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## Editor's preface

This *Development Update* is dedicated to the issue of HIV/AIDS in Southern Africa. This should not be surprising given that the AIDS epidemic has reached pandemic proportions in all but two SADC countries, and is now having a documented impact on most areas of life and development. Eight years ago, in 1997, the United Nations Development Programme (UNDP) was projecting that AIDS would devastate development, and described HIV as a 'new force of impoverishment in sub-Saharan Africa' that could 'reverse poverty gains and set off a cascade of economic and social disintegration and impoverishment'. Today the UNDP records the veracity of its own projections in its annual *Human Development Report*. For example, in the UNDP's *Choices* supplement, published in July 2004, Mark Malloch Brown, Administrator of the UNDP, writes:

The HIV/AIDS epidemic is Africa's most serious development crisis, with Southern Africa bearing the brunt with one in seven of the adult population living with HIV/AIDS. The scale, severity and impact of HIV/AIDS on these societies is destroying the capacity of governments and communities to function effectively.

Further on in the article he warns that:

It is no exaggeration to say that unless the world meets the HIV/AIDS Millennium Development Goal, we have little prospect of reaching the other seven goals – which include the overarching target of eradicating extreme poverty and hunger by 2015, as well as achieving universal primary education, promoting gender equality, reducing child and maternal mortality and ensuring environmental stability – because the impact of HIV/AIDS is felt across all these areas.<sup>1</sup>

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<sup>1</sup> Millennium Development Goal 6 is to 'Combat HIV/AIDS, malaria and other diseases'. The target by 2015 is 'to have halted and begun to reverse the spread of HIV/AIDS.' See [www.undp.org/mdg/goal6.pdf](http://www.undp.org/mdg/goal6.pdf).

In the first article in this volume, Mary O'Grady offers an extensive analysis of the statistics on HIV infection in Southern Africa, as published by the UNDP, UNAIDS and others. Unfortunately, statistics have become part of the problem in responding to HIV, because they are so large as to be unimaginable – and unbelievable. A complicating factor in Southern Africa's response to HIV/AIDS has been the very questioning of statistics about HIV, and hence of the epidemic itself, by the President of South Africa. This has been taking place for several years and has led to an anomalous situation where, in a country that places great reliance on statistics, one set of statistics is routinely ignored – the statistics on HIV prevalence. For example, the release of the 2003 antenatal statistics in September 2004 passed without comment from government. By contrast, the crime statistics, released the same month, merited a detailed comment and defence from the President in the weekly electronic newsletter of the African National Congress, *ANC Today*. On 1 October 2004 Mbeki wrote that:

Among other things, we must therefore use the Crime Statistics to improve our effectiveness in both areas of preventing and combating crime. This requires a careful study of these statistics and their correlation with other elements that characterise our society.

One only wishes that the HIV statistics, produced either by government departments or scientific researchers, merited similar responses from governments. Thus, in the face of continued scepticism about some statistics, it is important to draw the reader's attention to the fact that O'Grady draws from a wide range of statistical sources, including much more 'tangible' measurables such as infant mortality, child mortality and the mean ages of death of adults. Through these sources, a careful reading of the O'Grady analysis takes us to the crux of human suffering that the HIV/AIDS epidemic is *adding* to a sub-continent already suffering from hunger and poverty. In Swaziland, child mortality has risen (by 2002) to 149 per 1 000 live births. Put more simply, more than one out of every ten children dies before age five, or one out of every ten families suffers the early loss of a child. Compare this with Belgium where child mortality is 6 per thousand live births. This shocking fact makes the assertion of the Universal Declaration of Human Rights that 'all people are born equal in dignity and rights' sound rather hollow. And here is the rub, because the most frightening thing about HIV is that it is robbing the poor and rights-deprived of the hope of a better life in their life-times: as O'Grady again points out, the UNDP now believes that the Millennium Development Goal 4 of reducing child mortality by two-thirds in sub-Saharan Africa will have to be postponed by 101 years.

In the face of this unprecedented humanitarian crisis, there is a terrible disjuncture between what is known, said and written about HIV, and what is *not* done. Governmental neglect of, and distance from, their citizens, a problem President Thabo Mbeki of South Africa has recently admonished African leaders for, now no longer condemns millions of people to poverty, but also to early death by a relatively new disease – whose medical and social etiology now is better understood than any disease in history.

