Joint United Nations Programme on HIV/AIDS

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AIDS in Africa: Three scenarios to 2025

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- The AIDS in Africa scenarios project is a synthesis of many diverse and sometimes opposing perspectives. It does not represent any single individual's or institution's viewpoint.
- The aim of the scenarios is to provide a tool to help decision-making rather than a set of prescriptions about the future.
- Some aspects of scenarios may be described with numbers, but the richness of the scenarios as a strategic tool stems partly from the fact that they can include more intangible aspects of the future. The numbers and projections in the scenarios are illustrations, rather than predictions of what might happen.

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> **We live by hope, but a reed never became an Iroko tree by dreaming.**
> —Nigerian proverb.

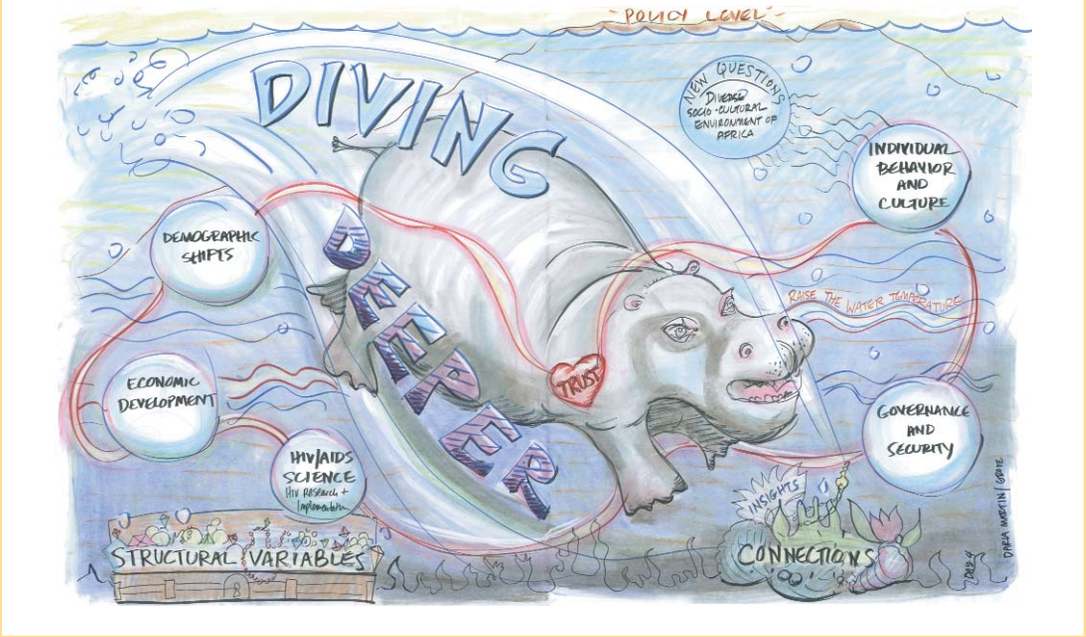
Welcome to
AIDS in Africa: Three scenarios to 2025

The decisions we make about the future are guided by our view of how the world works and what we think is possible. A scenario is a story that describes a possible future. Building and using scenarios can help people and organizations to learn, to create wider and more shared understanding, to improve decision-making and to galvanise commitment and informed action. People can use them to challenge their assumptions and implicit beliefs, and look beyond their usual worldview.

Scenarios draw on the age-old tradition of story-telling to help people think more imaginatively about difficult problems. Across the world, every culture tells stories, using them to make sense of the world and pass on that understanding from generation to generation.

This project uses stories rather than projections to explore the future of AIDS in Africa over the next 20 years. Statistics may give a succinct and tragic snapshot of recent events, but they say little of the AIDS epidemic's wider context, or its complex interconnections with other major issues, such as economic development, human security, peace, and violence. Statistics can only hint at the future. Indeed, by 2025, no one under the age of 50 in Africa will be able to remember a world without AIDS.

The book is rich and detailed—reflecting the complexity of its subject matter. There is a summary of the book, in the 'Executive summary', and the 'Scenario analysis' section provides a survey of the issues covered in the three different scenarios.



D. MARTIN, THE GROVE CONSULTANTS, LONDON, UNITED KINGDOM

Figure 1.
Looking beyond our normal worldview.

Some readers may be tempted to turn immediately to the numbers—how many treated, how many new infections, how many deaths by 2025? They are urged to remember that the scenarios are not predictions and that the goal of this project has never been to generate statistics. Its aim has been to explore how seemingly disconnected events and trends (for example, patterns of global trade, the education of girls and women, terrorist attacks on the other side of the world, the rise to power of a certain political regime) can work together to expand or limit an epidemic.

The scenarios were created by a team of about 50, mainly African, men and women. Most of them live and work in Africa, dealing daily with the effects of the epidemic. They brought a wide range of experience and expertise, and were anxious to look beyond, and below the surface of, everyday events, sharing and building on their wide range of understanding.

As the project developed, the team and participants used the image of a hippopotamus in a river to remind themselves of this idea. This is because, when a hippopotamus stands in a river, only a small part of it shows—most of it is hidden. In the same way, if we only pay attention to everyday events, then we may miss the complex patterns and structures that underpin them. A diving hippopotamus reminds us that patterns of behaviour lie below the surface of events, and the structure of the system lies deeper still.

Of course, given the widely varying circumstances, impacts, and effects of the epidemic in countries across Africa, no set of scenarios can describe all the possible futures that could occur. This project has set out to be provocative rather than comprehensive, stimulating questions and exploration, rather than trying to provide all the answers. We hope that the scenarios will prompt further thinking about the future of the epidemic, not only for the whole of the continent, but also for individual countries and communities. In stimulating further policy dialogue and thinking in the national context, the scenarios may need to be adapted to the particular social, economic, and epidemiological conditions that apply in a particular nation—some suggestions for exercises to explore these issues are made in **Appendix 6.**

For those who want to explore further, the accompanying CD-ROM contains most of the material commissioned for the project, both research papers and interviews, searchable by keyword. It also provides detailed reports of the project workshops and a number of presentations of the scenarios that can be used in group work.

These scenarios represent a crucial step in making sense of the future of the AIDS epidemic in Africa. It is the hope of the project initiators, participants, sponsors, and core team that this material will provide an essential starting point, not only for exploring and expanding people's understanding of the epidemic, but also for sharing that understanding with others.

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Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drug
AU	African Union
DAC	Development Assistance Committee (of the Organisation for Economic Co-operation and Development)
FDI	Foreign direct investment
GDP	Gross domestic product
GNI	Gross national income
HAART	Highly active antiretroviral therapy
HIPC	Heavily indebted poor countries
HIV	Human immunodeficiency virus
IBRD	International Bank for Reconstruction and Development
IMF	International Monetary Fund
MDG	Millennium Development Goal
NEPAD	New Partnership for Africa's Development
NGO	Nongovernmental organization
ODA	Official development assistance
OI	Opportunistic infection
OVC	Orphans and children made vulnerable by AIDS
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission (of HIV)
PRSP	Poverty Reduction Strategy Paper
QALY	Quality-adjusted life year
STI	Sexually transmitted infection
TRIPS	Trade-related aspects of intellectual property rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing (for HIV)
WTO	World Trade Organization

Section 1 Executive summary

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Section 1 Executive summary

This book is about AIDS and Africa, and the world's response to both, and presents three stories describing possible futures.

If, by 2025, millions of African people are still becoming infected with HIV each year, these scenarios suggest that it will not be because there was no choice. It will not be because there is no understanding of the consequences of the decisions and actions being taken now, in the early years of the century. It is not inevitable.

As these scenarios demonstrate, it will be because the lessons of the first 20 years of the epidemic were not learned, or were not applied effectively. It will be because, collectively, there was insufficient political will to change behaviour (at all levels, from the institution, to the community, to the individual) and halt the forces driving the AIDS epidemic in Africa.

What we do today will change the future. These scenarios demonstrate that, while societies will have to deal with AIDS for some time to come, the extent of the epidemic's impact will depend on the response and investment now. Applying and sustaining the learning of the last 20 years will make a fundamental difference to Africa's future.

Hundreds of people have contributed to building the scenarios in this book. The project has been grounded in a dedicated group of participants from all walks of life, mostly Africans living and working in Africa, who are involved in responding to HIV and AIDS, living with HIV, and dealing with the impacts of AIDS. Their efforts have been supported and supplemented by analysis and comments from other experts in a variety of fields, along with writers and artists, and the contributions of many supporting institutions.

The nature of the scenarios

Each of the three scenarios describes a different, plausible way in which the AIDS epidemic could play out across the whole of the African continent. They are rigorously constructed accounts of the future that use the power of story-telling as a means of going beyond the assumptions and understandings of any one interest group, in order to create a shared basis for dialogue and action about critical and difficult issues.

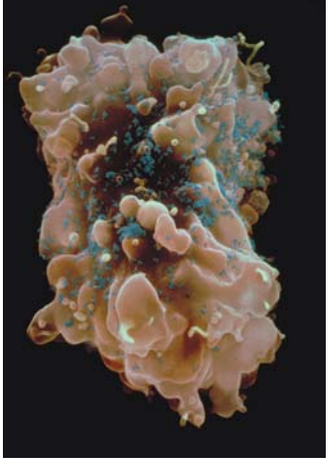
The epidemiological descriptions are explicitly not projections of what will happen. Rather, each scenario is illustrated by a model, based on one of three assumptions:

1. **'Traps and legacies' extrapolates current trends until 2025.**
2. **'Tough choices' applies the trajectory of the most successful response to date (Uganda), adjusted for respective national levels of the epidemic.**
3. **'Times of transition' illustrates what might occur if a comprehensive prevention and treatment response were rolled out across Africa as quickly as possible.**

Each scenario is also illustrated by regional epidemiological stories.

Similarly, the HIV- and AIDS-specific programme costs of each scenario are illustrative, and have been costed using the knowledge that has been built up over the last decade about the relationship between interventions and outcomes. These costs are also presented regionally.

The scenarios aim to go beyond a description of current events and to uncover some of the deeper dynamics that prompt the spread of the epidemic. These play out in three different ways in the three different scenarios.



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A diverse continent and a diverse epidemic

The scenarios are rooted in the complex and interrelated social, economic, cultural, and medical realities of HIV and AIDS in Africa today. One of the biggest challenges that pan-African scenarios face is the need to reflect the continent's diversity: a continent that encompasses 53 countries and numerous ethnic, religious, and linguistic groups, whose respective boundaries rarely coincide, as well as a wide range of economic and political regimes.

Moreover, the dynamics of the epidemic—indeed the virus itself—are not uniform across the continent. According to the latest UNAIDS estimates, the average HIV prevalence in 2003 in the countries of Southern Africa was 16%, in East Africa 6%, in West and Central Africa 4.5%, and in North Africa less than 0.1%. There are, in effect, a number of different, overlapping AIDS epidemics in Africa, of differing viral subtypes.

This diversity should not be viewed as a barrier to effective action. Rather, it is a source of creativity and rich experience, which presents important opportunities for inter-country learning and sharing across Africa.

Key assumptions and uncertainties

The scenarios project was based on two key assumptions:

- That AIDS is not a short-term problem-whatever is done today, it remains inevitable that AIDS will still be affecting Africa 20 years from now. However, it remains uncertain in what ways, and by how much, Africa's future will be shaped by AIDS.
- That decisions taken now will shape the future history of the continent.

This project does not prescribe what those decisions should be. Instead, it aims to provide a tool to help people make better decisions, by exploring the interconnectedness of social, cultural, economic, and political factors and by identifying—and challenging—the often implicit assumptions that influence their thinking.

The future is fundamentally uncertain, but these scenarios suggest that there are some critical uncertainties surrounding the AIDS epidemic.

1. How is the AIDS crisis perceived, and by whom? If AIDS is perceived primarily as a health problem, or an issue of personal behavioural change, the response will be very different to one where the magnitude of the AIDS epidemic in Africa is perceived to be a symptom of underdevelopment and inequality. It is one thing for governments to define the problem, but if their definition is not shared by their civil societies (or vice versa), the response is unlikely to be coherent. If the problem is perceived in one way by donors, and in another by governments, again, the ensuing action is unlikely to be optimal.
2. Will there be both the incentive and capacity to deal with it? Will the current level of interest in the AIDS epidemic be sustained, and will the incentive and resources available for addressing the epidemic and its impact be commensurate with need?

The different scenarios provide different answers to these questions of perception and illustrate the effects of differing levels of incentive and available resources.

In addition to these 'uncertain elements', there are also some 'predetermined elements' that will influence every possible future: one example is the fact that the population across Africa will continue to grow.

The five critical and uncertain forces driving AIDS in Africa

Five powerful driving forces were identified in the project as being crucial to the future of HIV and AIDS in Africa. These drivers each have their

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own dynamic and operate at many different levels, from the household and community, to the regional and international arenas. In addition, these drivers interact, creating further complex dynamics.

Consideration of these drivers and their interaction provides a powerful analytical tool for examining events in the past and present, and for considering plausible future developments. It is from the interplay of these drivers that the scenarios have been created.

The analysis of the drivers makes it clear that the shape and the extent of the AIDS epidemic is determined by a range of powerful forces, outside of the areas in which HIV and AIDS programmes normally respond. Addressing HIV and AIDS may act as a catalyst for addressing these broader socioeconomic and political dynamics. Equally, addressing HIV and AIDS effectively requires a consideration of these deeper forces.

The five drivers are summarized in the following sections.

The growth or erosion of unity and integration

This driver concerns the extent to which individuals, groups, and nations consider themselves connected. Unity and integration between individuals and their communities form the basis of peaceful, inclusive societies, which facilitate effective implementation of policies and programmes on HIV and AIDS. A perception of connectedness is necessary for the development of global solidarity. Societies will find prevention and care more difficult where: unity is eroding; there are high levels of inequality; or factionalism or ethnic and religious tensions predominate and lead to violence. Alternatively, tackling the AIDS epidemic effectively may contribute powerfully to the growth of national unity, through the creation of a sense of a collective challenge.

The evolution of beliefs, values, and meanings

Beliefs about how HIV is spread and how it can be prevented may be based on particular secular, traditional, or religious systems, or a mixture of all three. These include individual beliefs about personal identity and morality, and about sexuality, illness, life, death, and cosmology. Such ideas will determine whether HIV and AIDS are seen in the framework of transgression, stigma, and punishment, or of opportunity and risk. Cultural and religious leaders have shown that they can influence belief systems to ensure that HIV and AIDS are seen in a more positive light.

The leveraging of resources and capabilities

The struggle against HIV and AIDS is sometimes presented as simply a question of funding. While the scenarios presented here demonstrate that considerably more resources are needed, the issue is also about leveraging what is available to achieve more—especially when resources are limited. Resources include money, leadership, human capacity, institutions, and systems. Alternatively, the scenarios show that resources may become exhausted under the pressures of the epidemic and underdevelopment. Funds could be dissipated in short-term, conflicting initiatives, with little long-term benefit. The scenarios demonstrate that a remarkable window of opportunity is opening up and that it needs to be taken advantage of now. Making the money work, including through increased coordination, will be a critical part of mobilizing more resources, both domestic and international.

The generation and application of knowledge

New knowledge—and new ways of applying existing knowledge—about the virus and its spread will be crucial. The greatest impact is likely to come from combining three aspects: biomedical knowledge; a better understanding of sexual behaviour; and knowledge about the effects on

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people living with HIV and AIDS and those who care for them. Approaches that combine traditional and modern views of the world are already being developed, and will continue to be crucial to reaching broader population groups.

The distribution of power and authority

This driver describes the different ways in which power and authority are distributed in society and how they may interact with each other. It asks who has power in any given situation and whether power is centralized or shared. This driver relates particularly to the importance of gender and age in the impact of, and response to, the epidemic.

The scenarios

The scenarios initially set out to answer one central question: "Over the next 20 years, what factors will drive Africa's and the world's responses to the AIDS epidemic, and what kind of future will there be for the next generation?" In answering this question, the scenarios pose two related questions: "How is the crisis perceived and by whom?" and "Will there be both the incentive and capacity to deal with it?" The responses to these questions lead us into the three scenarios:

- ***Tough choices: Africa takes a stand;***
- ***Traps and legacies: The whirlpool;***
- ***Times of transition: Africa overcomes.***

Each scenario proposes very different answers.

Tough choices: Africa takes a stand

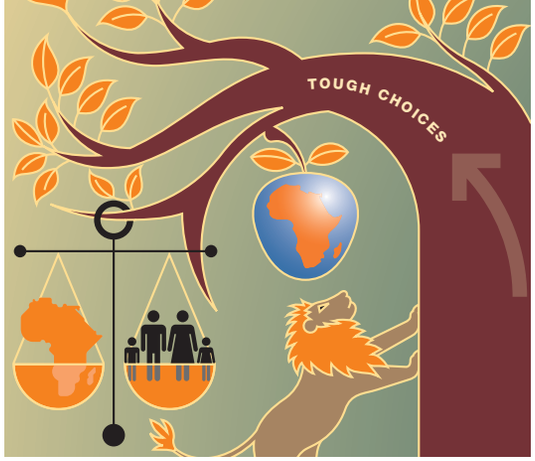
'Tough choices' tells a story in which African leaders choose to take tough measures that reduce the spread of HIV in the long term, even if it means difficulties in the short term. This scenario shows that, even with fluctuating aid, economic uncertainty, and governance challenges, collectively, Africa can lay the foundation for future growth and development, and reduce the incidence of HIV.

'Tough choices' is told as the script of a documentary film made in 2026, including observations by a range of African leaders and experts. It describes the tough economic, social, and ethical choices that leaders and governments have to make in order to generate national renewal. The scenario does not describe a time of abundance for much of Africa. In this context, skilful governance is of the utmost importance, and the development of regional and pan-African institutions assumes key importance as well.

In this scenario, governments insist that HIV and AIDS are tackled as part of an overall, coherent strategy for national medium-term and long-term development. They impose discipline on themselves, each other, and their external partners (if they refuse to take this on themselves) and demand that action match rhetoric.

The scenario identifies a series of tough choices and careful balancing acts.

1. The interests of the state as a whole versus those of individual communities, and individual rights versus the collective good. Inevitably, this includes managing dissent.
2. Immediate economic growth versus longer-term investment in human capital.
3. Choosing how to target resources—should the priority be to rapidly develop the skills and capacity of a minority essential for building and maintaining the functions of the state, or should most resources be spent on services for all and alleviating general poverty.
4. Navigating between helpful and risk-enhancing cultural traditions.
5. Balancing nation building with strong regional and pan-African alliances; and freedom from external control with the benefits of external resources.
6. 'Protecting women' versus increasing women's freedom.



7. Determining the focus of HIV and AIDS programming: 'targeting' versus generalized prevention; treatment for key cadres only or treatment for all.
8. The needs of rural areas (including agricultural reform) versus the benefits of urbanization and industrial development.

The scenario shows that it is possible to mount a response in which leaders and communities come together. This can happen with similar levels of resources for stand-alone HIV and AIDS programming to those used by Uganda in the 1980s and 1990s, although with only moderate levels of antiretroviral therapy included. The scenario demonstrates that an early and rigorous approach to prevention will pay dividends, although it will take a while for these dividends to become evident.

Population growth means that, even with considerable efforts in prevention, the number of people living with HIV and AIDS will continue to grow, but by 2025 numbers will fall to levels similar to what they are today and continue to fall as long-term investments in social, economic, and human capital over the two decades begin to pay off.

While the main HIV and AIDS programme effort in 'Tough choices' focuses on prevention, there is some scaling up of antiretroviral therapy: from less than 5% treated at the start of the scenario to just over one third of those who need it by 2025. The trajectory of antiretroviral therapy roll-out is steadily upwards, reflecting the continued investment in health systems and training, as well as drugs manufacturing capacity within Africa.

There continues to be a high number of deaths in the 'Tough choices' scenario—though the rate begins to fall by 2015, reflecting the fact that prevention measures take time to work through the system. Initiatives in support of children orphaned by AIDS are increased rapidly in the years to 2010 and then keep pace with population growth. Nonetheless, the number of children orphaned by AIDS almost doubles over the course of the scenario.

Overall, total HIV and AIDS spending grows rapidly in the years 2003 to 2013, followed by a more moderate rate until the end of the scenario. Much of the increase in costs comes from greater spending on prevention activities, which scale up rapidly between 2008 and 2014. Costs for care and treatment grow slowly in the early half of the period, then more rapidly in later years, as systems and capacity are put in place for a sustainable roll-out.

The total cumulative HIV- and AIDS-specific programme costs for this scenario are nearly US$ 100 billion. The scenario builds on the assumption of substantial and sustained donor assistance in the early part of the scenario, followed by a plateau where official development assistance stagnates. Nonetheless, there is a considerable expansion of domestic capacity to take up and sustain the response to HIV and AIDS with funding generated within the Africa region—building on sound domestic policies pursued throughout the scenario. Annual spending in this scenario rises to around US$ 5 billion by 2016, and to just over US$ 6 billion in 2025.

Traps and legacies: The whirlpool

'Traps and legacies' is a story in which Africa as a whole fails to escape from its more negative legacies, and AIDS deepens the traps of poverty, underdevelopment, and marginalization in a globalizing world. Despite the good intentions of leaders and substantial aid from international donors, a series of seven traps prevent all but a few nations or privileged segments of the population from being able to escape continuing poverty and continued high HIV prevalence.

This scenario is told as a series of lectures by an acclaimed African author. She explores why

Africa in 2025 still carries a huge AIDS burden, along with widespread poverty and instability. She recognizes that, even in an overall landscape of poverty, there are still those individuals, sectors, and even countries that have done well, but she does not seek to put their stories in the foreground.

The scenario suggests that HIV and AIDS will continue to receive very strong emphasis in the near future—but that responses are fractured and short-term, often fail to reflect the realities of everyday life, and therefore fail to deliver a lasting solution. By 2025 the demographic, social, and economic impacts of the epidemic, repeated over several generations (particularly in countries with an HIV prevalence of over 5%), have depleted the resources of households and communities. A 'missing' generation of grandparents is just one example of the demographic impacts, while a growing number of children orphaned by the epidemic are less skilled, less cared for, and less socially integrated than their parents. Many have little to lose, and perhaps feel they may gain from conflict and instability. The effects of these social impacts spill over into countries with lower HIV prevalence.

The scenario identifies seven traps that preclude effective, long-term, or widespread development in Africa.

1. The legacy of Africa's history (post-colonialism has been unable to overcome deep divisions).
2. The cycle of poverty, inequality, and disease (rising populations put pressure on inadequate social sector infrastructure, and AIDS further depletes capacity).
3. The divisions rupturing society (scarcity promotes division, and AIDS and stigma feed off division).
4. The quest for swift dividends (African leaders and their donor partners want to show quick results, so are unable to invest in long-term change).
5. The challenges of globalization: integration and marginalization (trade rounds and reducing foreign investment fail to benefit Africa, whose formal economy is left to rely on a narrow primary export base).
6. Aid dependency and the quest for global security (aid donors fail to live up to the rhetoric of harmonization and the so-called global war on terrorism spills over into Africa, determining donor funding patterns).
7. Responding to the AIDS epidemic: shortcuts and magic bullets (the scramble to roll out antiretroviral therapy leaves few lasting benefits and prevents the much needed scale-up of prevention).

'Traps and legacies' describes how AIDS does catalyse people and institutions into a response, but they cannot make sufficient headway with depleted capacities and infrastructure. The additional burden of responding to the AIDS epidemic detracts from other development efforts—continuing underdevelopment in turn undermines the ability of many countries to get ahead of the epidemic. The scenario shows growing disunity and disintegration, diminishing capacity, ongoing ethnic and religious tensions, and wasted resources, with (initially) abundant funding supporting a growing so-called AIDS industry alongside a discourse of blame and punishment around the epidemic. It shows how, despite good intentions, the epidemic will simply continue across many countries and populations in the continent as:

- HIV is seen in isolation from its root social, economic, and political context, is medicalized, and is treated primarily as an issue of individual behavioural change or personal treatment;
- Resource provision is as inconsistent and unpredictable over the next 20 years as it has been over the past 20;
- African countries fail to translate aspirations of pan-African unity into effective reality;
- Donors do not harmonize their responses;
- Aid is volatile and of poor quality, and AIDS

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funding continues but in the absence of deeper investments in social and economic development;

- It is easier to get antiretroviral drugs than adequate nutrition and clean water;
- The realities of human behaviour are denied; and
- The root causes of poverty are not addressed.

In this scenario, across the continent by 2025, HIV prevalence remains similar to today, at around 5% of the adult population, with some countries above, or below this level. The high prevalence rate translates into continuing reduced life expectancy across many countries, and an increase in the number of people living with HIV and AIDS of more than 50%. Prevention efforts are not effectively scaled up—although the level of services achieved in 2004 is maintained and expanded, it only grows at the same rate as the population.

Efforts to roll out antiretroviral therapy continue, but are impeded by a combination of underdeveloped and overwhelmed systems, and overall cost. By 2015 a little over 20% of people who need antiretroviral therapy have access to it and this figure stubbornly refuses to budge for the rest of the scenario. Care and treatment for a minority still costs an average of US$ 1.3 billion per year over the 23 years of the scenario. By 2025 this scenario is still costing US$ 4 billion per year in HIV- and AIDS-specific programme costs—just to keep service provision at the level that it is today. Because there is a failure to get ahead of the epidemic in terms of prevention, the costs continue to rise, and this rise continues into the foreseeable future.

'Traps and legacies' offers a disturbing window on the future death toll across the continent, with the cumulative number of people dying from AIDS increasing more than fourfold, and the number of children orphaned by the epidemic continuing to rise beyond 2025.

Times of transition: Africa overcomes

'Times of transition' is the story of what might happen if all of today's good intentions were translated into the coherent and integrated development response necessary to tackle HIV and AIDS in Africa.

The scenario is told as an account by a storyteller and some of her friends, as they look back from 2036 at the changes that took place in the first quarter of the twenty-first century. This scenario is about the transitions and transformations that must take place in the way in which the world and Africa tackle health, development, trade, security, and international relations, in order to achieve the goals of halving the numbers of people living with HIV and AIDS and ensuring that the majority of those who need antiretroviral therapy have access it by 2025.

A set of six interlocking transformations reshaping Africa's future, and its place in the world, is identified in the scenario:

1. 'Back from the brink' describes changes in how HIV and AIDS are dealt with, with a rapid roll-out of treatment and effective prevention strategies, supported by a very active civil society.
2. 'Setting the house in order' focuses on national policy responses to reduce poverty and spur development, crucial for limiting the spread of HIV.
3. 'Working together for development' investigates the improved collaboration between African governments and their external partners over the first quarter of the century, as resources are increasingly owned, directed, and coordinated by African governments and their people.
4. 'Trading on strengths' details the key changes that have taken place in global trade.
5. 'Human hearts and human rights' describes the people at the core of the scenario and the ways in which they have changed—including powerful

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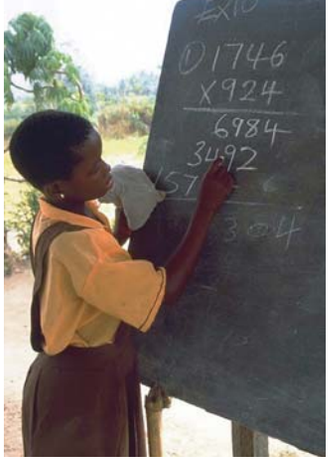

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changes in the ways women and men relate to one another and to their communities.

6. 'Planting peace' describes how the prevention of conflict and promotion of peace and security, both within and between countries, has been a vital part of the new African agenda for the twenty-first century.

These transitions begin with a growing perception of crisis: the AIDS epidemic acts as an overarching symbol of many other problems facing Africa and the world in this scenario, including the potential collapse of the regulation of world trade; the failure to meet the Millennium Development Goals; continuing global inequality; the undermining of the multilateral order; the growth of terrorism; and urgent evidence of continuing climate change. The prospect of another century of conflict and impoverishment drives changes in attitudes, values, and behaviour—catalysed by civil society as much as by state leadership.

Transitions in the delivery of aid, in the rules around trade, in addressing human security, and in national and international governance are fundamental, leading in time to a more stable world, with benefits for the global North and South. There is a doubling of aid flows to Africa, sustained for a generation, with investments in health systems, agriculture, education, electrification, water, roads, social development, and institutional and governance capabilities. 'Times of transition' describes fundamental changes in the ways donors provide aid and the ways governments deal with that aid so that it promotes sovereignty, does not undermine autonomy, is not inflationary, and does not promote dependency.

This scenario describes a mobilization of national and international civil society. It begins with treatment activists working towards the safe delivery of antiretroviral therapy, and leads to a gradual broadening of civil society concerns, skills, and engagements. It describes new roles and partnerships for international business. The story suggests that, if these transitions could be made in a generation, they could dramatically reduce the number of people infected with HIV. They could fundamentally alter the future course of Africa, and the world, in the twenty-first century.

In 'Times of transition', the number of people living with HIV and AIDS almost halves between 2003 and 2025, despite the fact that the population grows by 50%. The gender bias in infection and prevalence begins to even out, though women are still slightly more adversely affected at the end of the scenario.

The scaling up of antiretroviral therapy is dramatic: over the course of the scenario, access expands rapidly, to reach almost half of those who need treatment by 2012. By the end of the scenario, coverage has increased to 70%—reflecting the fact that expanding care beyond the capacity of existing health systems will be a time-consuming and painstaking process.

Despite lengthened lives due to antiretroviral therapy, total cumulative deaths on the continent continue to rise, leading to a steady increase in the number of children orphaned by AIDS, although the longer life-spans of parents has made a significant difference in the socialization of many children.

Achieving this scenario requires cumulative investments of nearly US$ 200 billion, in the context of greater overall investments in health, education, infrastructure, and social development. HIV- and AIDS-specific funding is increased at a average year-on-year rate of more than 9% and spending is most rapid in the early phases, with external donors covering approximately half of the overall costs. Spending reaches US$ 10 billion per year by 2014 and remains at this level until near the end of the scenario when it begins to tail off, reflecting the fact that earlier investments are paying off.

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The important message of this scenario is that early expenditure, with a continuous growth in prevention spending, means that the care and treatment budget can begin to decline as early as 2019, as the total number of people living with HIV and AIDS begins to fall.

Implications and learning from across the three scenarios

Taken as a set, the three scenarios introduce some important considerations for activists, policy-makers, programme-planners, and those implementing actions to take into account as they think about the future.

- A sufficient response to the epidemic is still not guaranteed: reversals in the current level of interest are still possible and everything must be done to prevent AIDS fatigue. The scenarios suggest that, while the worst of the epidemic's impact is still to come, there is still a great deal that can be done to change the longer-term trajectory of the epidemic and to influence the overall numbers of people who the epidemic will affect. Nonetheless, mortality rates in some countries, even with high rates of antiretroviral therapy roll-out, will continue to increase for a while and policy-makers need to prepare for this impact. Rapid and substantial investments in prevention will mean that these mortality curves begin to decline sooner rather than later.
- How the crisis confronting Africa is defined, and by whom, will make a fundamental difference to the outcome of tackling the crisis: leadership in the response to HIV and AIDS is vital—but strong leadership must be backed with institutional capabilities and resources, systems capacity, and effective public policy responses. 'Traps and legacies' makes it clear that leadership on its own is not enough.
- Local decentralized responses are critical: it is vital to include local culture, values, and meanings in shaping policies. Religious identity is also likely to play a major role in the future of the continent and the epidemic. However, effective responses will only be achieved by effective engagement and support from the centre.
- In the face of a crisis that manifestly exceeds the current capacity to respond, not everything can be done at once. 'Traps and legacies' demonstrates what happens if there is little or no time for reflection on the extent of national or international capacities because events are moving too fast, results are needed too quickly, and the priorities of stronger individuals, countries, or institutions dominate. 'Tough choices' demonstrates that, when resources are limited, governments need to take difficult decisions, but that skilful choices will pay important dividends. 'Times of transition' suggests that if African countries and the global community continue to expand the response to the epidemic, in the context of a broader development response, it will make a fundamental difference to the number of people living with HIV and AIDS in 2025.
- There is no magic bullet: just as the causes of HIV and AIDS are complex, so are the responses. There is no single policy prescription that will change the outcome of the epidemic. HIV and AIDS is a long-wave event, and needs consistent policy responses over several terms of government. Rapidly fluctuating policy responses will do nothing to stem the epidemic. It is essential to develop both short-term pragmatic solutions and long-term strategic responses. Working on both is critical to a successful outcome.
- The range of actors involved in tackling the

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AIDS epidemic will make a fundamental difference to the outcome. 'Traps and legacies' plays out a relatively limited cast of characters and actors who do not effectively coordinate their actions; in 'Times of transition', civil society and the private sector play fundamentally important roles; in 'Tough choices' governments play a key role, but also stimulate leadership at all levels of society.

- Women's social, economic, and physiological vulnerability to HIV is well understood, but the policies and actions that might best protect them have not been well implemented. In tackling HIV, it is important to go beyond a narrow focus on women's risk of HIV exposure. Measures to improve the status of women are also needed, such as universal education for girls; reducing violence against women; and ensuring that women have equal access to property, income, and employment. Effectively addressing the gender issues that lie at the heart of the AIDS epidemic would have immense transformative power, catalysing social, economic and political reforms.
- Until now, the resilience of communities to care for orphaned children has been considerable, but the ongoing, recurrent, and cyclical nature of the AIDS crisis means that this resilience may be worn away. More long-term alternatives need to be planned now. The scenarios show how investing in children as a resource for the future, and in keeping their parents uninfected and alive, contributes significantly to the overall outcome of the epidemic.
- The psychological impact of the epidemic has, in the main, been poorly addressed. Mental health as well as physical health must be included in treatment, care, and prevention plans.
- The death toll will continue to rise, no matter what is done. These scenarios explore the space between the best that can be done in terms of averting infections and saving lives, and what might happen if current trends continue. However, even if the best that can be done is done, communities across Africa will still face major challenges over the next 20 years.

Comparing key issues across the three scenarios

HIV and AIDS programmes thus far have been predominantly resourced with external funds and this trend looks as if it will continue for many years to come. However, most commitments do not extend beyond the next five years, and uncertainty remains about the level of resources that will be available in the future. 'Tough choices' shows what is possible when there are efficient domestic policies but stagnant external aid; 'Times of transition' shows what might happen if there are more efficient domestic policies and increased and high quality external aid; and 'Traps and legacies' shows what might happen if there are inefficient domestic policies and volatile or declining external aid.

Exceptionalism versus isolationism

A line must be drawn between treating HIV as an exceptional disease (exceptionalism) and paying attention only to HIV (isolationism).

In 'Tough choices', the AIDS epidemic is seen as part of a wider crisis of African underdevelopment, and actions are taken by each nation—within relatively limited domestic and external resources—to tackle underdevelopment and to find development models that suit their particular needs and environments.

Figure 2 **Potential outcomes for the scenarios (compared with 'Traps and legacies'), adults and children, 2003–2025**

Indicator	Scenario: Tough choices	Times of transition	Traps and legacies
Cumulative programme cost (US$ billion)	98	195	70
Cumulative deaths from AIDS (1980–2025, million)	75	67	83
Cumulative new infections (million)	65	46	89
Cumulative infections averted (million)	24	43	Baseline:0
Incremental cost per infection averted (US$)	800	1 160	Baseline:0
Incremental cost per QALY saved (US$)	20	29	Baseline:0

Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva, (historical data) and UNAIDS AIDS in Africa Scenarios Project.

In 'Times of transition', the AIDS epidemic acts as a catalyst, helping people and institutions across the world to perceive the wider international peace and development crisis. AIDS engenders an exceptional response, but it is not treated in isolation from its wider social and economic context. The funding for AIDS takes place in the context of much a much wider developmental response.

In 'Traps and legacies', HIV is treated as the object of interventions, in isolation from its social and economic context. Because of the emphasis on antiretroviral therapy, the overall response is medically focused: HIV and AIDS are treated as a medical emergency and they capture much of the additional aid that goes to Africa between 2004 and 2010, diverting resources and capacities from other areas. There is no sustained investment in infrastructure, or in the structural and development issues that fuel the epidemic—including gender relations, poverty reduction, or cultural issues.

Resource needs and utilization

The scenarios make it clear that it is not only how much that is spent on HIV and AIDS programming that counts, but how well it is spent and the context in which it is spent. They show that major increases in spending will be needed to produce significantly better outcomes in terms of curbing the spread of HIV, extending treatment access, and mitigating impact—but that more resources without effective coordination and an improving context may do more harm than good. Major funding increases may serve to drive a so-called AIDS industry, rather than to drive a massively improved response.

Figure 2 shows the respective costs and outcomes of the three scenarios.

Compared to 'Traps and legacies', 'Times of transition' achieves the better outcomes, averting 43 million new infections, while 'Tough choices,' which averts 24 million new infections, has a lower incremental cost per infection averted and quality-adjusted life year (QALY) saved. In pursuing universal goals, 'Times of transition' increases in cost, while 'Tough choices' covers the 'easier to reach' prevention cases. However, beyond the narrow calculation of relative cost-effectiveness, there is a far broader and longer-term social and economic benefit implied by the broad, concerted response to HIV and AIDS of 'Times of transition'.

Average annual spending in 'Times of transition' by 2025 will be almost US$ 11 billion, nearly three times the level of 'Traps and legacies', and twice that of 'Tough choices'. Outcomes will diverge dramatically: in 'Times of transition', the epidemic will have largely subsided; in 'Tough choices', the end will be in sight, but not yet achieved; and in 'Traps and legacies' it will continue to be a clear and present danger.

Using the scenarios

Developing scenarios is only a first step: they are more effectively explored and applied through interactive processes that encourage users to reflect on their individual and collective assumptions and understanding.

With these scenarios, the project hopes to achieve the goals outlined below. With this book and the accompanying CD-ROM, it is hoped that the reader can also achieve similar goals.

1. Raise understanding of HIV and AIDS and the forces shaping their future in Africa.
2. Raise awareness of (and possibly challenge) the perceptions, beliefs, assumptions, and mental maps held about the AIDS epidemic and its possible future.
3. Increase mutual understanding between

various stakeholders, through the creation of a common language for discussions about HIV and AIDS in Africa.

4. Raise awareness and understanding of the factors, drivers, and fundamental uncertainties (and the systemic relationships between them) that determine the HIV and AIDS future(s).
5. Raise awareness of dilemmas posed and choices that may need to be made.
6. Identify what gaps need to be addressed and in what sequence, in order to get any organization or country from where they are now to where they want be.
7. Generate and develop plans, strategies, and policies, and test or challenge the validity and robustness of any vision or strategy.
8. Analyse specific situations for a given country or region for specific risks and opportunities.
9. Provide a backdrop to a specific story that needs to be told, and create passion and support for a specific policy.

For those who want to explore further, the accompanying CD-ROM contains most of the material commissioned for the project, both research papers and interviews, searchable by keyword. It also provides detailed reports of the project workshops and a number of presentations, which can be used to present the scenarios.

In conclusion...

To build scenarios is to engage with time: the drivers of the present and the future, and the legacies of the past. Time has different meanings in the three scenarios.

'Tough choices' tells that time is intergenerational: that the past matters; the value of ancestors, family history and identity profoundly shapes the present; and actions in the present are consequential not just for those alive today, but for those generations yet to come.

In 'Traps and legacies', time is short, returns need to be immediate, targets are time-bound, and action is measured out in political terms of office. Long-wave events such as HIV and AIDS do not respond well to such short-termism.

'Times of transition' tells us something about the depth of time, rather than just its length. The transitions and transformations envisaged could take generations if they occurred consecutively. But this scenario tells of a world in which leapfrogging and synergy are dominant metaphors; where rapid progress against the epidemic is possible because it rides on the back of other transitions taking place simultaneously.

Development processes too rarely take account of time, other than to measure it out in conventional three-year or five-year cycles. Scenarios allow an engagement with a bigger picture, in terms of both the length of time considered and its depth. They allow an engagement with more dimensions of a problem, and provide a fuller canvas to explore. While the value of these scenarios will only be realized if they are widely communicated, debated, and used, what is offered here is a starting point for that process.

Above all, these scenarios tell us that, while on the one hand, any action is already too late for the millions who have died from AIDS, on the other hand, there is still time to change the future for many, many millions more.

Scenarios and their power

“It is the story that outlives the sound of war-drums and the exploits of brave fighters. It is the story... that saves our progeny from blundering like blind beggars into the spikes of the cactus fence...
–Chinua Achebe, *Anthills of the Savannah*.

Between now and 2025, profound uncertainty exists about how the AIDS epidemic will develop and the extent of its impacts. For Africa, what happens over the next 20 years and beyond will depend on actions and decisions taken today, both on the continent itself and in the rest of the world. Making and implementing those decisions will not be easy.

Heritage, culture, experience, training, education, religious beliefs, and fashions—all these areas shape people’s perspectives on, and interpretations of, the world. These influences can help us to focus. They can also create blind spots and prejudices, making it difficult for us to value a different point of view, or comprehend a fact that challenges our underlying assumptions. This is particularly true if we are deeply attached to our assumptions. In the case of HIV and AIDS, there are many myths about the reasons for the spread of the epidemic in Africa and the ways to tackle it.

We each need to look beyond our own assumptions and understandings to encompass other relevant perspectives.

Valuable stories

“Before shooting, one must aim.
–Ethiopian proverb.

Across the world, every culture has a story-telling tradition, which is used to make sense of the world and to pass that understanding on from generation to generation. Stories are mines of information, rich in memories and history. Couched in a story, lessons touch their audience at many levels: while the narrative explicitly relays the plot and sways the emotions, it also reaches into the unconscious. Stories raise and answer questions about meanings and values.

Scenarios are rigorously constructed, imaginative stories about the future. The scenario stories and the process of creating them are intended to help people think more deeply and freely about complex, poorly defined, or intractable problems. The story form provides a structure within which to think about decisions and their possible impacts. The process of creating the scenarios encourages people to challenge their usual views and use their imaginations to explore what might happen and how they might act.

Rather than seeking a single point of view, scenario building encourages the involvement and integration of a wide variety of ideas, drawing on the experience and perspectives of a large number of people. The process combines the strengths of analytical and intuitive approaches. As well as including what is commonly accepted or disputed, it focuses on exploring areas that are felt to be critical, but whose outcome is more uncertain.

To better reflect real life, a set of scenarios should span the range of positive and negative aspects, revealing the challenges and opportunities inherent in its events. The point of such an exercise is not to design the perfect future, but to explore the lessons that each possible future can supply and illustrate how our choices may shape the future.

Scenarios are a valuable tool: they can be used for thinking and talking with others about current decisions and future policies; for weighing up risks and opportunities; and for considering the implications of, and responses to, events. They are not just for individual use, but can be used across different groups to promote shared understanding and to provide a common frame of reference and shared language.

Process and terms

The first step for participants in a scenario process is to try to build a common understanding of the problem confronting them. This is fundamental, yet difficult, because everyone has a unique view of the world.

4 From stories to scenarios

Starting from the different branching points, the participants use their insights about the driving forces to weave a number of plausible stories about the future—the scenarios. In recognition of the fact that there is no single correct description of the future, scenarios are built in sets. Typically, a single scenario-building exercise will create between two and four scenarios.

5 Agreement

Perhaps the most fundamental challenge, especially with large groups of scenario builders with diverse views, is to agree on which, and how many, scenarios to develop. Ultimately, there must be agreement about which scenarios are plausible and will be most usefully challenging.

3 Branching points

By exploring the focal question and the interactions of the driving forces, participants reach the key 'branching points' of their stories. Each branching point provides a different answer to the focal question—and has different implications for the original problem. Branching points will provide the essential differences between the scenarios—providing a specific context in which the driving forces must play out.

2 Driving forces: predetermined and critical uncertainties

Participants then identify and explore 'driving forces'—the crucial factors and trends that are shaping the problem. They consider what direction these forces might take, and how they might interact. The outcomes of some of these forces will be predictable—and these forces can be described as 'predetermined'. Other forces are highly uncertain and may have a significant impact on how the future looks—these are called 'critical uncertainties'.

1 The focal question

Rather than driving to consensus, the process encourages the engagement of as many different perspectives as possible. This will then create as comprehensive and detailed a picture as possible of the range of issues and challenges that need to be addressed. The participants then collectively summarize what they all want to know in a 'focal question' that outlines a broad definition of the major challenges confronting them.

Section 2 Starting points

30 The virus and its impact
30 The spreading epidemic
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32 Responses to AIDS
32 National responses
33 International responses
34 Africa: a vast and diverse continent
34 Countries and cultures
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36 Population, movements, and connectivity
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44 People living with HIV
44 Mental health and stigma
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> **Before one cooks, one must have the meat.**
> —Niger proverb.

