will need political will in addition to political rhetoric. How will the Commission engage governments and leaders that are themselves less willing to confront AIDS? AIDS denialism aside, various factors collide around this issue including: the price of drugs, patent laws, world trade negotiations; bilateral relations with rich countries and debt service; and national constituencies, and the clash between traditional or conservative voices and progressives such as women's activists. Frequently, these interests and voices pull in separate directions. How will the politics

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[24] Shonteich, M, "HIV/AIDS and Security", Regional Governance and AIDS Forum, IDASA/UNDP HIV Development Project for Southern Africa, April 2-4 2003.

of AIDS at the national level shape continental approaches then? Moreover, are African leaders ultimately willing to concede that their past efforts to negotiate financial assistance from rich countries to combat AIDS and fill social welfare gaps has failed? Despite the global public spectacle to 'end poverty' during the G8 meetings in Gleneagles, Scotland in July 2005, the G8 only agreed to grant debt relief for some 18 countries. The AU - with AIDS Watch Africa leader Obasanjo also serving as the Chair of the AU - pushed heavily for 100% debt cancellation and determined at its July 2005 summit in Sirte, Libya that new resources should be without conditions. But, the countries tagged by the G8 to have their debt cut will also have their aid cut.[25] Debt relief has amounted to a smoke and mirrors trick of World Bank and IMF bookkeepers. African leadership on AIDS funding is only superficially more successful. The Gleneagles summit concluded in a promise to Africa that the G8 will increase resources for universal access to AIDS treatment. But this is only set to happen by 2010. By then, approximately 5,300,000 Africans will have died of AIDS.

IV. Conclusion

This paper concludes with more questions than answers. It is clear that the HIV/AIDS pandemic has epic proportions. From a historical perspective, dislocation, rapid mobility and movements of people, and inequality have been some of the factors that have created conditions for the rapid spread of HIV/AIDS. Interestingly, these factors - all of them related to broad social, economic, and political upheaval - have resulted in human *insecurity.* It is now 2005 and southern Africa is entering into the death stage of AIDS. This wave of AIDS will be the foreground; the background is continuing HIV infection. Both waves - mortality and morbidity - are happening on such a scale that life expectancy is decreasing in the subregion. This shift will undoubtedly result in transformation of states and societies, and is of real relevance to the human *security* policy agenda. The African response to these seismic impacts brought on by HIV/AIDS has been mixed at the continental level. But with a new AU strategy ready for implementation, there is plenty of room for a conceptual leap and practical giant step forward. While the AU's strategic plan is holistic and complements a human security perspective, the Social Affairs department within the AU Commission is under-staffed and most likely under-resourced. Moreover, because African presidents still represent the ultimate authority of the new AU, the Commission will have to generate and sustain political will at the top in order to effectively deliver on its strategic plan for the people on the ground. In the end, meaningful partnerships between the Commission and other actors, such as civil society, may be the best alternative to doing business as usual.

[25] See Mark, C, "Commentary: How the G8 Lied to the World on Aid: The Truth about Gleneagles Puts a Cloud Over the New York Summit," op.cit.