In this respect HIV is a historic challenge of good governance in our region and a test of the aspirations now ascribed to by the African Union (AU). HIV is a call to immediate action in one of the New Partnership for Africa's Development (NEPAD) priority areas, health. In this respect, the NEPAD Health Strategy recognises that 'One of the major impediments facing African development efforts is the widespread incidence of communicable diseases, in particular HIV/AIDS, tuberculosis and malaria. Unless these epidemics are brought under control, real gains in human development will remain an impossible hope' ([www.nepad.org](http://www.nepad.org) Priority areas/Health Strategy).

In this region of Africa, the Southern African Development Community (SADC) has pioneered a model response to HIV/AIDS – on paper. In 1996 the European Union and SADC held a joint conference on HIV/AIDS in Malawi which prepared a SADC Plan of Action on HIV/AIDS which was due to be presented to Ministers responsible for Human Resource Development, and thereafter to the SADC Council of Ministers in 1997. This did not happen, but since then there have been workshops, codes, guidelines and statements of commitment. This culminated in the July 2003 Maseru Declaration of SADC Heads of State on HIV/AIDS which notes with profound concern that:

the HIV/AIDS pandemic is reversing the developmental gains made in the past decades and is posing the greatest threat to sustainable development of the region due to loss of the most productive individuals in all sectors of our economies, decline in productivity, diversion of scarce resources from production to the care and support of the HIV/AIDS infected and affected persons, as well as mitigating the effects on various sectors, and resulting in an increase in the number of orphans and the disruption of family structures.

Despite the existence of the NEPAD health strategy and the SADC Strategic Plan (2003-2007), such pronouncements are still not matched by an underlying common

purpose or commitment of resources in SADC. As the articles in this volume show, AIDS is a regional epidemic, but SADC does not have a regional 'battle plan' to respond to it. There is instead a mismatch between countries' responses. On the one hand (as described in the article by Christine Stegling from the Botswana Network on Ethics, Law and HIV) is Botswana, which has swum against the stream of political neglect of HIV, and is now treating 20 000 people, but more importantly has explicitly recognised that tackling HIV has to be part of its national Vision 2016. On the other is a country like Lesotho, which has recently displayed a burst of political commitment to controlling HIV, but despite this has not formally recognised that its National Vision 2020 will be severely undermined if HIV is not controlled. The challenge for SADC now is to lift all country responses to the level of Botswana, and to co-ordinate a regional response that is infused with urgency and leads to much greater action.

## Interrogating the context(s)

In a recent article Hein Marais, formerly of UNAIDS, salutes the achievements of AIDS advocacy in the last five years, but warns of 'some troubling trends':

There has emerged a roster of truisms that, in some respects, convey a misleading sense of certitude, and that might even be steering institutional responses in ineffectual directions. As well, awkward gaps are cleaving the AIDS world – gaps that threaten to detach the staples of advocacy from the riches of epidemiological and social research, and spoil the kind of multidisciplinary ferment that the struggle against AIDS dearly needs (Isandla, 2004).

Marais' article is timely. There is no disputing that AIDS, like development generally, has spawned an industry of people who, while nominally committed to mitigating the epidemic, live off its wake<sup>2</sup>. A perpetual carnival of conferences drives the AIDS agenda, which pay lip service to the challenges that the epidemic presents, but have little power to enforce their own resolutions. Consequently political neglect of AIDS (and of development) has created a vacuum into which bilateral donors insert themselves, with their agendas often worked out without multi-lateral consultation or a proper understanding of the targeted communities. Donors, researchers, 'activists', and a few people with HIV (who often claim to speak for all people with HIV) have coalesced into

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<sup>2</sup> Originally this volume intended to carry an article examining the accountability of NGOs, who can sometimes be the most vociferous advocates in demanding government accountability, but set different standards for themselves.

a community that has insufficient critical peer review of its activities or outcomes, and which is frequently divorced from the mass of real people living with and affected by HIV. This should not have come to be. From the earliest days of the epidemic, people with HIV were supposed to be involved as both participants and police in all levels of planning and implementation. But in Southern Africa, despite having the world's largest affected population, there is still no movement that comprises people with HIV.