Section 2 Starting points

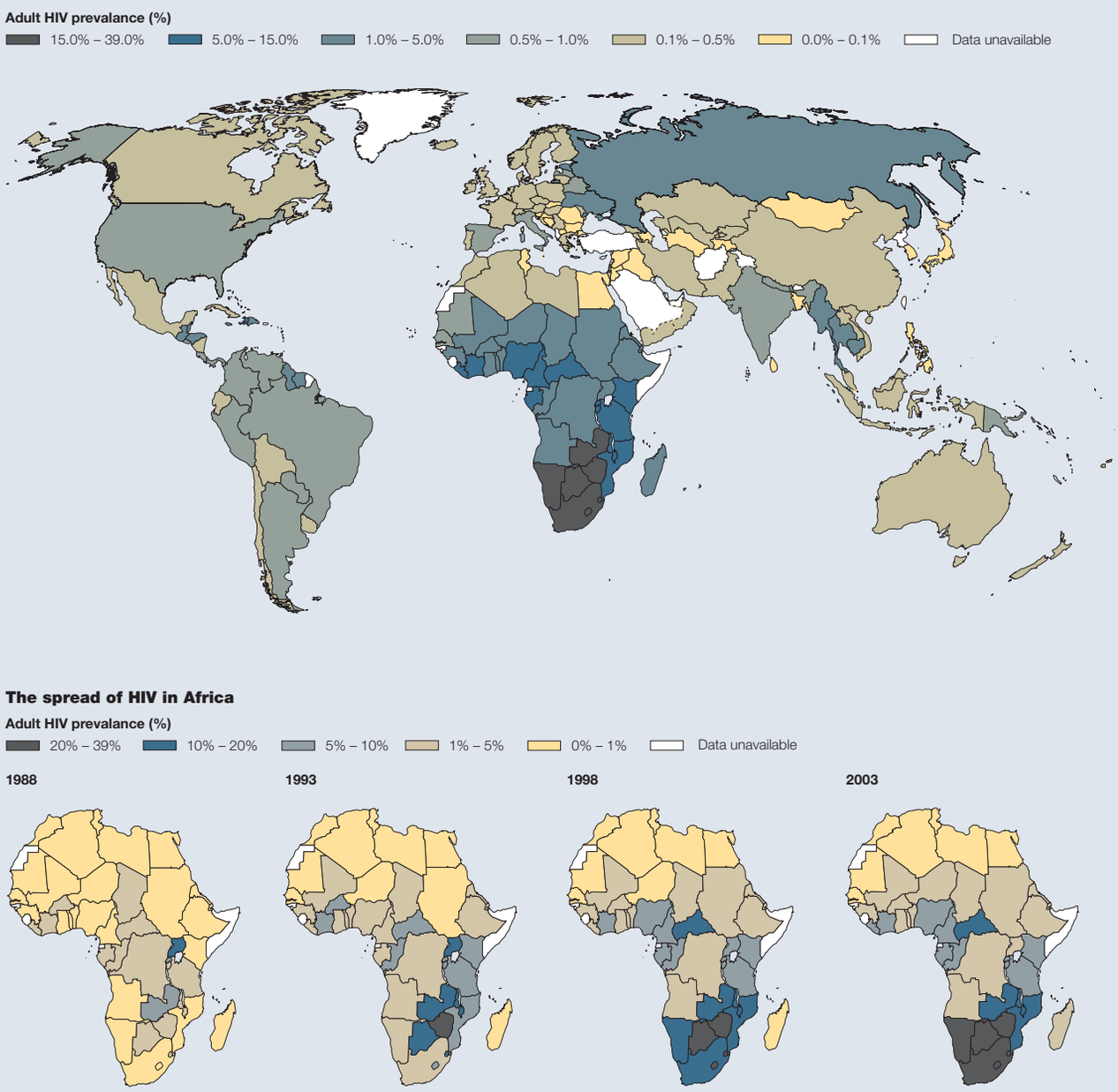
According to UNAIDS, between 35 million and 42 million people are living with HIV and AIDS across the world[1]. Around 25.5 million of them live on the African continent, where, so far, more than 13 million people have already died from AIDS (2.2 million in 2003 alone), and 12 million children have lost at least one parent to AIDS. HIV prevalence rates among young pregnant women (aged 15–24) in capital cities are greater than 10% in 11 African countries, and rates exceed 20% in five countries, all in the southern region of the continent. In countries in North Africa, over 91 000 people are living with the virus, and 11 000 have died (2 700 in 2003)[2]. Homes, villages, organizations, and societies have been visibly depleted.

HIV has been able to spread because, in order to replicate, it exploits one of the most complex areas of human life: our sexual relationships. These relationships in turn are shaped by our knowledge and beliefs, our customs and habits of authority, as well as the basic economics of individual lives.

As many of the participants involved in this project have emphasized, transmission of HIV happens because of the choices that individuals perceive they have—or do not have—and the actions they take as a result.

We know that a lack of economic development means few or no resources; that a lack of effective governance reduces the opportunities for effective HIV prevention or the maintenance of social safety nets; that these factors exacerbate the spread of HIV infection; and that these factors are exacerbated by the spread of the virus itself. Indeed, in some countries, AIDS actually helps to create the very social, political, and economic conditions in which the epidemic thrives—creating a vicious, downward spiral[3].

Figure 3 **A global view of HIV infection**



Source: UNAIDS (2004) *2004 report on global AIDS epidemic.* Geneva.

The virus and its impact

The spread of HIV has not been uniform—not all countries and not all sectors of society have been equally affected. The AIDS epidemic in Africa is in fact multiple epidemics in multiple places; in some places on the continent it is still in its earliest stages.

The spreading epidemic

The prevalence of HIV is different for men and women at different ages, and different for rural and urban populations. HIV prevalence probably also varies between rich and poor, educated and uneducated, employed and unemployed, but there are few statistics available so far that offer such breakdowns.

HIV prevalence rates across the continent vary widely. Southern Africa is most severely affected, with more than 16% of its adult population HIV-positive (2003). Average levels of prevalence are lower in East Africa (6%) and West and Central Africa (4.5%), and much lower in North Africa (under 0.1%)[4]. Depending on the context, these variations produce different economic impacts.

Regardless of these variations, the number of people living with HIV across Africa continues to grow. The combination of increasing overall population size and the large numbers of AIDS deaths means that HIV prevalence is stable in most countries of sub-Saharan Africa, although it's still rising in a few, such as Madagascar and Swaziland, and declining nationwide in Uganda. The AIDS epidemic has also led to a resurgence in the incidence of TB: one third of Africans now carry a latent TB infection—if they are also infected with HIV then many of them will develop active TB disease. Each year, 5–10% of those co-infected with TB and HIV develop active TB and up to 50% will develop the disease at some point in their lives.

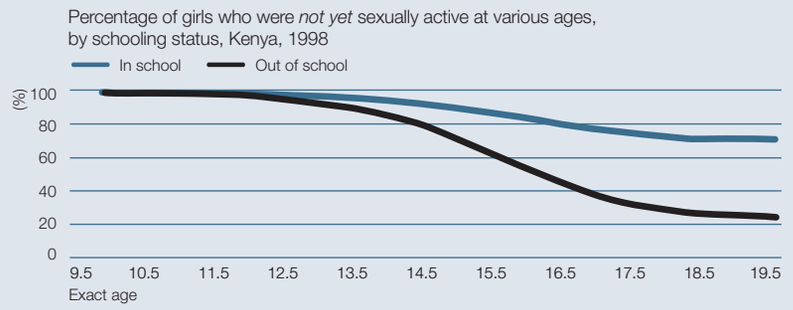
In the earlier period of the epidemic, the best available treatment was limited to dealing with the opportunistic illnesses that are a consequence of HIV infection. Effective antiretroviral therapy became available in high-income countries from the mid-1990s, but access in Africa was limited to small wealthy population sectors, with the exception of relatively small-scale public sector and NGO-supported programmes in some countries, including in North Africa where HIV numbers are relatively low and health infrastructures have greater capacity than in sub-Saharan Africa.

Whether treatment is in the Western or local African tradition, the first reaction of most families in Africa has been to care for those who were falling ill. To pay for treatment, poorer households have reduced their consumption, used up their savings, borrowed money, sold assets, and taken children, particularly girl children, out of school in order to save money and provide care or other support to the family[5]. This creates a negative feedback loop, as education has a 'protective effect' against HIV.

Many programmes have concentrated their efforts on preventing the spread of HIV infection. Early efforts sought to change sexual behaviours—the main path of transmission of HIV in Africa—by increasing people's knowledge of the disease and changing their attitudes towards it. Frank talking from society's leaders has proven to be especially successful. Similarly, campaigns, slogans, testing, and counselling services have all multiplied.

Yet still the epidemic has grown. Faced with a disease that is both deadly and hard to control, many have preferred to deny its existence and to stigmatize those who have the infection. These attitudes, combined with a lack of access to treatment services, help to explain why an estimated 95% of men and women across Africa do not know their HIV status[6].

Figure 4 **Education is a protective factor**



Source: Adapted from DHS and UNICEF.

The impact of AIDS

The AIDS epidemic has affected every aspect of life in Africa, from people's livelihoods to the capacities of nation states. Its deepening impact has been a key policy concern of many national and international bodies. Here, we outline some of the major aspects of the impact of AIDS[i].

Livelihoods

A study of AIDS-affected households in Zambia shows that in two thirds of families where the father had died, monthly disposable income fell by more than 80%[7]. A similar study in Côte d'Ivoire found that income in AIDS-affected households was half that of the average household[8]. In Botswana, where the infection rate is exceptionally high, per capita household income for the poorest quarter of households is expected to fall by 13% over the next 10 years, while every income earner in this category can expect to take on four more dependents because of AIDS[9].

Families

AIDS can also cause a family to fall apart. A survey carried out in two districts in Zimbabwe in 2000 discovered that 65% of households that had lost an adult woman had disintegrated and dispersed[10]. After the death of their parents, surviving children may be fostered by grandparents, other older female relatives, or sent to live with another part of the extended family. These children are less likely to attend school and are more likely to be working more than 40 hours a week than children with both parents, especially if they are fostered by distant relatives or unrelated people. Some children end up on the street, where they are particularly vulnerable to extreme poverty and exploitation[11].

Psychological impacts

HIV and AIDS affect relationships, the processes of decision-making, and attitudes to risk and uncertainty. Paradoxically, while the disease can lead to anxiety or depression, it can also lead to the discovery of new courage and focus[12].

Even with courage and focus, as the viability of households is compromised, community resilience can be undermined, especially where a community withdraws its support from the sick or dying, offering instead only blame and discrimination. Not all communities react this way, however. When an individual, especially someone with high status, is open about his or her own infection, fear and stigma in the community can be diminished, creating greater social cohesion, solidarity, and trust.

Public sector services

More broadly, many fear that HIV and AIDS will increasingly reduce the ability of state and civil society actors to provide essential goods and services. In Uganda and Malawi, nearly one third of all teachers are HIV-positive[13]. In Kenya, Uganda, Zambia, and Zimbabwe, the epidemic is expected to significantly contribute to future shortages of primary school teachers[14]. Even if people with the requisite skills can be found, the disruptions of illness, absence, and retraining will hamper the operational effectiveness of state institutions.

Health care

Health care is a doubly vulnerable public service. UNAIDS has estimated that, in some countries, illness and death rates among health workers have increased five- or six-fold as a result of AIDS[15]. This loss of skilled people comes at the same time as the demand for health care is rising, and when many African health systems are characterized by broken delivery infrastructure; inadequate human resources; poorly defined services, functions, skills, and protocols; and weak management and administration. These are circumstances that contribute to the incentive for trained professionals to leave African countries for better opportunities elsewhere[16].

[i] More comprehensive analyses can be found in UNAIDS (2004) *2004 Report on the global AIDS epidemic: 4th global report* and UNAIDS (2003) *Accelerating action against AIDS in Africa.*

UNAIDS/L. TAYLOR

Agriculture and labour

Some studies argue that agriculture and food security may be severely reduced, especially amongst the poorest rural populations, as illness forces people to work less, lowering the output of their subsistence farms[17]. However, the extent to which communities are able to overcome these impacts and adjust their long-term economic or food-gathering strategies is not known. For example, some studies have found that a fall in production was followed by a subsequent increase as households replaced the lost labour with that of relatives. No one knows what pattern of impact will show in the future[18].

The International Labour Organization projects that losses from the labour force in Namibia will rise from 3% in 2000 to 26% in 2020; in Botswana from 6.6% to 23.3%; in Zimbabwe from 9.6% to 22.7%; and in Mozambique from 2.3% to 20%[19]. In the South African mining industry, just under one third of all workers in South African mines will be HIV-positive by 2005[20]. Left untreated, sickness will lead to more absence and less productivity. In response to the growing impact of AIDS, several companies have begun offering antiretroviral therapy to their employees, prolonging lives and reducing the loss of skilled people. It remains to be seen how widespread these private sector initiatives will become and how that might change the economic impact of AIDS.

Responses to AIDS

The AIDS epidemic—and especially its impact on Africa—has mobilized responses at both international and local levels, including pan-African organizations, domestic and global faith-based organizations, and civil society groups across the globe. This concentrated attention on Africa has a range of implications. Some are positive, as more resources are directed towards the continent, and greater attention is drawn to African underdevelopment and the human rights of people living with HIV and AIDS[21].

National responses

The AIDS epidemic has broadened the bounds of public policy debate in at least three ways. First, it has required even greater debate on issues directly related to sexual activity, (more so than in a reproductive health context) and on issues that were formerly the preserve of families or religious organizations. Second, It has required public policy to deal with issues previously considered to fall within the realm of illegality (e.g., sex work and patterns of violence). Third, it has necessitated public policy consideration of matters that were previously seen as determined by market activities or political processes beyond policy, including the structure of social and economic conditions, as well as issues of violence and war.

Successful responses to HIV and AIDS have been seen in a number of parts of Africa for a number of years. In the late 1990s, UNAIDS drew attention to the marked reduction in HIV prevalence in Uganda, and to Senegal's efforts to keep prevalence rates low, as outstanding examples of success in HIV prevention[22]. Characteristics that these national responses share with other successful HIV and AIDS responses include:

- A willingness for public policy to be based on scientific evidence;
- High-level leadership; and
- An appreciation that, because transmission of the virus is related to sexual interaction and to basic social and economic patterns in society, the epidemic has a social character and must be confronted through a multi-sectoral (that is, not a purely biomedical) approach.

UNAIDS/G. PIROZZI

Implementing successful HIV prevention programming and scaling up care and treatment provision require the involvement of a multiplicity of societal organizations. Hence, national and international pressures have impelled governments to work with religious organizations and NGOs. But even the most vibrant mobilization of NGOs will fall short of effective and full-scale responses unless governments also act. Governments need to be in touch with the culture of the people under their jurisdiction. It is necessary for political leaders to understand patterns of sexuality in the population and popular beliefs about sex, and to relate campaigns for behavioural change to the popular idioms and practices that govern sexual behaviour. Authoritative government messages about HIV and AIDS have to contend with other messages that people receive, from faith healers, religious authorities, and the media.

Effective programmes to respond to HIV and AIDS have been related both to patterns of centralized and decentralized government organization, as well as to patterns of action by political organizations. Decentralization depends on having a strong centre that can provide knowledge, resources, and capacity to local levels. Centralized political authority is also crucial to directing resources to populations at high risk[23].

In 1986, Uganda's President Museveni was one of the first African leaders to speak openly about the threat of AIDS. Since that time, national AIDS commissions and control programmes have been established in nearly all African countries, and there are at least 16 countries on the continent where national AIDS bodies are personally headed by the President or Prime Minister[24].

Except in territories at war, it is now difficult for political leaders to avoid speaking openly about their commitment to fighting HIV. However, politicians rarely run their campaigns for election on platforms related to HIV and AIDS. Nor has the establishment of national AIDS programming been easy. In some countries, the creation of national commissions has weakened the core programmes and infrastructure of the Ministries of Health by diverting scarce personnel and resources to more diffuse programmes across ministries, the nongovernmental sector, and poorly resourced local governments. The expertise needed across all sectors of national and local governments is often not available. In the nongovernmental sector, religious organizations have generally developed their own approaches to HIV and AIDS, sometimes in coordination with national AIDS commissions or in consultation with particular donors or national authorities.

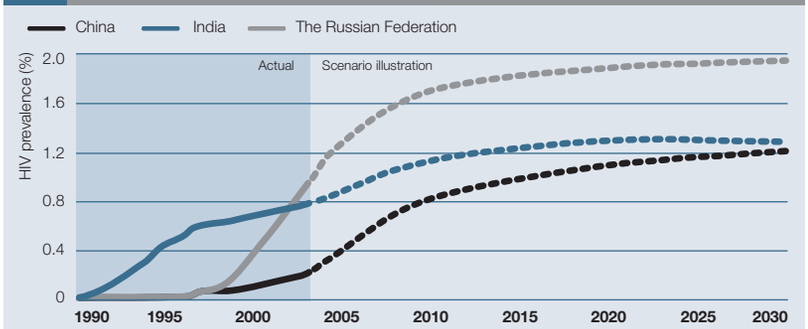
Powerful social institutions have championed conflicting AIDS messages in areas such as abstinence, condom use, the legalization of sex work, HIV testing, and male circumcision. This has been done with little awareness of how local people think about sex or how men realize their social position through their sexual prowess, and without any real thought to popular discourse about how HIV is spread and how people might be treated[25].

International responses

The international response to the AIDS epidemic has been substantial, even though there has been a large gap between actual needs and what is being done. In 1996, international expenditure on HIV and AIDS in developing countries worldwide amounted to US$ 300 million. By 2003, total spending on HIV and AIDS in developing countries from international and domestic sources amounted to US$ 4.7 billion, with international funds coming from both multilateral bodies, such as the Global Fund to Fight AIDS, TB and Malaria and the World Bank, and bilateral donor contributions[26].

An analysis of total bilateral and multilateral aid allocated to HIV and AIDS control shows 75% going to Africa in 2000–2002[27]. Based on current trends and taking into account pledges already

Figure 5 **Adult HIV prevalence projections, to 2030**



Source: French K (2003) *The future of the HIV/AIDS epidemic in China, India, Russia and Eastern Europe.* Project paper.

made for future funding, total resources available for HIV and AIDS in sub-Saharan Africa (from all sources, including domestic and international spending) amounted to over US$ 1.5 billion in 2003 and will rise to over US$ 4 billion in 2007[28].

Focusing attention on HIV and AIDS can reinforce perceptions of the African continent as a continent in crisis. Concern also exists that money spent on HIV and AIDS may be at the expense of resources required for other needs. It is possible that the rest of the world may learn from Africa's experience of HIV, and change its perception of the continent as one mired in disease and hopelessness. However, many fear that it is equally possible that, in the slightly longer term, international funds currently being spent in Africa could be diverted as new AIDS epidemics develop elsewhere.

Different epidemics are unfolding in different parts of the world, including China, Eastern Europe, India, and the Russia Federation. How these other epidemics develop and whether they evolve into global concerns will, in turn, affect international approaches to the spread of disease and, more specifically, the focus placed on HIV and AIDS in Africa.

In contrast to Africa, the HIV epidemics in China, India, the Russia Federation, and the countries of Eastern Europe are still largely in their early stages. Initially, HIV has been concentrated in specific population sub-groups in many parts of these countries, such as injecting drug users and sex workers, but the epidemics in these highly populous countries will continue to evolve. In the Russian Federation, the proportion of women infected has been growing and, given that most drug users in the Russian Federation are male, it is likely that sexual intercourse is playing an increasing role in HIV transmission. In both China and India, HIV prevalence is relatively low overall, but already a number of provinces, states, and territories have serious epidemics[29].

Africa: a vast and diverse continent

The focus of the project has been to identify those forces that act generally on the continent and that will have a material effect on the way today's AIDS epidemics might evolve over a 20-year time horizon. These 'driving forces' are discussed in more detail in the next chapter of this book.

Here, we briefly review some of the current realities that are our starting points for the process of building the scenarios. We cannot address all aspects in the detail they require. Instead, this introduction is intended to give an impression of their complexity and variation.

The continent of Africa covers more than 30 million square kilometres—an area equivalent to Argentina, China, Europe, India, New Zealand, and the United States of America, combined.

Africa's size and position on the globe means that the continent contains many different climates and cultures. The diversity and distribution of Africa's populations creates particular structural challenges for health systems and HIV and AIDS programming. For example, only one quarter of Africa's population lives within 100 kilometres of the coast, compared to an average of two thirds in the rest of the developing world, and 45% of Africa's population lives at low density, compared to 27% in the rest of the developing world[30].

Countries and cultures

The continent is divided into 53 countries, but many different aspects of culture—ethnicity, language, religion, and customs—transcend the current boundaries of nation states, fusing or dividing countries on the basis of their population's identity and affiliation.

Political diversity

In the mid-1800s, over 90% of Africa was governed by its own people and it supported a greater variety of political and social institutions than Europe[31]. There were possibly over a thousand polities or political groupings in pre-colonial sub-Saharan Africa and African history is full of examples of migration, incorporation, dynastic rise and fall, changing trade patterns, and both intellectual and economic contact with Arab and European cultures[32,33].

However, by the last quarter of the nineteenth century, all but Ethiopia and Liberia had been 'commandeered' by European powers that proceeded to rule the continent for over 75 years (or more in some countries). By 1912, the continent had been divided into approximately 50 states ruled by foreign powers. This partitioning meant the indiscriminate bundling of distinct and autonomous political, cultural, and religious groups into one geopolitical territory, forcing them to coexist under centralist colonial regimes, irrespective of their differences, were they sociopolitical, cultural, religious, or due to traditional practices. These imposed and arbitrary divisions are the source of some of the major conflicts that afflict Africa today.

Post-colonial Africa has seen a wide variety of political systems, from socialist experiments, single-party or no-party dominant states, pseudo-democracies, and military dictatorships, to kleptocracy and authoritarianism. Civilian governments have often been violently replaced by military regimes, and federal or quasi-federal arrangements supplanted with centralist unitary systems. Corruption, nepotism, élitism, political manipulation of ethnic and religious tensions, the personalization of power, and perennial incumbency were rife in several parts of the continent. The associated lack of social justice, inequity, increase in poverty, and endless struggles for political and economic power have contributed to many of the conflicts seen today.

Figure 6 **Map showing landmass equivalence of Africa**

Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 7 **How African leaders left office**

	Period					
	1960–1969	1970–1979	1980–1989	1990–1999	2000–2003	Total
Overthrown in coup, war or invasion	27	30	22	22	6	**107**
Died of natural or accidental causes	2	3	4	3	0	**12**
Assassination (not part of coup)	1	1	1	2	0	**5**
Retired	1	2	5	9	2	**19**
Lost election	0	0	1	12	6	**19**
Other (interim or caretaker regime)	6	8	4	14	1	**33**

Source: *Risk, rule and reason in Africa.* African Economic Research Policy Discussion Paper No. 46. Washington D.C., USAID.

However, the agitation for good governance on the continent, the growth of civil society organizations, and a rising educated urban class (which has grown from 23% of Africa's population in 1989 to 35% in 2001[34]) have all helped to foster multi-party democracy and political liberalization across the continent, although still fraught with irregularities. More democratic transitions have taken place on the continent in the last decade than at any other time in its history.

Between 1960 and 2003, 107 African leaders were overthrown; of these, two thirds were killed, jailed, or driven into exile. There are now signs that this pattern is changing, and hopeful signs that democratic values, good governance, and economic growth are becoming entrenched. Indeed, the African countries with strongest economic growth in 2002 (barring those with oil revenues), Mozambique, Rwanda, and Uganda, can plausibly attribute their economic growth to improved and stable governance, while a vision of pan-African government cooperation and support has been strongly promoted under the framework of the New Partnership for Africa's Development (NEPAD)[35].

Since the mid-1980s, almost every African country has held democratic elections. Although some of these elections are democratic in name only, 23 African leaders have been voted out since the 1990s, while a number of opinion surveys across Africa reveal a public appetite for greater democracy.

Wherever government has been a prize to be exploited for the benefit of a few, it has generated corruption, nepotism, and the political manipulation of ethnic and religious tensions to attain or maintain power. Where these circumstances have hindered effective governance, it has proved extremely difficult to establish or sustain effective HIV prevention programming.

Conflict

The causal links between the spread of HIV and conflict are not fully understood, but there appear to be both positive and negative influences[ii]. For example, conflict can interrupt normal economic activities, thus inhibiting the spread of HIV that might otherwise occur through supply chain activities such as movement along transport corridors and via transient labour forces. Refugee camps can act as a protective factor, although there are also contexts in which they could increase the risk of HIV exposure, for example where transactional sex is rife, or condoms are not available[36].

At the same time, conflict-induced economic disruption can force young girls and women into transactional sex. Peacekeeping troops deployed from low HIV prevalence to high HIV prevalence countries can be more likely to be exposed to HIV if they are insufficiently aware of or disciplined about the risks. Peacekeeping troops who contract HIV while deployed abroad can also act as a vector for importing the disease into their home countries, and subsequent demobilization can disseminate HIV widely in the population. Rape is often used as a weapon of war, either by rebel armies or uniformed service personnel, and thus contributes to the spread of HIV[37].

Population, movements, and connectivity

Africa's population is on the move. Helped by public health investments and continued high fertility, some African populations have doubled and others have trebled since the 1960s. Under the pressure of this rapid growth, rural resources and traditional methods of cultivating the land are less and less capable of providing subsistence for growing populations. As a result, more rural people have moved—either permanently or temporarily—to urban areas, mines, plantations, and other centres of economic activity.

[ii] See UNAIDS (2004) *2004 report on the global AIDS epidemic: 4th global report.* Geneva, pp.175–181.

Conflict and food insecurity are responsible for the displacement of people. Africans account for 40% of all displaced people in the world and it has been estimated that, in 2001, 13 million Africans had been uprooted by war or persecution, and 1.7 million fled their homes in that year alone[38].

Although countries define urbanization in different ways, in 2001, the United Nations Commission for Human Settlements (HABITAT) estimated that Africa's rate of urbanization, at 3.5% per year, was the highest in the world[39]. The rural population of Africa is decreasing as a proportion of the total population of Africa, while the urban population is increasing (although both populations are increasing in terms of actual numbers). In the three scenarios described in this book, the same levels of urbanization and population growth are assumed, using the UN Population Division projections (medium fertility assumption—see **Appendix 2**).

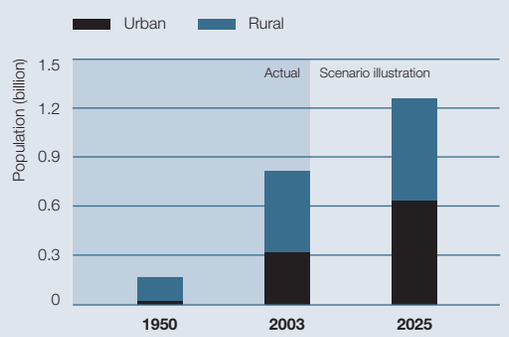
In Africa, the area of agricultural land has stayed constant over the last 30 years, while the population has continued to grow. This has resulted in a steady reduction in the number of hectares of agricultural land per capita.

So while the population in Africa has increased, land use per capita has fallen, without a green revolution, which might intensify the productivity of land. This therefore indicates falling productivity both in terms of yield and acreage.

There is a strong association between mobility, migration, and the risk of contracting and spreading HIV. However, the forces that impel people to leave home in search of a better life elsewhere, or in hope of finding additional income to support the family back home, are not likely to change in the next ten years. People are on the move, with all the hopes and hazards that implies.

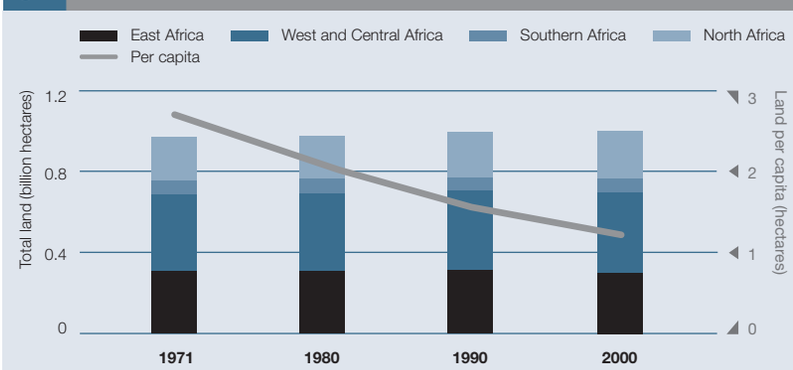
The continuing 'brain drain', which has seen an estimated 20 000 professionals leave Africa for high-income countries each year since 1990, has diminished the pool of available capacity within Africa.

Figure 8 Urban and rural populations in Africa, 1950–2025



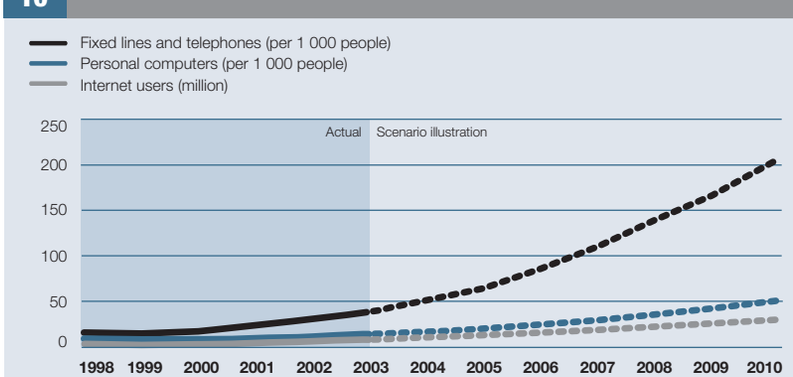
Source: Overseas Development Institute (2003) *How will Africa feed itself in the year 2025, under the three different scenarios?* Project paper.

Figure 9 Total agricultural land and agricultural land per capita in Africa, 1971–2000



Source: FAO (2004) *The state of food and agriculture 2003–2004,* Rome.

Figure 10 Connectivity in sub-Saharan Africa, 1998–2010

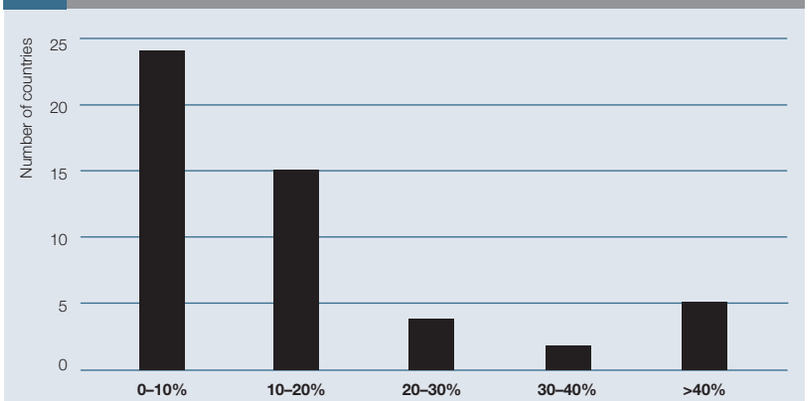


Source: Adapted from Miniwatts International (2004) http://www.internetworldstats.com/stats1.htm#africa

Figure 11 African countries and products accounting for more than 75% of export revenues, 2000

Source: UNCTAD/WTO, UN Statistics Division 2000.

Figure 12 African countries and aid as a percentage of GNI, 2002



Note: Aid includes both official development assistance (ODA) and official aid.
Source: World Bank (2004) *World development indicators*, Washington DC.

There are also countervailing trends. Connectivity within Africa and between Africa and the rest of the world has increased. There are signs that many parts of Africa will leapfrog developments in telecommunications infrastructure, with mobile telephone connections exceeding fixed-line connections across the continent in 2000, mobile telephone subscriber numbers forecast to rise two-fold to four-fold by 2010, and great potential for third-generation GPRS services to expand internet access[40].

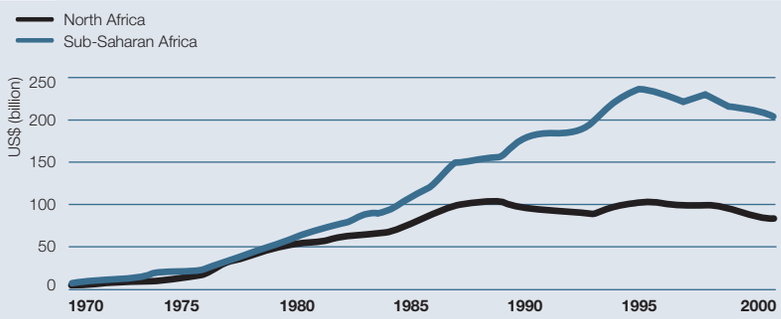
At the same time, the African diaspora has been an important source of social, cultural, and economic influence. Remittances have proved a stable and significant source of income in many developing countries, and are less subject to fluctuations of economic cycles than foreign direct investment. They are especially important in lower-income countries and those considered high-risk investment prospects. The World Bank estimates that US$ 4 billion in remittances was received by countries in sub-Saharan Africa in 2002, representing some 4% of GDP. This compares with a net inward flow of US$ 7 billion in foreign direct investment in 2002. The Middle East and North Africa attracted a further US$ 14 billion in workers' remittances in 2002 (2.2% of GDP)[41].

Economies: trade, aid, and debt

In Africa, 39 countries have been classified as low-income countries (ranging from US$ 90 per capita GDP in the Democratic Republic of Congo to US$ 775 in Côte d'Ivoire), and 14 have been classified as middle-income countries (ranging from US$ 1 250 per capita GDP in Egypt to more than US$ 8 000 per capita GDP in the Seychelles)[42].

Sub-Saharan Africa is the only region of the world that has grown poorer over the past 25 years, with half of its 700 million people surviving on US$ 0.65 or less per day[43]. The average annual GDP growth of countries in sub-Saharan Africa has

Figure 13 **African external debt, 1970–2001**



Source: World Bank (2004) *World development indicators*, Washington DC.

decreased from 7% in the first half of the 1960s to an average of less than 4% in 2001, and 2% in 2002[44].

On average across Africa, countries depend on commodities (of various different kinds) for 75% of their export revenues. Only five countries export more than 20 products in order to generate this significant percentage of their export revenue, and the smaller the number of commodities to export, the greater the vulnerability and volatility of export revenue[45]. Given this limited economic base, African economies have often relied on relatively high import tariffs.

In turn, many countries are highly dependent on foreign aid: about half of African countries rely on official development assistance (ODA) for 10% or more of their gross national income (GNI)[46].

For a number of countries, a significant proportion of the income they generate is spent on servicing debt: on average, the sub-Saharan economies devote 10.9% of their export earnings to servicing debt. This rate is even higher for North African economies, which devote 15.9% of export earnings to debt service[47]. Across Africa, 18 countries are recognized as heavily indebted poor countries[48] under the HIPC Initiative[iii].

The level of foreign direct investment (FDI) in Africa remains relatively low compared to other world regions. For example, of the global net total of FDI inflow to developing countries of US$ 143 billion, sub-Saharan Africa attracted only US$ 7 billion, and the World Bank predicts that it will grow only slowly to US$ 9 billion in 2005 (of a global total then of US$ 175 billion)[49].

The nature of Africa's economy—which includes the livelihoods of rural areas, informal trading and manufacturing, modern commodity exports, a small manufacturing base, and dependence on external assistance—has been one of the strongest drivers of the AIDS epidemic in Africa. It has defined the wealth and poverty of individuals, which in turn has influenced the decision to migrate or stay. It has also determined what taxes could be raised by governments and therefore what they could spend on managing the epidemic. Finally, it has influenced what businesses—whether small or large—could commit to countering the impact of AIDS and slowing the spread of HIV.

Scientific advances

Since 1981, when what is now known as AIDS was first identified in the United States, important advances have been made in the scientific understanding of HIV and its transmission[50]. These advances include learning about the different subtypes of the virus and how it evolves; the mechanisms of transmission and tracking the virus through epidemiological monitoring; and an increasingly sophisticated understanding of biological and social vulnerability to the virus.

Data collection and interpretation

Attempts to gain an accurate picture of the AIDS epidemic in individual African countries, let alone the continent as a whole, present a major challenge. Nevertheless, considerable resources and expertise are now dedicated to improving both the collection and the interpretation of the data, so that it is now one of the best described diseases on the continent. Better data and improved methodologies mean that today's HIV and AIDS estimates are considerably more accurate than those arrived at previously. However, these estimates are not definitive and should be used with this understanding.

New learning from one data gathering approach can help to improve the focus of another. For example, until recently, surveillance data tended to be drawn mainly from urban antenatal clinics—until population studies demonstrated that infection levels in rural areas may be as much as two to three times lower than in urban areas[51]. The latest surveillance surveys for a number of countries, including Burundi,

[iii] The IMF and World Bank launched the HIPC Initiative in 1996 in an attempt to reduce the external debt burdens of the most heavily indebted poor countries to sustainable levels.

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Ethiopia, Rwanda, and Zambia, now try to take better account of such variations by including data from a number of rural clinics in their surveillance systems[52].

As surveillance becomes more sophisticated, and more is understood about patterns of infection, and as more community surveillance studies and demographic and health surveys become available, the tools for planners improve. Much more is now known about the numbers of maternal, paternal, and dual orphans, for example, and the numbers of new orphans each year. Patterns of HIV transmission are also better understood. The AIDS epidemic is not static and good surveillance enables policy-makers to track where new infections are occurring, how the pattern differs from country to country, and how the patterns of transmission change over time.

Data that are gathered must also be interpreted carefully. For example, the apparent stabilization of HIV prevalence in some countries does not necessarily mean that the epidemic is beginning to ebb. It could reflect the fact that equal numbers of people are dying of AIDS as are being newly infected with HIV. As antiretroviral therapy becomes more widely available, HIV prevalence might rise (that is, more people could be living with HIV in some countries). However, this would not necessarily mean that more people are being infected with HIV, rather that people already living with the virus are surviving longer due to treatment.

There is also a lack of data regarding whether, or to what extent, different HIV-subtypes affect transmission or respond to treatment. Even more important than differences in subtypes in human populations is the fact that, once someone is infected with HIV, the virus continues to mutate. This is one of the factors that enables it to stay ahead of the body's immune system. Since antiretroviral drugs were widely introduced in North America and Western Europe in the mid-1990s, there has been an increase in drug-resistant mutations in newly infected people in those regions[53].

Treatment

Over the past 20 years, and in particular over the last 10 years, there have been major advances in the treatments available to counter HIV and its effects.

Treatments for many opportunistic infections can be relatively cheap. DOTS (directly-observed treatment, short-course) is the preferred treatment strategy for TB, and by the end of 2003 70% of African countries had implemented DOTS programmes, although the 70% cure rate for TB in Africa remains below target[54].

However, treating HIV itself has proved a more difficult task. It was not until the mid-1990s that using a number of antiretroviral drugs in combination was found to have lasting impact in reducing the level of HIV in the body (viral load) and hence prolonging life[55].

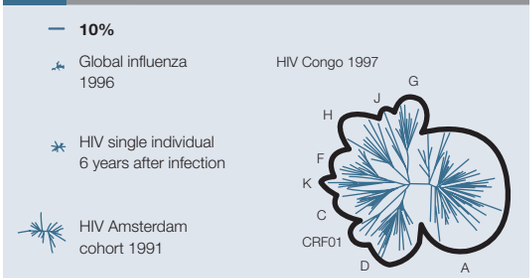
To date, it has proved impossible to eliminate HIV from the human body (in other words, to cure HIV), but careful use of combination antiretroviral drugs can keep levels of viral load very low for long periods. However, this therapy is not effective in all patients. In some cases, HIV quickly develops resistance to the drugs, which lose their potency in keeping the viral load down. There can also be severe side-effects with some drugs, rendering them unusable in some cases[56].

Current scientific investigation includes:

- Finding ways of optimizing antiretroviral therapy to stave off the development of resistance and to minimize side-effects;
- Salvage therapy—that is, second and third line treatment regimens after initial combinations have failed to keep the viral load low;
- The search for new medicines that will target other aspects of viral replication, thus creating new avenues for effective antiretroviral therapy.

Meanwhile, given that access to antiretroviral therapy is very poor in most developing countries, there has also been research on

Figure 14 **Genetic diversity of HIV**



Source: Garber DA, Silvestri G, Feinberg MB (2004) Prospects for an AIDS vaccine: Three big questions, no easy answers, *Lancet Infectious Diseases*, 4(7):397–413.

optimal strategies for antiretroviral therapy in resource-poor settings.

Importantly, recent studies have demonstrated the efficacy of fixed-dose combinations, where a number of different antiretroviral drugs are combined into a single pill. This makes therapy simpler at every level—from individuals taking the pills, to prescription and distribution.

Vaccines and microbicides

As with other infectious diseases, the best approach to control in the long term will be an effective vaccine that prevents infection when a person is exposed to the virus.

However, once HIV is established in the body it 'hides' from the resulting antibody assault. This enables a continuous replenishment of the HIV population, at a remarkable rate, and with an astonishing rate of mutation. During chronic infection, genetic variants of HIV harbouring single mutations have the potential of arising each time the virus replicates—thousands of times per day—giving rise to genetically novel populations.

The global diversity of the influenza virus in any given year is roughly comparable to the diversity of HIV within a single infected individual at one time point. This extraordinary variability makes the development of a vaccine particularly difficult.

The decision to carry out different types and levels of clinical trials of vaccines is a complex and often controversial process. There is a danger of unnecessary duplication of effort and unhelpful competition, rather than synergy. There are also considerable ethical and political issues to address. Once a vaccine is developed, another set of challenges emerges—in terms of both cost and practical barriers in resource-poor settings. Developing an effective HIV vaccine will require a coordinated scientific and public health effort of unprecedented magnitude and complexity. It will require all those engaged in HIV vaccine research and development work collectively to cover the breadth of the major scientific and practical challenges.

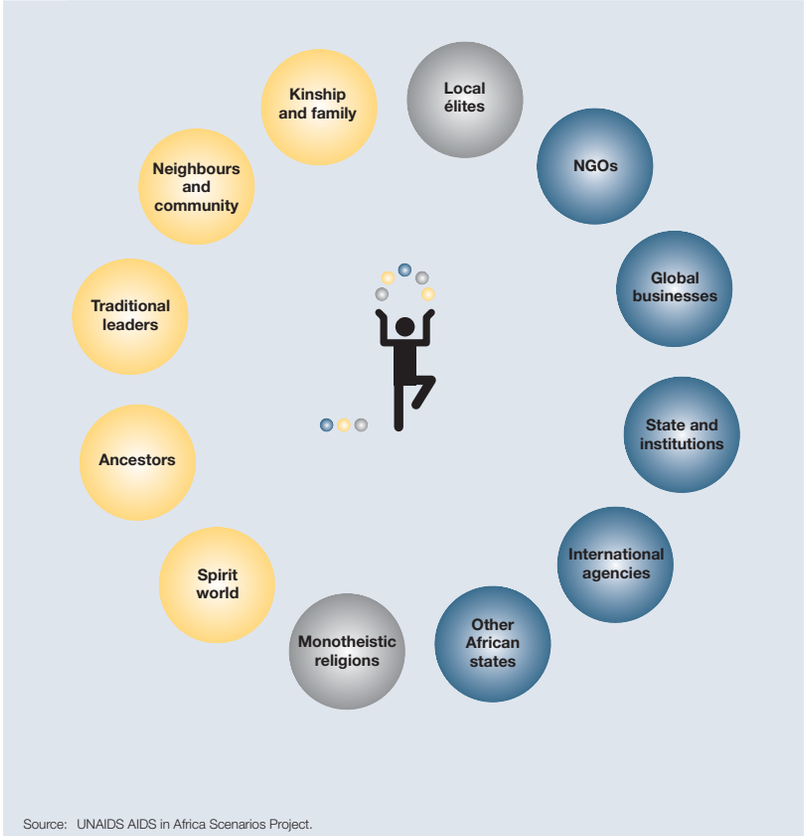
Microbicides are topical formulations designed to block HIV1 infection when applied vaginally or anally prior to intercourse. They could be delivered in a gel, a cream, or, for example, as a vaginal ring kept in place for a month or more at a time.

A microbicide would attack the virus at any point in its lifecycle. As such, a microbicide could theoretically be made from any of the antiretroviral drugs already being used for treatment, although the point of a microbicide is to kill HIV before it spreads throughout the body. This also means that some of the existing drugs, while not effective enough to cure HIV infection once it has a stronghold, may nonetheless be effective enough to block it from entering the body. Much microbicide research is built around advanced HIV drugs that target specific molecules or enzymes key to HIV. Three formulations, each containing a single antiretroviral drug, are already in human trials, testing their safety. Research is also going on to develop microbicides with drug combinations, analogous to the double and triple therapy regimes that have kept many infected people alive and healthy. At the same time, research into innovative ways of delivering these drugs into the vagina or rectum is being carried out.

Despite some encouraging signs, the steps towards a successful microbicide still face many challenges. The microbicide field is under-funded (it is estimated that more than US$ 1 billion is needed over the next seven to ten years) and funds that are available are not always used optimally. There is still much scope for improvements in coordination. There is little sustained interest from the big pharmaceutical research and development companies, although

one has recently donated the rights for one of its drugs to the International Partnership for Microbicides. The whole process is also slow: the six products that are currently in, or about to begin, large-scale testing for efficacy began development more than 10 years ago. It will be three or four years before it is known if any of them work. Even if one or more is successful, it will take still longer to move into approval and then commercial production. To be successful, microbicides need to be cheap, stable, and easy to use. One of the main challenges of microbicides is that they require just as much behavioural change as the use of condoms.

Figure 15 **Juggling influences**



Source: UNAIDS AIDS in Africa Scenarios Project.

Nonetheless, it does seem that a viable microbicide will be forthcoming.

The human factor

Life in Africa today is a juggler's world. While there are many visible signs of Westernized modernity (as in other developing world contexts), there is also the active legacy of local beliefs, traditions, and habits of social interaction. This means that a range of institutions and structures influence every action. As a result, people choose between worldviews or combine them in ways that flexibly adapt to changing circumstances.

This double legacy shapes individual's beliefs, values, customs, and economic choices—just as it shapes the treatment they seek. The juggler's world also conditions the movement of people, balancing links to the land and the need for mobility and independence to search for work.

Habits of governance, power, and authority are also shaped by both legacies. The desire to seek the aid of deities and ancestors, and the drive to create modern democratic institutions are both products of the multiple legacies of Africa. Clearly, it is not enough to rely on only one approach to meet the demands of the epidemic, because both modernity and tradition are failing. The very rapid spread of HIV may well be the loudest signal of this failure.

Behind the anonymous units of analysis are individuals and the social contexts they live and work in. The closest one can get to an explanation is to explore the context in which people make decisions and to try to forge some understanding of the relationship between those social factors and people's behaviour.

This social context is little understood, which is perhaps why it has only recently become an explicit part of many HIV and AIDS programmes, where donors and their partners have tended to "focus

exclusively on individual behaviours, rather than also addressing social norms, policies, culture and supportive environments"[57].

Myths, meanings, and motivations

So far, the countries that have made some headway against the epidemic in Africa are those that have also attempted to address the social scripts that direct sexual behaviour.

We may never be able to comprehensively identify and understand all the social, economic, or cultural factors that motivate another person to act in one way or another. There are no simple accounts of behaviours that put a population at risk: overlying the particular context of any sexual act are the norms and beliefs of the population concerned, which may include belief in predestination or in witchcraft.

Sexual behaviour is not just based on the relationship between two individuals, but also reflects expected roles for men and women. There are parts of Africa where polygamy is common, and in many societies men marry late at around 30 years old, but women marry when they are younger. Studies suggest that underlying these arrangements may be a notion commonly held by men that they are 'biologically programmed' to need more than one woman[58].