Thus despite the often genuinely heroic efforts of this 'community', there is an inherent danger in this situation. Where a vested interest in a 'truth' or a 'finding' develops, at best it tends to blind one's own critical capacities and at worst it can lead to deliberate deceptions. In AIDS this kills or maims people – not as directly as with a bullet, but because the outcome is the same; in lawyer's language it amounts to *dolus eventualis* (a predictable outcome where 'the accused foresaw the possibility that the prohibited consequence might occur in substantially the same manner as that in which it actually does occur'). This is why a meaningful, critical, analytical partnership against AIDS is so important – and why it is tragic that at every level of society's response it still eludes us. Thus, although governments (justifiably) bear the brunt of criticism for failed responses, there is no moral high ground, and neither should anyone seek it because the history of HIV/AIDS is about a social failure, as much as it is about government's failures.

Faced with our complicity in this tragedy, when I was first asked to act as Guest Editor for this edition, my gut response was to decline. What is not needed is yet another collection of essays on AIDS, especially under the imprint of a donor. This I would still maintain. However, after some consideration I agreed to act as guest editor because it may offer an opportunity to instigate thought and enquiry on a number of 'old' issues in new ways – as well as to demand once again an appropriate response.

The articles in this volume were commissioned and written quickly during September 2004. Ironically, in view of the assertions made by Peris Jones in his article ('Of Gifts and Return Gifts: Beyond the political and practical deficits of donor assistance'), the deadline was determined by the need to spend or lose donor funds for this project by December 1st 2004! Consequently, the articles are not all as polished as they could be. They are, however, an honest, incomplete and imperfect attempt to raise questions about some of the 'established truths' of HIV/AIDS, and to expose, analyse and tell the truth about issues that are often excluded or omitted from official discourses about AIDS.

The articles fall roughly into three groups: articles that set the scene; articles that interrogate 'truths' and articles that describe challenges, particularly around the implementation of antiretroviral treatment in resource-constrained settings. As the articles by O'Grady, Msimang, Ekambaram and Hachonda illustrate, the scene is a complex and shifting one. Collectively the articles demonstrate how AIDS is a modern reminder of a centuries-old insight: epidemiology requires more than the measurement of disease, but an appreciation of its political determinants – disease control demands social intervention as well as medical intervention. However, these articles do more than describe, they also provoke. Msimang and Ekambaram, for example, try to grapple with reasons why the traditional 'women's movement' has not mobilised against the risks to women of HIV infection. Indeed, with the exception of a few intellectuals, it has continued with business as usual, deserting the real battle field for gender equality for a more rarefied space in academia or 'politics'. They also warn against official and unofficial responses to HIV that undermine women's dignity, in particular the growing sanction of 'virginity testing'. In common with Berger they reject the notion that women's disproportionate risk of HIV infection is because they are the powerless victims of men's desires, but point out how custom, religion, unemployment and poverty conspire to rob women of the socio-economic status that would allow greater control over sex, and less dependence on sex as a rare commodity that can bring some security and relief.

In the article by Adudah and Hachonda there is a broader discussion of why the protection and fulfillment of human rights remains an integral part of HIV prevention and treatment. This is a timely discussion because the 'human rights model' that was developed in the early 1990s, particularly its emphasis on informed consent for HIV testing and confidentiality, is again under the spotlight (Heywood, 2004). The approach that must be taken to human rights and HIV is an illustration of one of the main themes of this issue of *Development Update*: the response to HIV/AIDS requires constant re-evaluation and ongoing assessment of strategies, rather than a rigid defence of positions that might have been true yesterday, but are not today. Thus, for example, ten years ago the risk-benefit ratio in relation to HIV testing was very different. The HIV test was commonly used as a means to try to enforce apartheid between the infected and uninfected; today in most countries there are laws and policies that intend to protect people from discrimination. Ten years ago, knowing your HIV status offered you very limited benefits in terms of treatment; today, knowing your HIV status can be an entry point to care programmes and access to antiretroviral treatment. On this basis there are those who now argue in favour of a practice of routine HIV testing, such as has been adopted in Botswana.

However, while recognising the changes that have taken place, and accepting the need for a change of emphasis in the way we approach human rights and AIDS, it is important not to risk endorsing a new approach – even tacitly – that will open the door to HIV testing without counselling and do away with even lip service to the rights of people to privacy. Australian judge Michael Kirby, for example, has publicly asked whether, in view of the scale of the epidemic:

the special needs of the developing countries, notably in Africa, are so large, so urgent, so intractable and so bedevilled by stigma and discrimination, that systems of routine testing must be introduced with less emphasis upon notions of individual patient prior consent? (Kirby, 2004).