Economics has also been a critical factor in defining sexual behaviour. Women may accept sexual relations with an older man—either inside or outside of marriage—because they need the economic support that he is more likely to be able to provide. Studies conducted in Kisumu, Kenya and Ndola, Zambia (2001), report that 40% of women, most of them single, had had sex in exchange for money or gifts in the previous year[59]. Where AIDS has left women and orphaned adolescents at the head of households, women and girls are particularly vulnerable to offers of economic support from so-called 'sugar daddies'. These men sometimes pay school fees and put food on the table, but may demand sex in return. Moreover, as one 15-year-old girl told researchers studying this issue in Zimbabwe, "If you refuse, you stay poor. If you take his money and refuse sex, he will rape you."[60] Across the continent, it tends to be the case that poorer young women have somewhat higher HIV prevalence levels because they are more likely to need to sell or trade sex, and economically better-off men also have somewhat higher levels, because they can afford to buy or barter sex[61].

In proclaiming behavioural change as a way of tackling the spread of the virus, individuals and communities are, in effect, being asked to

[iv] Moatti JP, et al (2003) Access to antiretroviral treatment and sexual behaviours of HIV infected patients aware of their serostatus in Côte d'Ivoire. *AIDS*, (Suppl. 3):69–77.

Figure 16 Examples of common myths and assumptions about HIV and AIDS in Africa

Myths and assumptions	Reality
If people understand the risks, they will change their lifestyles and give up high–risk behaviours.	People do not change their behaviour easily. Individuals may be constrained by wider economic and sociocultural factors, psychological, emotional, or physical needs or deeply-held beliefs.
Available resources should focus on prevention programmes, rather than treating those already infected.	It is not a question of one or the other—research also shows that there are limits to the efficacy of prevention programmes when no treatment is available.
Medical science can overcome HIV and a vaccine will soon be available.	A cure for HIV is not likely to appear in the next 15 years. If a vaccine does eventually become available, infrastructure and skills will still be needed to deliver it.
All AIDS epidemics can be treated in the same way.	A number of epidemics are unfolding within Africa and other world regions. They spread differently due to variations in sociocultural, economic, and health care contexts—and so must be tackled differently.
Providing free and wide access to antiretroviral drugs will undermine prevention efforts.	Evidence shows the contrary, e.g., people receiving antiretroviral therapy in Côte d'Ivoire use condoms more frequently than untreated HIV-positive people[iv]. An increased sense of hope and wider take-up of HIV testing in a context where treatment is available may have positive effects on prevention.

Source: Adapted from Irwin A, Millen J, Fallows D (2003) *Global AIDS: Myths and facts: Tools for fighting the AIDS pandemic.* Cambridge, MA, South End Press.

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address myths and assumptions about the world and their relationship to it. To do this effectively, it is necessary to develop a greater understanding of our own and other people's myths and assumptions—and the contexts that sustain them.

There are, of course, a variety of complex beliefs about the nature of sexual activity. These patterns would not be so disastrous perhaps, if sex was more easily discussed—but sex is often a difficult subject, making it harder to establish the risks involved in sexual activities. For example, there is little information about men who have sex with men in African communities, and the links between this activity and the spread of HIV may have more to do with this activity being a cultural taboo, rather than with claims that it does not happen. Indeed, avoiding this area of sexual activity leads to a bias towards talking only about vaginal intercourse and not acknowledging the dangers of anal intercourse for both men and women. Similarly, cultural norms around sexual practice change, sometimes rapidly. For example, gay rights groups are emerging in around 15 African countries, suggesting new kinds of identity formation are growing[62].

People living with HIV

Since the earliest days of the epidemic worldwide, people living with HIV and AIDS have played an essential part in confronting the epidemic through a variety of different organizations and approaches. In particular, as individuals, they continue to help to personalize the disease, challenging communities to tackle the disease more openly and honestly. In recent years, AIDS activism in Africa has 'come of age'[63]. Organizations representing people living with and affected by HIV and AIDS today have the organizational capacity and operate in a political environment where they are able to demand that rights be observed and pressure government and NGOs to take action.

The involvement of people living with HIV and AIDS in responses at national and regional levels is increasingly networked. The Network of African People Living with HIV/AIDS (NAP+) was founded in Dakar in 1993 and serves to unite people living with HIV and AIDS and their representative organizations, including through the provision of training and support to nationally-based HIV and AIDS support groups. NAP+, through its member groups, is estimated to involve some 2 million HIV-positive people in Africa[64].

Mental health and stigma

An adequate response to the AIDS crisis has to encompass and address issues of individual and community mental health. The impacts of the virus may be direct (for example, living with HIV) or indirect (nursing someone with AIDS). The impact is felt on people living with HIV and AIDS, their kin, friends, and colleagues. It crosses generations: children not only feel the direct impact but their nurturing also suffers. Blame and other manifestations of stigma serve to compound the psychological impacts of trauma.

For individuals, the impacts can affect relationships at all levels, the processes of decision-making, and attitudes to risk and uncertainty. They may trigger psychological problems, such as anxiety or depression; or seed psychological strengths, such as courage and focus.

In order to develop effective prevention campaigns, it is essential to understand how people tend to go about the complex processes of decision-making; their attitudes to risk; the causes and impacts of despair, fear, anxiety; how they weigh the costs and benefits attached to various options; and the influence of social expectations and issues around relationships, gender roles, and

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sexuality—to name but a few. In providing treatment, programmes need to be developed with a consideration of how individuals and communities prepare for treatment and what beliefs, cultural practices, and decision-making processes motivate starting, switching between, and adhering to different treatment regimes.

Fighting stigma and discrimination against people living with HIV and AIDS has been an integral part of the work of many individuals and organizations across Africa, ranging from church and other religious groups (in some cases tackling stigmatizing attitudes from within their organizations) to national human rights commissions and other legislative bodies[65].

New and old forms of social capital

While it is not well studied or publicized, much of the social capital in Africa is based on voluntary activity. Churches and mosques, savings associations, mutual health societies, and clubs for young professionals coexist with older forms, such as initiation sects, secret societies, kinship groups, and tribal bodies. Social capital exists and is nurtured in all these bodies. It also exists in informal training and businesses. On the beaches of Dar es Salaam, for example, one can find an old *fundi* repairing or building a boat with the help of the younger men he is training. Similarly, the small kiosks of watch menders on the streets of Nairobi and Kampala are not simply individual small businessmen. Rather, each kiosk represents three years of study, financed with the help of savings and personal loans, and organized in a system of fairly strict rules. Most market traders are also embedded in structures of informal financial relationships, trading agreements, and exchanges of labour.

Family relationships are another source of social capital. Family and kin are broadly defined and carry considerable obligations. If someone related to you shows up at your door then you may be obliged to help them, even if you have never met them before.

'Mama Afrika' was the name given by the project participants to one of the storylines that they developed. It describes the role of the informal social capital of the continent, in particular the strength and resources of the extended family.

The project participants felt that these resources have provided extraordinary, but unsung, sources of resilience in African society as it has responded to the spread of the AIDS epidemic. These resources have helped to replace lost labour in families, shared the burden of costs, and looked after orphaned children.

However, it is also true that such strong social systems can reinforce values, attitudes, and beliefs that inhibit the effective management of HIV and AIDS. Just as with the other current realities described in this section, it is important not to underestimate or oversimplify their complex nature; and to recognize that it is impossible to predict how such aspects of life in Africa will develop—and how they will affect the spread of HIV across the continent. Instead, it is important to explore the possible, plausible developments in these areas—and prepare for what might happen.

In the section that follows, we move our focus from the present to the future, to present the project's investigation of the key forces that are driving the epidemic, and the crucial questions they raise about the future of AIDS in Africa over the next 20 years.

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RESOURCES AND CAPABILITIES
UNITY AND INTEGRATION

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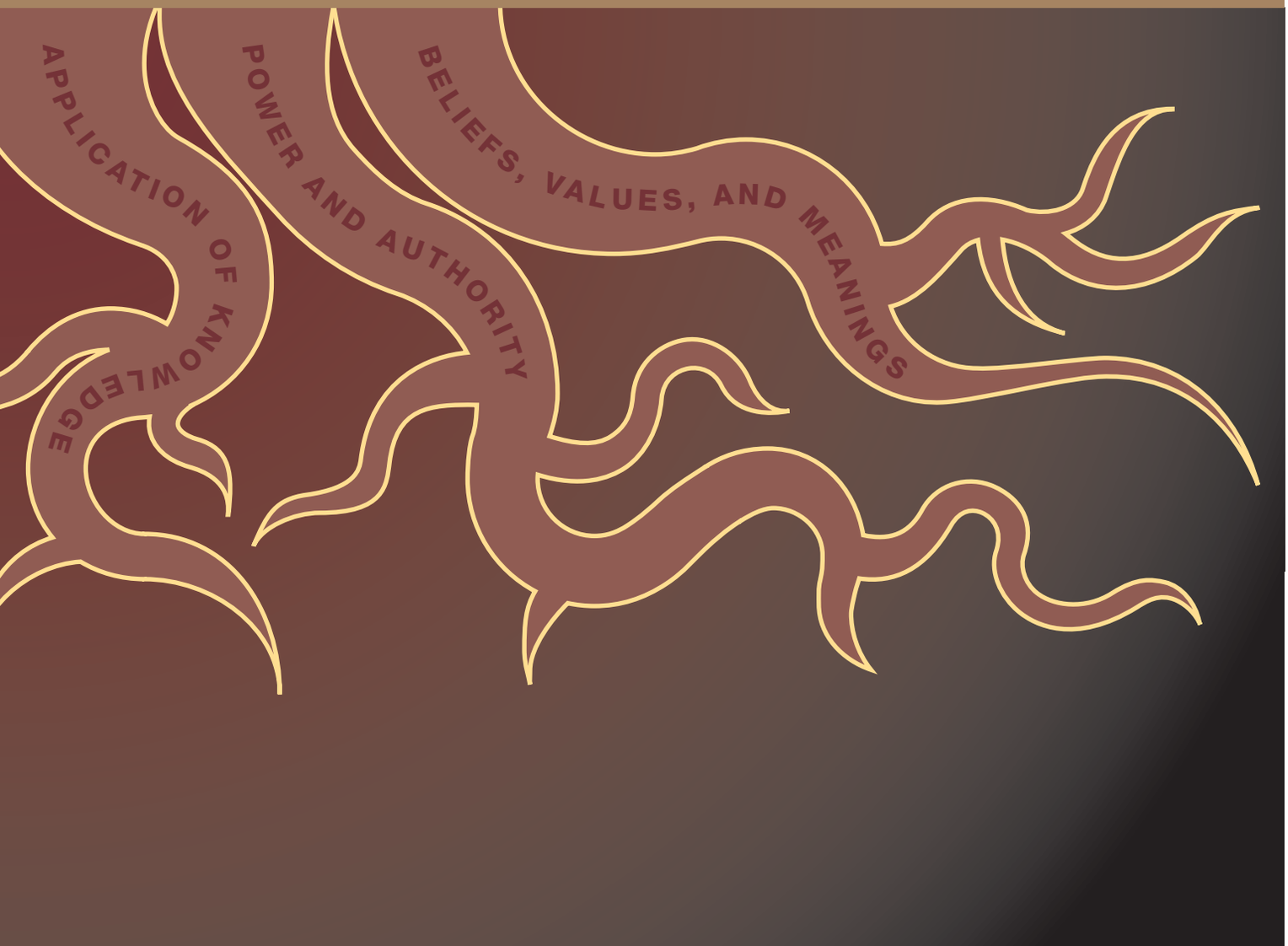
Section 3 Driving forces



Section 3 Driving forces

Five powerful driving forces were identified early on in the project as crucial to the future of AIDS in Africa.

Consideration of these drivers and their interaction provides a powerful analytical tool for examining events in the past and present, and for considering plausible future developments. It is impossible to predict how the drivers and their interaction will play out in reality: fundamentally different sets of dynamics and events may be created by their interplay. However, the scenarios provide a structure for exploring the different possible futures they could create.

The five critical, uncertain forces that are driving change

1

The growth or erosion of unity and integration

Will the next 20 years be characterized by greater cohesion and integration, or greater contestation and fragmentation?

2

The evolution of beliefs, values, and meanings

Will the next 20 years be characterized by respect and tolerance of beliefs, or contested values and intolerance, and how might beliefs change?

3

The leveraging of resources and capabilities

Will the next 20 years be characterized by the leveraging of additional resources and capabilities, or will there be depletion and wastage of resources and capabilities?

4

The generation and application of knowledge

Will the next 20 years be characterized by shared and effective learning, or will knowledge generation be neglected and contested?

5

The distribution of power and authority

Will the next 20 years be characterized by greater commitment to shared power, or will power be concentrated and contested? Will state power and traditional sources of authority be aligned, or in conflict?

These drivers have their own dynamics and operate at many different levels, from the household to the pan-African and international arenas. In addition, these drivers interact, creating further complex dynamics.

Figure 17 **Examples of the issues the driving forces raise at different levels of human organization**

Source: UNAIDS AIDS in Africa Scenarios Project.

The growth or erosion of unity and integration

This driver encompasses the extent to which individuals, groups, and nations find themselves connected. Unity and integration between individuals and their communities forms the basis of peaceful, inclusive societies, which facilitates effective policies and programmes on HIV and AIDS. Societies where unity is eroding, or where factionalism or ethnic and religious tensions predominate and lead to violence, will make prevention and care increasingly difficult.

There are fundamental uncertainties about how interconnected we will find ourselves over the next 20 years.

- Will there be a sense of global solidarity?
- Will pan-Africanism strengthen?
- Will rural communities across Africa feel integrated into national development or feel marginalized?
- In societies with high HIV prevalence, will cohesion in households and communities prevail?
- Will the epidemic exacerbate prior tensions and exploit existing social fault lines?

At regional and pan-African levels, this driver speaks of the nature and extent of political, social, and economic ties between states—both through the evolution of institutional ties and through the growth of civil society. Exploring this driver also leads into an examination of globalization and the benefits it may bring to Africa. It raises critical questions about Africa's relationship with the global North, for example, around aid, governance, and security. If these factors become more closely aligned in the future, what impact will it have on the AIDS epidemic?

Finally, exploring this driver raises questions about the nature of the future world order: to what extent will nations invest in multilateralism and its institutions; and to what extent will HIV and AIDS be seen as a global problem, needing a global solution?

The evolution of beliefs, values, and meanings

Beliefs about how HIV is spread, and how it can be prevented, may be based on particular secular, traditional, or religious belief systems, or a mixture of all three. These include individual beliefs about personal identity and morality; and about sexuality, illness, life, death, and cosmology. Such beliefs will determine whether HIV and AIDS are seen in the framework of transgression and punishment, or opportunity and risk.

If HIV infection is seen as inevitable, the subsequent fatalism engendered may make prevention very difficult. If AIDS is believed to be caused by witchcraft, breaking sexual taboos, or poverty, then biomedical prevention and care strategies are less likely to be adopted or have an impact. In turn, blame, stigma, shame, and discrimination, particularly gender-based discrimination, will also inhibit effective prevention and care. The extent to which individuals can be open about their sexual orientation, for example, will determine whether they can access appropriate services.

This driver raises additional issues about how individuals and social groups react to beliefs that are different from their own. For example, if HIV infection is perceived to be the result of an 'immoral' lifestyle, this might limit compassion and understanding. If HIV infection is seen as primarily the result of individual choices, it means that the social, cultural, and economic factors that determine how much choice individuals actually have are being overlooked. Looking at the future of AIDS in Africa, the extent to which societies accommodate diverse beliefs and values will be critical. Some will see diversity of beliefs and values as a strength to be encouraged; others may see it as weakening society in some way.

The leveraging of resources and capabilities

The response to HIV and AIDS is sometimes presented as simply a question of funding. While these scenarios demonstrate that considerably more resources are needed (financial, and human and institutional capacity), the issue is also about leveraging what is available to achieve more—including longer-term benefits—especially when resources are limited.

More importantly, these scenarios demonstrate that it is not just raising money that counts, but how that money is used. What matters in the future of HIV and AIDS is the nature, level, quality, and alignment of resources, systems, processes, and infrastructure, including leadership and governance, and a focus on a synergized and integrated approach. If, for example, resources for HIV and AIDS are fragmented into dozens of small projects, each requiring its own management and reporting systems, the transaction costs involved may detract from the overall value of the resources. Tied aid (where receiving governments have to purchase services or goods from the donor country) may also compromise the value of the aid.

The effectiveness with which HIV and AIDS resources are used will depend on the development of capable systems to absorb, transfer, spend, and account for large increases in funding. There is a real danger that large increases in funding may draw resources away from other development sectors or other parts of national health systems that are already under-resourced.

There are also real dangers that the emphasis on antiretroviral therapy, for example, could deplete capacity in other areas of health priorities, such as the ability to conduct immunization, advocate behavioural change, or deliver other basic health care. It is critical that increases in funding (and wider availability of antiretroviral therapy) should build systems that will benefit all health outcomes as well as government and civil society capacity.

There are also uncertainties around how far governments in Africa will be willing and able to raise their own internal resources for addressing HIV and AIDS, to what extent resources will have to come from private individuals, and for how long external donors will provide resources for HIV and AIDS programmes.

The extent to which governments, civil society, and the private sector can use resources effectively will determine the outcome of the epidemic. Money spent on rural and urban development, for example, can be used in ways that help reduce the spread of HIV at the same time as addressing other development priorities. Whatever the resource—drugs, human capacity, leadership, financial flows, oil, or diamonds—these scenarios suggest that there is no predetermined outcome in their use of resources over the next 20 years.

The generation and application of knowledge

New knowledge—and new ways of applying existing knowledge—about the virus and its spread will be crucial. The greatest impact is likely to come from combining biomedical knowledge and better understanding about sexual behaviour with knowledge about impacts on people living with HIV and AIDS and those who care for them. Approaches that combine traditional and modern views of the world will be crucial to reaching broader population groups.

Biomedical knowledge is critical in developing new drugs to respond to the AIDS epidemic, such as a microbicide, and, eventually, a vaccine against HIV. However, it is uncertain whether these will be developed with Africa's HIV and AIDS epidemic as a central concern. Neither is it certain whether a vaccine can ever be developed, or how long the current generation of antiretroviral drugs will be effective in Africa. It is

not clear to what extent African traditional therapies and medicines will be developed, or how effective they will be.

Furthermore, the development and uptake of new technologies are shaped by different influences. Successful development does not guarantee their effective deployment.

There also remain uncertainties about how to address sociocultural aspects of the epidemic. Better understanding of the different conditions and contexts that influence particular patterns of sexual activity may be as important as developing new forms of prevention: without the former, it is much more difficult to ensure that prevention actually works. Better understanding of the psychological impacts experienced by people and communities living with high HIV prevalence may be critical in developing better prevention and care strategies.

The dominance of any one aspect of knowledge about the epidemic will determine the direction taken to address the epidemic, shaping the substance of policy. Knowledge about the virus itself, from its molecular structure to its social dynamics, has increased hugely over the past two decades. As the next two decades unfold, increased knowledge, and its effective application, has the potential to drive far more effective HIV and AIDS responses. However, it is still uncertain whether new knowledge will be applied to the real challenges that resource-poor countries in Africa face.

The distribution of power and authority

This driver describes the different ways in which power and authority are distributed in society and how they may interact with each other. It asks who has power in any given situation and whether power is centralized or distributed. Within households and across communities, the distribution of power determines the extent to which girls and women can protect themselves from sexual relations that expose them to HIV infection. It needs to be remembered that different systems of power and authority may impact differently on women.

At all levels of society, the distribution of power and authority determines who is entitled to which development benefits, access to antiretroviral therapy, higher education, or jobs. Many parts of Africa are democratizing, and there are considerable efforts to ensure the benefits of development are more evenly distributed. At the same time, considerable inequalities remain, whether on gender, religious, ethnic, tribal, economic, age, or class lines. There are still uncertainties about how power will be shared across African societies in the next two decades. In addition, the manner in which governments balance the needs for patient privacy—in terms of data protection acts or the protection of patient information—and the need to share information between patients and medical staff will play a role in effective diagnosis and treatment.

When power and authority are not aligned, the result may be civil conflict. Traditional sources of authority that do not recognize or respect national power structures, and vice versa, are a key source of conflict, for example, where ethnic or tribal groups are in conflict with the government.

Comparing driving forces

Within each driving force, we can look at the extremes of how they may play out and the myriad possibilities in between. This can be described graphically on a continuum for each scenario, as shown in **Figure 18**.

- The growth or erosion of unity and integration can be explored along a continuum between fragmentation and contestation, and cohesion and solidarity.
- The evolution of beliefs, values and meanings

Figure 18 **Comparing the driving forces in each scenario**

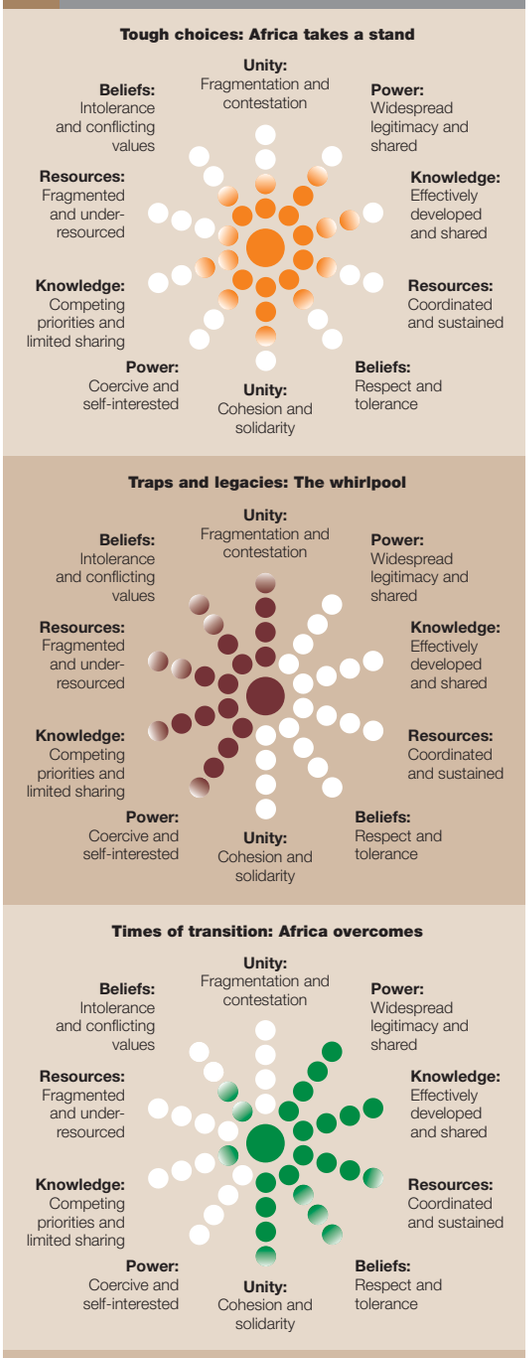
	Tough choices	Traps and legacies	Times of transition
1 **Growth or erosion of unity and integration**	**Unity:** Fragmentation and contestation / **Unity:** Cohesion and solidarity State co-option or coercion of tribal and religious authorities, with accountability devolved to local leaders and authorities. Forging of national identities. Greater autonomy of African countries leads to some managed tensions within the continent. Collaboration across borders to deliver services and facilitate trade leads to strengthening of regional blocs: this provides a platform for realizing pan-African aspirations and there is increasing integration with the G90.	**Unity:** Fragmentation and contestation / **Unity:** Cohesion and solidarity In global relationships, multilateralism gives way to bilateralism as Africa's dependency on aid increases. Within African nations, ethnic and religious tensions rise; increased strain on community and household networks causes some to disintegrate.	**Unity:** Fragmentation and contestation / **Unity:** Cohesion and solidarity Multilateral efforts to tackle health, development, trade, and security issues within Africa mobilize the international community, national and international civil society, and governments.
2 **Evolution of beliefs, values, and meanings**	**Beliefs:** Intolerance and conflicting values / **Beliefs:** Respect and tolerance State leaders unite different constituencies (religious and ethnic). Traditional values and customs are highly valued and are used and adapted as part of developing a sense of nationhood and, in particular, to help prevent the spread of HIV. Collective good is prioritized over individual liberty; potential future gains mean that present suffering is worthwhile.	**Beliefs:** Intolerance and conflicting values / **Beliefs:** Respect and tolerance Individuals and groups place great importance on their own values and beliefs, and offer little recognition to those of others. Policies and programmes tend to be built around the untested assumption that values and beliefs are common and shared. There are diverse and increasingly contested values and meanings; rising stigma and blame.	**Beliefs:** Intolerance and conflicting values / **Beliefs:** Respect and tolerance A new global covenant encompassing social justice and political equality leads to growing tolerance of a diversity of values, sometimes with the loss of traditional values. Incorporation of a more diverse, representative range of perspectives into decision-making.
3 **Leveraging of resources and capabilities**	**Resources:** Fragmented and under-resourced / **Resources:** Coordinated and sustained External assistance does not increase substantially, but tough decisions and effective use of existing resources leads to increased long-term capabilities for African nations. However, domestic resources only grow rapidly towards the end of the scenario period.	**Resources:** Fragmented and under-resourced / **Resources:** Coordinated and sustained Vertical, isolated, and rising funds for HIV and AIDS means fewer resources for other health programmes and depletes rather than builds resources and capacities needed for wider development. Health and other state-run resources and capabilities do not keep pace with the needs of the growing population. Initially, there are many resources, but they are uncoordinated, diminishing over time.	**Resources:** Fragmented and under-resourced / **Resources:** Coordinated and sustained Increasing sustained and shared international resources lead to enhanced capabilities. Within African countries, an increasing and sustained influx of international assistance, coupled with changes in terms of trade, enables critical infrastructure, basic public services, and wider access to treatment for HIV and AIDS to be expanded and to keep pace with the needs of growing populations. Gradual diversification of African national economies enables greater self-sufficiency over the much longer term.

Figure 18 **Comparing the driving forces in each scenario** *(continued)*

	Tough choices	Traps and legacies	Times of transition
4 **Development and application of knowledge**	**Knowledge:** Competing priorities and limited sharing / **Knowledge:** Effectively developed and shared In some countries, HIV and AIDS remain a lower priority than other health and development issues. Approaches are centralized, but community leaders shape approaches so that they are relevant to local contexts. Sharing of learning between different communities and countries increases as systems for exchange of knowledge develop.	**Knowledge:** Competing priorities and limited sharing / **Knowledge:** Effectively developed and shared Increasingly fragmented and competing systems of knowledge. Learning and application limited across society, within and outside Africa. Treatment and prevention approached as separate issues; focus on medical aspects of health, not wider causes and impacts. Uptake of biomedical technology increasingly inhibited by: limited access; frequent drug stock-outs; failure to address underlying beliefs; competition or ineffective integration with traditional healers; insufficient attention to the diversity of local languages; and deteriorating education. Decline in public health systems undermines ability to monitor, test, and collect data—scientific basis for evaluating the effectiveness of interventions eroded. Rather than competing priorities, there are fragmented, competing systems of knowledge.	**Knowledge:** Competing priorities and limited sharing / **Knowledge:** Effectively developed and shared Sustained resources and assistance lead to increasing experimentation and sharing of knowledge among and between different communities. Resources for monitoring, testing, and treatment of HIV and AIDS helps to strengthen primary health care systems. There is increasing integration between parallel systems and capacities, with greater inclusion of biomedical knowledge in traditional health care systems and vice versa.
5 **Distribution of power and authority**	**Power:** Coercive and self-interested / **Power:** Widespread legitimacy and shared Top-down alignment and co-option of formal and traditional power and authority. Opportunities for, and involvement of, women, youth, and people living with HIV and AIDS vary from country to country. State leaders effectively enforce social constraints with the aid of traditional and religious leaders.	**Power:** Coercive and self-interested / **Power:** Widespread legitimacy and shared Sources of power and authority increasingly splintered (between rebel, local and tribal, and religious groups) as government and other authorities lose power (undermined by lack of resources and capacities combined with conditions associated with external assistance and global trading opportunities).	**Power:** Coercive and self-interested / **Power:** Widespread legitimacy and shared Within Africa, new leadership emerges—spanning political, religious, and traditional authorities—but aligned by a shared vision of social justice. Civil society grows stronger in many countries (within and outside Africa), increasingly supported by changes in international law and national constitutions.

Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 19 Comparing the driving forces in each scenario



Source: UNAIDS AIDS in Africa Scenarios Project.

can be explored along a continuum between intolerance and conflicting values, and respect and tolerance.

- The leveraging of resources and capabilities can be explored along a continuum between coordinated, sustained systems and infrastructure, and fragmented, under-resourced responses.
- The development and application of knowledge can be explored along a continuum between effectively developed and shared, and competing priorities and a failure to share.
- The distribution of power and authority can be explored along a continuum between coercive and self-interested approaches, and a shared commitment to progress and empowerment.

In **Figure 19**, these continuums are expressed graphically as spectra, showing how the driving forces play out within each scenario and allowing a visual comparison to be made.

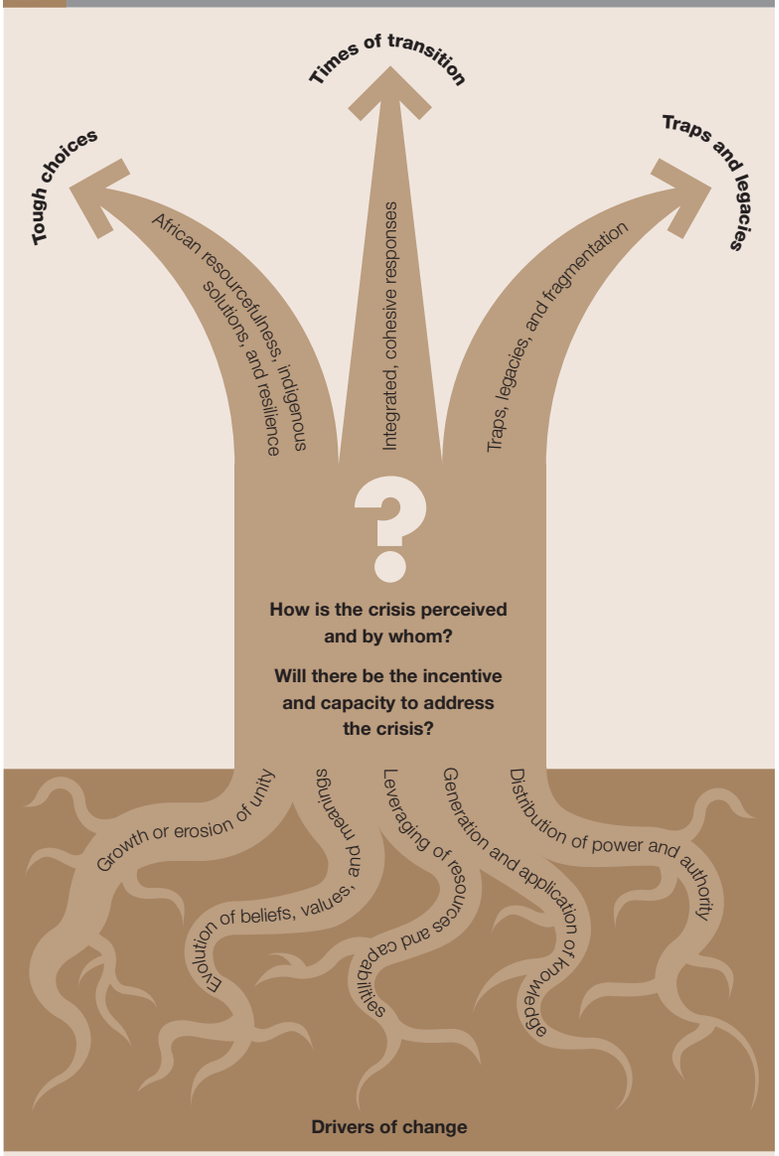
Branching points

In each of the three scenarios, the driving forces described above play out differently, interweaving to create a distinct story (**Figure 20** overleaf). Shaping these different developments are a set of fundamental differences between the scenarios—called 'branching points'. In this project, the branching points of the three scenarios are summed up in the different answers they provide to the following two questions:

- How is the crisis perceived, and by whom?
- Will there be the incentive and capacity to address the crisis?

So, for example, over the next 20 years, will African leaders recognize the crisis that besets

Figure 20 **Scenario branching points**



Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 21 **Branching points and different stories in the scenarios**

Branching points	Tough choices	Traps and legacies	Times of transition
How is the crisis perceived?	Broad development crisis.	Largely as a medical crisis. HIV is tackled in isolation from its social and economic context.	AIDS as a metaphor for global crisis.
And by whom?	African leaders.	By many, but no effective, coordinated action.	Civil society, Africa, and the global community.
Will there be the incentive to address the crisis?	Yes. Although HIV is seen as one of many challenges.	Yes. However, funding drives a so-called 'AIDS industry'.	Yes. AIDS is a key catalyst for a reconfiguration of international and national priorities.
And the capacity?	Yes. Major national efforts to rebuild capacity to respond to the epidemic. Key emphasis on prevention and antiretroviral therapy to maintain essential capacity.	No. High level of resources initially leads to wasteful duplication and uncoordinated efforts. AIDS strips out capacity to respond in high HIV prevalence countries.	Yes. Major mobilizing of national and international resources.

Source: UNAIDS AIDS in Africa Scenarios Project.

their countries and continent? If they do, will they focus solely on the AIDS epidemic or widen their efforts to include the larger problems of poverty and underdevelopment? Meanwhile, will Western governments and multilateral institutions share their perception of the crisis? If they do, will they harmonize and align their efforts to tackle it with those of Africa, or will African leaders be forced to rely on their own resources?

Figure 21 shows how the branching points influence the different scenario stories.

Interactions that create the scenario dynamics

The interactions of the drivers create the key dynamics of the scenarios. Some examples are given here of how particular story elements may be influenced by the interactions between these forces.

HIV and AIDS programming

All five drivers determine the effectiveness of HIV and AIDS programming. Effective programmes need adequate resources and robust systems. They need to be based on good scientific evidence; have high levels of support from both traditional (religious leaders, tribal chiefs, etc.) and state authorities; and must be in alignment about the best response to HIV and AIDS. Harmful beliefs about HIV and AIDS need to be addressed by programmes that promote values that influence positive behavioural change and the uptake of treatment.

The level of social cohesion in a society appears to be an important factor in protecting against exposure to HIV: great disparities in wealth, labour markets that split up families, or a lack of social trust can all have a negative impact on the sustainability of behavioural change. A level of peace and stability is also vital for the development of HIV and AIDS responses: while

the impact of conflict on the spread of HIV is still not completely understood, large movements of people make the roll-out of effective policies and programmes extremely difficult.

Access to and uptake of AIDS treatment
Access to and uptake of AIDS treatment will depend on the relationship between the generation and application of knowledge (which will influence the types of treatment that are developed) and the leveraging of resources and capabilities (which will in turn dictate to what extent treatment can be made available). Beliefs, values, and meanings also play a major role—they are important determinants of the acceptability and take up of services, even where they are available.

Gender relations
Gender relations are shaped by the distribution of power and authority. They are underpinned by cultural beliefs relating to the status of men and women. The nature of gender relations in turn affects the dynamics within families and communities, including their ability to hold together and their subsequent economic development.

Predetermined forces

The predetermined forces considered in the process of building the scenarios include Africa's geographical location, its landmass and varied climates, and the diversity of its cultures and ethnicities.

Within countries across Africa, there is evidence to support the idea that the population will continue to grow (albeit with some local declines): the population is predicted to exceed 1.2 billion by 2025[1]. In actual numbers, both rural and urban populations will be increasing, although urban populations will grow faster than rural populations.

It is also likely that the structure of the family will continue to change because of urbanization, and that religion will continue to be important.

Shocks and radical discontinuities

The project also identified five key categories of shock: war and conflict; collapse of ecological systems; famine; episodic or emerging diseases; and global, political, and economic shocks.

However, for the sake of simplicity, the participants and project team decided not to include such dramatic events or shocks in the scenarios, because they would introduce radical discontinuities.

It has been assumed that there will be no major external shocks, such as a world war, an influenza pandemic, or significant climatic shift. In addition, it is assumed that the transmission mechanisms of the virus—and current biological vulnerabilities to HIV infection—are not going to change over the next 20 years.

Were any such external shocks to occur, they would be likely to have a significant impact on Africa, and the world's, ability to effectively tackle the AIDS epidemic.

[1] United Nations Population Division (2003) *World population prospects: The 2002 revision*, and *World urbanization prospects: The 2001 revision*. Available at: http://www.un.org

TOUGH CHOICES

The African lion rouses from his shadowy lair
and roars his challenge through the clamorous earth:
– its billow blots all discords and all jars.

Hippo and elephant and buffalo without dispute
go lumbering to the drinking pools:
– but all the land he views he rules:

From here he pads on sun-picked bone and brittle thorn
sniffing the tawny skies of a new day:
– power ripples over him like the light of dawn.

—Brutus D. In: Pieterse C, ed. (1971) *South African poets: Poems of exile.* London, Heinemann. Entitled "Lutuli: December 10th 1961".

Section 4 Tough choices: Africa takes a stand

This scenario is told as the script of a documentary film made in 2026, including observations by a range of African leaders and experts. It describes the tough economic, social, and ethical choices that leaders and governments have to make in order to generate national renewal.

Folktale

Once upon a time, in a small village called Ogundugbwe, there lived a community of animals: Big Gentle Elephant, Fearless Lion, Tactful Monkey, Sleepy Jackal, Hard-nosed Mouse, Obedient Hyena, and Beautiful Zebra.

Life was never easy and now it was getting harder—a disease was killing all the crops and famine loomed. As the death toll began to rise, Fearless Lion, the Chief of Ogundugbwe, decided to summon all the animals to an emergency meeting in the market square.

Fearless Lion said, "I have called you here so that together we can think about what to do." Sleepy Jackal shouted, "I have a solution!… Let's go and ask for food and help from the neighbouring villages and faraway lands. Isn't that what we've always done?" "No… no… no…" roared Fearless Lion. "For many years we have looked to the outside world for solutions to our problems. Those solutions never came! Sometimes the strangers even made matters worse for us!"

"Today, in these difficult times, we must rely on our traditional values and ways. We must stand as one and work together. We must stop fighting each other and instead share whatever we have with each other," explained Fearless Lion.

There was a short silence among the animals, and then Beautiful Zebra spoke. "If all the male animals of the village have no answer, then I, as a female animal, have something to say!"

"The first thing we should do is ration our food. So we must collect all our food reserves and store them in a communal granary. Then someone, I propose our Chief, Fearless Lion, with the help of Obedient Hyena, can distribute it to the rest of us as they see fit."

Everyone agreed and Fearless Lion went on to speak directly to Sleepy Jackal and Hard-nosed Mouse. Fearless Lion said, "I order you forthwith to abandon your lazy and thieving ways. Too many of our citizens are already gone from us! Many more are dying! If the killer disease keeps destroying our crops, all we will have are our food reserves. In the circumstances, I, Fearless Lion, will not stand any misdeeds within our community… I will not stand indiscipline… and I will not stand any wastefulness!"

"But, our respected Chief, Fearless Lion," Tactful Monkey called out, "Why are we only talking about the food? What are we going to do about the disease that is killing our plants? Perhaps we should try to produce other things that the disease can't touch?"

"Oh, I know what to do," said Big Gentle Elephant. "We can keep bees, and get honey. The killer disease cannot touch our bees or our honey."

The animals of Ogundugbwe spent much of their time on the bee farm whilst still living through hard times. With the careful rationing of food, Fearless Lion and his fellow animals had managed to lessen the number of deaths in the village. But the mysterious disease remained around for a very long time.

UNAIDS/L. TAYLOR

One World Review 2026

Special edition: Miriam Muntu's film: *Tough choices*

Twenty-five years ago, many countries in Africa were facing a catastrophe—but the catastrophe didn't happen.

complete transcript included

Last year, acclaimed filmmaker Miriam Muntu set out to create a record of what went right in *Tough choices,* she documented what she calls 'the balancing act' managed by African leaders and their people, as they struggled to mitigate the more immediate impacts of underdevelopment and poverty, while both respecting the traditions and customs of the past and building for the future.

Across the continent, profound and disturbing social and economic changes were beginning to take place, particularly in high prevalence countries. People were talking about the inevitable psychological damage to individuals, especially children orphaned by the epidemic and families disrupted by the impact of AIDS; declining state capacities; domestic and regional challenges to security; growing demographic distortions; loss of social and institutional memory; and deep and sustained losses in the productive and nurturing capacities of society. These were tensions that no country had had to cope with in modern times: there were no precedents to follow.

This was not a time of abundance for African countries—there was no equivalent to the Marshall Plan, no international rescue package offering salvation. In this context, the film highlights the difficult choices that African leaders have had to make.

Muntu's series comprises four parts that describe events in Africa over the past 25 years.

1 **'The early years'** looks at the initial period, when a new generation of leaders were developing a new vision for their nations.

2 **'Years of building'** examines the difficult choices that those leaders had to make, as they led their nations towards greater self-sufficiency and prosperity.

3 **'Living in a world with AIDS'** looks at the challenges of facing up to the epidemic and the rewards of doing so.

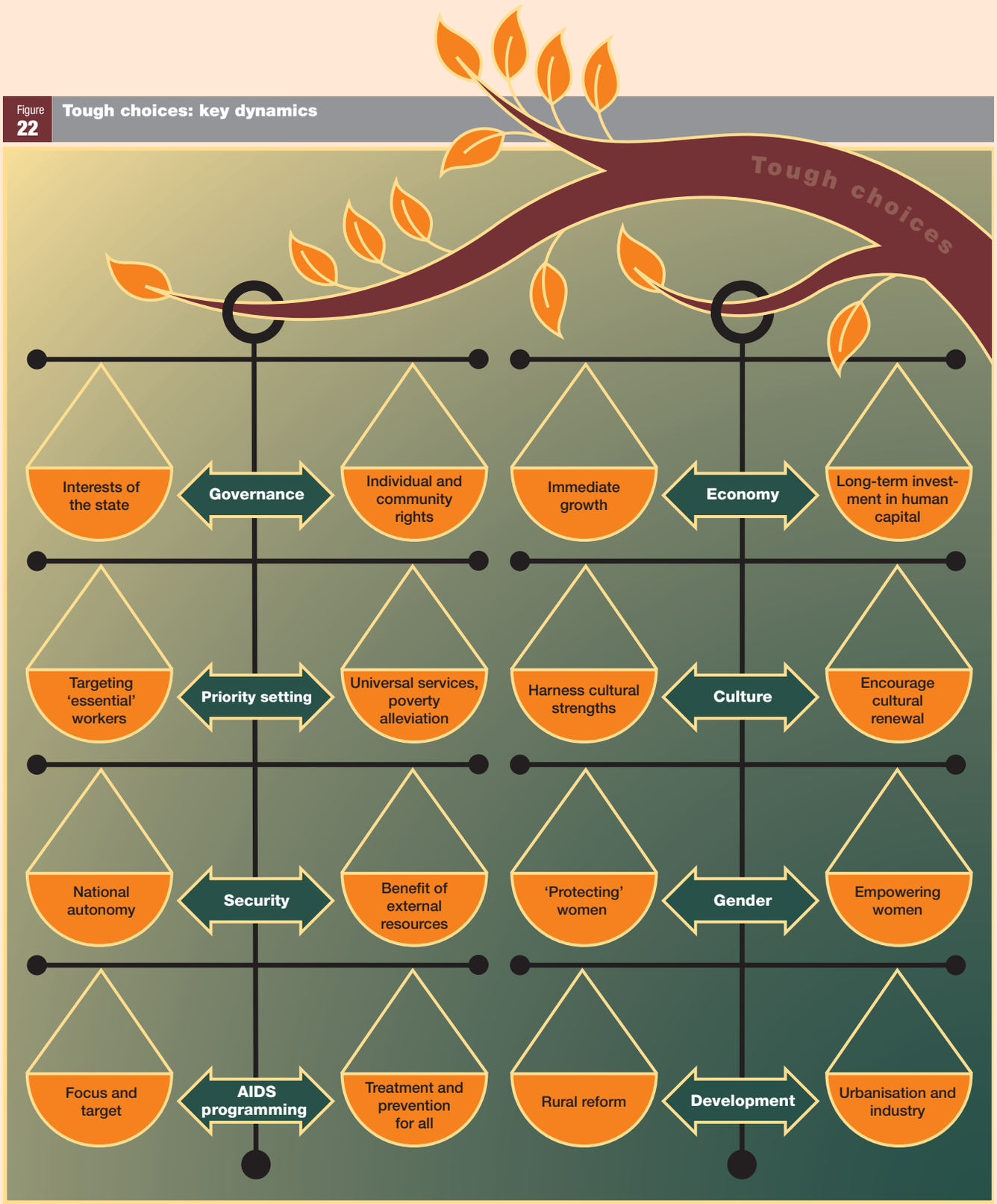
4 **'Years of reward'** looks at where Africa is now, and how national development has been shaped by, and helped to shape, regional and pan-continental cooperation.

In this special edition of *One World Review,* we provide a complete transcript of the four parts of the documentary, and then lay out the epidemiology and the costs of Africa's response to the AIDS epidemic.

The *One World Review* editorial team have developed a summary and diagram to guide readers through the key tough choices and balancing acts that we see in the film script.

1. The interests of the state as a whole versus those of individual communities, and individual rights versus the collective good. Inevitably, this includes managing dissent.
2. Immediate economic growth versus longer-term investment in human capital.
3. Choosing how to target resources—should the priority be to rapidly develop the skills and capacity of a minority essential for building and maintaining the functions of the state, or should most resources be spent on services for all and alleviating general poverty.
4. Navigating between helpful and risk-increasing cultural traditions.
5. Balancing nation building with strong regional and pan-African alliances; and freedom from external control with the benefits of external resources.
6. 'Protecting' women versus increasing women's freedom.
7. Determining the focus of HIV and AIDS programming: 'targeting' versus generalized prevention; treatment for key cadres only or treatment for all.
8. The needs of rural areas (including agricultural reform) versus the benefits of urbanization and industrial development.