The answer to Kirby is to remind ourselves that much has changed – but much has not. According to the UNAIDS 2004 report on the global AIDS epidemic only 7 per cent of people in developing countries have access to ARVs; HIV prevention programmes still reach only 20 per cent of those who need them; condom supply is only 4 per cent of what is needed; and only 10 per cent of women have access to health interventions to prevent mother-to-child HIV transmission. Thus, while it is accepted that 'the content of human rights principles is not inflexible', and that risks are occasionally warranted, we must still be alive to the possibility that a weakening of our guard on human rights could have disastrous consequences for hundreds of thousands of people.

## Interrogating the truth(s)

Five of the 'truths' that are interrogated in this volume are:

1. *That women have an added vulnerability to HIV infection mainly because of their 'powerlessness', rather than because of choices and risks that are inherent to desire and sexuality.* In his article, Jonathan Berger argues that 'women's vulnerability' is an 'incomplete' explanation for higher rates of HIV infection among women and girls. He does not dispute that gender inequality, violence, and socio-economic dependence are major determinants of risk. However, he argues that this explanation, which comes more easily off the lips of people who prefer not to talk about or admit sexual desire, has crowded out consideration of other risk factors. It causes us to overlook what research has taught us about human sexual behaviour, including about women's enjoyment of and desire for sex. Ignoring the evidence (or not asking the questions) affects HIV prevention and exposes people (women and girls in particular) to risks that are greater than they need be because their choices about

sex (sometimes driven by desire rather than being almost always imposed by 'the male other') are omitted from the discourse of prevention. HIV prevention, Berger argues, must be about encouraging people to enjoy sex safely and not mainly about the restraint of both men and women. In the era of virginity testing and the artificial targeting of 'abstinence-only' programmes by the world's largest AIDS donor (the United States) this message is apposite. But it does not address itself only to the extremes for it is the mainstream that has mistakenly fallen into a description of women, men and sex that is incomplete.

2. *That HIV prevention programmes targeting heterosexual populations are properly conceptualised and constructed.* Building on his argument about 'Re-sexualising the Epidemic' Berger also points to the manner in which HIV prevention programmes in Southern Africa exclude large groups of people, and in particular those whose sexual behaviour carries the highest risk of HIV infection. Prisoners, gay men and sex workers are the primary 'victims' of State's (by commission) and donor/United Nations (by omission) refusal to provide all people with life-saving information. The rationale often given for this is that 'in developing countries HIV is mainly heterosexually transmitted'. However, Berger correctly warns against the unspoken notion that 'dirty people's' sex can be separated off from 'the rest of us'. Returning to the primacy of sexual desire in influencing sexual activities, he points out that the cross-over between 'dirty' and 'acceptable' sex is far more common than prevention programmes admit. Many married men have sex with other men; many heterosexuals practise anal sex; and more people 'use' sex workers than is admitted by the polite society that constructs AIDS messaging.
3. *That 'partnerships' between government and civil society are easily constructed, rather than inherently problematic.* It becomes deeply problematic when wishful thinking rather than realistic social analysis dominates a public health programme as important as HIV and AIDS prevention. Fortunately, with encouragement from the drivers of the African Renaissance, after a long period where colonialism and then post-colonialism excluded the majority of citizens from decision-making, most SADC countries (Swaziland, the Democratic Republic of Congo and Zimbabwe excepted) have now actively committed themselves to the practice of democracy. However, in most countries of SADC this democracy still amounts to the periodic exercise of voting rights, rather than being a principle that suffuses all public relationships, including relationships around HIV and AIDS. The *de facto* isolation of the non-governmental sector and HIV/AIDS activists from the planning of HIV/AIDS prevention and treatment is directly described in a number of articles in this



volume that look briefly at the experiences of Angola, Zambia and Zimbabwe, and in more detail at Botswana and South Africa. The purpose of these articles is not to detract from the notion of partnerships, but rather to attack such a platitudinous approach. An example of the danger in glossing over the difficulty of building and maintaining partnerships is the *modus operandi* of the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM), where proposals are accepted only through partnerships called Country Co-ordinating Mechanisms (CCMs). Because many CCMs are not genuine partnerships, the world's foremost mechanism for soliciting and disbursing funds to non-governmental actors has been effectively closed off.