Figure 22 **Tough choices: key dynamics**



ONE WORLD REVIEW 2026 VOLUME 21, NUMBER 5

UNAIDS/L. TAYLOR

Transcript of *Tough choices*

Part 1: The early years

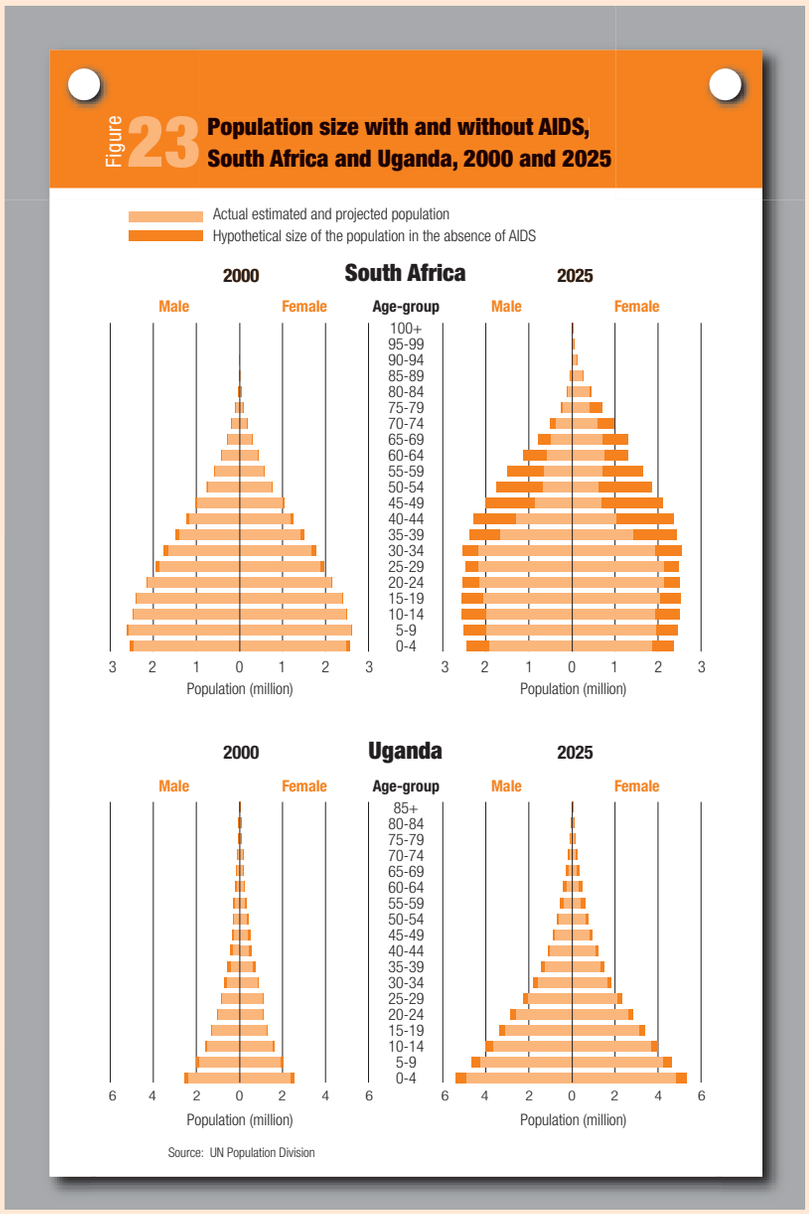
Camera action	Script
Initial montage sequence filmed in a vox-pop style with people speaking from the street.	*Man:* This story starts and ends with leadership. If our leaders had been weak, then we would be telling a very different story. *Woman (1):* It was not a question of involving everyone, but of how to bring enough people along, without blurring the vision of the path ahead. *Woman (2):* We were on a journey of reawakening—it was a profoundly moral and ethical journey.
Narrator, speaking while walking through the bustling streets of an African city. We can hear a slow drumbeat coming from somewhere in front of the narrator.	*Narrator:* **In 2005, it seemed that many countries across Africa were facing imminent catastrophe. On every front, crisis loomed:** ● **Chronic underdevelopment was being cemented into place by the drain of debt, corruption, rising unemployment, and a growing population drawing on failing public services;** ● **Development assistance came with major transaction costs and was driven by constantly changing donor agendas;** ● **The continent's economic marginalization was deepening;** ● **Violence and war continued and some conflicts appeared intractable.** **And AIDS made everything worse. Even the countries where the epidemic did not reach tragic proportions could not isolate themselves from the fates of their neighbours. The effects of economic stagnation, institutional disrepair, strife, and AIDS heeded no national borders.**
Narrator reaches a local drumming group playing on a street corner for the public—as the drumming gets faster the narrator turns away and continues to talk to the camera.	**But that catastrophe did not happen.** **And in the face of these challenges, Africa has not only survived but large parts of her have begun to thrive. In a few countries, strong, effective leaders started to emerge, who were prepared to confront the crisis of human development. Constrained by scarce resources—and needing to bridge social, religious, and ethnic divides—they have confronted their countries' problems by taking tough, sometimes unpopular, decisions and managing potentially treacherous tensions. They set a powerful example that many others started to follow.** **And, for the most part, they have succeeded.** **In order to understand what happened, we need to ask the crucial question: where did those leaders come from?**

	Camera action	Script
Balancing strength with democracy	*Noise of the street fades. The narrator enters a dusty library with towering shelves, where Professor Damilola Oyo sits reading near the window—the table is littered with books. The narrator walks to him, sits, and is seen to greet the professor. Over this footage, the narrator speaks off camera.*	*Narrator:* **I met Professor Damilola Oyo at Lagos University where he has been studying this question of leaders and leadership in African history and I put the question to him.** *Professor Oyo (speaking with obvious enthusiasm):* Africa's history has shaped its leaders. From the anti-colonial struggles of the late 1950s all the way to the early 1990s, Africa had been dominated by civilian autocracy, military dictatorship, or pseudo-democracy. There had been one-party and no-party states, or states where the dominant ruling parties stifled opposition. Ideological experiments included socialism, and even some forms of consensual governance—where quite disparate groups coexisted in the one state, partly through the cooperation of their ruling élites. However, variants of capitalism became the norm. The truth is that different ideologies often merely disguised the patrimonial and, at times, even kleptocratic character of the systems.
	Camera pulls back to a nodding headshot as the narrator speaks.	*Narrator:* **I remember reading that, by the late 1990s, there was increasing pressure from the people for more democratic, transparent, and responsive governance in African countries, a trend that Western countries, especially donors, welcomed.** *Professor Oyo:* That is true—African populations were exerting pressure for change; civil society was growing more active and vocal, with increasing support from overseas. So, by the beginning of the twenty-first century, Africa had a higher number of democratically elected leaders than at any time in previous history. The rising tide of change, in turn, allowed the new generation of leaders to change the face of Africa. *Narrator:* **How did this new generation of leaders affect African politics?** Professor Oyo: There were some countries with a maturing political process, strong civil society, and high levels of civic education. In other countries, the candidates of the old order held on to office—some by force, some through the mistakes of the opposition. By 2010, Africa had a mixture of leaders: certainly some of the old kleptocrats remained—and some new ones had emerged—but in other countries there were democratically elected leaders from both old political families and new political backgrounds, including an increasing number of women.
A crisis—a way forward...	*Camera cuts to the narrator passing through swing doors, walking down a corridor, and speaking to camera.*	*Narrator:* **But whatever their origins, almost all of the new generation of leaders had one thing in common... regardless of the level of HIV prevalence they were facing, they recognized that Africa was immersed in an unprecedented crisis that needed new political solutions and shared responses to common economic difficulties, cycles of conflict, rising absenteeism, problems of public sector service delivery, and limited human resources. Early attempts at regional collaboration and pan-African unity had started to yield encouraging results. Professor Betty Amanzi has worked specifically on the changes taking place in Africa at that time.**
	Narrator enters a plant-filled office and greets Professor Betty Amanzi, who is dressed in bright national attire.	*Narrator sits and asks:* **So, did the leaders perceive the depth of the problem?** *Professor Amanzi:* Oh yes, leaders at all levels had a terrific sense that the continent was in crisis. The optimism of the post-colonial generation was

Camera action | **Script**

becoming a distant memory. Crime, poverty, and disease were as bad as ever—in some places even worse. Services were crumbling. Life expectancy in some countries was dropping—largely because of AIDS. Corrupt, or ineffective leadership was pervasive. At the same time, the rest of the world's promises of help were too often rooted in the North's perception of the problems and solutions, and aid was volatile, unpredictable, and often ineffectively used.

Camera moves to large graphic on the wall and zooms in.



Professor Amanzi contiues to speak while the graphic is on screen and as the camera pulls back to show her in her office.

Professor Amanzi: In some high HIV prevalence countries, leaders—including business and religious leaders—recognized the long-term impact of HIV on demographic change and tried to learn from countries where strong leadership had had some success in controlling the epidemic. Others looked at the measures that were taken by countries that had kept HIV rates extremely low. It was becoming clear that no country could remain an island in the face of the epidemic's impact: HIV respected no borders.

Mind you, AIDS wasn't the only challenge—in many countries it was not even the most important one—but where the epidemic was worst, it served as a metaphor for the struggle Africa was facing.

Camera action	Script
	Narrator: **So what did they do?**
	Professor Amanzi: By 2010, one way or another, many state leaders had articulated strong visions of the way forward. This was not just some nebulous confection, but a concrete goal—involving increased economic autonomy, better use of internal and external resources, and a real goal of sustainable long-term development. Around this time, perhaps before, there is certainly evidence of a groundswell of opinion that Africans needed to find their own solutions, and remember their own traditions—recover something of their own value, political, and social systems—in order to build a better future. The best leaders responded to—and were products of—the new mood of the people. While there was great variety in the visions they developed, in many cases they promoted a new moral sense of where their countries ought to be headed.
	Narrator: **Talking about it from this distance suggests a smooth passage—but it was far from easy...**
	Professor Amanzi: You're right, there wasn't some magical meeting of the minds across the continent… While these approaches won support from some, among others there was strong suspicion. Rival regional powers were particularly distrusting but, encouraged by the principles of pan-Africanism and examples set by others, they found value in improving relations with their neighbours and in securing crossborder cooperation. The influence of regional trading and economic blocks was growing. Gradually from there they developed the strong spirit of pan-Africanism we see today.
Professor Amanzi stands and walks to the window while speaking.	*Narrator:* **Did this happen within countries, as well...?**
	Professor Amanzi: Sometimes yes, sometimes no—some leaders dealt with opposition by force, others tried leveraging popular support. Wherever anyone tries to impose one vision, he—or she—is going to come up against opposition.
Professor Amanzi turns from the window and continues to speak to the seated narrator.	You see, human and financial capacities were in short supply and, certainly in some countries, much of the authority and legitimacy of political parties and institutions had been eroded. The instruments of state power and control were weakened under the stresses that were confronting them. The low morale and low capacity of many armies was being compounded by high HIV prevalence in their ranks. With some important exceptions, business investments were not rising. Furthermore, the wider impacts of the AIDS epidemic, as well as rising disputes over natural resources and the distribution of state revenues, made it all too evident that chaos was not far away.
Camera cuts to the narrator walking through the plain and slightly dishevelled hallways of a government administrative building.	*Narrator:* **I have come here to ask Hulda Esi about how Africa stepped back from the brink. Hulda was working in local administration in a high HIV prevalence country at that time.**
Camera and narrator enter a small bare office. A computer and mobile phone are on the desk, but this (cont.)	*Esi:* It was a strange time, a great time. Events were moving fast. We knew there was a crisis, you see. It's not something that just hits you one day. No. But gradually, with things falling apart, people awakened to this sense of, well, almost doom. And yes, there was a time when we knew we had to take our destiny into our own hands. Our leader's words gave us great hope. She spoke from the heart. If we didn't do something, then who would? We had to be prepared to confront the crisis of development that was facing Africa, and the spread of the epidemic—and turn it around.

	Camera action	Script
Local responses, national pride	*is not the office of a senior person working in a wealthy company—the walls need a fresh coat of paint and a new desk and chair would be welcome.*	*Narrator:* **So, who saw the problem first?** *Esi:* Well, many leaders emerged who realized that financial, social, and human resources would need to be mobilized across every area of state activity, and that they needed the resources and engagement of local and traditional leaders. Local leaders were the first to express the view that their people were in a social and political crisis. The renewal of the state gave them their chance: cooperation could mean key posts for local leaders and, for their people, a better chance of getting clean water, better roads, and brighter prospects. For some of them, unfortunately, their primary concerns were less altruistic. They were keen to seize any opportunity to reverse the decline of their power and political relevance. But I can also think of leaders who really believed that Africa's future lay in a return to the rural past, or to a barefoot revolution among the urban poor, even though others dismissed this as a romantic dream. And there were those who just really, deeply wanted to recuperate the rich history of their own countries—and saw local and religious leaders as essential to the task of regenerating institutions and value systems. Either way, they helped inspire a new vision of development.
	Cut to narrator, walking towards a café and speaking to camera.	*Narrator:* **There were plenty of people outside the continent who wanted to spur them on—much of development 'best practice' across all development sectors drew attention to the crucial role of local responses. We have invited our two professors and Esi to meet to discuss the wider ramifications, particularly in relation to responding to HIV and AIDS, of Africa's leadership coming to rest on two pillars—the formal power of the state and traditional, local networks of power.**
	The three guests are sitting at a table. The camera and narrator join them as they are talking.	*Professor Amanzi:* Through traditional authorities and local institutions, African governments could gather intelligence and quell dissent—I'm not saying it was right, but the reality was that these were effective means to pacify powerful troublemakers and maintain relative peace and stability. *Professor Oyo:* Well, of course, where persuasion failed, some of the new leaders used force, even in the face of international outcry. Governments took steps to ensure that they had a near-total monopoly on the use of force in society—but they have also placed great emphasis on respect for local governance systems and the rule of law, and most have invested in an effective—although not always wholly independent—judicial system. *Esi:* In addition, the cooperation of traditional leaders or local administrators created fresh energy, though the state leaders never dropped the reins. In many countries, it has even resulted in an administrative approach that could be described as controlled or managed decentralization. In reality, I'd say it was far from a liberal strategy—more a sort of 'inclusive authoritarianism'. *Professor Amanzi:* But it was far from easy… You see, these leaders had to balance the interests of the state as a whole with the interests of individual communities, and then not be seen to be favouring any one of those individual communities.

	Camera action	Script
		Narrator: **So, what held it all together?**
Cooperation and negotiation		*Esi:* In the early years, when some of the choices were really tough, the only thing holding the people of some countries together was a commitment to building their nation. But that didn't make it any easier to navigate the rifts of tribal or religious identity. *Professor Amanzi:* Some leaders wanted to reclaim a pre-colonial state. These tended to be more conservative and resistant to external, non-African influences and thinking, and they made very strong links with religious groups and traditional leaders. *Professor Oyo:* Then there were those who just wanted to make sure that what they took from tradition was the best—or could be adapted to provide the best—for their people. But whatever the route, these leaders knew they were in the best position to make the decisions, and they had the support of an increasingly able staff of advisers and technocrats. *Narrator:* **It seems like there were some tough choices to be made about government administration—choices between different social forces, economic development approaches, security... the list is long. Surely, where AIDS had weakened the administration, it couldn't cope with everything—and how did they decide on who should and should not get access to antiretroviral drugs?**
Maintaining a minimum crew		*Professor Amanzi:* You're right, it *was* hard—governments had to decide which essential personnel would have access to antiretroviral therapy when so many other people needed it. It was a nightmare devising the criteria for access. The military were often first in the queue, senior government administrators and politicians always seemed to find their way to private clinics, and in some cases, there were specific antiretroviral therapy access schemes, such as for teachers. *Esi:* The question was what kind of essential staff to maintain? But priorities were set not only in relation to HIV and AIDS. Different leaders chose different priorities, according to their country's needs, weaknesses, or strengths. Sometimes, it meant making sacrifices—supporting technical and vocational skills at the expense of universal primary education; or choosing between urban housing or rural development strategies. *Narrator:* **The problem was, of course, that in the face of these tough choices, tolerance for opposition was increasingly limited.** *Professor Oyo:* Yes, but in most places dissent *was* tolerated. OK, so it was only to the extent that it could be managed. Many governments coopted local civil society and traditional leaders by giving them advisory appointments, access to government funding, or awards for 'service to the nation'. Indeed, we should stress that this strategy of cooption reduced the public criticism of government by the vocal third sector and traditional authorities. Of course, there was a downside—public trust was watered down and there were fewer new ideas around. *Narrator:* **Amazingly, they were still able to weave a united nation—there was, and still is, a clear will to work more closely together. So, what was the glue?**

Camera action	Script
	Professor Oyo: Accountability between leaders at federal, provincial, and community levels increased, aided by information technology and media development. They learned to negotiate with each other, and adapted and learnt from each other. That is not to say that all tensions were resolved—far from it. In particular, unscrupulous leaders—there will always be some—were still prepared to play on ethnic or religious divisions, or incite xenophobia for short-term political ends…
	Esi (interrupting): But even where social divisions were kept under control, there were drawbacks to holding on so tightly to the reins of power. It's difficult to encourage a spirit of entrepreneurship, be it in the programmes and approaches suggested by NGOs or the administration of government policy.
	Professor Amanzi: This was a difficult balance to achieve for many leaders… But at this early stage, most leaders were focusing on setting their domestic house in order—building support, and a strong sense of national identity and shared responsibility among the educated and middle class, and across religious and ethnic groups. They were taking that most difficult of first steps—instilling hope. They needed to galvanize their people and, of course, to build trust, by delivering what they promised. Governments held on to the idea that a strong sense of stability or control by government can encourage investor confidence…
	Esi: Again and again, during this period, we come back to the importance of ideology. I remember one of the slogans was, "How do you want your children to remember you?" Many set their ideals against a background of pan-Africanism, even if this wasn't the political reality. There was one government that stressed 'negritude', another argued for anti-imperialism… Some reached out to their people—maybe they staged spectacular events; others enlisted popular artists, you know, DJs and singers, playwrights and filmmakers. For others, the iron fist was never very far from view.
Narrator turns to the camera as it draws back from the table, glancing at the group.	*Narrator:* **It seems like they needed their people to understand that there were no miracles, but things would get better… that lasting foundations, particularly for fighting AIDS, were being laid…**
The narrator turns back to the group over a long shot of them all continuing to talk at the table. The screen fades to black.	*Narrator:* **Professors, Ms Esi, thank you for joining me for this first part of our documentary series.**

UNAIDS/L. TAYLOR

Part 2: Years of building

Camera action	Script
Opening film sequence covers images of Africa-based international financial and development institutions, a warehouse full of foodstuffs, a busy port, fields of wheat and maize, a schoolroom setting, and a busy hospital ward… Initial montage sequence filmed in a vox-pop style with people speaking from the crowded market in a small town.	*Woman (1):* Certainly, most of the leaders saw a crisis—but they didn't see the same thing, and they didn't tackle it the same way. They had to prioritize. *Man (1):* Some tackled AIDS as a priority; for others it was the resurgence in TB that came in the wake of HIV; some highlighted malaria, or safe water and nutrition; others focused on diversifying their core industries; and some put linking the formal, popular, and communal economies at the top of their list. Many tackled social and cultural obstacles. It wasn't that the other problems didn't exist, but with restricted domestic and international resources, they had to make careful choices. *Man (2):* It was tough—as well as looking at what was needed, say economically, to confront the crisis, they had to balance this with political demands. *Woman (2):* Some leaders made brave choices—and dealt with the political consequences. Most leaders were forced to make difficult decisions about the preservation, allocation, and cultivation of resources. *Narrator (walking through a market crowded with people):* **The crisis that most African leaders saw confronting their countries was one of development. Certainly HIV and AIDS added a sense of urgency, but most understood that despite its horror, the epidemic was also a symptom of a far larger problem facing Africa. They realized that the context of the epidemic—their country's extreme underdevelopment—had to be tackled. But how?** **Today we are looking at how the (then) new leaders responded, and addressed the issues that most concerned their populations—job creation, crime, AIDS, education, housing, and corruption.**
Camera returns to the narrator, who turns out of the market to a quiet area with a large shady tree. Narrator walks up and joins two people sitting on stools in the shade and introduces them.	*Narrator:* **We welcome again Hulda Esi, who was working in local administration in a high HIV prevalence country at that time, and we welcome for the first time renowned commentator Professor Mohammed Parkes, to tell us what the leaders did.**
Aid—whose targets?	*Professor Parkes (speaking rapidly and with great energy):* Back in 2005 to 2010, it became clear that there would not be a massive increase in aid from wealthy countries. Despite all the work of the Millennium Development Project, there were no signs that a doubling of aid was likely. Indeed, by 2010, aid was stagnating, though it seemed to hold up well enough for HIV and AIDS. Donor countries had a growing list of competing demands, and much of their aid was tied to their

Camera action	Script
	perceptions about how Africans should govern and conduct themselves. It was clear by 2010 that only a few countries—largely in North Africa—were going to achieve any of the MDGs. After all, the *UN Development Programme* had predicted as early as 2004 that trends showed poverty in sub-Saharan Africa would *never* be halved. The huge boost of external resources that many believed was necessary to facilitate the process in other countries was not forthcoming. Anyone could see that. We would have to look to our own resources, and make development assistance work much harder for us. If we couldn't reach the MDGs by 2015, it did not mean that we should simply abandon the effort—but it had to be our struggle, not anyone else's.
	Esi: This realization changed the relationship between African governments and their external partners. One of the defining moments came in 2009 when a new protocol for partner consultations was established. Once it caught on—and more countries took it up—donors and multilateral institutions were invited to present their case for investment together, not separately.
	Professor Parkes: Donor partners still had very clear lists of favoured countries, the ones defined as having favourable policy environments—and they were beginning to find that more countries joined the list.
	Esi: Confidence grew. We approached the donors as sovereign equals in order to start anew. They said they wanted to stay in our countries—but when we took them up on their rhetoric of greater fairness in defining the terms of our agreements, they were taken aback. We made it clear that aid gave them no license to create parallel governance or administration systems, particularly where substantial improvements in governance had been made. And we talked of leveraging their resources more effectively. Many countries had made major headway in improving the quality of government systems by 2010: why should they not be used? I have to say, the best of them stayed, and the others were not much missed. Even some of our partners, who at the outset were keen on their own financial systems, agreed to work within our broad national strategies.
	Professor Parkes: Africa knew from the start that choosing autonomy and self-direction was a long, hard road. We had to choose what to tackle first; we had to keep our eye on the long-term goals of building our future… and the temptation to borrow heavily again was always there.
	Narrator: **And, in many countries, AIDS loomed in the background, with its urgent priority to save lives. Was it possible for governments to cope? Could they diversify, experiment, and reduce the corruption? Could economies grow sufficiently to provide essential public services and, not least, to cover the costs that responding to HIV and AIDS incurred?**
Aid, trade, debt, and development	*Professor Parkes:* Well, at the same time, some economies did begin diversifying—as confidence grew, private sector involvement in service provision and in training grew. In some countries, incentives came from tax breaks. With improving stability, these countries proved attractive to many companies. Investment came from other African countries, particularly Egypt, Nigeria, and South Africa, in a range of sectors such as ICT, business development, tourism, and infrastructure. Investment also came from China and India. Countries were trying a huge range of different development and economic policies. Some pursued industrial policies (for example, selecting

Camera action	Script
	potentially winning sectors and facilitating their emergence through subsidies, legislation, and other incentives). Others moved up the value chain by increasing the value of exports by processing local raw materials and finding more lucrative markets. Some signed bilateral agreements to secure markets for their export products, while others dedicated time, resources, and manpower to exploring the room they had within the existing multilateral agreements to change their use to their advantage and generate the greatest potential possible. They sought to keep their options open for economic development in the future by avoiding integration agreements that compromised their countries' development potential and plans.
	Esi: It's true—countries were trying different development and economic policies and very few countries adopted the exact same strategies. It was far from a one-size-fits-all approach. Some countries drafted an increasing number of poor men, women, and children into the formal labour market where they were given basic training and education. For other countries, it was more expedient to pursue foreign trade and investment. Of course, some were successful while others remained stagnant.
	Professor Parkes: Some countries, those that had specialized in exporting one commodity, started to experiment with diversification through industrial policy. Those that had more than one primary export and had already moved into manufacturing, outsourced labour to larger countries and to countries with lower HIV prevalence.
	Narrator (turning to the camera): **We asked Aida Michel, a successful businessperson, to tell us about what happened next. We caught up with her while she was inspecting a storage facility.**
Cut to a woman walking through a warehouse full of foodstuffs. Narrator greets her and they sit on benches.	*Narrator:* **Aida Michel, those times can't have been easy?**
	Michel: No, they weren't. It was no easy task to try and increase the productivity of the informal—and underused—workforce. Sweeping changes were needed to extend property rights to the informal labour force—many of whom were mightily resistant to being drawn into the regulated, taxpaying labour market. Then came the empowerment of a substantial number of rural and urban unemployed and underemployed. This entailed an aggressive agricultural strategy based on land reform and redistribution, linked with an industrialization strategy based on the development of small, medium, and micro-enterprises and appropriate large-scale enterprises.
	Narrator: **Did this work for everyone?**
	Michel: No—you see, targeting was essential: obviously not all unemployed and underemployed could become self-employed. Some needed to be retained in schooling and training, others were good candidates for later social welfare interventions, and many others were suited for waged employment and cooperatives, while a few could be nurtured into entrepreneurship.
	Narrator: **But you have become a successful entrepreneur. How did that happen?**
	Michel: Well, some governments learnt that there were some essential steps to promoting women's participation in the economy—and they worked.

Camera action	Script
	Narrator: **Can you tell us what they were?**
	Michel: Well, I don't want to generalize. Remember that there were—still are—some countries where local customs and religious values define what women can do. I can only speak about my country—my region really. First, we had to remove discriminatory laws and legislation, then provide support, education and training, credit, and agricultural extension services. It sounds simple, but it was a long, slow road. Of course, particularly as urban areas developed, the gradual provision of basic social and economic infrastructure helped relieve us women of some of the burdens of housework and childrearing. More nurses meant there was more support for the general caring for those affected by AIDS, and we were more able to contribute to our countries' economic potential. Spending less time getting water, for example, made a big difference to many women. Less time in queues. Of course, a lot of the changes were a matter of trial and error. Success was never guaranteed, but we learnt from our mistakes.
	Narrator (turning to the camera): **While Aida Michel was working on building her business, the issue of trade was becoming more important. We rejoin Professor Parkes on a visit to the national port.**
Cut to shot of the busy port with Professor Parkes leaning back on a railing overlooking a working crane and talking to camera.	*Professor Parkes:* Behind me, you can see how busy this port is. During the last 20 years, trade has also demanded leaders' attention. Unfortunately, the multilateral trading system was not providing Africa with opportunities it could pursue—indeed, it had crippled the efforts of some developing countries to emerge. Complicating the picture was the economic role of China and India, which continued to grow, making trade diversification harder for a number of lower-income countries… Outside Africa, the economic and security concerns of developed countries were leading to a plethora of bilateral arrangements with African countries in an attempt to ensure security of supply. Multilateral talks on the regulation of global trade, unsurprisingly, continued to flounder. African nations, despite the different bases of their economic opportunities, increasingly stood together. They fought for clarification and assertion of multilateral laws and rules. They were happy to hold up, delay, or derail trade talks that were perceived to be unfair. They were prepared to endure pain in the shorter term, while they tried to secure longer-term gain. Many countries, especially those whose economies relied on exporting only one or two commodities, wanted to see tariff protection and subsidies in the North dropped, or at least lowered, and for the international community to live up to its commitments.
Camera draws back to include the narrator in shot.	*Narrator:* **And they became more skilled in the process?**
	Professor Parkes: Indeed. When they didn't get what they wanted, a number of them went to the *Dispute Settlement Mechanism* of the *WTO;* some won. It was remarkable—no African country had ever gone successfully to the *Dispute Settlement Mechanism* before… This created a domino effect, encouraging increasing numbers of weak commodity countries to follow suit.
	Narrator: **In the same way that they stepped up the pressure on trade issues, some countries were more willing than others to address the debt issue. What happened?**
	Professor Parkes: Africa wanted the industrialized countries to take their share

	Camera action	Script
		of the debt problem. A significant number of highly indebted poor countries achieved debt relief under the *HIPC* initiative, and by 2010, at least 15 countries had had their debts reduced to what were described as 'sustainable levels'. Mind you, all that was really sustainable was their ability to repay the loans. However, avoiding further debt became a policy touchstone—meeting with much popular support. Some governments were not content with what they saw (under the *HIPC* initiative) as overly restrictive expectations on how they allocated debt savings—to social sectors, for example. They argued that their countries needed essential infrastructure and spending on civil order. For them, debt relief negotiations were far more fraught, and not always resolved. Some African leaders called for the cancellation of the fraction of those debts that they identified as either odious or criminal.
		Narrator: **Meanwhile, sporadic urban riots and popular unrest in some places did much to turn government minds on the dilemma of where to focus public spending.** **One crucial change most leaders made was to shift emphasis from immediate goals like poverty alleviation to long-term strategies for growth, including partnerships between political and business aspirations.**
		Professor Parkes: To begin with, in some countries, inequity did increase. Targeting the fractions of the population most vital to future development meant tolerating inequity and putting the goal of universal service provision on hold. Rights came with responsibilities—for example, through food for work and public works programmes. Agricultural development was a priority for most countries—self-sufficiency in food has long been a source of national pride. At the turn of the century, malnutrition was widespread and contributed to poor health and lowered resistance to HIV. As rural infrastructure slowly developed, internal and regional commerce became more efficient, and, hence, more competitive. So, in the long run, such initiatives worked to reduce poverty, as well as increasing the availability of affordable food.
	Camera returns to close up on the narrator	*Narrator:* **I met up with Miriam Ogola, the head of an agricultural cooperative, on her own farm to ask her about how agriculture had changed and how policy choices were made.**
	Camera cuts to the narrator and a woman walking through large fields of waist-high wheat.	*Narrator:* **African governments have always thought food security is important, but there must have been some tough choices?**
Feeding the nation		*Ogola:* Well, nation building has often started with solving the problem of national food availability through domestic production, but by 2005 yields had been stagnant for a decade and, with a growing population, the amount of agricultural land available per capita was falling. While agriculture was economically significant (at the beginning of the century it accounted for 17% of Africa's total gross domestic product, and 40% of its foreign currency earnings), leaders still had to find a balance between stimulating urban economic development and improving agricultural production. Back then, some governments revived more effective forms of parastatals. I was working for one, a state-run agricultural organization, which, in those days, provided smallholders with seed, fertilizer, and pesticides on credit, and then we would buy the harvest! It was good work and the worst corruption among officials had been tackled, transport was more flexible, storage was improved, and the

	Camera action	Script
		processing technologies were very effective. Prices stabilized and, increasingly, crops were transformed into other foodstuffs closer to the site of production. Of course, genetically modified crops were very controversial then. Some governments took a strong GM-free position and looked to European markets. Others sought out GM researchers to develop drought-resistant strains.
		Narrator: **So, what happened after the devastating drought of 2006–2009?**
		Ogola: I shall never forget that time. It was truly awful and many governments rethought policies, and we worked to have a strategic grain reserve equivalent to at least one year's harvest. Of course, some people said it would be ruinously expensive and inefficient, but that is where improved regional cooperation started to make a difference: not every country could do it, but close cooperation between neighbouring countries and regions meant that we worked harder to put distribution mechanisms in place. By avoiding having to buy food with foreign exchange in an emergency, it was hoped they could still pay off debts during drought years. While these policies were costly to public budgets in the short term, leaders argued that these investments would redeem themselves in the longer term… by reducing the need for any future heavy dependence on food aid; by avoiding the large movements of people in times of food scarcity; and by helping to ensure people could get adequate nourishment. During the last drought, while it was tough, and watching crops die is always terrible, the deeper fears of food shortages, large-scale migrations, and starving children were less strong. It was hard, but we survived in a way that wouldn't have been possible even a decade earlier.
		Narrator: **More affordable food, less movement of people when the rains failed, less rural poverty: all of these had a positive impact on HIV prevention programmes.** **And now you are managing an agricultural cooperative—congratulations, Miriam.**
		Ogola: Thank you.
Reassessing education	*Camera focuses in on narrator.*	*Narrator:* **Of course, Miriam started out with a good education. But the education sector has not always worked so well. To explore this further, I met Mrs Patricia Ombaka—the highly respected Minister for Education. We spoke on a visit to her old school.**
	Camera shows the two of them entering a simple town school—it is empty. They walk to a classroom and sit at desks to continue their discussion.	*Minister Ombaka:* When I first started at school I was one of the lucky ones… Africa entered the new millennium with the lowest school enrolment figures in the world. The 1980s and 1990s had seen a drastic reduction in state investment in education systems as the debt crisis reached its peak in many countries. For every 1 000 children who entered primary school, less than a handful graduated from university. With AIDS still killing off our skilled workers, including teachers, we were facing an acute shortage of people to provide services and run the country. Of course, we have had to rethink the education models that placed emphasis on primary education for all and allowed the neglect of secondary education that was occurring—and different countries did that in different ways—but I believe we are better served by the more holistic approach of today. We—like many other countries with a serious AIDS epidemic—also had to try and rebuild much of the capacity that had been lost to HIV and AIDS.

	Camera action	Script
		Narrator: **Do you support the emphasis on civic responsibilities?**
		Minister Ombaka: Yes indeed, and I support the focus on higher levels of education. I know it was hard, and I left many of my school friends behind when I went on, but my country needed me to be part of a critical mass of well trained personnel. Of course, my brothers and sisters who stayed behind did get post-primary training. In the end, I had to go to southern Africa for university—you see, some countries had managed to rejuvenate their universities much more quickly. Not only were my teachers better paid, but I could access learning resources.
		Narrator: **You stayed away for almost a decade. When you came back, you entered the teaching system. Was it different from when you left?**
		Minister Ombaka: Yes, it was very different—there has been a gradual increase in academic standards, particularly in secondary education, and I would say that this has, in turn, led to higher standards of service delivery in the public sector. We have seen the expansion of vocational training as well, with new enterprise development centres springing up. Not surprisingly, we are witnessing the emergence of a new generation of young African entrepreneurs. And the interesting thing is that many of them see Africa as a place they want to stay. I am not the only one who can return to see her old school.
		Narrator: **So, what made the biggest difference for girls like yourself?**
		Minister Ombaka: Well, it's generally accepted now, but back then the promotion of female education in particular really made a difference to the response to HIV and AIDS. Of course, the provision of targeted services, such as microfinance, also helped. My mother, for instance, was involved in a savings group in our village. Without education, it would have been an entirely different story for me… If I had not had the life-skills training that gave me the knowledge and strength to avoid high-risk sexual behaviours… I would probably be dead by now.
		Narrator: **Were your family shocked by what you learnt?**
		Minister Ombaka (laughs): Perhaps. But by then, after hard debate, the decision had been made in my country to tackle HIV head on… to take the tough decisions needed to really tackle the epidemic… and that meant using schools, and every available platform. Today, I am committed to our policy of making condoms available for senior secondary school students, free of charge. Despite some fierce protest from some religious leaders, in some countries, the policy is proving to be very successful. If we had had them back then… a lot of my classmates would still be alive.
		Narrator: **Thank you very much for joining us, Minister Ombaka.**
Reinvigorating health policies	*Camera closes in on the narrator.*	*Narrator:* **On that note, we will now look at how health priorities were dealt with back then, in countries across the continent. Just as in agriculture and education, there were tough choices to be made. Doctor Kandeke spoke to us in the teaching hospital he has run for 15 years.**

Camera action	Script
Camera cuts to a shot of the narrator being greeted by the white-coated and bespectacled Doctor Kandeke and shown to a medical teaching theatre.	*Narrator:* **Doctor Kandeke, even in countries where AIDS had struck hard, many leaders felt that the best long-term strategy lay in tackling the epidemic in the wider context. How did this take shape?** *Doctor Kandeke (appearing nervous):* Fairly early in the roll-out of antiretroviral therapy, it became clear that we were going to make the problem worse rather than better unless we concentrated on developing proper health systems. But it wasn't just the impact of AIDS. Health ministries in many parts of Africa concentrated efforts at the secondary and district levels of health systems, and in urban hospitals, because it was easier to drive up standards there, recentralizing to keep better control of limited budgets and secure essential skills and staff. Of course, they also had to invest in communications and transport to get poorer people to better care. *Narrator:* **What drove this approach?** *Doctor Kandeke:* I think this approach was an acknowledgement that local level services were being underutilized, and partly that primary health continued to attract donor funds, as well as service provision from willing NGOs and faith-based organizations. It also seemed to be a strategy that kept our medical staff happier. *Narrator:* **One issue that governments tackled with stern action was that of the emigration of health personnel. Did this affect you, personally?** *Doctor Kandeke:* No, I never wanted to leave, but I had friends that did. They were slowed down by the new bilateral agreements. Some of my friends had to come back because the government insisted on personnel returning after a set period. Some even had their passports withheld. By the time I was running a hospital myself, I agreed with the government. I did not want to lose good staff and I supported the naming and shaming of companies and countries that were poaching our people.
Doctor Kandeke leans forward to emphasize his next point, and is now much less nervous	But I want your viewers to look at the real issues. Let's take maternal mortality rates, which are now falling in many countries—they provide a ready indicator of the overall success in health provision. Improving maternal health services also acted as a foundation programme for more effective programmes to prevent mother-to-child transmission of HIV, which have also provided a safe and effective way to approach a more general roll-out of antiretroviral therapy, as funds and systems were put in place. And the TB programmes as well—they were gradually aligned with HIV efforts. TB patients are now routinely tested for HIV. Patients are increasingly offered TB prophylaxis as a cost-effective way of improving their quality of life. The governments have subsidized faith-based organizations and NGOs so they can provide outreach programmes in rural areas. In many parts of Africa, malaria has become a success story too… Governments had long understood the economic impacts of malaria and over the last 20 years they really acted on the knowledge, focusing on prevention and rapid treatment with newer drugs, made by and large in Africa. It is an area donors have always been interested in funding, particularly as we began to make real progress.
They walk down the corridor, deep in conversation. The screen fades to black.	*Doctor Kandeke (standing and leading the narrator out of the room):* Come with me. I'd like to show you our new ward.

UNAIDS/G. PIROZZI

Part 3: Living in a world with AIDS

Camera action	Script
Camera pulls back from darkness to show a busy hospital. Initial montage sequence filmed in a vox-pop style with nurses speaking.	*Woman (1):* We broke the silence—but first we had to find our voice. Once we found it, we couldn't be stopped. *Man:* Of course there were choices to be made—but it never came down to a simple choice between prevention and treatment. *Woman (2):* Rather, we had to make choices about how we could best use precious resources to secure our future.
Open with the narrator walking through a rural hospital towards the antiretroviral therapy clinic. People are gathered all around, some queuing, others talking. The narrator stops to look at a baby in a mother's arms. Camera moves to focus on a man interviewing people in a queue. He is short and very intense, wearing rumpled clothes—he is Doctor Asaba, a local researcher. The two men move together to sit down on the steps of the clinic.	*Narrator (speaking to the camera):* **Welcome to the third part of our series—we are looking at why the catastrophe in Africa didn't happen as some had predicted.** **Demographic projections for today, 2025, were causing considerable consternation 20 years ago. In high HIV prevalence countries, high mortality was showing up in demographic distortions, with long-term consequences. And in low prevalence countries, leaders were determined to prevent their epidemics spinning out of control.**
Prevention—openness or stigma?	*Narrator:* **Doctor Asaba, an historical epidemiologist, has made a particular study of responses to the AIDS epidemic in Africa over the last 20 years.** **Doctor Asaba, what stands out to you about the early twenty-first century?** *Doctor Asaba:* I would say that three things stand out: first, most governments focused on prevention—it's cheaper in the long run, after all. Second, whatever their strategy, the rights of the individual were subsumed into the rights of the community and the good of the nation. And third, what drove many governments was a shrewd pragmatism: they needed to halt the epidemic even if it meant tackling issues that were considered embarrassing, even taboo. Out of these, I would stress the importance of prevention: a great deal of money, both from donors in the early years and increasingly from our own domestic budgets, went into slowing down transmission—with considerable success. *Narrator:* **Leaders had to find some way to encourage and enable people to change their behaviour—either voluntarily or, if necessary, by coercing them. How was this handled?** *Doctor Asaba:* In most cases, rather than explicitly confronting and challenging current sexual behaviour, political and community leaders tried

	Camera action	Script
		to work with existing practices, trying to evolve or reinforce those cultural and religious practices that reduce transmission, while adapting or abandoning those that were more dangerous. You see, the values and beliefs of a community are crucial tools for reinforcing safe and constructive behaviour by individuals. Of course, for governments, navigating between helpful and harmful traditions was a minefield.
		Narrator: **A huge variety of approaches have been adopted—some concentrated on creating an AIDS-free generation, where the goal was to reach children before they become sexually active.**
		Doctor Asaba: Yes and a few leaders were a lot tougher as they tried to control group behaviour—instituting mandatory HIV testing of workers in the public sector and recruited labourers. Others tried to regulate the movement of seasonal workers who they feared might be helping to spread the virus. All kinds of techniques were used to get information across—radio, street theatre, poster campaigns, village meetings…
	The camera focuses on the attractive face of Babadawa, star of stage and screen, as he moves through the crowd to join Doctor Asaba and the narrator.	*Narrator:* **There certainly was a lot of communicating going on…** **Babadawa, welcome** *(shaking hands)*. **You have become famous, not just as an actor, but also as an advocate for the Africa-wide popular theatre movement.**
		Babadawa: That's right—since I was a boy, popular theatre has mushroomed. In the theatre, we can do stories about every kind of difficult issue. Hey, we can do tribal conflict, disease, illiteracy, gender, even child abuse. I heard about a group that even made the debt crisis and bureaucracy into a really fine play.
		Narrator: **Well, how is it done?**
		Babadawa: Well… we use dance, drama, poetry, and songs to tackle some of the problems of life head-on. And I am proud to say that performance gets everyone involved—there's nothing élitist about popular theatre. You know, sometimes the after-performance discussions go on for days, or even weeks. It can get heated! I have seen these discussions and debates lead to real life changes in actions and attitudes, especially about HIV and AIDS.
Encouraging behavioural change		*Narrator (turning to the camera):* **Many national leaders coopted religious and local leaders to give strong leadership on the ground. These local leaders were able to tailor campaigns for their particular communities. On the whole, local leaders did take responsibility for delivering prevention messages and developing coping strategies, as well as supporting legal and cultural reforms.**
	Pastor Jean-Paul, a priest, and Dr Abdul Raheem, an Islamic scholar, come out of the clinic and sit with them on the steps:	**Pastor Jean-Paul, Doctor Raheem, thank you for coming. You have both been working in this area for a long time. I wanted to ask you about those leaders who have been reluctant to acknowledge that vulnerability to HIV remains—especially when sexual behaviour is driven underground.**
		Pastor Jean-Paul: It is true that in certain countries, government treatment of certain groups—I'm thinking of sex workers, men who have sex with men, and homosexuals—has provoked outrage. You see, the problem is that when they blame particular people for spreading HIV, they just fuel the stigma, which affects everyone living with HIV.

Camera action	Script

Narrator: **Exactly; but didn't the condom issue cause even more heated debate?**

Doctor Raheem: Yes, the approach to condoms does provide a vivid example of how different leaders have used different approaches. Instead of trying to suppress sexual behaviour, increasingly the more pragmatic leaders campaigned for greater use of condoms—mostly the male kind, but some female, too.

In some countries, condoms were provided for 'transactional sex' with availability enforced on pain of closure of bars and hotels. More countries have legalized prostitution, and commercial sex workers are regularly tested for HIV.

We support campaigns to persuade men to take more responsibility for their sexual behaviour. Many religious schools now have programmes that incorporate relationship education.

Narrator: **This was a difficult process, one not helped by the absence of quality condoms in sufficient numbers to meet the demand. But in some countries, the emphasis on condoms was met with major resistance from religious leaders. How did that affect anti-AIDS campaigns?**

Pastor Jean-Paul: Well, actually, on the whole, most governments managed to overcome such protests. In a number of countries, religious leaders were persuaded to help: in these countries, condoms were seen as 'the lesser evil', since many religious leaders encouraged their use by describing them as the lesser evil compared to infecting another person.

Of course, in other countries, things were looked at differently. They campaigned instead for abstinence, some arguing that condoms would encourage promiscuity, or claiming that they didn't protect against HIV infection. Some of these leaders even stopped condom imports from external donors and closed down campaigns promoting condom use.

The thing I think we need to emphasize is that both very conservative and more pragmatic approaches could work—or could fail. And condoms alone were probably not the main issue; it was more complex than that. Even if there were enough condoms, if a campaign wasn't coupled with more open conversations about sexual behaviour or age mixing, then its success would be limited. Similarly, if an abstinence campaign stigmatized those who caught the disease, or drove extramarital sex underground and fuelled an increase in sex work, then its success would be limited too.

Narrator: **Many leaders had to choose whether or not—and to what extent—to talk openly about the epidemic. Why was that?**

Pastor Jean-Paul: Well, on the one hand, they risked embarrassing—or angering—certain groups within their community. And, on the other hand, they had to destigmatize the epidemic.

Many struggled to find a balance.

Take for example, attitudes towards different expressions of sexuality. Over the last 20 years, there has been very limited progress. In some countries, both men who have sex with men and gay men and women have just been ignored. In other countries, they are oppressed—there are still campaigns against 'unnatural practices'. In some cases these are specifically tied to AIDS-awareness programmes. Obviously, these approaches have meant that these groups have not been able to get the information they need about safer sex.

Camera action	Script
	In other countries—a minority, I have to say—governments anxious to tackle HIV have been pragmatic, and have allowed limited condom distribution programmes, in prisons for example, and at outreach points. Very few indeed have amended their constitutions to guarantee non-discrimination on grounds of sexuality or sexual practices—and even fewer have put existing clauses into practice. Finding the balance between conservative and more liberal approaches has been the hallmark of much HIV prevention work. But, even so, in the early years, we saw members of governments in an increasing number of countries talking openly about their HIV status and staging public tests, while people living with HIV and AIDS were encouraged to play a key role in public, government-supported campaigns.
	Doctor Asaba (rejoining the discussion): Mind you, there have been increasing numbers of interdenominational initiatives by various religious groups responding to the epidemic. They have made big strides on the issue of sex education for HIV prevention.
	Doctor Raheem: Yes, that's right—most of these programmes have a moral component. Official statements stress compassion and acceptance, although misconceptions of the disease as divine punishment for transgression still colour the approach of many individuals, and have, in some places, done nothing to tackle silence, stigma, and blame.
	Doctor Asaba: I have to say that some leaders have continued to believe that stigmatizing the disease will have a positive effect. They reason that because people fear stigma, people would change their behaviour. Of course, where stigma was used, it has tended to backfire—particularly on women. They tend to be tested first, so the stigma of being infected attaches to them and we have known for a long time now that stigma inhibits HIV testing, particularly among men. But across Africa, more people know their status than in the early days, helped a bit by the growing availability of treatment. Some places have made a virtue out of declaring your status openly.
	Narrator: **At the same time as Africa was tackling the social aspects of AIDS, there were big changes in access to antiretroviral drugs as well. There was a focus on intellectual property rights and the need for compulsory licensing of patented products.**
The intellectual property story	*Doctor Asaba:* Oh yes, there was. This has always been an important subject for me. Can you imagine an historical epidemiologist getting interested in trade issues! But you see, trade issues had a powerful effect on the disease, so I had to be interested. I remember celebrating—yes, I was much younger then—when the unity shown by African and other *G20* governments in the world trade rounds finally paid off and they succeeded on extending the period for compliance with *TRIPS* from 2016 to 2026!
	Narrator: **Ah yes. Back in August 2003 there was early agreement making it clear that countries without manufacturing capacity could import generics.**
	Doctor Asaba: Without the pressure of compliance deadlines, countries were freed up to pursue pragmatic solutions.

	Camera action	Script
		Narrator: **So what did they do?**
		Doctor Asaba: They seized on the opportunities provided by the *TRIPS Agreement* and *Doha Declaration* and pursued whatever mix suited them best: importing from developing country generic manufacturers; deeply discounted or donated products from research-based manufacturers; locally manufactured products; or importing under voluntary or compulsory licenses.
		Narrator: **So, by 2015, the production and supply of first line antiretrovirals in fixed dose combinations had become standard?**
		Doctor Asaba: Yes—governments demanded and secured fixed dose regimen supply. Initially established as subsidiaries of Brazilian, Indian, South African, and other manufacturers, a number of publicly-regulated low-cost manufacturing sites were established in East and West Africa.
		Narrator: **What happened with new patented products as they became available?**
		Doctor Asaba: Well, there remains a vigorous international debate, led by our governments, on ways to make newly patented drugs available as soon as possible and as cheaply as possible to developing countries. Governments have made it clear early on that they would not be interested in bilateral trade agreements favouring the interests of patent-holders or restricting governments' capacity to procure medicines as cheaply as possible. The new generation of bilateral trade agreements converged with multilateral agreements, maintaining a balance between, on the one hand, the aspirations and safeguards of the *Doha Declaration*, and on the other hand, realizing the investment potentials of intellectual property.
		Narrator: **And today?**
		Doctor Asaba: Well, in three or four countries local manufacturing capacity has become well established. Sites are not widespread, but they are able to operate with acceptable quality standards and at high volume. The generic production of older antiretroviral drugs is established practice and does not attract international controversy. There are also some African companies that are beginning to consider transforming themselves into research and development companies—it took the Indian industry some 30 years to reach this stage.
Antiretroviral drugs—a question of distribution	*A mature woman in a nursing uniform comes to sit with the group. Her voice is quiet but very authoritative.*	*Narrator:* **At this point, let me introduce Nurse Masiga. She is Head of Nursing at the hospital here and has seen the human side of all the talking.** **Nurse Masiga—at the turn of the century, everyone's thoughts were concentrated on antiretroviral therapy, what was it like to be working in nursing at that time?**
		Nurse Masiga: Well, my dear, on the ground things were not so simple. We already had a lot of experience in delivering palliative care and in treating the opportunistic infections, but the new drugs were a different story. And even when the price of antiretroviral drugs came down dramatically, there were still tough choices to be made. There simply weren't enough drugs for everyone. Who to treat, how to treat, and what to treat with—it certainly challenged my belief, as a medical person, that everyone should be treated equally. But we could always do something to help even if antiretroviral drugs weren't there.

Camera action	Script
	There were major efforts to make simpler drugs—cotrimoxazole, for example—much more widely available. Even this was a challenge in some countries.
	Narrator: **All governments treated antiretroviral drugs with extreme care, not least because they needed to extend their efficacy—their limited government resources meant that it was never possible to supply drugs for all.**
	Nurse Masiga: Well, governments had to make difficult decisions about rationing antiretroviral drugs, even if this was only implicit. In some countries, this provoked protests. It was a real test of the leaders—they had to communicate their vision with enough power to persuade people that they, the government, were making the right choices. It sounded sensible to me—well, it did until my brother needed help and he was just a smallholding farmer.
	Doctor Asaba (leaning forward): Some leaders did manage it. Some conjured strong arguments—captured the trust of key people in communities; others put together incredible information campaigns. But some countries just weren't ready for the violence of the response… There were riots—most of us remember them—the outcry when they called the army out to deal with them…
	Nurse Masiga: Yes, we had to make real efforts to prevent drugs seeping out of the public sector or licensed private sector and NGO settings, as governments understood that preserving the efficacy of first and second line regimens for as long as possible is essential. They even increased our pay to encourage us not to sell drugs illicitly. This was mainly in urban areas, though district hospitals were established as delivery points for key rural workers. Others argued that the drugs should be limited to those who were leading the country and its people, the teachers, the doctors, the public servants—some said that antiretroviral drugs have been used as a tool to win support among key groups. Either way, as systems have been put in place, the number of people who can get drugs has gone steadily upwards. More than a third of people needing them get them now…
	Doctor Asaba: Don't forget that, as well as working for behavioural change and wider use of modern medicine, we were also working hard to encourage the development of African traditional therapies and medicines. The *Annan Centre for Holistic Therapy* is renowned for its innovative research into the combined use of traditional and biomedical approaches to AIDS.
	Nurse Masiga: Yes, my dear, and early microbicide trials revealed a demand for female-controlled protection methods, even though they didn't produce an effective microbicide. Combined with a widespread sense that African women were being treated as 'guinea pigs' by Northern researchers, this made it clear that there was a market for an 'African' microbicide, developed in Africa, for Africans, using African products. There was even research into the development of a genetically modified plant-based microbicide. Some governments decided that the threat of GM crops was a lesser evil than the HIV epidemic—and the first successful microbicide became available around seven years ago. Now, of course, we have a microbicide based on antiretroviral drug technology. But it is being prescribed quite carefully—there is concern that viral resistance may develop if it is used inconsistently.

Camera action | **Script**

Doctor Asaba: And there were vaccine trials. Hopes for rapid progress at the beginning of the century didn't materialize: development stalled, hampered by the need for money and capacity. I remember them saying that a minimum of US$ 1 billion was needed for efficacy trials, and manufacturing infrastructure had yet to be put in place. It took a while to recover momentum. The good news was that the microbicide development generated interest, funding, and laboratory facilities for the further development of a vaccine. Phase III vaccine trials are now beginning in three countries as we speak. We are very optimistic—and much of the work has been led by African researchers.

Nurse Masiga: And I had the best time training traditional healers. They had such a different perspective on the world. It really taught me something, too. And there were more of them than doctors. They really took the training seriously, and while not every one of them has been a success, enough of them have taken on new roles, and it has boosted our health service—and certainly our outreach to more remote places.

Pastor Jean-Paul: I'm afraid I still remember the sick and the dying. Even now, illness and death still stalk the continent. Yes, we have changed our attitudes, beliefs, and rituals. But… sometimes I wonder at the human cost of it all… the losses…

Narrator: **But there is good news. Even though the total numbers are still high today, the rigorous approach to prevention in the early years has led to fewer infections since 2010. The rate of illness and death from AIDS has been declining for the last decade. That is surely an achievement…**

Pastor Jean-Paul: …but there is still a toll of suffering that we must never forget…

The sound fades out while the camera stays on the group as they talk and then fades to black.

Figure 24 Ratio of healers and doctors to population in selected countries, 2003

	Ratio to population	
Country	**Healers**	**Doctors**
Zimbabwe	1:600	1:6 250
Ghana	1:200	1:20 000
Uganda	1:700	1:25 000
Tanzania	1:400	1:33 000
Mozambique	1:200	1:50 000

Source: Gbodossou EVA et al (2003) *The role of traditional medicine in the fight against HIV/AIDS in Africa.* Project paper.

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Part 4: Years of reward

Camera action	Script
Camera slowly fades from black to scenes of hushed people pouring out of a large football stadium. There is rousing national music in the background. Montage sequence filmed in a vox-pop style with people leaving the football stadium. They speak with quiet pride.	*Man (1):* We are Africans, first and foremost, now. And, as Africans, we're proud of what we've done and confident about what we will achieve. *Man (2):* It's been a long hard road, and there's been a lot of suffering, but now we've turned the corner. *Woman:* We have honoured our history and our ancestors and made the world safer for our children. *Narrator (walking into the stadium and turning to camera):* **Over the past 25 years, there has been a growing spirit of African pride across the continent—at individual, community, country, and continental levels. We are still living with HIV and AIDS, but the worst of the predicted impact has not happened. In this final programme, we look at how and why the crisis is lessening in impact.** **I have asked Professor Oyo and Professor Amanzi to join me again after today's presidential address, in order to look at what went right.**
Growing peace... *The two professors emerge from the stadium tunnel, moving against the crowd. They and the narrator seat themselves on nearby stadium chairs.*	*Narrator:* **Many leaders have succeeded in managing the balance between pursuing their national interest and developing regional alliances. Have there, in fact, been shared solutions?** *Professor Oyo:* Why, yes. Shared solutions between countries have proliferated. At the 2014 *African Union* Summit on African crossborder spillovers, leaders gathered to tackle common problems, such as the effects of conflicts and scarcities, to discuss new approaches, and, importantly, to pool skills, capacities, and resources. *Professor Amanzi:* To begin with, peace looked particularly difficult to maintain. As the number of security officers, both police and military, that had been directly or indirectly affected by AIDS increased, the strength and capacities of many national security forces began to decrease. *Professor Oyo:* Yes, in some countries, governments targeted the provision of antiretroviral drugs, at least in part, at the security forces... although, in other countries, military budgets would not stretch that far. In some countries, infection, bereavement, care responsibilities, and low morale rendered the security forces ineffective, and as a result their duties were neglected.

Camera action	Script
	Narrator: **For foreign direct investment to be possible, peace and security were crucial. Governments also knew that if crime went unchecked, it could fuel public anarchy and dissent, which would threaten regime security. How did they address this problem?**
	Professor Amanzi: Some turned to private security firms, at times with personnel from other countries. Governments were able to keep firm control of these groups, and scrutinize them effectively. Some invested more heavily in the military and the police.
	Narrator: **Did that work?**
	Professor Amanzi: Oh yes, these approaches have worked and crime has been reduced considerably as a result. But other governments have looked the other way—they just want to get the job done—so there have been all kinds of problems, such as extrajudicial activities, corruption, and nepotism.
	Professor Oyo: Around 2010, sporadic riots and social unrest erupted in several parts of the continent. In response, the *AU Peace and Security Council* called an emergency meeting to agree on the necessary intervention strategies to promote public peace and communal security. If these social eruptions were not to escalate into full-blown conflicts, something drastic had to be done.
	Professor Amanzi: Many national governments also agreed. They feared that if it wasn't contained, countries would be rendered ungovernable, terrorists and their recruiters would find good cover for their activities in Africa, and then could successfully enlist a hoard of angry young people for their activities.
Nelson Abba joins the group. He is younger than the professors, but older than their current students.	*Narrator:* **Nelson Abba, you took part in the demonstrations—even led some of them. What did people think about the violence?**
	Abba: Well, the governments feared that the demonstrations could trigger latent ethnic or religious tensions or create the right atmosphere for a coup d'état. However, we human rights activists and protesters felt that democratic values were fundamental to effective nation building and good governance. Even in the midst of it all, we sounded a note of caution against the drastic use of force or a clampdown on fundamental freedoms.
	Narrator: **So... what happened?**
	Abba: Two camps emerged among the government and civil society leaders: the 'hawks'—who felt that a state of emergency should be called and the constitution suspended in instances of unrest; and the 'doves'—who responded by insisting on peaceful approaches, minimal use of force, and respect for the rule of law and dialogue. They argued that interventions had to be rapid but constitutional, robust but measured, without undermining the gains that had already been made in securing public confidence and in enshrining civil rights.
	Narrator: **So who won?**
	Abba: The situation was pretty fluid: sometimes the 'doves' won the argument and at other times the 'hawks' did. In many cases, countries did what was best for their specific circumstances, but without threatening regional allegiances. In those times, regional support was most important and no country could do without it.

Camera action	Script
	Professor Oyo: That's right—the *AU Peace and Security Council* decided to take a balanced approach and, in tandem with the *African Court on Human and Peoples' Rights* and the *Pan-African Parliament,* provided an intervention framework that included human rights training for national security forces to enable them to quell social unrest with minimal force, while at the same time maintaining human rights, peace, and security.
	Professor Amanzi: Security was in many ways a catalyst for new forms of regional cooperation across the continent, and the renewed sense of pan-African unity went from strength to strength as the century unfolded.
	Professor Oyo: At the end of the first decade of the twenty-first century, it was clear that the spirit of African governments was to look to themselves and each other. In this spirit, the *AU's New Partnership for Africa's Development (NEPAD),* was renamed the *African Partnership for Africa's Development (APAD).* Although the ideals of *NEPAD* remained in *APAD,* in terms of poverty reduction and ensuring enabling environments for peace and security to flourish, African governments this time changed their approach and decided to find much more of their funding from within—as difficult as this was.
...And prosperity	*Abba (slapping his leg):* But we were very excited! There were two options put forward by the *AU.* First, member countries of the *AU* could contribute 0.5% of their GDP and a portion of these contributions would be earmarked for *APAD* and another for the *Peace and Security Council.* Or, the other option was to ask countries to increase their value added tax and contribute the increase to the *AU.*
	Narrator: **What did the public think of these ideas?**
	Abba: Well, we thought that the value added tax option stank! So it was rejected. Mind you, don't get me wrong. We were determined to face the challenges head-on. So, *APAD* focused on tapping the resources within the continent, mobilizing its skills and capacities, and directing these to meet both development goals as well as towards fighting the AIDS epidemic—it was a very brave effort for the *AU.*
	Professor Amanzi: They *were* brave—they refused to be junior partners in global development plans or strategies. They also refused funds from sources that demanded a deviation from their own strategies. The thinking behind their position was that it was not just Africa that needed to change, but rather the global system that had exploited it for years.
	Abba: It was great—they demanded fairer and increased integration into the global markets, as well as greater representation in multilateral institutions. We were outraged when we found out that, while most countries did toe the line, some countries made side deals in their own national interest. But these countries met with sanctions and isolation from within Africa and soon most countries kept to the *AU* position: "only on our terms".
The group is joined by Professor Parkes, who walks up from the tunnel entrance, flushed with exertion.	*Professor Parkes:* Isn't this where I take up the story?
	Narrator: **Yes, please do, Professor. You are a respected commentator—tell us the story as you see it.**

	Camera action	Script
		Professor Parkes: Well, if you are sitting comfortably... *(laughter from the group)* Most African countries found extraordinary benefits—through both internal and external trade—from standing together.
		Professor Oyo (interrupting excitedly): By 2018, Africa–Africa foreign direct investment had reached a stable peak at about 2% of African gross domestic product. In the African continent today, most countries have signed up to regional trade agreements.
		Professor Parkes: Thank you, Professor! The increased regional integration improved the resilience of individual countries by reducing the risks associated with being isolated and exposed, and by providing the opportunities to access resources and skills beyond those existing within individual national borders. But it did also raise feelings of insecurity about those shared resources and capacities. There have even been questions asked about the behaviour of the bigger, more powerful countries in these regional arrangements.
		Narrator: **Let's hear from Nurse Masiga about how health care survived—Nurse Masiga, where are you?**
Targeted solutions and growing impacts	*A woman emerges from the tunnel, taking a tray of drinks from a steward. She walks up the steps to the group.*	*Nurse Masiga (slightly out of breath):* Well, from my perspective, there's been a strong focus on providing health care—although antiretroviral drugs have been prioritized for public servants. However, it is argued that this has wider benefits: for most people, the increasing political and economic stability of their countries has meant that they face fewer situations of risk. There are generations of adolescents now—my own niece for one—who believe strongly not only that abstinence is acceptable, but also that it is desirable. And stigma is now turned against those who don't seem to be conforming to the national HIV prevention policies.
		Professor Oyo: We should welcome what the public servants did: they also watched friends, family, and colleagues dying of AIDS but they organized themselves into a unified voice and soon were far less than neutral in the debate on HIV and AIDS. Taking up the pan-African banner, they became a pressure group for accelerated HIV programming.
		Nurse Masiga, (handing round the tray and taking a seat): Mmmm, yes my dear, but now you see what is really a sort of 'community policing': citizens monitoring each other—each other's children; religious congregations not just looking out for their members, but actually overseeing them! Maybe it can be described as the other side of the support they offer each other… But what you have to remember is that in most of these communities there are groups who are marginalized, for whatever reason—it'll vary according to the values of each culture.
Women—greater safety or greater freedom		*Professor Amanzi:* Well, it's a complex story—while there are an increasing number of African women rising through the ranks of business and politics in many countries, other women have found that life has not changed. Some would say that the emphasis on behavioural change to prevent the spread of HIV in some countries has led to a curtailing of women's social and economic freedoms.
		Nurse Masiga: Of course, in some countries, men have invoked the past to trample all over any vestiges of 'Western feminism', and have attempted to put women back into their boxes. Thankfully, they usually fail, but there are still plenty of countries where there are double standards around 'promiscuity' with,

Camera action	Script

for example, considerable pressures—sometimes intolerable—on young women to remain virgins.

Now don't get me wrong, dear, I'm not criticizing abstinence as an approach to preventing infection. But I am criticizing it when there is no equivalent focus on the sexual behaviour of men, or any greater openness about relationship dynamics, or the realities of social pressure.

In particular, I take objection to the blind eye that is still turned to the problem of age mixing—in too many countries, the tendency is still for older men to look for younger brides, especially 'certified' virgins. I know that in some countries this practice has been made a focus of public campaigns, especially trying to deal with the problem of so called 'sugar daddies', and some countries have even introduced pre-nuptial HIV testing for men as well as women—though I have always worried about compulsory testing.

But there are still too many cases where certain leaders treat the whole age-mixing approach with indulgence, or even officially sanction it as part of their anti-AIDS approach. You know—keep the girls virgins 'til marriage and we'll slow HIV transmission. Of course it doesn't work. Unless you can guarantee that the older man is not already HIV-positive, it simply means that his virgin bride finds herself infected in no time at all.

Professor Amanzi: Mmmm yes, but in other countries, quite the opposite has happened, at least for women. They have been encouraged to play a far more active role in fighting the disease. Some have managed to take the opportunities presented by such changes to assert and negotiate their social position. Many of these are educated, wealthier women, most of whom are living in cities, but there are also examples of poorer, rural women—heads of households—who have achieved greater local recognition of their key role in fighting the virus and supporting their community.

Nurse Masiga: My niece wrote to me recently… to send me a copy of a letter that she sent to a local newspaper

I'll just skip to the good bit… This is what they published…

Nurse Masiga takes out and shows letter as she reads out loud.

Letters to the Editor

In general it's true that across Africa there is greater equality between the genders than there used to be. These changes have come about in some countries because of practical measures taken by governments to halt the spread of HIV.

In a number of countries women now feel safer: this might be because there has been a greater enforcement of a zero tolerance attitude to rape or other similar protective measures. In many countries, there are improving living standards, and so fewer women need to migrate to find work. Commercial sex work is better regulated in some countries now, which also means greater protection for women. And there have been more national women's organizations formed, including groups of women living with HIV and AIDS, in order to help implement national strategies against the HIV epidemic. Some women living with HIV and AIDS have found employment as prevention advocates.

My friends and I are proud to say that we are still at school—we have almost finished secondary education—and a number of us are hoping to go on to university. Many of us believe that abstinence is the best way forward.

You cannot imagine how proud we are of what we have achieved, and how proud we are of our parents, our leaders, of Africa. We are almost an AIDS-free generation. And now we want to contribute to our nation's future and we want a greater involvement in community decision-making.

Many of us are involved in finding new ways to deal with the epidemic—new ways to encourage behavioural change. I am a member of the school AIDS Club: we make presentations to the younger classes about safer sexual behaviour and help with the life skills or social studies classes for younger students. We are determined to carry the values of our ancestors and our people forward into the future: we will make sure Africa goes from strength to strength.

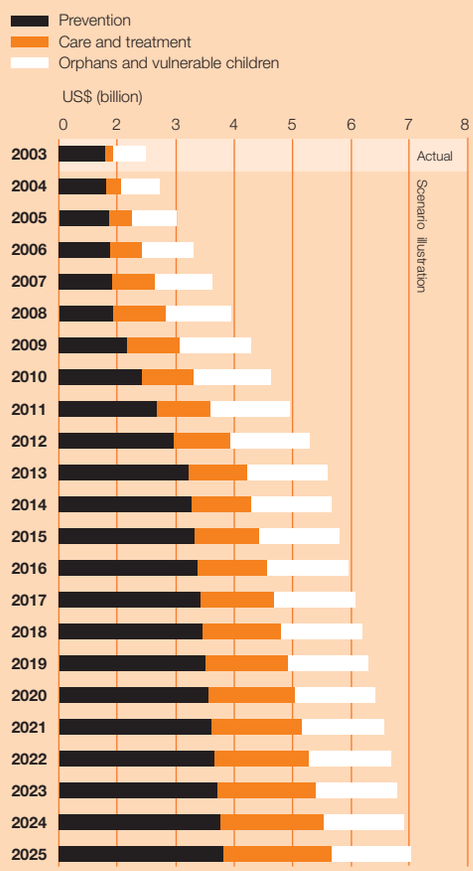
Camera action	Script
	Narrator: **What an excellent letter. Did she grow up with you?**
	Nurse Masiga: Yes, she did… and I've been able to see first hand how attitudes are changing to children who've been orphaned by the epidemic. I think there have been some positive developments. Children are treated with compassion, and they are also getting far more concrete help and real opportunities.
Orphans are valuable children	*Professor Amanzi:* You know, we used to call orphans 'vulnerable children'—and the attitude was that they were victims, walking disasters waiting to happen. We have worked really hard to change all that. One day I heard someone refer to 'valuable children'—and it struck a chord with me. We started to use it in our documents, in meetings, wherever we could. Gradually, I think that's what took hold. Not just the phrase, obviously, but the whole mindset—the way of looking at young people who have lost their parents as being 'valuable children'. There were some tough choices here. In some countries, leaders regarded vulnerable children as a useful, untapped resource, and used a variety of approaches to make sure they were taken care of, socialized, and educated or trained. This included food for work programmes, and community and family placement schemes, alongside community schools and orphanages. In some places, children without adult guardians have been 'contained' in government-run orphan camps: not the greatest place to be, but some would argue that it is better to be there than on the street. Local leaders were held responsible by central government to ensure no child slipped through these nets. As a result, communities have become more resilient and are better able to negotiate the impacts—physical and psychological—of AIDS and other shocks.
	Narrator: **During this time, remittances from the diaspora were growing. Was this a good thing?**
The diaspora comes home	*Professor Oyo:* Well yes, yes it was. In the past, the story of the African diaspora was predominantly one of loss and wasted opportunity: the phenomenon was described in terms of the flight of human capital or the 'brain drain'. But over the past 15 years or so, this has been changing. African leaders have reached out to Africans living abroad and vice versa, placing great emphasis on their potential for helping to create much needed economic wealth for their mother continent.
	Professor Parkes: And increasing numbers of diaspora Africans have been returning home, while members of the next generation leave to take their place. The ones returning are inspired by the changes taking place—they see their home countries, or their parents' home countries, as places of renewed hope and economic development—worth investing their hearts, their lives, and their children's futures in, as well as their money!
	Abba: Some of my old friends have come back—it's good too that younger people—people not even born in Africa—are coming back. They bring us precious skills, which they can put to good use.
Standing together, standing tall	*Professor Oyo:* Over the last 20 years, our leaders have led their countries out of the chaos of underdevelopment. In the process, they have made a series of extraordinarily difficult choices, managing tensions, soothing frictions, often walking a knife-edge between two extremes. Some have been more successful than others, and what exactly constitutes success has been the subject of much debate.

Camera action	Script
	Professor Amanzi: I think we have to be frank. In a number of countries, the approaches of the last 20 years have had their dark sides. Some leaders have reinforced values and policies that have, for example, failed to advance prior gains for the rights of women, or even reversed them. Some approaches have heightened xenophobia—and I'd say that there is considerable tension between some communities in various parts of Africa. On the other hand, many have pulled their countries out of the woods. I guess, in a couple of cases, we have to ask, do the ends justify the means…? Our *United Nations* friends would say never, but I'm not sure it is so simple.
	Professor Oyo: I would have to say yes. Across the continent, most of these leaders have managed to effectively operationalize their strategies—both in terms of capacity and infrastructure, and, in turn, instilled a new ethos.
	Narrator: **But can this be sustained?**
	Professor Parkes (laughing): If I had 20/20 foresight I could answer that question!
	Professor Amanzi (gesturing to the centre of the stadium, where a stage is being dismantled as people continue to disperse): We had a new vision for our country, and our continent, and we have seen it through. Can you see the hope and the pride? Africa's nations and people are standing together, and we're standing tall.

In the remainder of this article, and in line with its practice of providing summary historical data, *One World Review* presents an overview of some of the key indicators that help illustrate the progress achieved during the first 25 years of this century.

Tough choices: An overview

Figure 25 **Annual expenditure on HIV and AIDS, by component, 'Tough choices', 2003–2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

The human toll

The epidemiology of HIV shows how hard it has been to begin to turn the corner of the epidemic, at least in terms of lowering prevalence. Considerable efforts and expenditures have been made and there has been a significant increase in prevention activities. Today, in 2026, the number of adults and children with HIV and AIDS, about 25 million, is similar to what it was in 2003. As Africa's population has grown to 1.4 billion, we can be proud of the fact that, as a percentage of the population, there has been a considerable decline in HIV prevalence, from over 5% in 2003, to nearer 3% today.

Today, we are well ahead of the AIDS epidemic, but we have not succeeded in overcoming it.

The gender bias still remains, and women are more adversely affected by the epidemic. In 2003 adult male HIV prevalence was 4.9% and female prevalence was 6.4%. Today, these figures are 2.8% and 3.8% respectively.

Africa's path over the last 20 years has focused on prevention, although there has also been an effort to provide antiretroviral therapy: 1.5 million adults are receiving treatment today, compared to less than 78 000 in 2003. It is encouraging to note that the roll-out of antiretroviral therapy is on a steady upward trend, and just over 30% of those who need it today are receiving it.

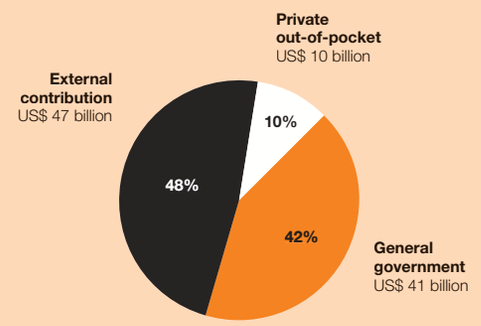
Africa has continued to see a high number of people dying from AIDS—60 million adults and 15 million children have died since the beginning of the epidemic. The annual number of deaths will continue to be high for some time, as reducing the rate of infection takes time to work through a population. Sadly, nearly 2 million adults across Africa are still dying from AIDS each year, as well as some 340 000 children.

Africa has responded—initiatives to help children orphaned by AIDS were increased significantly in the years up to 2010, and subsequent provisions are keeping pace with population growth. Nonetheless, the number of children orphaned by AIDS has risen from 12 million in 2003 to 22 million in 2025.

Costing action

Total AIDS spending in Africa has grown at an average rate of 6.6% per year since 2003. The growth rate between 2003 and 2013 was much faster at 12% per year, followed by a more moderate 2.3% per year from 2013 to 2025, due to earlier and effective prevention spending.

Figure 26 **Total expenditure on HIV and AIDS by source 'Tough choices', 2003–2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

Much of the increased spending has been on prevention activities, which were raised significantly between 2008 and 2014. Spending on care and treatment grew slowly initially, and then more rapidly in later years. Comparing the first and last bars in **Figure 25** illustrates how resource allocation has changed over the last 23 years.

Care and treatment has increased to 30% of total expenditure, and prevention-related expenditure has held up very strongly at nearly 50% of the total in 2025. The proportion allocated to orphans and vulnerable children is smaller now than in 2003, although in actual monetary terms the level of expenditure rose rapidly from 2003 to 2010, and has remained constant to 2025.

The cumulative costs have been just under US$ 98 billion dollars over the 23 years, 2003 to 2025. Fortunately, there was substantial and sustained donor assistance in the early years, although this reached a plateau around 2010. There has also been a considerable expansion of domestic capacity to take up and sustain the response to HIV and AIDS.

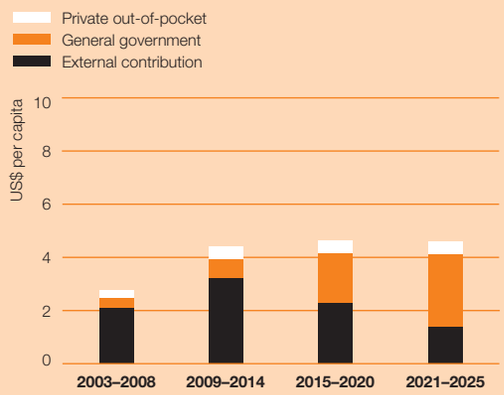
African economies grew at an average of 2% per year in real terms, and government budgets at 0.75% per year. The proportion of government budgets devoted to health increased to 13%. As a result, there was a considerable increase in domestic public sector capacity to resource HIV and AIDS spending. Over the period 2003–2025, investment came from several sources, including private spending, government expenditure, and international assistance.

There are regional variations in the proportion of costs met from the different sources of revenue (**Figures 27-30**). East Africa, and West and Central Africa, for example, required more aid and have remained more aid-dependent (due to greater populations and faster population growth) in recent years. Although the per capita programme costs were relatively low, at around US$ 4 per person per year, the size of the populations inflated the total costs to very large amounts.

Although receiving higher proportions of aid, both East Africa, and West and Central Africa have made efforts to self-finance their programmes. The initial programme costs, matched by growing government budgets, meant increasing budget deficits in some countries, particularly as tax revenues did not grow at the same rate as the government budgets. Similarly, the moderate economic growth strained individual financing, as out-of-pocket payments continued to be an important part of overall programme finances.

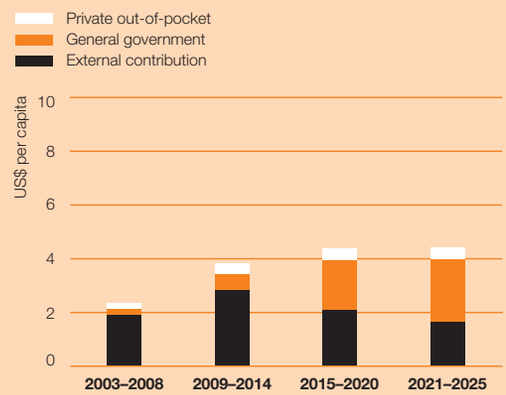
East Africa, and West and Central Africa attracted most of the available official development assistance, accounting for 74% of aid dedicated to HIV and AIDS intervention programmes in Africa over the last 20 years.

Figure 27 **Average annual per capita expenditure on HIV and AIDS in East Africa, by source, 'Tough choices', 2003–2025**



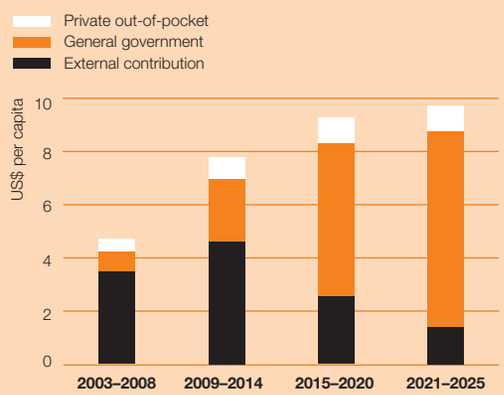
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 28 **Average annual per capita expenditure on HIV and AIDS in West and Central Africa, by source, 'Tough choices', 2003–2025**



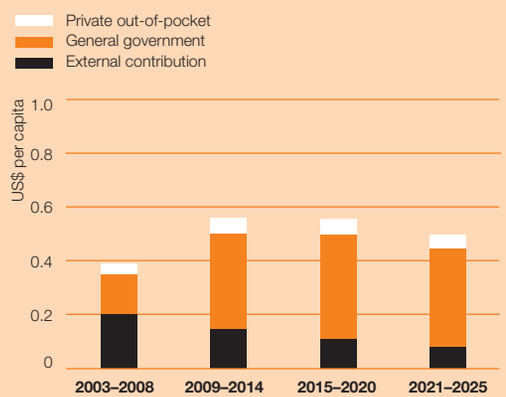
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 29 **Average annual per capita expenditure on HIV and AIDS in Southern Africa, by source, 'Tough choices', 2003–2025**



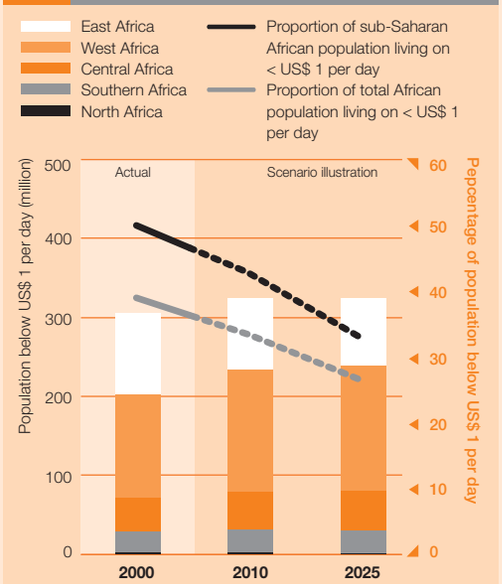
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 30 **Average annual per capita expenditure on HIV and AIDS in North Africa, by source, 'Tough choices', 2003–2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 31 Population living on less than US$ 1 per day, by region, 'Tough choices', selected years



Source: UN (2003) *World population projections – 2002 revision*, Geneva (2000 data); UNAIDS AIDS in Africa Scenarios Project.

Southern Africa faced a different financing situation. The region's lower demographic growth and its somewhat stronger economic base made it more independent of aid. Nevertheless, the high prevalence rates of the region and continuing population growth have had the cumulative effect of pushing up the annual per capita costs to over US$ 9 per person as of 2025. Much as in East Africa, and West and Central Africa, the early years of the intervention programme caused budgetary strains for governments and individuals.

Overall, the HIV and AIDS programming has been affordable. Overseas aid levels kick-started programmes, and levels were later reduced as governments took on a greater share of expenditure.

Millennium Development Goals

Figure 32 illustrates progress made against the Millennium Development Goals up to 2025. In North Africa, progress has been rapid and sustained. In sub-Saharan Africa, although progress has been slower, it has been constant and sustained.

Poverty

The proportion of people living in poverty has decreased across Africa over the last 20 years: from nearly 40% in 2000 to 27% in 2025 (in sub-Saharan Africa, from 50% to 33%). The actual number of people living in poverty has decreased in North and East Africa, remained steady in Southern Africa, and increased only slightly in West Africa (to 158 million) and Central Africa (to 51 million). On a pan-African basis, this translates into a slight actual overall increase from 306 to 325 million people.

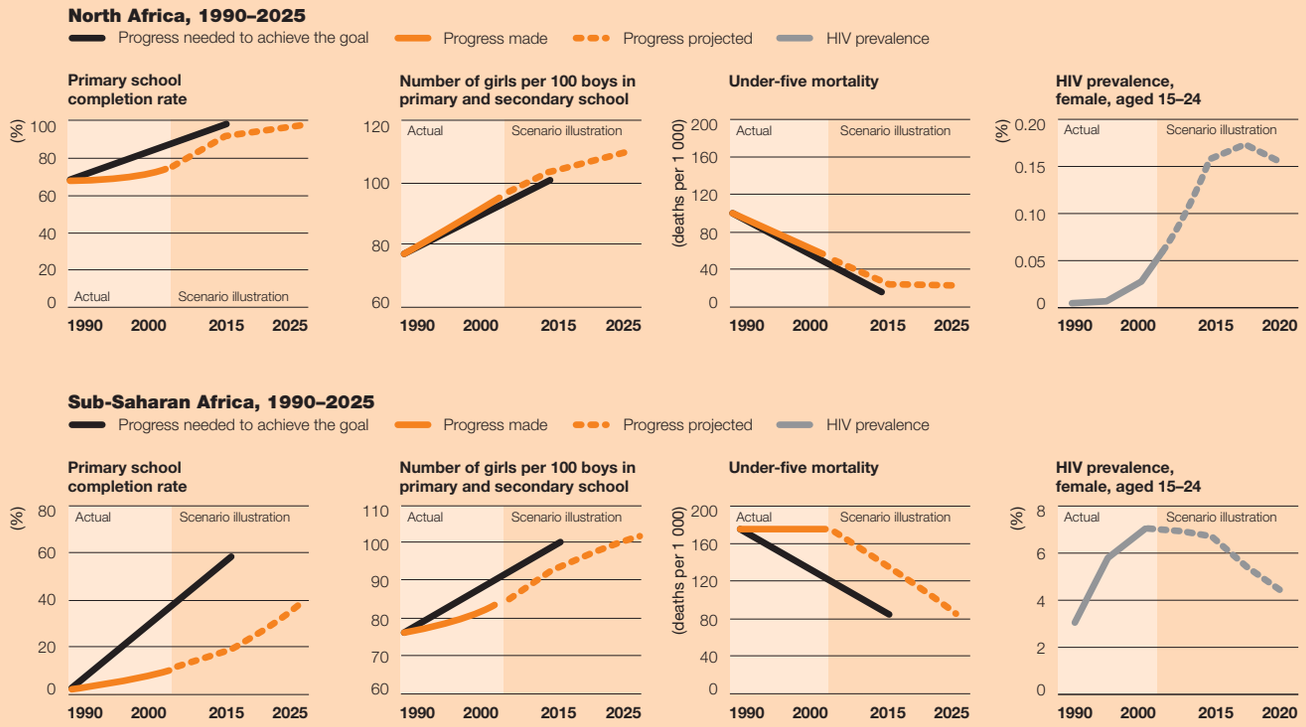
All Africa overview

Figures 33–36 are illustrations of trends in HIV and AIDS up to 2025. A full explanation of what is included in the costs is in **Appendix 1**. Over the last 20 years, overall adult HIV prevalence has fallen from 5.6% in 2004 to 3.3% in 2025.

Even though HIV prevalence fell most steeply from 2010, the total number of HIV-positive adults in 2025 (23.9 million) is almost as high as in 2004 (24.1 million). The growth in the actual number of new infections after 2015 is due to sustained population growth.

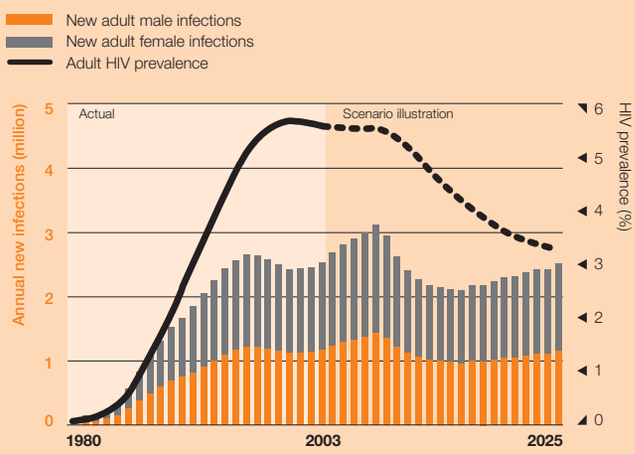
Women are still more adversely affected by the epidemic: the estimated number of new infections per year for adult females is 1.4 million in 2025, while for adult males it is 1.2 million.

Figure 32 **Progress made against Millennium Development Goals in North and sub-Saharan Africa, 'Tough choices' 1990–2025**



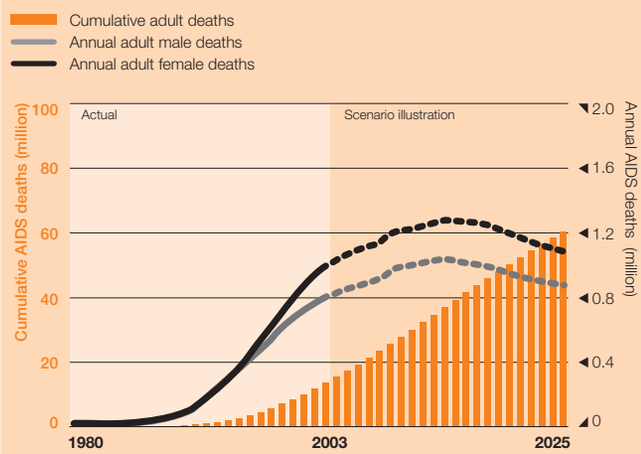
Source: UNDP/UNICEF (2002), *The Millennium Development Goals in Africa: promises and progress,* New York; UNAIDS AIDS in Africa Scenarios Project.

Figure 33 **Annual new adult HIV infections and adult HIV prevalence in Africa, 'Tough choices', 1980–2025**



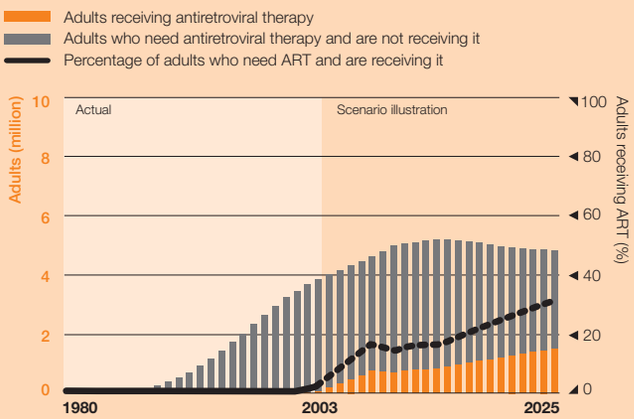
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 34 **Cumulative and annual adult deaths from AIDS in Africa, 'Tough choices', 1980–2025**



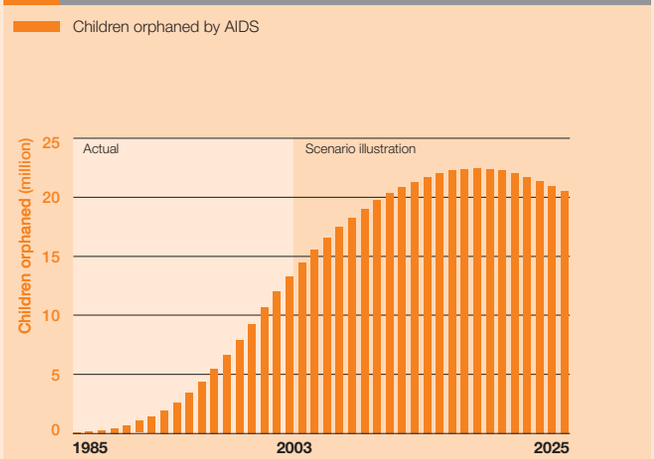
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 35 Adults receiving antiretroviral therapy and adults in need of antiretroviral therapy in Africa, 'Tough choices', 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 36 Children orphaned by AIDS in Africa, 'Tough choices', 1985–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

By 2025, 60 million adults and 15 million children had died of AIDS since 1980. The number of deaths per year for adults and children began to decline from 2016, to a total of 2.3 million in 2025 (**Figure 34**, previous page).

The difference between female and male deaths is less in 2025 than at the peak of annual mortality in 2014.

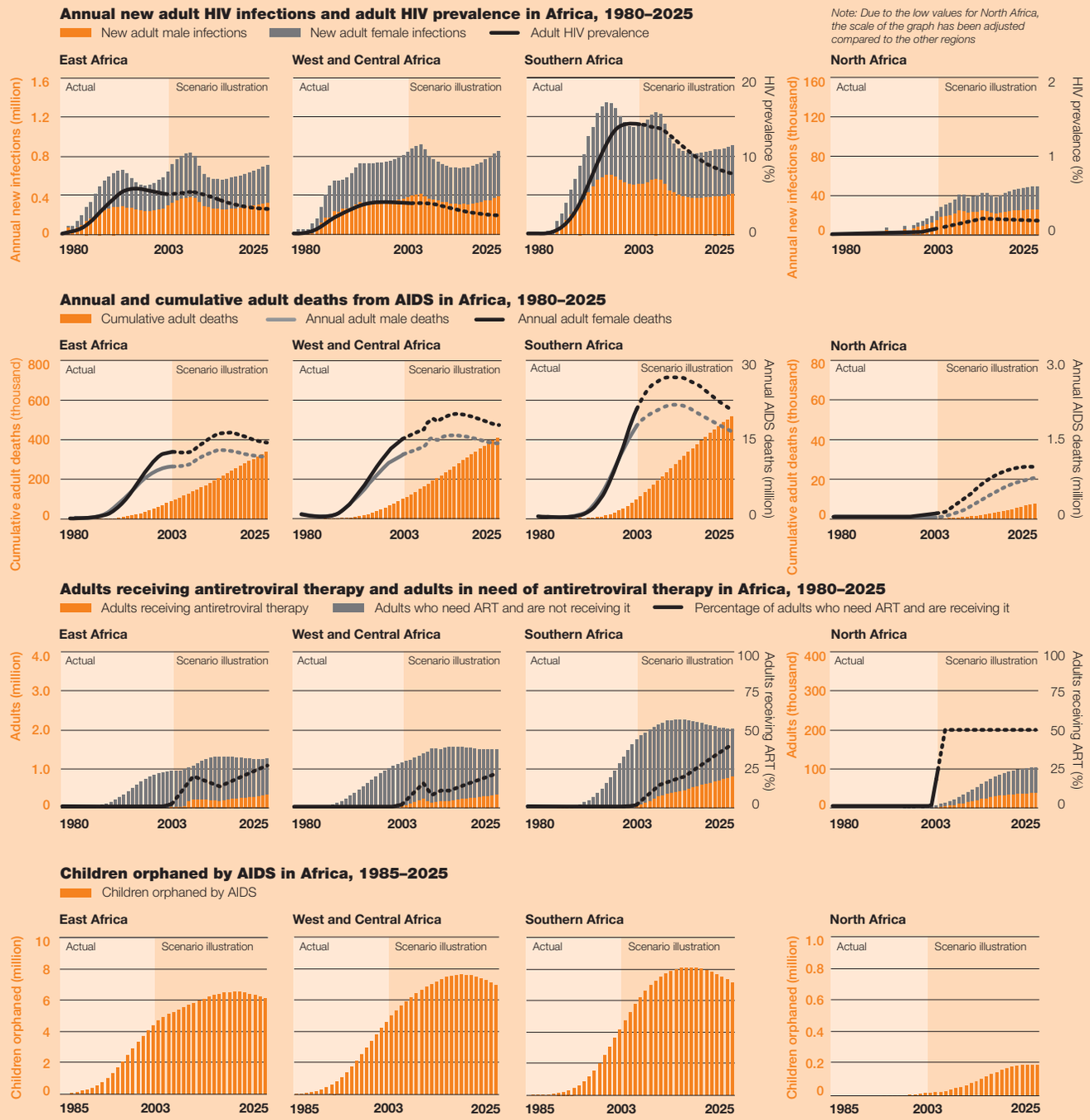
Of those needing antiretroviral therapy, 31.2% (1.5 million adults) had access to it by 2025. The increasing provision of antiretroviral therapy resulted in a reduction in the number of deaths per year from 2015. The number of people needing antiretroviral therapy and not receiving it will continue to reduce beyond 2025, as HIV prevalence falls and access to antiretroviral therapy continues to increase.