4. *That all donor aid is good.* It has long been recognised that donor aid for development is a double-edged sword. The same is true of HIV/AIDS. Peris Jones examines and documents the difficulties and dangers created by bilateral donors, whose own agendas, which are rarely malign, underlie their generosity. Again, it is important to stress here that the purpose is not to renounce donor aid for HIV/AIDS. On the contrary! In fact, sub-Saharan Africa needs as much capital as is currently being spent on the war on Iraq or subsidising European farmers, but donor aid needs to be far better co-ordinated between donors and the recipient governments, premised on trust, and conditional only to the extent that it is used properly and transparently on programmes that an organisation like the World Health Organization (WHO) validates as contributing to public health and improvement.
5. *That all research on HIV and AIDS is justified.* HIV infection is probably the most researched medical condition in the history of medicine. Basic science and clinical research have, in a relatively short period, discovered and documented the characteristics of the viral pathogen that causes AIDS. In less than 20 years, effective and safe treatments were made available – although not accessible. There are mountains of research on the links between risk of HIV and poverty, gender, age. However, as Geoffrey Setswe warns implicitly in his article, there is a danger of AIDS research becoming a self-perpetuating monster and AIDS researchers a law unto themselves, beholden more to the next conference or publication than to the HIV-vulnerable communities their research is supposed to benefit. In an ideal response, rather than the fissured one that this volume describes, much more attention would be paid to ensuring effective utilisation of the knowledge gained from research. There might even be grounds for a moratorium in certain areas of enquiry to concentrate on implementation of existing knowledge and to allow more focused, intense and resourced research into some of the areas of science that still elude us, such as for an HIV vaccine or microbicide.

The purpose of interrogating these five 'truths' is not to deconstruct our understandings of HIV, but to reconstruct them. None of the authors of the articles deviate from scientifically established knowledge about the virus we call HIV, its infectivity, or its consequences on the human immune system and thence on human society. The consequence of that type of contrary enquiry is described in an article by myself that attempts to track some of the history of 'AIDS denialism' in South Africa ('The Price of Denial'). It is likely that the article will cause some anger. Some might even argue that it is unduly provocative and will further damage and delay collaboration. This need not be so. It is a fact that AIDS denialism has had tragic and lasting consequences for the profile of the epidemic in Southern Africa, and it is essential that its course be documented and never repeated. To pervert the famous Orwellian phrase, when it comes to documenting the history of this epidemic, we will find that 'all people are culpable, but some people are more culpable than others'.

## Examining the roll-out of treatment

Fortunately, the economic and political dominance of the South African government in the SADC region did not facilitate a transfer of its views on HIV and its treatment into the region. Indeed, countries such as Botswana chose exactly the opposite path, and from 2002 commenced ambitious treatment programmes for people with AIDS. Given the importance of these interventions, and the relatively limited amount that has been written about the actual implementation of treatment programmes, a significant part of this volume is focused on the 'roll-out' of antiretroviral treatment. The regional overview by Adila Hassim reveals that with the help of a fillip from the WHO '3 million people on treatment by 2005' ('3 by 5') campaign, HIV treatment programmes using antiretroviral medicines have now commenced in most of the countries of Southern Africa.

Treating people with HIV is a moral and social imperative that the world may not in good conscience turn its back on any longer – the delay has already condemned many to preventable death. However, now that treatment has commenced, the Northern AIDS activist community – which helped drive the demand for treatment – must be honest and accept that expanding access to treatment is a developmental and medical programme of unprecedented scale and complexity. Never in the history of medicine has anything so ambitious been undertaken in such difficult circumstances. In all countries of SADC, the medium- and long-term sustainability of this programme will depend on the rapid development of health systems, improved social infrastructure and

the mitigation of poverty. This will require AIDS activist groups in the 'First World' to unify their work with development organisations, campaigns for debt relief, democratic governance in their own countries (as well as in our countries), and above all to begin to persuade ordinary people of the first world of the need to feel injured by, and act on, the injustices and manifestations of global inequality, HIV being one of the foremost.

The three articles by Belinda Beresford, Christine Stegling and Fared Abdulla prove that treatment can be provided in rural, urban and under-resourced settings in Southern Africa. In the Western Cape Province of South Africa, Abdulla, the head of the AIDS programme in the Province, estimates that 6 000 people are receiving treatment and that during 2005 most of the people needing ARVs will have access to the medicines through the public health service. In the village of Lusikisiki in the Eastern Cape Province of South Africa, 350 people are receiving treatment and the aim is to have 1 000 adults and 100 children on treatment by the end of 2004. Out of Princess Marina hospital in Gaborone, the capital city of Botswana, 8 300 people receive treatment. These articles show that the lives of tens of thousands of people with AIDS are beginning to improve because they have such access to treatment. As importantly, they begin to make science out of claims made by many who in the past depended on anecdote to advocate for the introduction of treatment on the grounds that it would strengthen HIV prevention and catalyse an improvement in health services. For example,

- In Botswana the take-up of Voluntary Counselling and HIV testing (VCT) increased by 41 per cent in 2003, partly as a result of the availability of treatment.
- So far, adherence to treatment at Botswana's Princess Marina Hospital, the biggest ARV treatment site in Africa, has been in the region of 85 per cent.
- In the Western Cape the ARV programme is 'proving indispensable to addressing staffing needs of a whole facility' thereby improving morale. It has also led to an improvement in pharmaceutical services.
- In Lusikisiki rising numbers of people are choosing VCT, entering support groups and 'there are signs that stigma is diminishing and there is a greater community awareness about HIV/AIDS, prevention and treatment.'

These few examples demonstrate that even our region's meagre and constrained efforts to treat people have already generated lessons and knowledge that can be of much wider application.

But the articles also reveal the ongoing challenges and potential pitfalls associated with establishing treatment programmes. These include:

- *The crisis of a shortage of medical personnel in SADC's public health systems.* In the article on Botswana, for example, the head of the AIDS programme at Princess Marina admits that 90 per cent of the country's practising doctors are not Batswana. In other SADC countries the situation is even worse. In Malawi, where it is estimated that 6 000 health professionals are needed to provide a comprehensive care and treatment programme, more than 50 per cent of health posts are vacant. In comparison with Botswana, which has 241 nurses per 100 000 people, Malawi has only 28.
- *The need for governments and their partners to have a plan and timetable to integrate ARV programmes, like the Médecins Sans Frontières site in Lusikisiki, into the public health service.* Unless this takes place, the longer term sustainability of the programme is in jeopardy, and so are many people's lives. In addition, parallel health systems will divert attention from the greatest challenge – to revive Africa's public health facilities.
- *The need for ARV programmes that are run from the public health service to be integrated into the mainstream of medical care, and for new models of treatment to be developed that take account of the demographics of health in Southern Africa.* For example, both the Lusikisiki programme and the Botswana model emphasise the importance of reforms to conditions of service for nurses to permit a greater utilisation of nurses in all aspects of HIV care.
- *The need for much stronger public information campaigns about HIV and its treatment.* Although HIV has insinuated itself into all of our lives, hard information about HIV remains scarce. In villages and towns throughout Southern Africa there is a dearth of printed or electronic media that can tell a person about how they may be infected; how the virus 'works' once it is in our bodies; and how it is treated using antiretroviral medicines. Again the prevalence of the virus and the prevalence of information about it are grossly out of sync. Much more visible and accessible information would raise society's general knowledge about HIV and almost certainly reduce stigma, encourage testing and support treatment.
- *The need to step up HIV prevention and in particular to tackle stigma.* Here, for example, it is important to take note of the points made by Stegling, who alleges that despite the extensive roll-out of treatment in Botswana most people still regard HIV as a disease of 'the other' and communities still lack basic knowledge about HIV.

There is only one conclusion that can be drawn from the articles in this volume: that is, that in the face of what we know, and what has been described here for the umpteenth time, there is a great duty on the leaders of government, business and civil society in the SADC region to move beyond declarations to detail. The response to HIV is a test of Africa's commitment to its own renaissance. The rampant spread of HIV in Southern Africa has a great deal to do with conditions created by colonialism and apartheid, but the solutions lie with ourselves. HIV has become a development disaster – it can become a development opportunity. Up to this point, SADC and its bilateral donors have failed to provide more than window-dressing on the epidemic, or to follow up on their own well-formulated string of resolutions. However, with a united voice the opportunity now exists to link debt cancellation to concrete plans for investment in social services; to take advantage of the recommendations of the WHO Commission on macroeconomics on health to demand greater investment in health by developed nations; and to use the WHO's '3 by 5' campaign to draw resources back into health systems.

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