The number of children orphaned by AIDS continued to rise throughout the period until 2021, and in 2025 there were 22.4 million children orphaned by AIDS.

African regions overview

Figure 37 shows a breakdown of the epidemiology of the epidemic into the geographical regions of East, West and Central, Southern, and North Africa.

Figure 37 **Tough choices: Regional overview**



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data), UNAIDS AIDS in Africa Scenarios Project.

The Sea Eats the Land at Home

At home the sea is in the town,
Running in and out of the cooking places,
Collecting the firewood from the hearths
And sending it back at night;
The sea eats the land at home.

It came one day at the dead of night,
Destroying the cement walls,
And carried away the fowls,
The cooking-pots and the ladles,
The sea eats the land at home;
It is a sad thing to hear the wails,
And the mourning shouts of the women,
Calling on all the gods they worship,
To protect them from the angry sea.

Aku stood outside where her cooking-pot stood,
With her two children shivering from the cold,
Her hands on her breast,
Weeping mournfully.

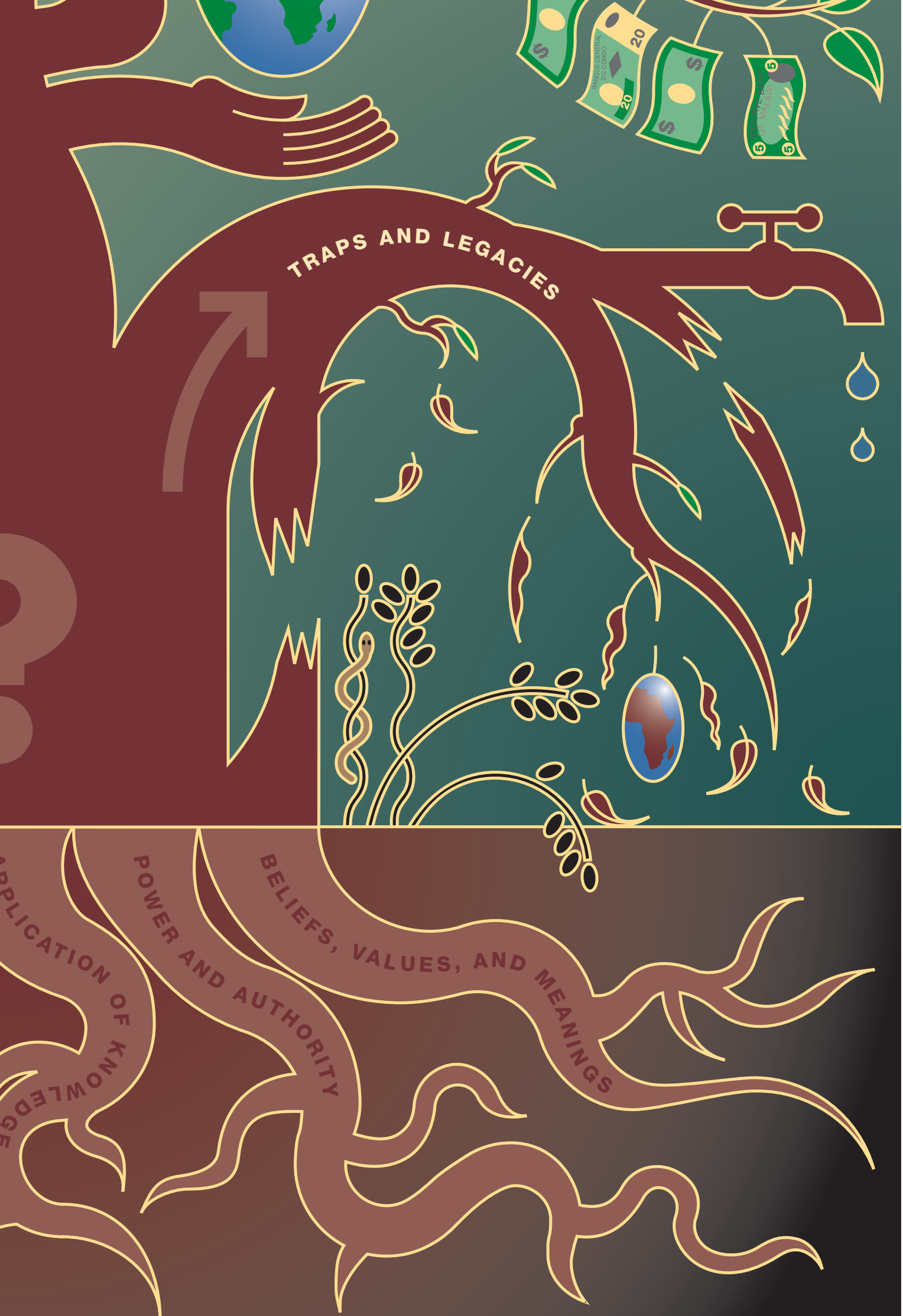
Her ancestors have neglected her,
Her gods have deserted her,
It was a cold Sunday morning,
The storm was raging,
Goats and fowls were struggling in the water,
The angry water of the cruel sea;
The lap-lapping of the dark water at the shore,
And above the sobs and the deep and low moans,
Was the eternal hum of the living sea.

It has taken away their belongings
Adena has lost the trinkets which
Were her dowry and her joy,
In the sea that eats the land at home,
Eats the whole land at home.

—Awoonor K. In: Beier U, Moore G, eds. (1999) *The Penguin book of modern African poetry.* New York, Penguin Classics.

Section 5 Traps and legacies: The whirlpool

This scenario is told as a series of lectures by an acclaimed African author. She explores why Africa in 2025 still carries a huge AIDS burden, along with widespread poverty and instability.


TRAPS AND LEGACIES
BELIEFS, VALUES, AND MEANINGS
POWER AND AUTHORITY
APPLICATION OF KNOWLEDGE

Folktale

Once upon a time, in a village called Ogundugbwe, there lived a community of animals: Big Bully Elephant, Tricky Monkey, Lazy Jackal, Stubborn Goat, Shameless Mouse, and Hard-working Zebra.

Life was never easy and now it was getting harder—a disease was killing all the crops and famine loomed. So Big Bully Elephant, the self-appointed leader of Ogundugbwe, decided to summon all the animal families to an emergency meeting in the market square.

The proceedings started with a long, time-wasting speech by Big Bully Elephant about how he had this and that dream, and how he had organized this and that family occasion. By the time the real debate started, most of the animals were convinced that it would all be a waste of time.

Big Bully Elephant suggested that everyone should bring to him half of whatever food they had left, so that he could store it and distribute it when it was needed. But few animals trusted Big Bully Elephant because in the past he had tricked them and used the communal food reserves as if they were his!

Those who didn't succumb to the 'suggestion' of Big Bully Elephant, like Stubborn Goat, paid a heavy price. His homestead was ransacked, and all his food stocks were forcefully taken away. Stubborn Goat and his family managed to flee from the village to live in exile in faraway lands.

The village's problems were made worse by the lack of cooperation between the animals. In the daily struggle for survival, the animals saw each other as foes rather than friends, and even fought each other over the limited food and water.

Now that famine was in the village, most animals looked on Hard-working Zebra's family with envy, because the Zebra family had always worked hard to grow as much food as possible. But Lazy Jackal and Shameless Mouse took turns, under the dark of night, stealing some of Hard-working Zebra's food.

They would then sell what they stole to Tricky Monkey. Tricky Monkey's sales of maize, beans, and peas were growing by the day and his profits were skyrocketing, as poverty and death engulfed the animals of Ogundugbwe.

Tricky Monkey was also making frequent secret visits to Big Bully Elephant's homestead. He would offer money and foodstuffs in exchange for promises of security and access to moneymaking opportunities.

In the village, as in other villages far and near, the plants and crops kept dying… And because the plants and crops were dying, the famine was everywhere… And because the famine was everywhere, the animals kept dying.

Unfortunately for the village of Ogundugbwe, the animals remained divided so they never worked out a solution.

Special edition
Maria Diop's "Other History Lecture Series"

One World Review

VOLUME 20, NUMBER 12 DECEMBER 12, 2025

2025

Back in 2005, there seemed so many reasons for hope. The activities of the *African Union* and its initiatives, such as the *New Partnership for Africa's Development (NEPAD)* and the *Abuja Declaration*, seemed to represent a marshalling of pride and determination. Increasing numbers of elections across Africa suggested improved and responsive governments. Beyond the continent, bilateral aid flows were rising again, while the *WHO's* "3 by 5" initiative; the *US President's Emergency Plan for AIDS Relief (PEPFAR)*; and the *Millennium Project* all demonstrated the need for urgency in tackling both the AIDS epidemic and other aspects of the continent's underdevelopment. Donors were talking increasingly about harmonization, about working within one national framework, especially regarding HIV and AIDS.

As 2005 began, leaders within and outside Africa proclaimed their intention to stand together "to save Africa". Over the course of that year, more than US$ 5 billion was spent on HIV and AIDS programmes in poorer countries around the world—a sizeable proportion of that was in Africa.

So, what went wrong?

Acclaimed author Maria Diop set out to try to answer this question in this year's Other History Lecture series. She took as her subject '*Traps and legacies*' and examined the events of the last 20 years in Africa, identifying seven 'traps'—social, economic, and political—that have snared the governments and people of many African countries. These traps, she argued, provide the root context of the AIDS epidemic, shaping people's perceptions of, and responses to, the disease.

Her traps and legacies can be summarized as follows.

1. **The legacy of Africa's history**
(post-colonialism has been unable to overcome deep divisions).

2. **The cycle of poverty, inequality, and disease**
(rising populations put pressure on inadequate social sector infrastructure, and AIDS further depletes capacity).

3. **The divisions rupturing society**
(scarcity promotes division, and AIDS and stigma feed off division).

4. **The quest for swift dividends**
(African leaders and their donor partners want to show quick results, so are unable to invest in long-term change).

5. **The challenges of globalization: integration and marginalization**
(trade rounds and reducing foreign investment fail to benefit Africa, whose formal economy is left to rely on a narrow primary export base).

6. **Aid dependency and the quest for global security**
(aid donors fail to live up to the rhetoric of harmonization and the so-called global war on terrorism spills over into Africa, determining donor funding patterns).

7. **Responding to the AIDS epidemic: shortcuts and magic bullets**
(the scramble to roll out antiretroviral therapy leaves few lasting benefits and takes precedence over the much needed scale-up of prevention).

Figure 38 **Traps and legacies: key dynamics**

Special edition
Maria Diop's "Other History Lecture Series"

ONE WORLD REVIEW VOLUME 20, NUMBER 12 DECEMBER 12, 2025

UNAIDS/MICHEL SZULC-KRYZANOWSKI

Lecture 1

We present here the full transcript of Dr Maria Diop's lecture series *Traps and legacies*—along with some of the graphics and supporting documents that she used.

Transcript of *Traps and legacies*

Good evening.

Somewhere tonight in Africa—probably in every country, perhaps in every village—a man is taken ill.

While nursing him, his wife can't weed the maize and cotton fields, mulch and pare the banana trees, dry the coffee, or harvest the rice. This means less food crops and less income from the cash crops.

Trips to town for medical treatment, hospital fees, and medicines consume savings. There is not enough money to pay school fees, and the girl children are taken out of school. The children help to care for their father. Traditional healers are paid in livestock.

The man dies.

Farm tools and cattle are sold to pay for burial expenses. Mourning practices forbid farming for several days. Precious time for farm chores is lost. In the next season, unable to hire casual labour, the family plants a smaller area. Without pesticides, weeds and infestations multiply. The boy children leave school to weed and harvest. Again, yields are lower. With little home-grown food and without cash to buy meat or fish, family nutrition and health suffer. If the mother becomes ill with AIDS, the cycle of asset and labour loss is repeated. Families withdraw into subsistence farming. Overall production of cash crops drops[1].

My reasons for starting with this image are simple. So much of what follows may seem like an abstract discussion of the context and impacts of the AIDS epidemic in Africa.

I do not want my audience or myself to forget the people at the heart of this debate, and that behind every number are people just like you and me.

In addition, this story reminds us how long Africa has carried the burden of AIDS. Back in 1999, the cycle described had already been repeated many millions of times—and it has continued, each time gouging a deeper wound.

As we sit here, perhaps 40 million Africans live with HIV or AIDS. More than 80 million people have died. But that number may well be higher—collecting statistics remains difficult, even after 40 years.

The sickness of each infected person affects, in turn, their household and community: we could say that now, in 2025, there are many more millions who live with the virus' wider effects.

The World Health Organization says that 7 million people need drugs right now, but only a fifth of those who need treatment are receiving antiretroviral therapy. Of these, a far smaller proportion have access to drugs that really work—resistance has ensured that the old drugs don't work anymore.

In this lecture series, I want to attempt to explore ***why*** this has happened. To do this, we need to look at the wider context.

I will describe seven traps that we have fallen into and explore their complex interactions. The traps are not sequential—they are constantly interacting—as each trap moves forward, it triggers or reinforces one or more of the others.

The seven traps

Over the last 50 years, many people and countries in Africa have become ensnared by these traps. Of course, some people, some countries even, have managed to escape these traps—indeed, some have done remarkably well. But it's not their story that I want to focus on here.

The first six of these traps have, together, helped establish the severe poverty and lack of development that continues to ravage much of our continent. They include: the legacy of Africa's history; the cycle of poverty, disease, and inequality; the divisions rupturing society; the quest for swift dividends; the challenges of globalization: integration and marginalization; and aid dependency and the quest for global security. The final trap—which I call shortcuts and magic bullets—seems to me to sum up all the other traps. It focuses on how leaders and their societies (both within and outside Africa) have responded to the AIDS epidemic in Africa over the last 20 years and, in the process, deepened both the trap of AIDS, and the other traps and legacies that Africa has struggled so hard to escape from.

Let us now look at Traps 1 and 2.

Trap 1:

The legacy of history

The first trap that holds Africa back is its history—and the legacy of that history. For example, over the centuries, slavery has imprisoned 40 million Africans and killed millions more. How can we ignore the impacts of slavery on the contemporary social, economic, and political landscape? The colonial period changed our continent in profound, perhaps irrevocable, ways—many of them for the worse. In the 30-year period that followed, many countries in Africa became pawns in the Cold War struggle. In many places, the legacy is division and instability at best, and political, social, and economic chaos at worst. In many countries, it exacerbated strife; recast, disrupted, or destroyed communities and traditional cultures; and damaged lives. Little of use was left behind, in terms of education, health care, physical infrastructure, or state administration.

Not all countries within the continent have followed a single path. There have been episodes of optimism and expectation. Think of the anti-apartheid struggles, pan-Africanism, mass and free education, multiparty campaigns against one-party rule—just a few of the things that have prompted hope. Moreover, the development of the *African Union* and *NEPAD*, the *African Peer Review Mechanism*, the *African Parliament*, and *African Standby Force*—all seemed so promising.

But, in the main, steps forward have been followed by new setbacks and fresh adversity. As we look back from 2025, we survey a continent that has endured not just decades, but centuries of exploitation, underdevelopment, and ravaging disease, including four decades of AIDS. Sometimes these horrors have been used to justify outrages or as excuses for inaction—I am not doing that.

I would emphasize that we cannot overlook the problem of internal leadership: it's a sad fact that many African leaders have used their positions only to enrich themselves, while their people have suffered.

The trap of the legacy of history has powered another: a dynamic of deepening poverty, disease, and growing inequality. This is my second trap.

Trap 2:

The cycle of poverty, inequality, and disease

Poverty, disease, and inequality have roamed through Africa's history, hand in hand, for a long time now. Poverty usually results in a lack of crucial health care, be it medicines, education, or adequate nutrition. This fosters the spread of disease, which, in turn, weakens people who may already be struggling to escape poverty, making it difficult for them to work enough to support themselves. AIDS is only the latest incarnation—malaria has been having the same effect for countless decades. Add to these two factors a third, increasing inequality—not just within countries or regions in Africa, but also between Africa and the rest of the world—and you have three gears that are tightening this trap.

Poverty

Regarding poverty, the debates of the early 2000s continue: should poverty be measured proportionally, in absolute

numbers, or using some other metric? Although the decline in poverty in North Africa offers some hope, the proportion of people living in poverty in sub-Saharan Africa remains a problem. In 2025, as in 2000, about 40% of Africans (and 50% of the population of sub-Saharan Africa) live on less than US$ 1 per day. But this constant proportion hides growing actual numbers. Over the last 20 years, actual numbers have risen hugely with population growth: now over 450 million people live on less than US$ 1 per day, a huge increase from around 300 million in 2000.

The actual number of poor has fallen only in North Africa. It has increased in West Africa by 65% (from 130 million in 2000 to over 210 million in 2025); in Central Africa by 70% (to 75 million); in Southern Africa by 90% (to 50 million); and by 16% in East Africa (to nearly 120 million).

Why? One camp lays the blame on inadequate global integration by African countries, while others argue that there has been too much integration. Still others blame Africa's lack of reforms or the inadequacy of many of its countries' institutions.

Disease

Meanwhile, disease is flourishing. This might seem inevitable, but in fact, in the 20 or so years after independence, many African countries made great gains in health care. After 1980, many of those achievements were lost amidst the demands of debt repayments, Structural Adjustment Programmes, the exodus of health care professionals, and falling terms of trade. Since 2004, there has been little systematic and long-term investment in crucial public health systems and infrastructure, particularly in rural areas. Efforts to catch up have proved too little, too late. For instance, TB notification rates increased rapidly as HIV made people much more vulnerable to developing TB disease.

Some argue that it isn't so much that trends in disease are worsening, as that the African population is growing—and investments are not keeping up. Meanwhile, the number of children dying from preventable diseases—particularly malaria, pneumonia, and diarrhoea—has risen from 4 million in 2005, to over 5.5 million in 2015, and now stands at around 8 million in 2025. Although private health care has grown, it only benefits a few.

Inequality

Inequality is a crucial aspect of all the traps I will describe. Across the continent, unequal access to power, status, money, education, goods, and health fragments populations, splits households, and divides men and women, generations, communities, and nations. It warps the regional dynamics of the continent; and muddies the many different relationships of trade and aid between Africa and the rest of the world. Three factors are exacerbating inequality.

- **The first** is a population that is growing without commensurate economic growth and without adequate mechanisms to distribute the benefits of what little growth there is. In most African countries, people still have no surplus to invest in order to be able to generate more—or to put away for times of trouble. More people need services, but the number who can afford to pay for them has grown too slowly. Existing assets are depleted, while inequality and poverty continues—often expressed in poor health, including AIDS—across sizeable populations in sub-Saharan Africa.

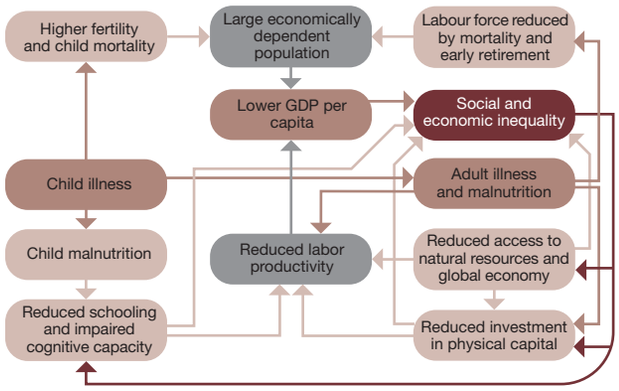
  The result, over the last 30 years and more, has been a vicious, cumulative cycle that drags down individuals, families, communities, sectors, and nations. Sometimes a better event will disrupt the cycle, creating a few improvements—a string of good harvests, a business that succeeds, a new job—but these are the exceptions.

- **The second factor** is the apparent impossibility of maintaining consistently good national and regional governance for a sufficient period of time to tackle some of the stubborn cycles of poverty and underdevelopment that so many people find themselves in. Usually it is a question of one or the other: on the one hand, there are corrupt leaders who manage to maintain their grip on a country; on the other, there are leaders who care

Other History Lecture Series

Figure 39 **Health's links to GDP**

Poor health reduces GDP per capita by reducing both labour productivity and relative size of the labour force



Source: Adapted from Ruger JP, Jamison DT, Bloom DE (2001) Health and the economy. In Merson MH, Black RE, Mills AJ, eds., *International Public Health*, p.619, Sudbury, Massachusetts, Jones and Bartlett.

about their people but have found that they face too many challenges, or have insufficient resources, institutions, or experience to be able to make a sustainable difference. Others have made progress only to see it destroyed by, for example, an upsurge in conflict or an influx of refugees.

- **The third factor** is HIV and AIDS. It's been here for at least 40 years now. Silently it spread through the population—unknown, at first unnoticed. And then the sickness started… and people have been dying. Over the last 10 to 15 years, HIV prevalence levels in Africa have remained steady. Some have seen success in this, but, in fact, it offers cold comfort, especially when adult HIV prevalence is still above 5% in almost 20 countries. The truth is that prevalence is holding steady because, for every person that is dying of AIDS, another is being infected with HIV—a diabolical equilibrium has been reached. As populations grow, the total number of people living with HIV and AIDS grows, as does the number of deaths. Before HIV and AIDS, life expectancy in most African countries was increasing rapidly. But for the last decade or so, in countries with an HIV prevalence rate above 5%, it has been dropping.

AIDS compounds all the problems of poverty, inequality, and ill health. In the early days of the epidemic, AIDS showed no respect for anyone: rich and poor alike were infected. But over the last decade or so, epidemiologists tell us we are seeing new patterns emerge. Being poor, having little formal education, few assets—especially having lost your parents to AIDS—and HIV is never far away. If not you, then your sister, your cousin, your son, or your niece. Vicious cycles have emerged, which drive further poverty, further inequality, and more disease.

Links

The diagram you can see now is from a briefing paper written for Baroness Omumali, prior to a speech she made to European Parliamentarians in 2006. It illustrates contemporary understanding of the relationship between health, underdevelopment, and poverty (both its monetary and non-monetary dimensions).

The epidemic has eroded the current and future capacities of more than 20 countries across the continent—their households, health care, governance, and education. It continues to do so.

An example of the repercussions would be the impact of the droughts that have repeatedly ravaged regions of the continent, in 2008, 2016 and, again, in 2023, affecting nearly 60 million people in the Horn of Africa, southern Africa and the Sahel region of West Africa. In the periods between these events, there have been attempts to build some resilience, but with limited success. There were some food stores, but little infrastructure through which to distribute it. Conflict can have the same effect, since it forces people to abandon their land.

But it doesn't even need events as extreme as this to tip people into catastrophe—the rising population itself is placing growing pressure on available arable land, particularly as farming for many remains so basic, with little support from new agricultural technologies. In many areas, this is catalysing alarming environmental stress and reducing productivity.

The impact of the AIDS epidemics in Africa has unfolded over a range of time periods and touches not just the economic sector, but also public health and education, the capacity to govern, and the transfer of specialist knowledge and life skills. We should note that high prevalence (say, over 7.5%) translates into a 30% lifetime risk of HIV infection for a 15-year-old today.

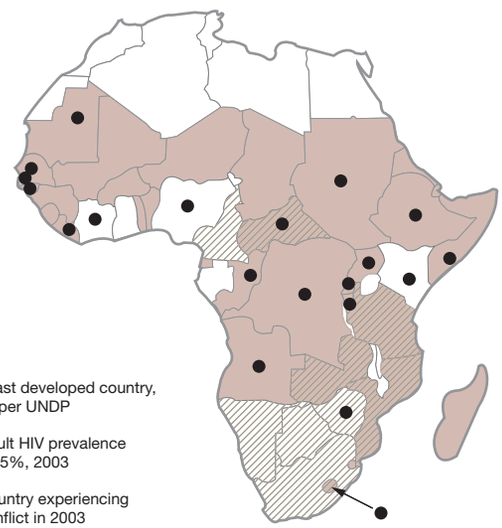
In response to such pressures, millions continue to move across the continent, splitting families and communities. Some end up in the growing squatter settlements around the cities. Life may perhaps be a little better there, since they do have access to some services. But most suffer poor living and working conditions, inadequate transport, sanitation, and other utilities—and they remain terribly poor. Although there are important exceptions, in a number of countries urbanization has continued to take place without the economic growth needed to support thriving cities.

Despite efforts to create employment, there are few jobs, at least in the formal economy: over the last two decades, shortages of skilled labour and physical infrastructure have discouraged foreign investment. Instead, people barter labour for food and other essentials; they hawk goods on city and town streets; they juggle debts; some even steal. People resort to trading sex for money, food, or protection for themselves or their families—it's nothing new, here or in other parts of the world. People do what they have to in order to survive. When they return to their rural homes, bringing money, perhaps seeking care because they have fallen sick, they may also bring the virus. If they're uninfected, coming home may, in turn, confront them with new difficulties—perhaps because the head of the household has died, leaving them to support the family…

Over the last 20 years, poverty, inequality, and disease have ground down countries, communities, and people. In my work, I have described the depressing no-win pattern that has emerged across the continent: many of those countries that, in 2004, had the potential to do well, have had to deal with the highest HIV prevalence rates. But those countries that are less affected by the epidemic remain the least developed. Meanwhile, those countries that have achieved some development and avoided the worst of the AIDS epidemic are ravaged by civil conflict. As this map shows, surprisingly few countries were free of all of these problems in 2004.

Other History Lecture Series

Figure 40 **Challenges to development, 2004**



Source: UNAIDS (2004), Conflict Barometer (2003), UNDP.

ONE WORLD REVIEW VOLUME 20, NUMBER 12 DECEMBER 12, 2025

Lecture 2

The breakdown of trust

In my second lecture, I will describe how the breakdown of trust has led to social division and the search for swift results.

As we sit here, perhaps 40 million Africans live with HIV or AIDS. More than 80 million people have died. We are asking: what went wrong?

Today we are going to look at: Trap 3: The divisions rupturing society; and Trap 4: Swift dividends.

Trap 3:
The divisions rupturing society

As 2025 begins, there is a steady increase in the number of households in high HIV prevalence countries that have disintegrated, beaten down by successive waves of HIV infections. In the early days, social analysts and researchers spoke of the resilience of the African family and society, bound by an intricate system of obligations and reciprocity. But after four decades of illness, this resilience is failing.

The fear of being left alone has led to a breakdown of social trust and systems of reciprocity. Women with HIV and AIDS are particularly badly affected—if it is believed that they can no longer have or care for healthy children then, in many societies, they lose much of their value and status. Domestic violence often follows.

Urban crime is rising. Meanwhile, many people, seeking reassurance and hope—not least in the face of a disease against which they feel powerless—have increasingly turned to religion: along with a rise in Millenarian sects and traditional secret societies and cults, fundamentalist forms of religion are proliferating.

Across the continent, social tensions have worsened as new opportunities have opened up new divides—for example, between those who can afford the latest treatment and care or can access resources and services, and those who can't; between different ethnic and religious groups; between one community and another.

Under these pressures, in countries across the continent, social, political and religious tensions have tightened to breaking point; xenophobia is increasing; nepotism, cronyism, and ethnic bigotry are rife. In some countries, in the absence of effective government, different leaders—cultural, political, and religious—have come to the fore. Some offer stability, others simply seek power and wealth.

They say that wood already touched by fire is not hard to set alight—and the truth of this proverb is clear in Africa in 2025. There are increasing numbers of criminal and paramilitary groups, feeding off the large numbers of jobless, disaffected, and angry youth. Parts of the continent have become fiefdoms for warlords, religious sects, and ethnic militia.

Over the last five years or so, conflicts have repeatedly flared, for example, in West Africa and the Great Lakes region. African governments have tried to confront this, but even when they have the political authority, they lack the means to make and keep the peace.

The fact is that the ranks of many nations' armies are so depleted by AIDS that they are unable to muster enough soldiers to participate in peacekeeping operations. Some governments have all but demobilized their armies, replacing them with paramilitary forces or contracting multinational security firms when national sovereignty or interests are threatened.

The family and friends of those in the army now talk of how brave soldiers fall, not in battle, but struck down by 'the curse'. Unfortunately, some rebel groups see this curse as a useful part of their arsenal: there has been evidence of special units of HIV-positive soldiers, specifically instructed to use rape as a deliberate tactic, by leaders determined to wipe out their enemy. Meanwhile, although the prevalence of conflict and strife has made foreign investors even more reluctant to invest in Africa, it has led to a bonanza for the private security industry, which is, by the way, dominated by multinational firms!

The disease feeds on division

The AIDS epidemic has functioned as both a cause and an effect of this social fragmentation. Some leaders still argue that their culture or religion will naturally protect their community—presenting the virus as always being somebody else's or some other community's problem. Early on, it was recognized that strategies must be designed to fit the local cultural context—but even so, many campaigns are still so out of touch with local popular beliefs that they are simply ignored. Other leaders encourage their people to rely on indigenous medicines and traditional healers for help, because they recognize that most people cannot be reached with affordable health care.

Meanwhile, in terms of the relationship between religion and the epidemic, the conclusions drawn by Dr Wek (in her much cited 2008 paper on the politicization of religion) still hold true. Some religious leaders are still giving out incomplete or inaccurate information about HIV and AIDS and how HIV spreads. In the same way, some associate AIDS with the alleged transgressions of adherents to rival faiths, or interpret the epidemic as a form of divine retribution. At the same time, many of the best care services continue to be provided by religious groups, even if the controversy over the effectiveness and consistency of their prevention messages continues after 30 years.

To quote from *Religion and the epidemic* by Dr Wek (2008, PublishAndBe)

Patterns of religious organization appear to have an important impact on the spread of the virus, but their involvement holds significant difficulties. While leaders from most religions find ready consensus that fidelity and abstinence are the most advisable means of protection from HIV, I have also recorded instances where religious institutions—some small independent institutions, but also some mainstream ones—have promoted unscientific and damaging practices with regard to healing and health. Despite major public health campaigns for over 20 years, people still trust the authority of their religious leaders above that of scientific evidence. Responding even to this is not simple, however, since it is also not always clear where people's religious allegiance lies. Many hold a mixed cosmological outlook, overtly affiliated to Islam or Christianity, for example, while actually behaving according to their indigenous beliefs, so that it is difficult to know how best to communicate with them.

Despite continuing calls for multi-religion collaboration in response to HIV and AIDS, there have been scarcely any operational networks. Reasons for this include: intolerance between certain groups; economic constraints; communication barriers; the spread of both Christian and Islamic fundamentalism in many countries; and the politicization of religion in others.

All of these dynamics have tended to reinforce stigma against people living with HIV and AIDS (PLWHA), helping to inhibit clear communication about the risks of infection. In many countries, overzealous scare campaigns aimed at encouraging safer behaviour have instead promoted fatalism. Many poor young people regard early death as inevitable and have few hopes for the future. As a direct result, substance abuse has become more widespread in urban areas.

Fear, discrimination, stigma, and denial have never gone away—some argue they have increased. The result is that, even now, even in 2025, few people officially die of AIDS. Meanwhile, unofficially of course, there seem to be more people dying (yes, it's true) of witchcraft. Indeed, individual accusations of witchcraft are on the rise: when survival is so difficult, any success breeds resentment and jealousy. Even where stigma is not manifest in literal witch-hunts, figurative 'witch-hunts' are myriad, helping to ensure the exclusion of those affected by the virus and widening the distance between those who have power and those who do not.

Women's empowerment

I'm often asked about the rights of women in Africa. At the end of the twentieth century, hopes were raised by the increasing numbers of local and international nongovernmental organizations (NGOs) campaigning for female empowerment across Africa; by the subsequent appearance of successful, western-educated, wealthy female heads of state and ministers in several African countries; and by the growing number of articulate, well educated, middle-class women.

Sadly, these aspects have been outweighed by the increasing numbers of poor women, for whom life is a constant struggle. If you look in your lecture packs, you will find an extract from a letter written to a French newspaper by a woman who was working with an NGO in a low HIV

Letters to the Editor

I am writing in response to the article 'Success for Women in Africa'. This letter is not intended to undermine the accomplishments of women who have managed to rise to the tops of their professions. However, your article failed to emphasize the almost insuperable difficulties placed on most women by social and cultural expectations, and made only passing reference to the links between the spread of HIV and gender inequality.

Over the past decade, women have been key recipients of HIV- and AIDS-related aid and assistance. But it hasn't made the difference it should—partly because of the size of demand, but also because these efforts are not tailored to specific contexts, which means crucial information is lost. In addition, the focus on women means that they then carry the responsibility of handling risk in relationships. The truth is that women rarely have the economic or political power to match this responsibility—especially as it is often younger women who marry older men. Programmes that seek to empower women sometimes fail to recognize that social norms still inhibit most women from challenging the behaviour of their partners.

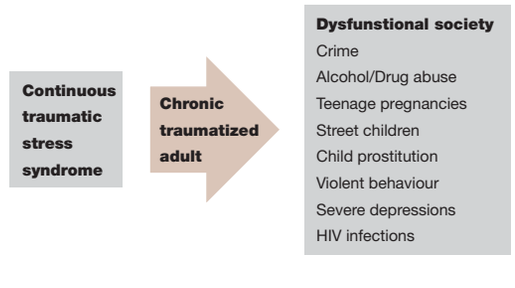
Many young women have grown up watching AIDS claim the lives of their mothers, sisters, daughters, and friends—some are sick themselves. Few have completed—or even begun—their education. They are discovering that their limited possibilities have shrunk even further.

It may seem surprising, but the women I have met don't think of themselves as victims. They are finding hope, and ways to survive, even among their terrible losses. Many women have formed cooperatives, supporting each other. They keep going as long as their resources or networks can sustain them.

Many young women are choosing not to enter relationships—this is the origin of The Sisterhood, the celibate, charismatic movement, rapidly gaining followers across countries in southern Africa. A number of these are married women who have refused to take back husbands they believe may have become infected while working away from home. Whereas their mothers and grandmothers were taught to remain silent, these women are less hesitant to articulate not only their fears and anxieties, but also to share what they have learned. And it seems that some men are beginning to listen, and maybe to change their behaviour…

Other History Lecture Series

Figure 41 **Potential long-term impact of continuous traumatic stress in children**



Source: ECI Africa (2003) *Report to UNAIDS on the impact of orphans and vulnerable children on fiscal systems and governance in Africa*. Project paper.

prevalence country a couple of years ago. I will read from it.

Of course, there are prominent, successful women and men who have escaped the traps described in this article—many of them are highly educated and enjoy international lifestyles. But too few of them actually live full-time in Africa now. If they do, it tends to be behind the high walls of guarded compounds and in comparative privilege.

A lost generation

One of the reasons often given as to why many cities across Africa are so dangerous is the gangs of youth and orphaned children roaming the streets. This is not a new problem—but, over the last 20 years, the AIDS epidemic has claimed the lives of many parents, nearly doubling the number of children orphaned by AIDS (from 14 million to 27 million).

The scale of the problem has been known about for at least two decades—even in 2004, it was clear that, by 2025, the increase in the number of children orphaned by AIDS would double the total number of orphans—but, governments made little preparation. The burden of care is still chiefly on extended families. In some countries, there are state services or NGOs who look after a small number of children, but most orphaned children are on their own—and most face extraordinary prejudice, despite apparent public support.

Ifeoma 'Blessed' Ejitsu is an orphan herself, who now works with street children in a high HIV prevalence country in the west of the continent. She calls herself 'Blessed' because she is not HIV-positive, although many of her brothers and sisters were. Her early years are something of a mystery—she tells me that, along with two of her sisters, she was adopted by an uncle, but she won't talk about what happened to make her run away. After that, she was brought up in an orphanage, where she was educated to primary school level. Now, somewhere in her early thirties (she's not certain of her age), she is trying to get funding to maintain one of the few orphanages operating in the capital city. She told me what motivates her:

People have prejudices against homes and orphanages—but where else can the children go? They have no family to take them in. Sometimes these kids form gangs—they steal or sell themselves to live. They don't go to school. They don't have anyone to tell them how to live, to teach them right or wrong. How will they look after children themselves if no one has shown them how to do it? How will they learn how to give love? Yes, many of them are infected with HIV—sometimes it kills them; but there are lots of other diseases that can get them first. And not just diseases: last week, a man shot two children for trying to steal his watch. In other cities, shopkeepers and restaurant owners pay vigilante groups to clean the kids off the streets—they call them vermin.

It is easy to say that governments should do something—but, in many countries, governments just can't afford it. Nobody really anticipated or invested, soon enough or in sufficient amounts. They thought that orphaned children could be fostered by their extended families, but family resources are just as depleted. All too often, when families do take extra children in, there's not enough care, time, or money to go round. These are situations that lead to abuse.

Meanwhile, the children think that nobody cares about them, and their daily lives just confirm that belief. You can see the effects: those who are not infected don't care about protecting themselves—and those who are infected don't care about protecting others. They just say: "We are all going to die anyway—I don't want to die alone." The graphic now displayed is extracted from my book *HIV/AIDS: The Legacy*.

Trap 4:
The quest for swift dividends

The trap of swift dividends stands in sharp contrast to my friend Ifeoma's more long-term approach. This trap describes the need to demonstrate rapid—often quantifiable—results: another symptom, and cause, of the breakdown of trust. As we look back over the last 20 years, we can identify a number of governments caught in this trap. It's understandable: it's much easier to tell people what they want to hear than ask people to trust you while you insist on difficult or unpopular

decisions—even if, in the long run, they are better for the country.

As an example, we can point to the continued lack, in many countries, of effective legislation to tackle discrimination against people living with HIV and AIDS. Negotiations around aid and trade provide another example: far easier for African leaders to agree to particular conditionalities and surrender the freedom to manage their country's development, in order to gain desperately needed funds or market access.

My analysis of the approaches taken to Africa's debt also provides examples of the trap of swift dividends. For example, the liberal acceptance of new debts by a number of countries has, in the end, helped to discourage foreign investment. In turn, the haphazard cancellation of some debts can raise issues of moral hazard, while the decision by some countries to simply default on debt will make it hard—if not impossible—for them to borrow in future. These are all likely to have serious repercussions for a number of countries seeking debt relief.

But leaders—African and otherwise—are certainly not the only ones to be snared by the trap of swift dividends: as we survey the last 20 years, we see people at every level throughout society and in every discipline who have been caught in it. For example, the medical research scientists who hankered for the kudos of their next discovery—and so refused to collaborate, splitting funding and concealing important knowledge; the AIDS activists who agreed to abandon HIV prevention programmes that used condoms in favour of abstinence agendas, because it meant that they would get the funding they desperately needed; or the officials at every level who take bribes to help them get by.

The deceptive promise of swift dividends also plays a significant part in the next three traps: the trap of integration and marginalization; and the trap of aid and security; which will be the subjects of my next lecture; and the trap of shortcuts and magic bullets—which I will describe in my final lecture.

ONE WORLD REVIEW VOLUME 20, NUMBER 12 DECEMBER 12, 2025

UNAIDS/G. PIROZZI

Lecture 3

The failed promises of trade and aid

As we sit here, perhaps 40 million Africans live with HIV or AIDS. More than 80 million people have died. We are asking: what went wrong?

While all of the traps and legacies that I've described so far have global dynamics, the next two traps particularly illustrate the challenges that Africa has had to face in finding its place in the world over the last 20 years.

Trap 5:
The challenges of globalization: integration and marginalization

The united front presented by developing countries, that prompted the collapse of talks on world trade at Cancún in 2003, was not maintained, but replaced instead by a plethora of bilateral and preferential trading agreements. Some developing countries found favour; others were overlooked. For many African countries, any protection they gained from multilateral trade agreements has disappeared. Many of the new bilateral arrangements are 'deep integration agreements', indicating the opening of markets and restriction of local production and financial autonomy of African states. Increasing bilateralism has spurred competition, not just within Africa, but also between Africa and other developing countries. The united opposition that stalled the earlier talks has splintered across diverse national and economic agendas.

We should recognize the very different types of economy in Africa, with different international opportunities and national agenda. It is, however, possible to make some generalizations.

- Some countries are disadvantaged by the commodities they have to trade, particularly those depending on three or fewer commodities for over 50% of export revenues. Often based on low-value primary (raw or unprocessed materials) exports—such as cocoa, coffee, bananas, sugar, or cotton, for example—these commodities generally suffer from high price volatility or even falling prices over time. They're extremely vulnerable to price drops, product disruption, bad weather conditions, and slumps in demand.
- In contrast, there are countries whose economies are based on the extraction of high-value primary commodities such as gold, diamonds, or oil; or rely on more than three commodities for 50% or more of their export revenues. Their commodities often attract the attention—and money—of foreign investors. However, these countries also tend to be especially vulnerable to political instability and resource-based conflicts.

These two categories of countries can each be further divided into those with high HIV prevalence and those with lower prevalence.

As we've seen, AIDS hits hardest in the most productive age groups—as those countries with high prevalence began to experience around 2005 to 2010. As more people fell sick, skilled workforces shrank, locking economies into low- or no-growth paths. This, in turn, made it impossible to meet the

growing demand for health care, while, for those receiving treatment, antiretroviral drugs only delayed death by a few years.

In countries offering low-priced commodities, the impacts were seen more quickly—since there simply wasn't the money to provide necessary services. A number of those countries that were able to export a high-priced commodity were able to keep things going for longer. Some sucked labour in from surrounding countries to replace the people who were dying; others received financial support from foreign governments anxious to ensure the security of their supply of a particular commodity.

After a while, even these more optimistic stories started to sour. For some, the epidemic spread too fast; for others, global market prices sank and their export revenues dropped. For most people, these changes made little difference—only a small, privileged part of most populations had seen any benefits from national income and few of even the wealthier governments had invested their money in developing rural infrastructure.

Foreign investment hasn't helped much, either. Few countries with medium or high HIV prevalence have been able to attract sufficient levels of foreign investment because it costs these foreign firms too much to train—and treat—people who would probably have to be replaced soon anyway. Countries with high HIV prevalence that could still afford to invest in the education and health of their people were diverting much of their revenue to treatment and the replacement of sick employees. Across the continent there has been little available to invest in new technology. In 2004, Africa captured around 3% of global foreign direct investment (FDI) (some US$ 12 billion of around US$ 400 billion globally). This proportion has gradually decreased, struggling to exceed 2% in 2010 and 1.5% in 2025. Most FDI in Africa had been going to mineral-rich or semi-industrialized economies—but many of these economies have been seriously compromised by the effects of the AIDS epidemic.

Few countries were able to diversify their resources and escape from dependence on what were usually primary commodities. In a number of countries, despite the environmental improvements in resource extraction, the context of poverty, under-development, and population growth has led to serious environmental degradation, both directly and indirectly.

International business digs in…

Back in 2004, there were many different kinds of businesses setting up in Africa. However, for most it has proved too dangerous and difficult to continue: companies with movable assets have relocated somewhere safer; others, after weighing up gains against potential risks to security or reputations, have divested and pulled out.

Exceptions are the international extractive businesses, which tended to cling on, protecting their assets through the creation of camps and safe havens—and other tactics. Oil and gas producing countries have attracted the funds and attention of the international superpowers and multinationals. Money has flooded into a number of these countries, and some with enclave economies have been able to create small centres of excellence. There are, even now, countries and individuals who are thriving on the proceeds of a particular commodity. The process of commodity extraction, and the lives of those enriched by it, is hidden behind the high walls and barbed wire of gated communities. Some of these havens are very large, complete with residences, offices, shopping centres, sports facilities, and Western metropolitan lifestyles and health standards. They also come with small armies of cleaners, nannies, and gardeners—and of course, security guards—each of whom is certified 'AIDS-free' as a condition of employment. But few of these benefits are filtering through to the general population, and resentment builds among those who are not so fortunate.

In the early 2000s, many multinationals tried to provide health programmes to staff, families, and the surrounding communities—and, in many cases, this was positively received by local or state governments. But as expectations rose in local communities, global competition intensified with the rise of the economies of Brazil, Russia, India, and China (the BRICs) and the availability of local skills declined, and the programmes proved unsustainable.

Partnerships within the private sector, and between the public and private sectors, have faltered and outreach programmes have shrunk.

Back in 2000, a World Bank survey identified the impacts of AIDS on business, including: costs of insurance and benefits going up; increasing disruption and absenteeism in the work force, which affects overall productivity; and worker experience falling and morbidity increasing, which affects labour productivity.

Initially, an increasing number of big companies in Africa were making concerted efforts to tackle the effects of AIDS. Their approaches varied—for example, some focused on just AIDS and some on wider health impacts; some focused on just core workers, while others also extended health care to contractors. It was felt that effective partnerships with other private sector actors, and state and civil society actors might help to ensure cost-sharing and the building of the wider infrastructure and capacities needed to meet other health, nutrition, and psychosocial needs—but these partnerships were difficult to negotiate and manage. Furthermore, the private sector was not allowed access to global funds and financing relating to AIDS treatment, irrespective of whether private sector consortia might be more efficient and effective than NGOs in developing and executing wider treatment and care plans in parallel with initiatives for their own staff.

Africa's rising population and level of underdevelopment meant that health needs, and the expectations of contractors and wider local communities in which companies operate, have continued to rise. It has been increasingly difficult for companies to draw a line between who gets treatment and who does not.

As Jaruzelski points out in his *Brief history of the integrated world (2023)*:

In retrospect, it is clear that, after the first of the big terrorist attacks on September 11th, 2001, there was more concern about failed states in Africa providing shelter for terrorists than about facilitating knowledge and technology transfer to the continent.

It took a long time before the newest and most complex drugs were manufactured generically. However, first generation antiretroviral drugs, that made possible first and second line regimens against AIDS, continued to fall in price because of price-cutting from the research-based industry and supply from the generics industry. But low prices did not resolve the supply chain and infrastructure problems in getting the drugs to patients. At the same time, things were made worse by corrupt local officials and arbitrageurs diverting drug shipments to the highest bidders around the world.

At the beginning of the century, some countries issued compulsory licences under the TRIPS agreement—but that didn't seem to make a big difference. Polarization deepened. In response to the continued slow progress in drug access in Africa, many activist organizations campaigned for the total abolition of patents. Quality generics manufacturers in India and South Africa were more interested in obtaining voluntary licences from the research-based industry or exploiting out-of-patent drugs for middle-income countries than they were in relying on the uncertain and politically fraught world of compulsory licensing. Several of the least developed countries began manufacture of generics, but poor quality control led to low confidence in their products. And the US Government–negotiated bilateral trade agreements spread beyond their initial high- and middle-income country partners, including provisions that compensated for delays in regulatory approval—effectively extending patent periods.

By 2015 developing countries still saw little return on the commercial exploitation of their genetic heritage, while the cost of financial obligations established by new patent regimes was many times higher than the value of any tariff concessions given by developed countries[2].

The Doha agreement to extend the period of grace for less developed countries' compliance with TRIPS to 2016 was not extended further. As a result, the ambition of some countries to take over from India as centres for non-patent governed manufacture came under legal challenge. The problems of counterfeit or adulterated drugs also continued to plague small-scale manufacture.

Nevertheless, there were efforts by the research-based industry and by

generics manufacturers in countries as diverse as Brazil, Canada, India, and South Africa to transfer technology to, and develop manufacturing capacity in, Africa. However, the continuing polarization of the global intellectual property debate has meant that these efforts were not well supported across the continent. Developing countries remain net importers of technology; even as globalization of intellectual property protection continues to expand.

A growing informal sector

Throughout this period, global markets and consumers have become increasingly concerned with the security of their supplies. But many smaller African producers are unable to meet the resulting costs, which keep rising. On the whole, there has been little incentive for people to set up businesses or make any kind of formal investment.

Most people have never managed to leave the informal sector—which means that there's never enough tax revenues to support the needs of growing populations. There is less money per capita accruing in state revenues and not enough to spend on services—education, health care, diversification of industry, and training the next generation, who, as a result, tend to remain in the informal sector, where it's hard to make a dependable living. Few people build savings—and the widespread failure to address individual property rights or strengthen, revive, or adapt traditional forms of collective stewardship means that most people have no collateral. For most farmers, the lack of development of rural infrastructure has meant that it is very costly and difficult to reach urban markets—and market prices are not high enough to compensate for this. Although rural farmers have plenty of land, they have little incentive to produce more than they need: most have fallen back into subsistence farming. There are a few islands of high, intense growth, mostly in areas that are either close to cities or ports, have well maintained connections, or enjoy fertile soils and reliable rains or irrigation systems.

The paradox of economic integration *and* marginalization primes the other traps—exacerbating underdevelopment, poverty, and disease; and increasing social divisions and inequality. It is also closely related to the next trap—that of aid dependency and concerns about global security.

Trap 6:
Aid dependency and the quest for global security

At the start of the period, there was evidence, and great optimism, that the decline in development assistance was finally beginning to reverse. At the Monterrey International Conference on Financing for Development in 2003, donors committed to increasing aid levels first by US$ 12 billion per year by 2006, then by an additional US$ 16 billion per year. The 2005 UN review of the Millennium Development Goals (MDGs) gave further impetus—along with the fact that sub-Saharan Africa was so far from meeting any of the goals (although North African countries were closer).

The UK's dual presidency of the *EU* and the *G8* in 2005 allowed the UK Prime Minister to draw international attention to Africa's plight, while the launch of the UK *Commission for Africa* report in 2005 fuelled international debate. The report, which was mostly commended in the West but treated with scepticism or polite indifference in parts of Africa, argued that increased financial and political commitments were needed to reverse Africa's decline. It highlighted the urgent need to tackle the twin terrors of AIDS and terrorism. For half a dozen summits in succession, the *G8* kept renewing its Africa action plans, building on the models first cobbled together at the Kananaskis Summit and Monterrey Conference, promising that half or more of new development assistance would be dedicated to African nations.

Absorbing the money

In a handful of African countries, the Poverty Reduction Strategy Paper (PRSP) process meant national ownership of development plans—these became the 'success stories' chased by donors. But for many countries, even after promising starts, the process faltered. National ownership and policy autonomy were more difficult to achieve than theory suggested, especially with a dearth of key capabilities, or continuous internal power struggles. Moreover, the *IMF*

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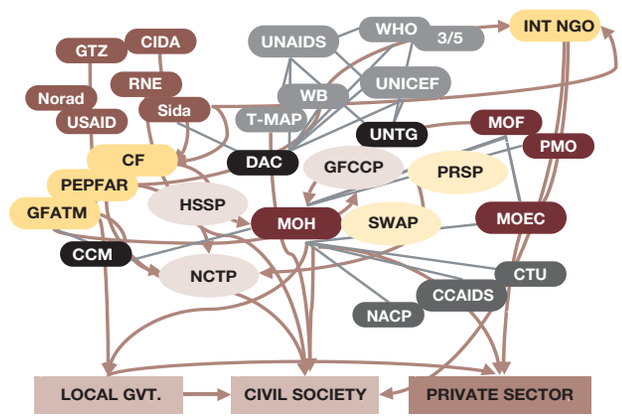
Figure 42 **Partial map of the AIDS sector in Tanzania**



Source: Swedish International Development Cooperation Agency.

and *World Bank* still preferred adjustment-oriented approaches: pro-poor expenditure patterns combined with deeper and broader structural reforms, and the same kind of macroeconomic reforms adopted in earlier adjustment programmes. Just looking at a partial map of the AIDS sector in Tanzania shows us how convoluted, and thus probably inefficient, the sector had become by 2005. If it is any simpler now, in 2025, then it is because there is less interest and fewer partners.

A number of countries found that their failing infrastructure and lack of economic reform meant that the money they received just sat there. The rush to build the infrastructure to deliver antiretroviral drugs saw a proliferation of capital works… but by 2012 the new monies had dried up. An eerie replay of the failures of the 1960s and 1970s saw new facilities crumble, or stand empty for lack of staff, medicines, and equipment. Old arguments about Africa's limited 'absorptive capacity' were revived in the Western popular press—what was the use of giving African countries money they couldn't use?

Other African countries faced different problems: some were refused the funding required, although their governments had assembled accurate plans reflecting what they felt needed to be done. Usually, geopolitical calculations and economic self-interest determined where donors sent aid.

Until early in the 2010s, some African governments successfully used regional organizations to assert their global trade interests. But a mix of coercion and sugarcoated bilateral deals sabotaged many such alliances. The trap of swift dividends reared its head: African governments needed Western aid and political support too much to be able to make more than the occasional mild statement in protest. But progress on the increase and channelling of funds was stalling.

As pressure to achieve the MDGs grew, the donor rhetoric of harmonization continued as an array of new projects sprouted—all MDG-focused. In reality, however, ideological differences about how best to deliver aid and other forms of assistance remained: different donor bodies moved resources into Africa through various systems and structures, with different or conflicting goals, or different means to the same goal—many of them continuing to bypass national government control.

As you can see from the diagrams being displayed (see **facing page**)—although most of the MDGs were achieved by 2015 in the countries of North Africa, there has been a shameful lack of success in sub-Saharan Africa. Since the 1990s, for example, the proportion of the population completing primary education has hardly increased, while the proportion of children who die before they reach the age of five has hardly dropped.

The 2015 review of the MDGs was a deeply painful event, not least because of the combination of spin and blame. Donors pointed to the investments they had made—this project, that sectoral investment programme. The main emphasis was on examples of success—where things were working. India and China got a huge amount of coverage. When it came to ascribing blame for what had happened in sub-Saharan Africa, there were plenty of places to point the finger, and very few were willing to take any responsibility.

After the review, the MDGs really fell from use as a public policy goal. Other priorities took their place. Perhaps the most serious backlash was the collapse of the case for aid: there was a gradual swing to the right in many donor countries, and the failure to achieve the MDGs gave real ammunition to those who argued that aid doesn't work: "All the billions of dollars directed at Africa over a decade and a half, and so little return." Of course, the real story was much more complex, and some journalists and academics, both within Africa and outside it, struggled to tell it. But the simplistic messages were the ones that grabbed the headlines.

A global war on… terror

But donors were increasingly distracted by other needs: as global terrorist threats escalated, international attention and aid flows to Africa were increasingly diverted from development to counter-terrorism initiatives. By 2010, aid flows were falling back to the level they were at in 2000. The same was true of trading initiatives, such as the *African Growth and Opportunities*

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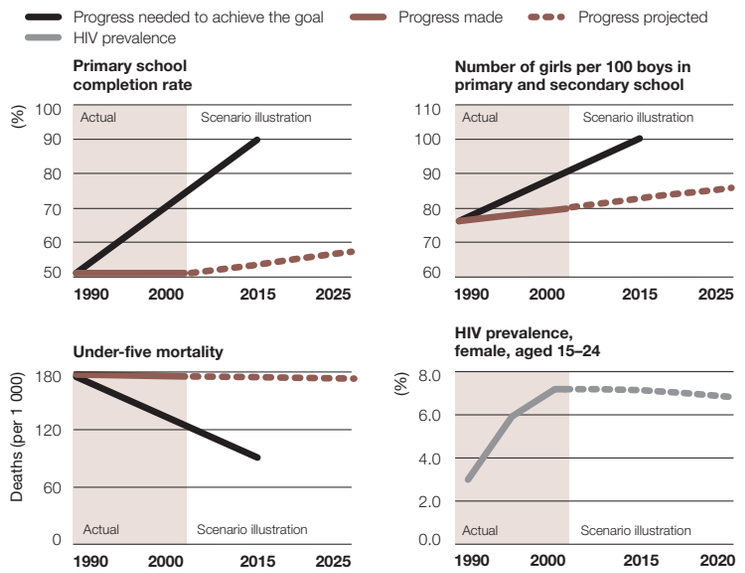
Figure **43** **The Millennium Development Goals—since 2004, sub-Saharan Africa, 'Traps and legacies'**



Source: UNDP/UNICEF (2002) *The Millennium Development Goals in Africa: promises and progress*. New York; UNAIDS AIDS in Africa Scenarios Project.

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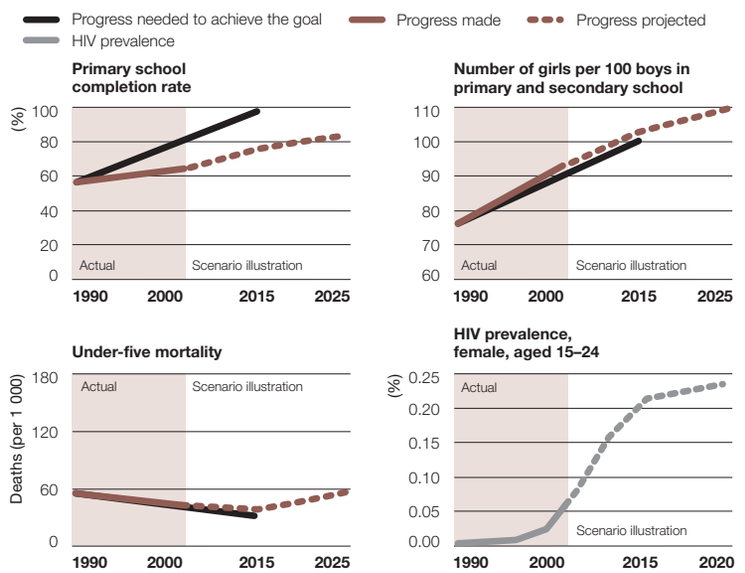
Figure **44** **The Millennium Development Goals—since 2004, North Africa, 'Traps and legacies'**



Source: UNDP/UNICEF (2002) *The Millennium Development Goals in Africa: promises and progress*, New York; UNAIDS AIDS in Africa Scenario Project.

Act (AGOA): priority was given to rewarding cooperative countries. Donor countries followed the objectives of counter-terror programmes such as the *Pan-Sahel Initiative (PSI)* and the *Combined Joint Task Force–Horn of Africa (CJTF-HOA)*. They developed counter-terrorism military capacity, built-up border policing, sharpened intelligence gathering capabilities, established military bases at select airports and remote camps—and provided funds for addressing HIV and AIDS in the security forces of strategically important African countries. Meanwhile, leaders who were struggling to keep the lid on rising internal tensions were happy for the help—it allowed them to bolster the armed forces of their countries, while the supply of antiretroviral drugs helped them to secure their soldiers' allegiance.

But it has done little good: increasing numbers of youth, often middle-class, have joined militia or terrorist groups. When asked, they give as their reasons: unemployment, disease, growing anti-Western sentiment, and the demands of their faith. Some say that death is guaranteed anyway, if not by a bullet, bomb, disease, or starvation, then by the virus—the opportunity to become a martyr gives some comfort. The Western-led alliance against terror has made pre-emptive anti-terror strikes. The increasing numbers of civilians killed by terrorist and counter-terrorist attacks have only fed anti-US or anti-Western feeling.

In general, threats on oil sources have raised the price of oil—and turned terms of trade sharply against developing countries. By 2015, following a period of extended instability in the Middle East, West Africa accounted for 25% of US oil imports and an increasing proportion of China's imports. The presence, influence, and activities of foreign oil companies and their governments in West Africa have increased over the last 10 years, as they pump money into the economies of oil-rich countries.

Although some African governments have tried to ensure that revenues are invested in services and infrastructure for their people, they have been plagued, and their efforts undermined, by political instability. Others—as I've noted earlier—have not made any such efforts, and old patterns continue: corruption remains rampant. African countries without oil have suffered increasing neglect, inequality, and poverty—economic migration has increased. There is growing rivalry between and within states, as countries covet their neighbours' assets.

Unsurprisingly, conflicts have increased. Back before 2010, the *African Union's* newly established *Peace and Security Council* attempted to tackle the conflicts igniting across the continent, but it was soon overwhelmed. The *African Standby Force* was difficult to maintain—AIDS had weakened national armies, which meant they could not send the soldiers they had committed. They were also handicapped by their lack of financial and material resources. Now within many countries there is increasing unrest, often leading to looting and violence. In a growing list of countries, foreign governments have placed a moratorium on consular activities, closed their embassies, or evacuated non-essential staff. Currently, the *UN Security Council* is struggling to gain consensus on sending peacekeeping troops to conflict spots in Africa, as most developed countries have refused to send troops: they say their electorates will not support it.

Under these conditions, long-term projects become impossible: the case for developmental aid has collapsed, and, when it isn't harnessed to geopolitical interests, aid is largely delivered in response to perceived humanitarian needs and emergencies. Global civil society is unable to unite effectively to place pressure on Western governments—its members have splintered around single issues or, if they can agree on the end they want, divided around the means to reach it.

In the meantime, working against this background—and inextricably intertwined with it—has been the trap of shortcuts and magic bullets. I will turn to this in my final lecture…

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UNAIDS/CHRIS SATTLBERGER, WHO/ERIC MILLER

Lecture 4

Running so hard—to stand still?

As we sit here, perhaps 40 million Africans live with HIV or AIDS. More than 80 million people have died. We are asking: what went wrong?

This last trap is perhaps the logical working out of all the other traps, the other legacies. Despite the efforts of so many to halt the epidemic, much of what was done paid too little regard to the other traps. We were running to stand still. It was clear that there was a fire, an emergency, and all our efforts were put into dousing the flames. Too few of us were able to focus on what was feeding the fire in the first place.

Trap 7:
Responding to the AIDS epidemic: shortcuts and magic bullets

There were those who warned of an impending catastrophe when the mass roll-out of antiretroviral therapy was begun back in the early 2000s. They were heavily criticized: everyone agreed that an all-out effort must be made to save African lives. Anyone who advocated a more cautious approach was accused of applying different rules to the rich and poor worlds.

But they were proved only too right. Most of the funds available were spent on treatment—it was a clear and quantifiable need, but not the only one. Prevention efforts lagged behind need and focused largely on trying to change individual behaviour, rather than tackling the wider context of the epidemic.

Meanwhile, the pipeline of new drugs began to fall off (**Figure 45 overleaf**). HIV prevalence rates in the rich world had stabilized and were falling: the markets for antiretroviral drugs just weren't there. Predictions made in 2004 proved all too accurate. New generations of drugs did appear, but at far less frequent intervals.

As treatment initiatives began to scale up, the challenges mounted up too. Even when money or drugs were available, there just weren't the trained staff or systems to implement the programmes on the scale needed. At the time, one frequently cited estimate suggested that more than half the doctors in high prevalence countries would have to be assigned to antiretroviral therapy programmes, if treatment targets were to be reached. The problems are well illustrated in the email included in the lecture notes… (**facing overleaf**).

Training fails to boost numbers of health staff

In the years around 2010, almost 20% of all donor funds went on training—including both long-term and short-term courses outside Africa. Unfortunately, armed with their new diplomas, large numbers of health workers from poorer countries treated this as a ticket to better opportunities—in wealthier African countries or overseas. It is hard to blame them—**Figure 46 overleaf** shows the shortfall in the numbers of health staff required.

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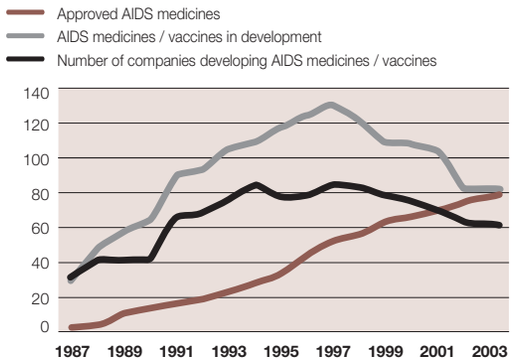
Figure 45 **Drugs to combat HIV and opportunistic infections**



Source: Dr Roger Bate, Africa Fighting Malaria and American Enterprise Institute for Public Policy Research, based on PhRMA data.

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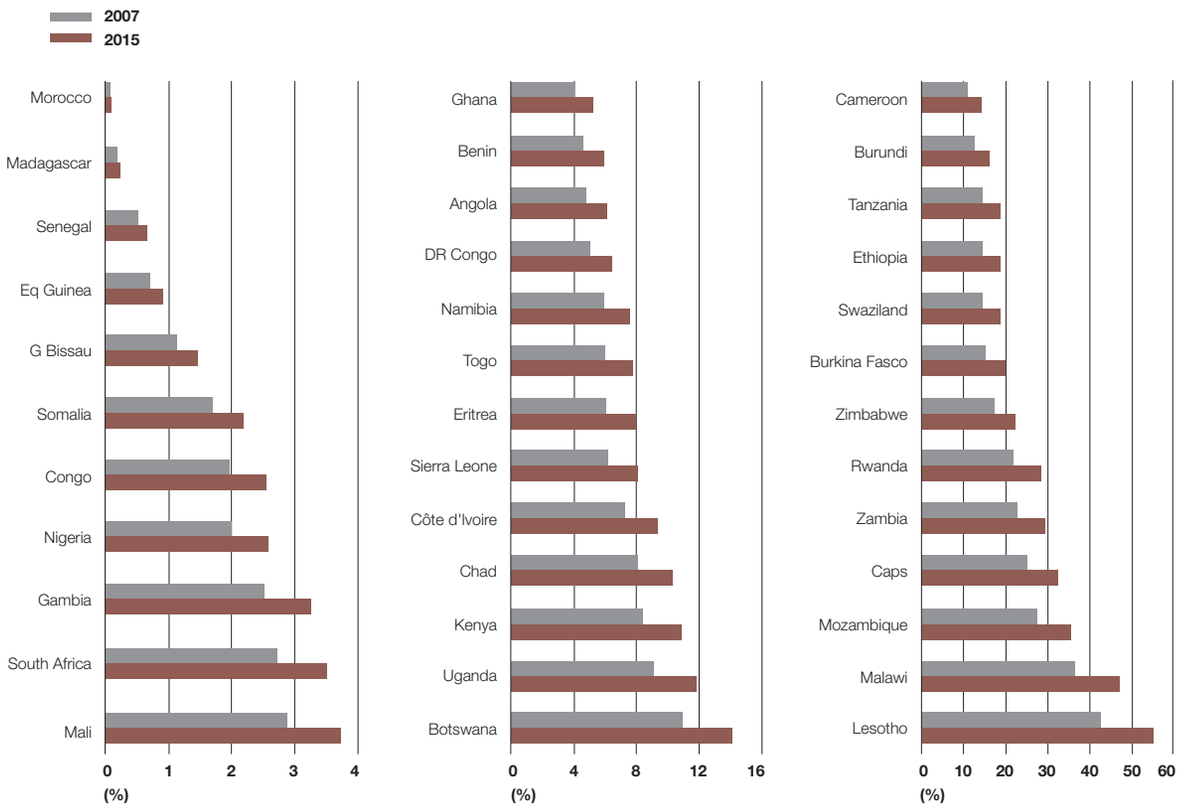
Figure 46 **Physicians required in addition to available physicians, to achieve CMH targets for antiretroviral coverage in Africa, 2007 and 2015**



Note: The CMH is the Commission for Macroeconomics and Health. The CMH envisages a coverage of 48% of the population eligible for antiretroviral therapy in 2007 and 62% in 2015. Due to the wide range of values, subsets of data have been displayed on different scales.

Source: Pearson M (2003) *Review of human resources in the health sector*. Project paper.

From: Senior ART Planning Officer, Office of the Minister of Health
To: Chief Advisor, Public Affairs, President's Office
Date: May 23, 2007
Strictly Confidential

1. We are going to miss the President's target (260 000 people on antiretroviral therapy by the end of this year). You may remember we strongly advised against the President making the announcement in the first place. You will recall we managed to stave off the initial embarrassment of missing the 2005 target by deferring it to this year. Our records demonstrate that we are likely to have managed to have started just under 54 000 people on antiretroviral therapy. Considering the size of the challenge, this is no small feat—but still less than 25% of the President's target.

2. The problems are manifold. The recommended ratio of doctors to patients is approximately 130 per 100 000. Even revising this down to new norms, we cannot achieve this. We have managed to secure the assignment of 28 doctors in 11 locations, around half of whom are also assigned to other duties. Of these doctors, 12 are expatriate, paid for by various international NGOs, and the remaining doctors are receiving additional remuneration because of their increasing workload. Approximately half these doctors are receiving training at work.

3. The factors limiting the rate of delivery at present include: 1) shortage of pharmaceutical and laboratory staff; 2) poor quality of the supply chain of antiretroviral drugs (the many attempts to break into drug stores around the country mean we can keep only very small volumes of the drugs at distribution centres); 3) problems of clerking, record keeping, and tracking of patients; 4) problems of patient compliance, where we do not have adequate counsellors to provide support; 5) growing evidence of resistance to the current supply of drugs; and, finally, 6) the volume of seriously ill patients that our staff can deal with. On this point, I should point out that we have abandoned efforts towards a rational distribution of drugs. Increasingly, we operate on a first come, first served basis, with the sickest patients most likely to get access to the drugs, although they are least likely to survive. The guidelines provided by your office on supplying drugs to essential cadres are simply not workable. Medical staff cannot be expected to make decisions about care at the point of delivery, beyond cursory attempts to ensure local residence requirements are satisfied.

4. Wherever we have opened clinics, a tremendous number of extremely sick patients have come forward, most of whom are highly time and resource intensive (estimated to take perhaps 10 times as long as putting a less ill patient on antiretroviral therapy). For many of them, we can do nothing—we lack adequate facilities for advanced HIV illness. Nonetheless, medical staff do whatever they can. This pattern repeats itself time and again. The natural triage that occurs at facility level means that the sickest demand the most attention. Our efforts to put the less ill on therapy are constantly curtailed, even though we have tried various strategies in different clinics (e.g. providing specific days and times for those who are critically ill).

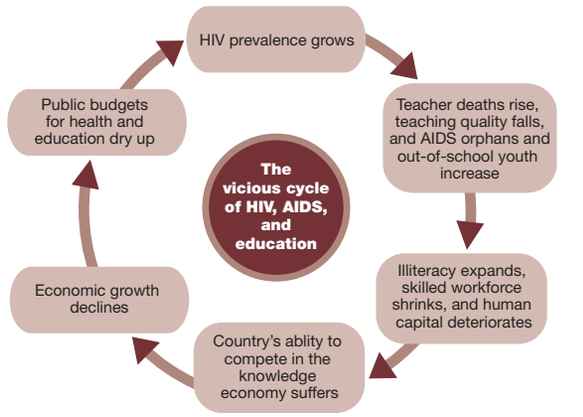
5. Our single greatest constraint is human resources. My minister cannot meet the President's demands on the existing budget provided to the MoH. Already we are losing at least 25–30% of patients to follow-up because of inadequate procedures for contacting patients who do not appear. You are well aware of the ceilings put on additional staff recruitment by the Minister of Finance. The only alternative is to continue to seek extra-budgetary resources—and we are doing this. However, our donor group insists that staffing for antiretroviral therapy is a national priority and must be met as far as possible through existing human resource planning exercises.

6. Maintaining even current levels of roll-out for antiretroviral drugs is a challenge; expansion even more so. My minister continues to resist expansion of roll-out where security of drug supply and adequate medical and laboratory staffing are not available, but your minute suggests that we have little choice but to open a further 15 centres before the end of the year, regardless of the staffing consequences. There are serious questions to be addressed concerning the efficacy of existing drugs. There has been some suggestion that part of the problem may be a contamination of the generic drugs with counterfeit drugs: this has clearly been a problem in neighbouring countries, but one we have not yet encountered within drugs distributed from Central Medical Stores. The necessary investigations to determine whether the problem is resistance or counterfeit drugs will be handled by this ministry, but I must warn you that it may be a lengthy process.

7. In short, the consequences of the President's demands may be disastrous: I would request a meeting at your earliest convenience.

Other History Lecture Series

Figure 47 **HIV and AIDS undermine education**



Source: World Bank

By 2015, it had become increasingly difficult to make up for these losses. In most countries there was still inadequate investment in secondary and tertiary education. The explosion of nursing colleges during 2005 to 2010 meant that there were more places than there were qualified high-school graduates. In fact, in many countries, especially those with high HIV prevalence, where the number of teachers had failed to keep up with the growth in population, most children weren't even finishing basic education. In general, there were too few educated graduates to supply the public sector, whether it was in education, health, or more general civil service requirements. In response, the few existing medical schools lowered their standards for entry. The diagram showing now describes the vicious cycle of the spread of AIDS and the undermining of education.

Five years and a series of superficial measures later, the quality of training, trainers, and trained was still largely deteriorating. Expatriate trainers who arrived with new curricula encountered a different world—of so few modern medical resources that their manuals were useless. Those students who could emigrate continued to do so—leaving behind those with too few skills to find jobs elsewhere.

Decentralization spells disaster

All of this, of course, had a direct impact on the antiretroviral therapy roll-out in Africa. During the period 2005 to 2015, it became increasingly difficult for health ministers to organize the delivery of AIDS treatment—different donors were funding different programmes using different drugs that demanded different regimes. In the period 2005 to 2010, the urgency of rolling out treatment led many governments, urged on by donor partners, to decentralize delivery of antiretroviral therapy to district-level—or even lower—facilities. But successful decentralization demands a strong centre that can provide knowledge, resources, and capacity for those working at local levels. And in most countries, it simply wasn't there.

There was considerable confusion, not only around delivering HIV and AIDS health care, but also in other health areas as well, since the funds, staff, and clinics that were focused on responding to HIV and AIDS and providing antiretroviral therapy were often diverted from other projects, distorting the structure and management of already overstretched and underfunded public health systems. Local staff had to take care of large numbers of foreign 'experts'. People were pulled off other high-priority activities, particularly other categorical programmes—notably staff experienced in administering directly observed therapy (DOTS) for TB programmes. In some countries, even immunization rates fell. Vast quantities of prepackaged drugs were delivered to health centres whose staff had little training for managing the process. Since each box of drugs was valued at well over US$ 100, it's not surprising that many were stolen, often by the medical staff themselves, and sold on the rapidly developing black market or for illegal export.

Parallel health care systems evolved, with privately financed clinics only providing voluntary counselling and testing, and antiretroviral therapy. But staff in these clinics could do nothing to help people arriving with other health emergencies—pregnant women and women in labour, sick and dehydrated babies—and there was nowhere to refer them.

From 2008 to 2015, in some countries, it was easier to get antiretroviral drugs than first line antibiotics. The belief that an antiretroviral therapy programme could rebuild and reinvigorate health systems through high levels of investment was found to be misplaced, except in a very few countries where health systems were already improving—but these still had to cope with the pressures arising from civil unrest and increasing floods of refugees and economic migrants.

Even well-run clinics faced two major problems: in the first place, as the news spread about antiretroviral therapy, many extremely sick people arrived to claim treatment. Many needed far more medical help than the clinics could supply—taking up large amounts of staff time, and making it difficult to start the less sick on treatment. Many of these patients died shortly after starting treatment, devastating staff and other patients.

The second problem was that the less sick patients often improved very

quickly—and then stopped attending the clinic regularly. Some stopped taking their drugs because the side-effects were so bad—besides, they lacked the nutrition and other aspects of care needed to ensure effective drug therapy. Drugs were routinely collected for one member of the family and shared among several; stock-outs of particular drugs meant that instead of triple therapy, people took two or even one drug, switching their therapy as new boxes of different drugs arrived in the clinic. There was shock and some horror when fake drugs appeared in 2005, but by 2010 no one was surprised—most medical journals refused to publish any more papers about drug leakage in, and from, sub-Saharan Africa… it was old news.

Knowledge ignored

Some private clinics in urban areas, run by dedicated local and international NGO staff, did achieve great success, treating large numbers of patients. But even this has proved destructive to the public sector, since these clinics tend to cream off the few capable staff. They also draw skilled personnel away from poorer rural areas—and it was already difficult for governments to staff these clinics.

HIV and TB programmes did not share their experiences, so that the lessons learned by TB programmes over many years about the need for effective decentralization and coherent delivery systems were not fully appreciated by HIV and AIDS programmes.

As time went on, donor efforts divided: some donors have pumped money into parallel treatment networks, arguing that is the quickest way to save lives. Others have desperately tried to strengthen the public sector system. Small, local NGOs and community and faith-based organizations have received considerable resources—but they have only added to the confusion.

The results have been chaotic. Resistance to antiretroviral therapy has spread swiftly through populations, as people who have experienced erratic treatment develop resistant strains of the virus and pass them on. This is made worse because African countries have received only early lines of antiretroviral drugs, which have barely kept up with viral mutation, rather than newer drugs, which are more effective against resistant strains, but are more expensive and not easily available. Activism continues, protesting against these inadequacies, but the roll-out has still never reached more than 25% of those needing treatment.

This need never have happened. Even in 2005, we knew that some countries had already experienced antiretroviral drug stock-outs; some drugs in circulation were past their sell-by date; in many places, follow-up was close to impossible most of the time; in most places, preparations for antiretroviral drug delivery had not been made. But a missionary zeal from within and outside the continent helped drive the belief that it was possible to build the boat and sail it at the same time. African governments had little choice but to comply—there was little or no debate or parliamentary oversight. For them, ticking the right boxes meant that aid would flow, although it would also lock them into commitments with profound implications.

A narrow focus

Twenty years ago, major efforts were initiated to respond to HIV and AIDS across Africa. For a while, spending did appear to be increasing at a satisfactory rate. Indeed, by 2010, around US$ 2.8 billion was being spent across Africa, every year—much of this (as much as 80% at some points) from external sources. But for many countries it was already too little, too late.

One of the major problems was—and still is—the way in which HIV and AIDS has been treated only as a medical phenomenon.

In the early years, governments and their donor and civil society partners discussed the need to address people's underlying vulnerability to HIV exposure. Many said they were committed to addressing the deeper drivers of the epidemic: mobility; ethnic tensions; urbanization (without employment); food security; the complex relationships between men and women and between the generations; and the effects of power, status and, of course, poverty. But programmes continued to emphasize prevention and treatment of HIV and AIDS in the narrowest possible sense, focused on addressing 'high-risk individual behaviour' and the possibilities of personal behavioural change, rather than putting into

practice the wider learning about the context of the epidemic. This has had tragic consequences.

If these programmes had been a real success, they would have made a difference. Certainly, there are more condoms in Africa today than there were 20 years ago, but not relative to the growing population. In truth, in some parts of Africa it is not that much easier to find a condom now than it was 20 years ago. Government ministers talk about the millions of dollars going into AIDS programmes, but this disguises the fact that service provision has really only expanded at the same rate as the population. For all our efforts, we have never managed to get ahead of the epidemic; never managed to even close the gap significantly.

The continuing failure to put knowledge into practice continues to have tragic consequences. Let me give you an example:

When a woman becomes pregnant, antenatal programmes will ensure that she is tested for HIV. If she is infected then, all too often, because she has been tested first, she is blamed for bringing the infection into the relationship. As we have long known, her husband may react with violence or by leaving her, or both. Attempts to support women, however well meant, must be made in the context of the beliefs and attitudes of the societies they live in—or they will only bring trouble. We have known that for decades. Why do we still not put it into practice?

The focus on personal behaviour seemed to spur on the development of microbicides and vaccines—but it still took a long time. There was little commercial incentive—the market for any product was considered too small and too poor. Much of the work was small-scale, and there were problems with wasteful duplication of efforts—such as similar compounds being moved to Phase III trials, rather than rational agreements being made about which ones were the best candidates. There were some efforts to coordinate and improve the situation, but efforts were always hampered by competition for inadequate resources. Besides, there were those who argued that it would only increase promiscuity.

Now that there finally is a microbicide, there is no really effective system for ensuring that it's available to those who need it. It is still too expensive for the majority of really poor women: access is still largely limited to women who are the targets of projects and programmes. Among young rural women, one recent study suggested, only 25% have even seen a tube of the microbicide (and some commented they wouldn't have anywhere to hide it anyway).

The same problems are true of the recently released vaccine. Although most countries have licensed it and introduced it to national programmes, few have benefited. It needs to be given in three doses, over the course of a year. Although a large number of people get the first dose in most countries, there simply aren't the systems or people to ensure that they are followed up adequately. Obviously, where there are dedicated programmes, often run by NGOs, the story is a bit different. But widespread vaccine programmes for young adults, especially when they are out of school, is a tremendous challenge for most public health programmes.

The psychological and emotional trauma of the epidemic for people living with HIV and AIDS and their carers is also seldom addressed—there are few resources left after the other programmes have been paid for. Even now, in 2025, the largest funds are still being spent on AIDS-specific activities, and the deeper drivers and effects are just as neglected as they were 20 years ago.

Conclusion:
Breaking the circle of blame

The Ashanti say that the ruin of a nation begins in the homes of its people. Now, in 2025, we might rephrase this proverb to talk of the ruin of a continent. And it is not surprising: any one of the traps that I've described would provide a monumental challenge. Of course, individual countries have managed to escape one or other of the traps, but most countries in Africa have faced all seven.

Am I being unreasonably pessimistic?

There have been some success stories. In response to the epidemic many among the educated middle classes have changed their behaviour: young people use condoms; more men

use condoms; women sometimes leave husbands they can no longer trust; and some young women use microbicides and know how to protect themselves. And if someone does become infected, they can access drugs—sometimes by joining an international NGO scheme. But it's also true that higher rates of HIV persist among better-off men. They can buy sex—and they tend to buy it from poorer women, who make their livelihood selling sex and are more likely to have HIV. Despite all we know, this pattern continues, with little effective intervention.

Over the last 20 years, there has been some expansion of gay and lesbian organizations on the continent. Some of these have received international funding and support—excessively severe crackdowns by some governments on these organizations are regularly met with international outrage. But, on the whole, this support is rarely sustained. In most countries, the existence of men who have sex with men is denied, and the risks of anal sex seldom, if ever, discussed.

Some countries have been remarkably successful in keeping HIV prevalence rates low, but the reasons are unclear: some believe they have just been lucky; others put it down to a particular culture; others credit astute leadership and good programming. Still others argue that the reasons are much simpler: a number of these countries just managed to acquire more of the available resources than others. But, as prevalence has remained high in neighbouring countries, and conflict and scarcity forces people to migrate across borders—there are signs that the luck of these countries is running out.

In countries where prevalence remains high, the outlook is now very bleak indeed. The number of new infections inches up year after year, as does the number of deaths. Governments are unable to provide for their people: the effects of the virus have systematically undermined the capacity to supply services such as security, health care, and education. There are few left who can organize a response to this catastrophe—AIDS has decimated the ranks of skilled administrators, diminishing the reach and responsiveness of government institutions. Those who are left are likely to be snapped up by international organizations, the private sector, or NGOs.

Against this background, people look for someone to blame: global North censures global South and vice versa; government leaders berate ministers; youth charge their elders with neglect. Next month, African leaders gather again to discuss the plight of our continent; *BandAid+40* kicks off another international tour.

But perhaps we need to pause… avoid the temptation to look for someone to blame; resist the urge to rush into immediate action. Perhaps, instead, the critical question we need to find an answer for is, "What can we do that will really make a difference?"

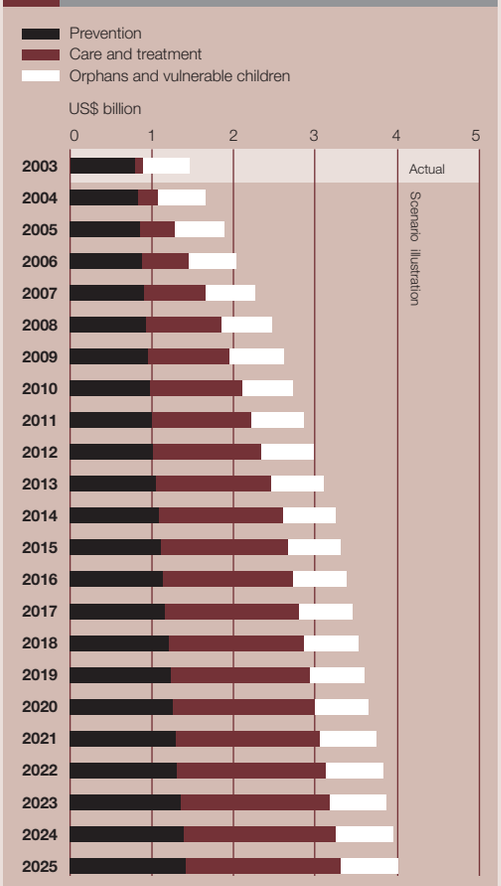
Thank you for listening.

Special edition
One World Review
ONE WORLD REVIEW VOLUME 20, NUMBER 12 DECEMBER 12, 2025

In the remainder of this article, and in line with its practice of providing summary historical data, *One World Review* presents an overview of some of the key indicators that help illustrate the progress achieved during the first 25 years of this century.

Traps and legacies: An overview

Figure 48 **Annual expenditure on HIV and AIDS, by component, 'Traps and legacies', 2003–2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

The human toll

Our history provides a deeply disturbing window on AIDS in Africa.

In 2004, it was clear that HIV prevalence had stabilized in much of sub-Saharan Africa, although the number of new infections continued to rise with a growing population. In some, mainly urban, areas and in some population groups, HIV incidence was declining.

It was not that there weren't significant efforts to respond to HIV and AIDS, or to build health-sector capacity, or to roll out treatment. There were, and they were sometimes heroic. The problem is that they were never quite enough to get ahead of the impact of the epidemic and the demands of growing populations.

Today, in 2025, across Africa, 3% of the total population are living with HIV and AIDS. Among adults, this figure is over 5%, or 1 in 20. There has been only a slight reduction in overall adult HIV prevalence, from 5.6% to 5.3%, over the last 20 years.

In East Africa, adult HIV prevalence is 5.9%; in West and Central Africa, 4.4%; in Southern Africa, 14%; and in North Africa rates are around 0.3%. Within these larger regions, there are often considerable differences between countries and within countries; and between regions and population groups.

These regional variations hide a dynamic epidemic. For example, some areas where the epidemic was worst 10 or 15 years ago now have fading epidemics, whereas areas that once seemed relatively free of HIV have developed slow-burning epidemics.

Unfortunately, the HIV prevalence figures hide the growing numbers of infected people. In 2025, because of population growth, a 5.3% adult HIV prevalence means that over 38 million adults across Africa are living with the virus. AIDS remains a clear and present danger in many countries. In 2025, of the 4 million new adult infections across Africa, 2.3 million will be women and 1.9 million men.

The cumulative death toll among adults and children since the start of the epidemic is over 83 million—66 million adults and nearly 17 million children. The annual death toll among adults and children is currently 3.5 million people and still rising.

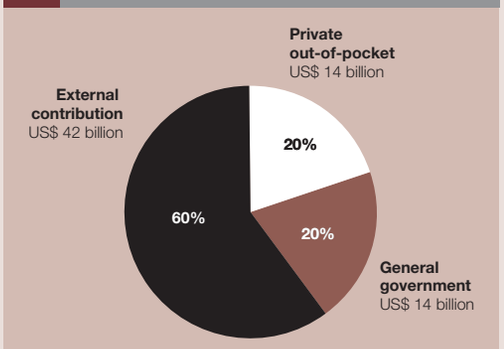
We have seen the efforts to roll out antiretroviral therapy continue, but we should also note that they are impeded by a combination of underdeveloped and overwhelmed systems, as well as overall cost. By 2015, a little over 20% of the adults who needed antiretroviral therapy had access to it, and this figure has stubbornly refused to budge since then. Care and treatment cost over US$ 1.5 billion per year in 2015 and it costs more than US$ 1.8 billion annually to maintain the same level of treatment today.

Approximately US$ 0.8 billion was spent on prevention in 2003. This figure has now risen to around US$ 1.4 billion per year, covering interventions in schools and for out-of-school youth; targeted programmes with sex workers; supplies of condoms and treatment for sexually-transmitted infections; some voluntary counselling and testing; workplace prevention; screening of blood; prevention of mother-to-child transmission; and mass media campaigns. Spending on the epidemic has kept pace with population growth, but has not exceeded it.

Support for orphans and other vulnerable children has not been expanded significantly, and has not kept pace with need, as the number of children orphaned by the epidemic has risen to 27 million. The number of children orphaned by AIDS now nearly equals the number of children orphaned through all other causes. In addition, nearly 2 million children now live with HIV and AIDS.

In 2025, HIV- and AIDS-specific programmes across Africa cost US$ 4 billion per year. Because we are failing to get ahead of the epidemic in terms of prevention, the costs are continuing to rise, and will continue to do so into the foreseeable future.

Figure 49 **Total expenditure on HIV and AIDS by source, 'Traps and legacies', 2003–2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

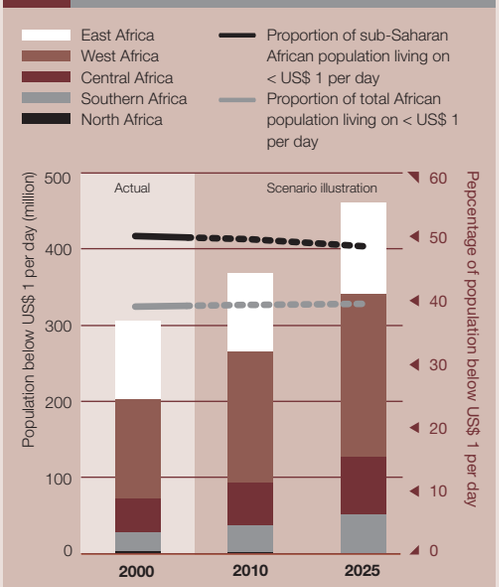
Costing action

The cumulative costs of AIDS-specific interventions have amounted to over US$ 69 billion dollars over the 23 years from 2003 to 2025. To some extent, aid flows (although erratic and stagnating) have enabled the implementation of some programmes. Importantly, the per capita costs of the programmes continued to increase, indicating that the programmes were too under-resourced to significantly affect the epidemic and that prevalence rates were not being reduced substantially.

Comparing the first and last bars in **Figure 48** illustrates how resource allocation has changed over the last 23 years. Although less than a quarter of adults who need antiretroviral therapy have access to it in 2025, care and treatment consumes almost half of all expenditure. Support for orphans and vulnerable children has not increased significantly since 2003 and in 2025 represents just 17% of total expenditure, while the proportion of resources allocated to prevention has reduced as more resources have been directed towards treatment and care.

Despite hopes for stronger economic performance, economies in Africa have grown slowly, and often erratically, over the past two decades. Most government budgets have expanded by only about 1% per year, with health budgets increasing only marginally at about 0.5% per year. In this sluggish economic context, the expenditure on HIV- and AIDS-specific programmes has grown only slowly. The fact that expenditure has grown at all reflects the high profile that HIV and AIDS have maintained over the last 20 or so years.

Figure 50 **Population living on less than US$ 1 per day, by region, 'Traps and legacies' selected years**



Source: UN (2003) *World population projections – 2002 revision.* Geneva (2000 data); UNAIDS AIDS in Africa Scenarios Project.

Total external contributions to Africa peaked around 2015–2018, when disbursements reached US$ 23 billion annually. In real terms, the level is similar today, though there has been considerable volatility in between. Funding for HIV and AIDS programmes has held up reasonably well however, accounting for just over 10% of all the external assistance reaching Africa. Donors have continued to prioritise HIV programmes, especially treatment, but there are still serious shortfalls.

Increasing programme costs for both governments and individuals have meant continued dependency on external contributions, even though it is now estimated that 20% of programme costs come from government funds, and at least 20% from individuals' out-of-pocket expenditure. In some countries, new loans have been taken out to cover the rising costs of treatment programmes, contributing to the burden of debt. As the number of people becoming infected continues to rise, the outlook remains bleak.

The graphics on the facing page show per capita expenditure on HIV and AIDS across Africa over the last 20 years, illustrating the high dependency on external contributions.

Poverty

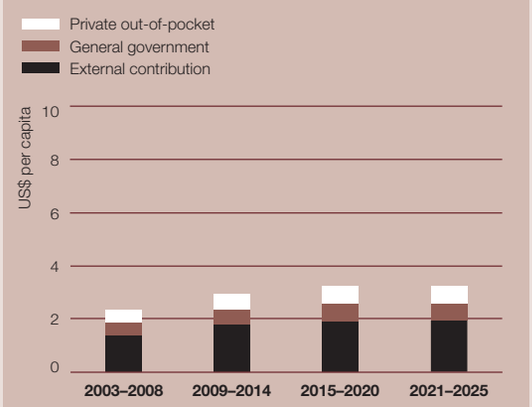
The fact that the proportion of Africa's population living on less than US$ 1 per day has remained constant over the last 20 years hides the growing actual numbers of people living in poverty. As the population of Africa grows and puts increasing pressure on already scarce resources, the number of people living on less than US$ 1 per day has grown from about 300 million to over 450 million. The actual number has reduced in North Africa, but in East Africa it has increased by 16% (to nearly 120 million); in West Africa by 65% (to over 210 million in 2025); in Central Africa by 70% (to 75 million); and in Southern Africa by 90% (to 50 million).

All Africa overview

Figures 55–58 (overleaf) are illustrations of trends in HIV and AIDS up to 2025. A full explanation of what is included in the costs is in **Appendix 1**.

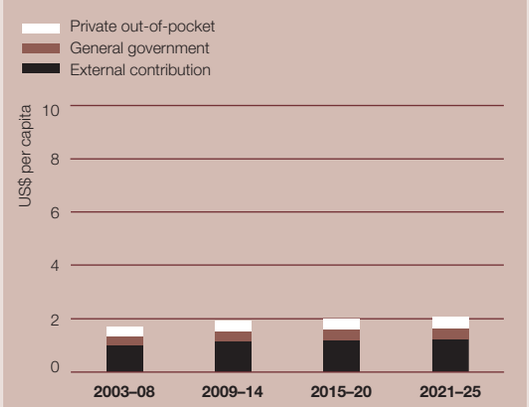
Adult HIV prevalence in Africa remained reasonably stable, declining slightly from 5.6% in 2004 to 5.3% in 2025, reflecting the moderate impact of HIV prevention programmes. However, this apparent stability disguises the fact that the number of new infections was growing every year, outweighing the number of annual deaths, so that the actual number of people living with HIV and AIDS grew throughout the period. This is a consequence of sustained population growth on the continent.

Figure 51 **Average annual per capita expenditure on HIV and AIDS in East Africa, by source, 'Traps and legacies', 2003–2025**



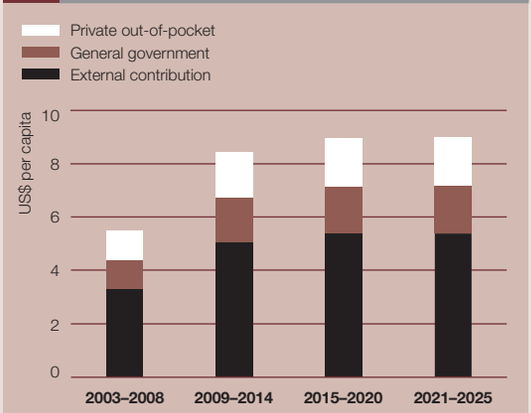
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 52 **Average annual per capita expenditure on HIV and AIDS in West and Central Africa, by source, 'Traps and legacies', 2003–2025**



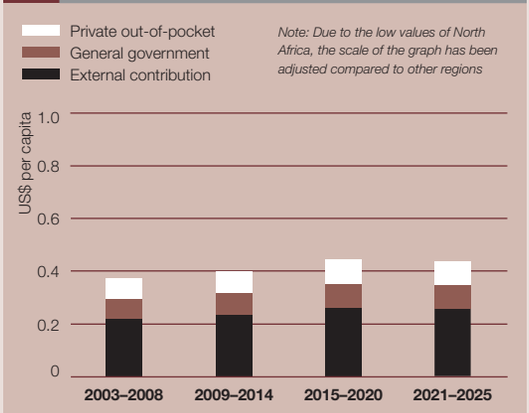
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 53 **Average annual per capita expenditure on HIV and AIDS in Southern Africa, by source, 'Traps and legacies', 2003–2025**



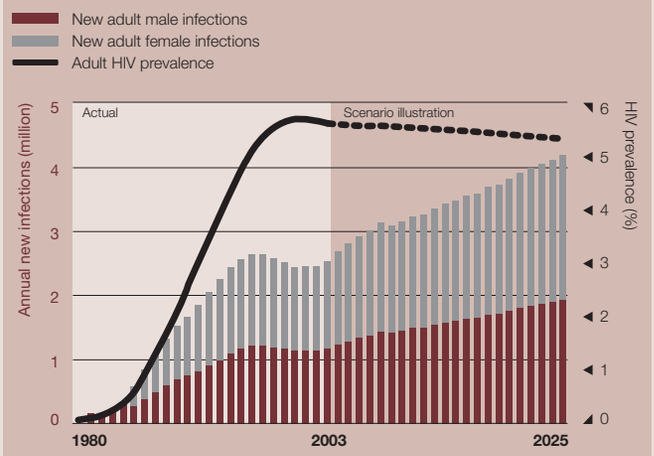
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 54 **Average annual per capita expenditure on HIV and AIDS in North Africa, by source, 'Traps and legacies', 2003–2025**



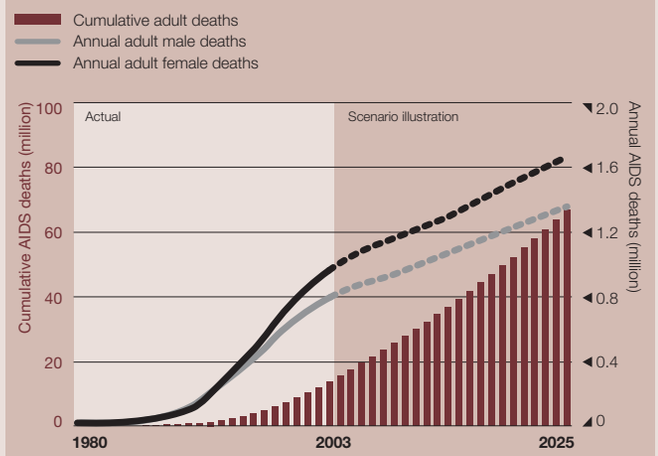
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 55 Annual new adult HIV infections and adult HIV prevalence in Africa, 'Traps and legacies', 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 56 Cumulative and annual adult deaths from AIDS in Africa, 'Traps and legacies', 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Women are worst affected by the disease: during 2025 the number of new infections among women is expected to reach 2.3 million, while new male infections are expected to reach 1.9 million.

The temporary decline in the number of new infections after 1997 was a result of national and international attention to the issue. The long-term increase that follows is the result of prevalence remaining relatively stable and the population growing—increasing the overall number of people living with HIV and AIDS.

Women are also more adversely affected in terms of annual AIDS deaths. Despite the slight decline in HIV prevalence, the actual number of annual deaths from AIDS has increased from about 1 million in 2004 to 1.7 million in 2025 for women, and from 820 000 to 1.4 million for men.

Initially, the rate of increase in the number of annual deaths reduced, thanks to antiretroviral therapy and a reduction in the number of new infections. After 2009, new infections increased and, in the longer term, the number of female deaths increased more quickly than male deaths.

The cumulative number of adult deaths from AIDS since 1980 will exceed 66 million in 2025, with deaths in the whole population exceeding 83 million.

The number of people in need of antiretroviral therapy but without access to it is still very high: in 2025, of the 7.2 million people who needed antiretroviral therapy, only 21.5% (1.5 million people) had any access to it.

The number of children orphaned by AIDS continued to increase through the period, from 14 million in 2004 to 27 million in 2025. The total number of orphans (from AIDS and other causes) is expected to reach 58 million in 2025.

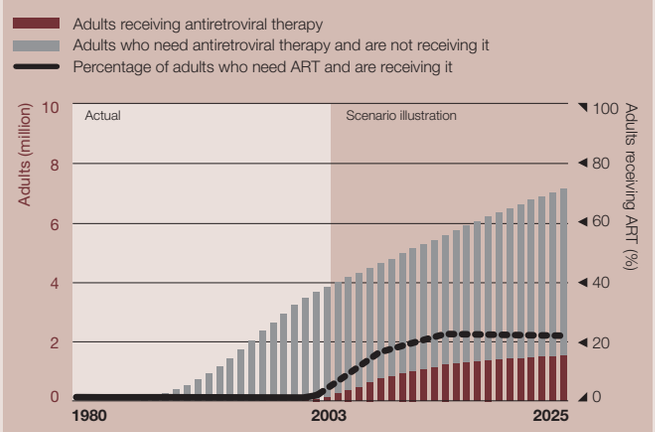
African regions overview

Figure 59 shows a breakdown of the epidemiology of the epidemic into the geographical regions of East, West and Central, Southern, and Northern Africa.

[1] Adapted from Sayagues M (1999) How AIDS is starving Zimbabwe. *Mail & Guardian*, 16 August.

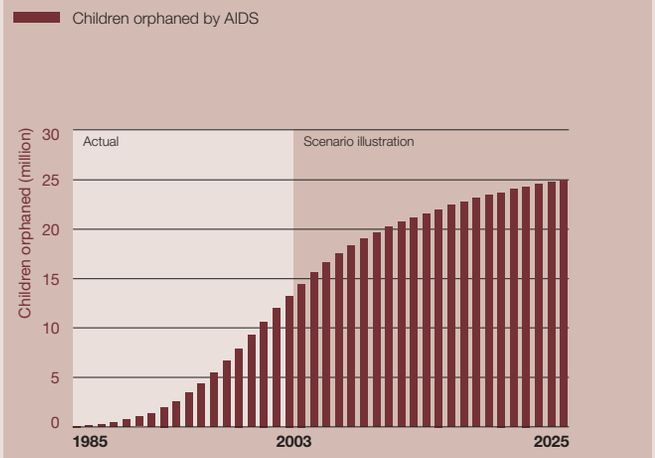
[2] Ten Kate K, Laird SJ (2004) Bioprospecting agreements and benefit sharing, p.133–158. In: Finger JM, Schuler P, eds. Poor people's knowledge: *Promoting intellectual property in developing countries*. Washington D.C, World Bank and Oxford University Press, and Finger JM (2002) The Doha agenda and development: *A view from the Uruguay Round*. Manila, Asian Development Bank. Available at http://www.adb.org

Figure 57 **Adults receiving antiretroviral therapy and adults in need of antiretroviral therapy in Africa, 'Traps and legacies', 1980–2025**



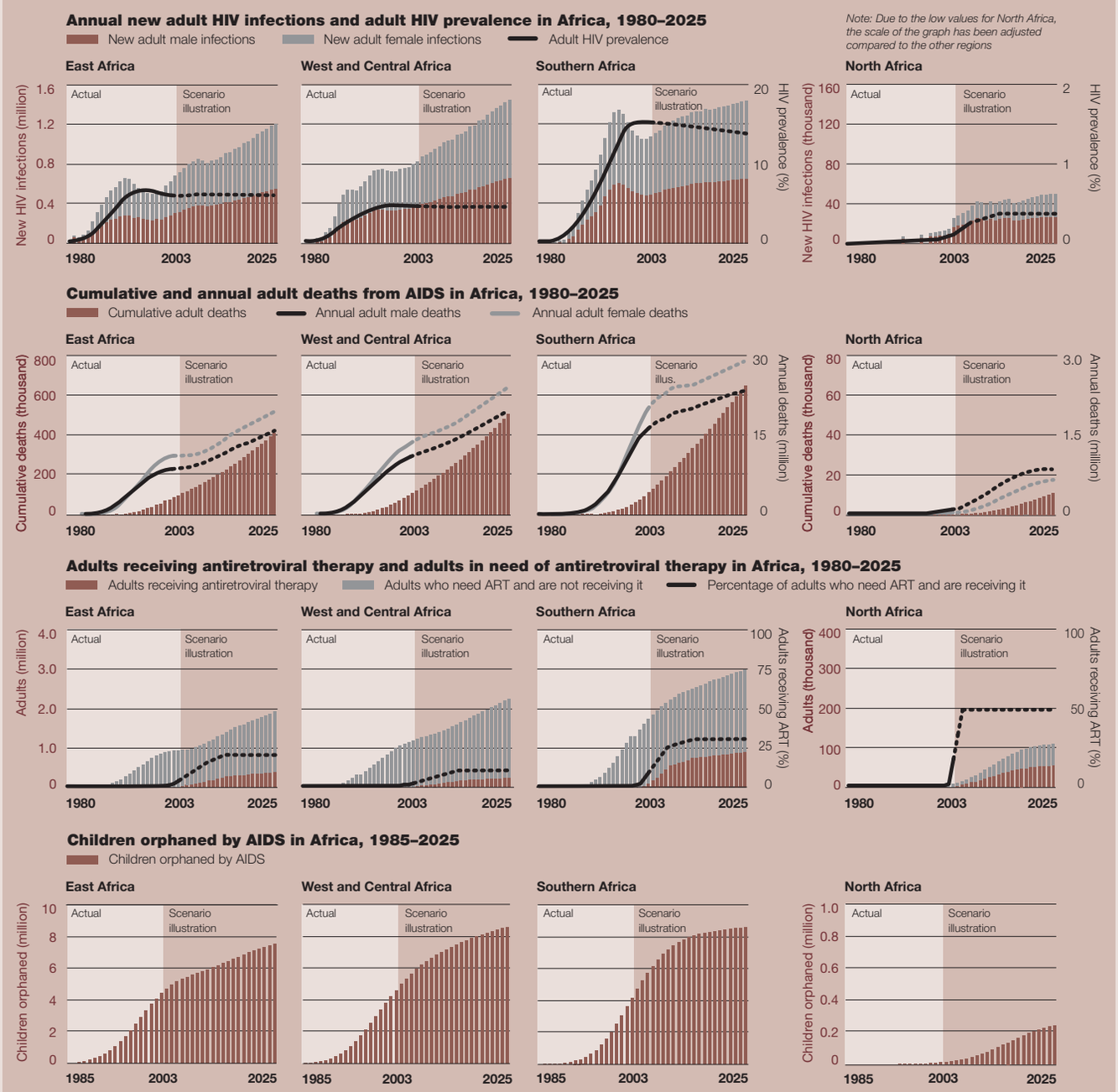
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 58 **Children orphaned by AIDS in Africa, 'Traps and legacies', 1985–2025**



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 59 **Traps and legacies: Regional overview**



Source: UNAIDS AIDS in Africa Scenarios Project.

I Sing of Change

I sing
of the beauty of Athens
without its slaves

Of a world free
of kings and queens
and other remnants
of an arbitrary past

Of earth
with no sharp north
or deep south
without blind curtains
or iron walls

Of the end
of warlords and armouries
and prisons of hate and fear

Of deserts treeing
and fruiting
after the quickening rains

Of the sun
radiating ignorance
and stars informing
nights of unknowing

I sing of a world reshaped.

—Osundare N. In: Beier U, Moore G, eds. (1999) *The Penguin book of modern African poetry.* New York, Penguin Classics.

Section 6 Times of transition: Africa overcomes

This scenario is told as an account by a storyteller and some of her friends, as they look back from 2036 at the changes that took place in the first quarter of the twenty-first century.

Folktale

Once upon a time, in a small village called Ogundugbwe, there lived a community of animals: Big Gentle Elephant, Fearless Lion, Tactful Monkey, Sleepy Jackal, Obedient Hyena, Beautiful Zebra, Hard-nosed Mouse, Long-mouthed Goat, and Harmless Cat.

Life was not easy for the animals of Ogundugbwe. For a long time a mysterious disease had been destroying their crops.

Even though the animals of Ogundugbwe were so different from each other (they even used to be arch-enemies), they now lived together peacefully, their community enriched by the presence of animals that had come to visit the village from faraway lands. They had brought news that a similar disease had attacked crops and plants in their own homelands. Their battle to eliminate the disease had achieved some success because remedies that had been found had made the killer disease temporarily dormant.

In Ogundugbwe, however, the gruesome disease was truly on the rampage. The animals had tried, in vain, to eliminate the killer disease with traditional and non-traditional remedies, but it just grew stronger and stronger.

Unfortunately for the animals of Ogundugbwe, a deadly famine was now staring them in the face. As the death toll climbed higher and higher, Fearless Lion, the much-loved and popular chief of the village of Ogundugbwe, decided to organize a meeting.

As humble and pragmatic as ever, Fearless Lion announced beforehand that he would not be giving an official speech at the meeting, but instead would listen to the contributions from those animals best suited to provide the most brilliant ideas of how to deal with the problem.

And so, Big Gentle Elephant and Tactful Monkey, as well as Hard-nosed Mouse, were asked to prepare speeches detailing the experiences of the animals of Ogundugbwe. Fearless Lion had also invited two very special guests to speak at the meeting. One was Clever Hare from the faraway Kingdom of Gondwana. Clever Hare was said to have discovered the powerful remedy that had helped to make the killer disease dormant in Gondwana.

The other guest speaker was Watchful Eagle, from the neighbouring village of Bongolo. Watchful Eagle was rumoured to have flown around the world, visiting all the lands where the killer disease had attacked crops and plants. Along the way, Watchful Eagle had collected useful information, not just about the killer disease, but also about how the different animals of the world were dealing with the problems caused by the destruction of their crops and plants.

This was a unique and very important occasion indeed! The animals of the world had come together to fight the monstrous, unforgiving, and mystifying killer disease! As a result, there was hope all around… Deaths of the world's animals from famine would be minimized. Even small villages like Ogundugbwe would be able to share their little experiences of life.

If Hard-nosed Mouse and Harmless Cat could share the same chair, and if Fearless Lion and Beautiful Zebra could eat from the same plate, then what was not possible in the Animal Kingdom!

VOLUME 31, NUMBER 11 **NOVEMBER, 2036**

One World Review 2036

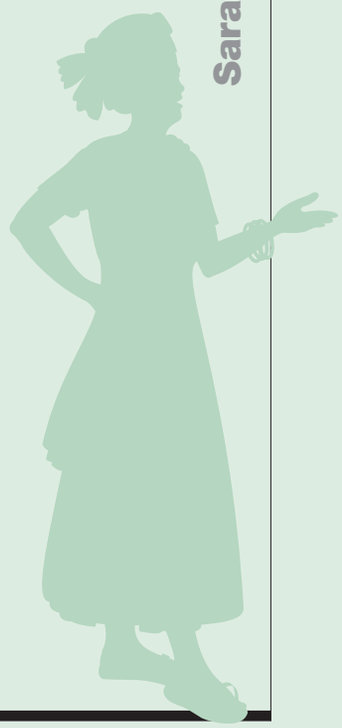
One World Special edition

Sara Afrika's oral telling: *Times of transition*

In this exclusive extract from her oral history telling, *Times of transition,* the oral historian Sara Afrika, explores the remarkable changes of the last 30 years that have transformed our world and, in particular, Africa. The transcript is taken from her latest recital—performed with a group of citizens—and has been nominated for the New Millennium Orator prize.

In her introduction, Ms Afrika told us: "It's an immensely complex story: it involves many smaller transitions, across diverse spheres—social, political, economic, etc.—taking place in many different places, and with the involvement of countless people, both within and outside Africa."

To be able to tell the story, she travelled widely across Africa: "From presidents to poets, from soldiers to scientists, from ministers to mothers, I have talked with them all." She went on,



"This is everyone's story; everyone played their part.

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She asked these people to describe the events they thought were crucial in reshaping Africa's future—and she uses these to tell her story. She calls them the six key transitions:

1 **'Back from the brink'** describes changes in how HIV and AIDS are dealt with, with a rapid roll-out of treatment and effective prevention strategies, supported by a very active civil society.

2 **'Setting the house in order'** focuses on national policy responses to reduce poverty and spur development—crucial for limiting the spread of HIV.

3 **'Working together for development'** investigates the improved collaboration between African governments and their external partners over the first quarter of the century, as resources are increasingly owned, directed, and coordinated by African governments and their people.

4 **'Trading on strengths'** details the key changes that have taken place in global trade.

5 **'Human hearts and human rights'** describes the people at the core of the scenario and the ways in which they have changed—including powerful changes in the ways women and men relate to one another and to their communities.

6 **'Planting peace'** describes how the prevention of conflict and promotion of peace and security, both within and between countries, has been a vital part of the new African agenda for the twenty-first century.

Figure 60 **Times of transition: key dynamics**

VOLUME 31, NUMBER 11 **NOVEMBER, 2036**

We present here a complete transcript of *Times of transition*, an oral history telling, as told by Sara Afrika.

Transcript of *Times of transition*

Introduction

You know, it is always wise to ask a storyteller why she is telling the story. Let me start with my reasons. So, come and join me last October, in 2036. It was early morning and a cool yellow light was spilling across the road. I closed my eyes and listened to the crowd around me shift and murmur—sudden bursts of laughter, a child's cry, snatches of conversation. Another day, another march. But unlike those of the early years, when it seemed that every day was marked with painful, angry protest, this day we were walking together in celebration.

These people were off to the city hall, to give a warm and loving welcome to Ilena Ejitsu, the new Secretary-General of the *United Nations*, who had come back to visit her home town. It was a typical gesture from this brave and responsible woman whose service to the world stretches far back. She was a volunteer in the trials of the first-generation HIV vaccines back in 2015; she helped to push through our country's laws protecting women from domestic violence; and fought for the protection of those with HIV—but she never forgot where she came from.

You may remember—even in her acceptance speech—she talked about her love for her home town and what its people had taught her. She described how, as a child orphaned by AIDS, with no extended family, the local community had taken her in, cared for her, given her counselling, and encouraged her to go to school. The community stood together, and in their unity they found tremendous strength. Those were the early years of the fight against the virus, when such gestures were so much more difficult. She says she has carried the lessons of those days and those people with her all her life.

I stood among the marchers—my people—on the dusty street. I remembered there was a time when nobody mentioned AIDS; when it was taboo; when the stigma was too great. You see, I am an old woman and I remember far back to a time when, if anyone spoke about the virus, all they would get is a frown and stony silence, perhaps averted eyes, sometimes muttered threats, even outright violence…

I looked around at my people and then I saw a man with a huge grin, wearing an M-Net T-shirt, moving through the crowd, rattling a tin and handing

out flyers. I took one and glanced over the headlines: "TB—we've got it on the run", followed by "Almost eradicated from the African continent, TB is still endemic in some areas. We need your help to make Africa a TB-free zone…"

As I stood reading about what we still had to do, a little girl approached, big-eyed with purpose, dragging her mother by the hand. She'd read my stories in school, recognized me from the photos on my website. She wanted an autograph from the storyteller. Her mother, a woman in her early 30s, wearing a small button advertising antiretroviral therapy ("Want to know how? Call me now…" with a phone number and website address), apologized shyly for her daughter's enthusiasm.

The mother told me that my stories inspired her at school as well; that they filled her mind with a vision of the future, her heart with hope, and her stomach with ambition.

I realized then and there, standing with the TB leaflet in my hand, that there was a story I still had to tell.

And I will try and tell it now, with the help of three dear friends: the minister, Dr Ibrahim, who entered the world of politics as a young activist; the lawyer and renowned civil society leader, Steve Phorano; and Sister Bweupe, famous for her work in the rural clinics of Africa.

Setting the stage

Storytellers remake the world—don't they? If you believe that, then you could say that there was never a greater need for storytellers than in 2005.

And we were lucky: over the 30 years that followed, more and more people became storytellers. It would have been so easy for them to surrender to despair. Instead, people wove individual tales of hope, spoke the words that turned fear into purpose, which broke the silence and shattered isolation.

We didn't know it then, but together, those people were creating a sweeping narrative of great synergy and transformation. It was a transformation of action, unity, and understanding. From the four corners of the world, people began to appreciate that it wasn't enough to try to make a single change or start a single campaign. That would never work.

If you want to achieve fundamental change, you have to think beyond that single change to all the other factors that are involved.

Dr Ibrahim: But that sounds too simple. If we describe it in such simple terms, we risk ignoring the pain of those early years. I may be a government minister now, but I, like so many others, felt quite alone in those early years.

Steve Phorano: He's right! It's easy to talk now about 'the reconfiguring of international relations', but back then, the path to change was not so clear…

You're right, my friends. Many different battles were being fought—and with such dignity, despite so much suffering and pain… So how shall we tell this story?

Steve Phorano: Well most stories have a clear beginning, middle, and end, but this one is different. Certainly, as I look back from 2036, I don't feel it has an end or indeed a beginning!

Signs of hope… and intimations of disaster

Dr Ibrahim: I'd say that it begins with a shift—in the values, beliefs, and actions of people across the world.

Steve Phorano: Many of my colleagues say this grew out of the work of the anti-globalization movement…

Dr Ibrahim: Some, especially Westerners, point to the commitments made by wealthy countries in the early years of the twenty-first century.

They can see the early promises made to Africa in particular—the *Global Fund to Fight AIDS, Tuberculosis and Malaria*, the *Millennium Project,* the *US President's Emergency Plan for AIDS Relief (PEPFAR)* and the UK's *Commission for Africa* report and its impact on the *G8* 2005 Summit—as the seeds of a deeper change.

Others say it was the new international mechanisms for accountability—for multilateral institutions, NGOs, and governments, and especially corporations.

Steve Phorano: I have heard people argue that it was the crises that struck in the early years of the new millennium: the stalling of trade negotiations in 2004/5; the terrorist attacks across Europe in 2006/7; the obvious failure of the global community to keep the promises made in the Millennium Development Goals; the increases in oil prices; the 2008 floods in Europe and Asia, which made people take the reality of global warming seriously; the fears of another century of wars...

Africa itself is often named as one of the crises—in the early 2000s, many African countries were experiencing reverses to the economic and health gains of the preceding decades. Some people thought the AIDS epidemic was responsible. Others blamed the lack of sociopolitical stability and economic progress, inadequate African leadership and governance, the parsimony of the rich world or the inequalities fuelled by economic globalization...

Sister Bweupe: Most people I know say that the AIDS epidemic itself was the catalyst. Certainly, people saw it as a grave humanitarian crisis—unprecedented in the modern world—and economic analyses made it clear their worries were well founded. Once public opinion and economic rationale coincide, it's not long before the politicians get involved—so perhaps this had something to do with it. What do you think, Doctor?

Dr Ibrahim: We should not forget there were already important changes taking place in Africa—shifts in governance approaches and processes, like the *New Partnership for Africa's Development (NEPAD)* within the *African Union* beginning to lead the response to HIV and AIDS. There were crucial cultural changes, too: people moving to the cities, forming a new and expectant middle class, forging novel ideas about individual identity and youth culture; mobile phones and internet cafés were spreading across the continent, spreading ideas.

Then there were the growing numbers of Christian churches that were springing up across Africa, emphasizing individual and community empowerment through increased self-esteem, spirituality, bodily integrity, and economic empowerment. And there was the growth in Muslim organizations across the continent, which generated a new sense of community as well as intensely practical Islamic forms of charity, investment, and development. Or I could focus on the changing role of women; or the elections which, across Africa, were beginning to uproot entrenched regimes, and...

Do you see how difficult it is to describe? A thousand individual stories of change; so many people seemingly working for different things, but in the end a remarkable synergy.

To help us tell our story, let us focus on three key groups of people:

- Civil society;
- African leaders; and
- The international community.

Civil society in training

If you look up the history of this period on the Net, the search engine frequently fetches the name of the *South African Treatment Action Campaign (TAC)*—one of the first of the activist groups that would catalyse sustainable change. Their approach was driven by strong political analysis and sound, up-to-the-minute scientific research. Call it fortune or strategy, they had access to high quality legal and computing resources and the expertise to use them—didn't you, my friend?

Steve Phorano: But we also understood the crucial importance of committed membership. We could mobilize massive community-based support and involvement at extremely short notice. And, believe me, through *TAC* and all the other groups that have taken its example, we still do…

Over the last 30 years, this model of advocacy has been adopted across different areas of concern, among activists campaigning around different political issues of all kinds. These groups have learned how to join voices, visions, and technical knowledge; how to link extraordinary political and technical savvy with deep community involvement, beginning with the problems their own people were facing, rather than setting an agenda from the outside. They have learned from each other's victories and failures, growing stronger with each campaign.

Dr Ibrahim: Campaigns that became a movement for change—that may describe it for some countries—but remember, many of us had never done anything like this before. In many parts of Africa, civil society was still embryonic or fragile. Even with the *African Charter on Human and Peoples' Rights,* many of us knew that speaking out could mean imprisonment, marginalization, and intimidation.

New leaders taking aim at… peace

Alongside these initial voices, there were other signs of change. By 2012, a new generation of African leaders had begun to appear. Some of them were literally the children of former leaders; but some emerged from other areas…

Dr Ibrahim: I had worked as an activist and a number of my colleagues were active members of civil society. Others hailed from academia or the private sector. In addition, there were increasing numbers of women holding high political posts. I believe it brought a new dimension to governance, catalysing more gender-sensitive policies and processes.

Charismatic and ambitious, many of them—such as Nkrumah, Azikiwe, and Kenyatta, the architects of independence—were educated abroad in Western institutions. They were determined to bring their countries and their continent to the same level of development as countries in the global North: they were convinced that Africa could do the same and much more with her resources. To do so, they knew they would have to address the evils—the inequalities, conflicts, corruption, conflict, poverty, and disease—that haunted their people and their countries. The magnitude of the AIDS crisis seems to have been what galvanized many of them—but perhaps it would have happened anyway?

Dr Ibrahim: But you cannot build a house on shaky ground—and we knew it was crucial to institutionalize and entrench good governance. We had to establish a solid foundation of peace within our countries and gain the support of the different ethnic and religious groups.

Democratic culture, and plural and inclusive governance increasingly took root—but in many different forms: each one designed to meet particular local needs, processes, and practices; each one drawing on the best of both traditional African approaches and Western governance models to establish political equality and inclusiveness for all. Some of us called it 'Afrocracy'...

In a number of countries, these new administrations succeeded in bringing together different hierarchies of leadership. In some countries, proportional representation provided a mechanism for soothing and including dissenting voices; in other countries, with multiple ethnic identities, quasi- or semi-provincial autonomy was adopted, allowing each group relative control over its resources and local priorities. To ensure the legality and public legitimacy of their reforms, a number of leaders held constitutional referenda or national conferences to determine how the people wanted to be governed.

In quite a number of cases, this was not about doing new things: it was about enforcing longstanding constitutional commitments that had not yet been put into operation, or passing old legislative bills that had become blocked. Local governments and traditional authorities were empowered to respond to the needs of their constituencies, and the previously marginalized rural people began to gain a strong political voice and increased economic means.

Dr Ibrahim: As leaders pursued reforms at the national level, Africa's regional governance also came under increased pressure and scrutiny. You see, many new leaders felt that the borders that divided their countries were, often, essentially artificial. They undermined people's ability to travel, trade, live, and work together—and were frequently the cause of tensions that escalated into conflict.

They came to the conclusion that the best way to overcome the governance, security, and development challenges before them was to collaborate, finding regional solutions to regional problems. A new way of thinking and acting together about development, governance, and security was needed—so that their aims in all three areas reinforced each other. You see, th-...

Thank you, brother. But this story of collaboration is a further chapter to the story—we will talk more about this later…

International realization… and reform

First, we must talk about what was happening outside the continent. There were changes there, too.

Some of these changes spread outwards from Africa—like ripples in a pond: information technology has long made it possible for civil society groups in Africa to plug into global civil society networks. Though miles and cultures apart, they often found they spoke the same language and they wanted to tell the same story. They understood that action taken in one part of the world could affect what happened elsewhere; and inaction could carry just as much weight.

Together, these groups began to lobby multilateral institutions, transnational corporations, and western governments to confront how existing patterns of activity were prolonging inequality and worsening corruption and conflict.

An increasingly vocal, networked, and sophisticated campaign started, always combining meticulous analysis with powerful communication and a daunting knowledge of law and politics.

Steve Phorano: I worked for a while with *Action Now!* We had headquarters across the world: in New Delhi and New York and, of course, Johannesburg. Many of our approaches were influenced by the *Treatment Action Campaign*; some of us had even worked there before. We would regularly send out email to tens of millions of addresses. And many of the people we emailed would, in turn, mobilize more support and more action.

Was it this that prompted an increasing number of big corporations, foreign governments, and international institutions to begin to change? Global public opinion certainly played a major part… Or was it the burden of the AIDS epidemic itself? Others will tell you that change was inevitable; in fact, it was already happening…

Dr Ibrahim: But we can be certain of the events themselves. I played a small part in the Extraordinary Meetings and Agreements of 2009 and 2010 (EMA09 and EMA10). These meetings brought together members of government, North and South, with global civil society in an effort to find new approaches to some of the apparently intractable global problems. The list of issues was monumental—global peace and security, terrorism, climate change, the AIDS epidemic, and other emerging health threats.

The initial consultations for the EMAs were held out of the public gaze. Of course, as soon as word got out, we had our critics. But even they had to admit that there was a sense of commitment and urgency to these proceedings that was new. It's not surprising: the choice facing leaders, particularly in the global North, was stark: either become a fortress, and try to wall off persistently encroaching global problems; or seek a new global order, working together to develop international law, enhance the capacity of international institutions for peacekeeping and peacemaking, and expand economic globalization. But always, always with social justice as a priority.

And, in the end, the EMAs—held under the auspices of the *UN* and *Bretton Woods Institutions*—reviewed many of the previous international agreements and set benchmarks for subsequent good practice. They established the fundamental standards for all human life: starting with an expansion of, and renewed commitment to, global frameworks and standards and linking them to a larger social and economic framework of global governance.

Sister Bweupe: There were reforms happening in multilateral institutions, as well, weren't there?

Dr Ibrahim: Indeed, the pressure of global events in that first decade of the millennium put multilateralism under extraordinary pressure. We needed it more than ever, but we needed a new approach. The *World Bank* and *IMF* responded decisively—increasing the voice of the least developed countries in their governing bodies, for example.

Steve Phorano: And, of course, the *UN* itself went through an accelerated process of change and reform. 2009 stands out as an

important year in my mind. Top of its list was finding ways to respond faster and more effectively to humanitarian disasters, epidemics, and conflict situations. But it also wanted to make sure different *UN* organizations in the same country could function together as a single development team, directly supporting government frameworks, and making the best use of shared administrative services, infrastructure, and communications technology. 2009 stands out because that was the year that it merged the Boards of its funds and programmes. A few years later even some of the specialized agencies were incorporated.

Thank you friends… Little by little, the many different voices we have described were finding each other, and coming together, weaving together—with extraordinary synchronicity. And, as they wove, the results of their efforts multiplied and grew, creating six powerful, crucial transitions.

The six transitions

1 Back from the brink

Tackling treatment

From around 2005, resources, political will, activism, and technical know-how finally came together in responding to HIV and AIDS. One of the first steps taken in many countries was to roll out antiretroviral therapy as widely as possible—on the basis that it would not only keep as many people as possible alive for longer and so help to maintain crucial skills and capacities, but it would also encourage more people to get tested, since they would have the reassurance that there was treatment available.

Moreover, in those early years, for the first time, there was enough money coming from the international community for these endeavours… the "3 by 5" initiative was an early flag on this path. Many were sceptical whether it would make a difference, but it stands out in my mind as a rallying point, a stake in the ground…

Dr Ibrahim: I think it's much more interesting to describe how it happened. You see, to begin with, there was limited understanding about how best to spend available finances, and little coordination between the many projects and…

Thank you brother, I was coming to that.

There was, at first, a great deal of confusion. But chaos was averted—through effective leadership around coordinated national treatment plans.

Dr Ibrahim: The word 'coordinated' is important. 'Skilful' is another: skilful channelling of resources to where they could really be used. Public policy was increasingly based on well-tested science, and national programmes increasingly saw a role in facilitation rather than trying to control or impose what should happen.

Practically, it turned out that the absorptive capacity of many national governments was not as poor as some had feared. In part this was because of the rapid progress in decentralizing that was going on—by 2010, the strenuous efforts of a number of governments to work with many different groups and organizations

in order to provide health services—especially in rural and poor urban areas—was really beginning to pay off. This was a particularly useful—and necessary—approach in those countries where decades of underinvestment and structural adjustment had eroded public sector services, and those countries where the spread of HIV, and the 'brain drain' meant there were insufficient doctors and nurses. Little by little, governments began to build bridges with civil society, the private sector, and international partners in new ways.

For the activists, it meant they could stop fighting and start to build. As governments chose to focus on treatment in the early part of this period, it was the presence and knowledge of the activist groups, coupled with community and faith-based organizations, that helped make the roll-out of antiretroviral therapy possible.

Steve Phorano: But that doesn't mean we stopped fighting: remember the stock-out marches of 2007 and 2012 when the antiretroviral drugs ran out?

Sister Bweupe: People like you also stepped in to help in places where health infrastructure was crumbling or public information systems were inadequate. You smoothed out the technical and social difficulties of supporting people on antiretroviral drugs. Many of our health facilities still rely on you... Activitists, many of whom were themselves HIV-positive, helped to educate other people living with HIV and AIDS about the drugs they were taking, what to expect, and how to handle unwanted side-effects. It was because of you that the uptake was so swift.

Dr Ibrahim: It's true—by 2010, we were disappointed that antiretroviral therapy was still only reaching around 50% of those who needed it, despite the major efforts that had been made.

Steve Phorano: And, crucially, it meant that the widespread drug resistance that everyone had feared was delayed. Of course, there was some—but first and second line regimens remained effective far longer than people had predicted. Wider access to antiretroviral therapy also led to a transformation in people's willingness to get tested, especially as they could see the benefits of starting treatment before they got sick. Less than 10% of people knew their status in the early years of the century. By 2015, perhaps 50% or 60% knew—helped by the easy availability of HIV–urine tests.

The private sector—big and small businesses—has also given its expertise and resources. Back in 2004, companies were already providing health care, either through not-for-profit NGOs, or private for-profit clinics, or workplace health facilities. An increasing number were also contributing to other aspects of human development.

Sister Bweupe: We could hardly believe it when organizations really began working effectively together. In 2011 our government awarded a health care contract to a consortium of companies to provide health care to the region surrounding their operation site. A bank, a pharmaceutical company, a foundation attached to an energy company, and a European donor—they all worked in partnership with local faith-based organizations and NGOs. It was very successful—and similar partnerships soon followed!

Long-term, more inclusive prevention: first HIV, then…

Alongside treatment, there has been growing appreciation of the need to address prevention in new and different ways—and all the factors that made that so difficult. After all, some countries had almost 20 years of experience by the early 2000s, didn't they, Sister?

Sister Bweupe: **Oh yes: for example, by then people knew it was pointless to present biomedical messages to people whose beliefs about HIV and AIDS were rooted in a completely different view of how the world worked. It makes no sense to link HIV programmes to family planning campaigns, if people believe that these are some form of conspiracy to reduce their fertility. It is also crucial to engage the right people within a community.**

Once this was understood, remarkable coalitions began to develop. In some countries, older men and women, who never usually spoke in public about sex, gave lectures to youth groups about why and how to use condoms. In other places, an increasing number of religious ministers gave out condoms along with spiritual counsel.

Steve Phorano: **This developing sensitivity to local beliefs helped to further research and its application. For example, carefully designed and administered research made it clear that a higher proportion of HIV transmission than had previously been estimated was due to male to male sex. This helped to prompt the creation of some discreet intervention programmes with local community groups with safe spaces created for meetings, and readily available information about safe anal sex. Not everyone has changed, of course, but enough have.**

Dr Ibrahim: **Governments quickly recognized that they could multiply service provision very rapidly through awarding contracts to organizations in rural and urban areas—it was especially important where we wanted to rapidly increase HIV and TB services in combination. Managed networks of providers—for many different services, not just health care—gradually became the norm. But, of course, governments set careful standards and implemented regulation. The poor were protected… There's a reasonable public sector safety net, in most countries, with decent, if not great, standards of care.**

The idea of working with multiple partners to extend the reach of services spread rapidly. In 2009 the *Global Fund* awarded grants to several multinational corporations to provide malaria, TB, and HIV and AIDS services to significant populations in their catchment areas. All in all, the period 2010 to 2020 saw a massive expansion of service provision, reaching more and more people—even those living in isolated rural areas. Now, the health service across Africa is something of a mosaic…

Dr Ibrahim: **Of course, it meant more staff were needed and great strides were made in developing new cadres of health workers. Because of the expanded tax base and economic growth in many countries, between 2005 and 2025, per capita expenditure on health care tripled!**

Sister Bweupe: **We set up training facilities in countries that could produce a staff surplus. Many of our trainees have been drawn from**

rural areas. The assumption has been that they are more likely to return there after graduation, especially if a cash incentive is included. It meant we had to lower the entry requirements, at first, and bring in more intensive training, but that's been helped by improvements in secondary and tertiary education.

In addition, many government programmes have successfully harnessed the talents of traditional healers, providing them with a significant role in health care, working alongside, and in harmony with, other health care professionals.

At our clinic, we offer programmes of alternative medicines. A number of governments have made a significant effort to test traditional therapies and medicinal practices, often in partnership with international organisations. If they are shown to be effective, they are incorporated into national guidelines.

We also have healers as part of the regular staff. They offer spiritual and psychological therapy to patients—it's very effective...

We're one of the countries with more flexible employment practices. Certain key health workers get higher pay rates and other special incentives. Many of our employers let migrant health workers return to their homelands for short periods to share skills and learning; telemedicine and distance learning helps, too.

Altogether, it just means that health is a very attractive career. When staff do leave, they tend to go into the private sector rather than migrating overseas.

Thank you, Sister. Before 2015, sustained aid flows already supported much of this reform and expansion process. Additional resources focused on improving access by the poor to primary health care: it got a lot easier to meet the basic health needs of people in most countries. Since 2015, resources have switched to improving secondary and tertiary care, in line with the public's expectations.

Of course, there were many places across Africa where, for a long time, nothing much changed. But in the places that had recorded the highest HIV prevalence and suffered the most, extraordinary changes were happening. Doctors came from all over the world; heroic efforts were made. And, at the centre of it all, the activists kept up the pressure. When some drugs were seen to be increasingly ineffective, they lobbied, protested, used judiciaries both in Africa and internationally, to make sure the next wave of drugs did not pass us by. By 2020, few countries had not achieved the Abuja targets for health spending, and some had exceeded it!

Dr Ibrahim: **But we mustn't ignore how hard it has been: many people died despite all the medicines, all the effort...**

Sister Bweupe: **But in some ways it was at least bearable—we knew that even as the deaths continued, fewer were getting infected.**

Steve Phorano: **The combination of antiretroviral therapy; the new focus on, and energy behind, prevention; and the fact that these were both supported by other social policies, meant that there was more and more hope. By 2015, most parts of Africa had turned a corner. There were no longer just one or two successful examples: there were 16 or 17!**

Health needs, of course, have remained huge. However, health workers feel better equipped to deal with the problems they face. Morale and productivity have improved. And—the real reward—health indicators across the continent have slowly improved.

Meanwhile, of course, the private sector has boomed: in 2008, the *Lodestone Hospital Group* moved from India to East Africa. By 2025 there were big, gleaming hospitals in most capitals across Africa, offering international standards of care.

2 Setting the house in order

But success in overcoming HIV and AIDS would not have made sufficient difference alone. In fact, it couldn't have been achieved, if that was all anyone had focused on. We needed to restore the years that had been taken from us—restore the years that the locusts had eaten.

Dr Ibrahim: We had a growing appreciation of all the other aspects of life that had to be addressed: health was just one part. In those countries where HIV prevalence was high, the virus had been able to spread faster because people were poor; because they had so few real choices, especially about sexual partners; and because public services were insufficient and they had untreated STDs. In those countries, attempts to prevent the spread of HIV had to be linked to policies to address its impact. Policies that would help reduce poverty, increase agricultural production, establish microcredit programmes, and set up personal empowerment initiatives. Education received particular attention.

Steve Phorano: And many of those countries that were not facing full-scale AIDS pandemics still suffered from several decades of underdevelopment and had other profound problems, ranging from malaria, to widespread chronic poverty, to severe underemployment and malnutrition. They all had to be addressed.

National development plans

From around 2007 to 2009, the overall development goals of many countries were coordinated through a new generation of National Development Plans, or Nadeps, as they came to be known.

Dr Ibrahim: Ah yes. I was involved in the first generation of Nadeps. Growing from the Poverty Reduction Strategy Paper process and the *Millennium Project*, these looked at the whole system—beyond those aspects captured by macroeconomic indicators—including: roads, schools, electrification, health, jobs, and, above all, people. They aimed to ensure investment in the things that would reshape the future for the majority, rather than just for the élite.

One critical step in many countries was to encourage people in the informal sector to accumulate assets—for example, by allotting and enforcing property rights, in some countries on an individual basis and in others on a communal basis. This meant that increasing numbers of people were becoming involved in contributing to the 'formal' economy, rather than being trapped in subsistence activities.

Steve Phorano: In many countries, the Nadeps put the response to HIV and AIDS centre stage, especially where the adult HIV prevalence rate was over 5%. But this was not a one-size-fits-all approach! Countries worked according to their own national priorities and carefully costed their plans. In many cases, these became the basis for a series of daring new initiatives in international cooperation...

Dr Ibrahim: It started with eight countries in 2012: donor partners made, in principle, decade-long commitments to their plans, while African countries also drew down resources from the new Africa Finance Facility (AFF) set up by the *G8* and other *OECD* members.

Steve Phorano: Governments got local people engaged in these development processes using radio broadcasts and film shows. Villagers were consulted about what they needed, and encouraged to send representatives to national development meetings held in local towns. And this was followed by money—quite sizeable amounts! And, because of all the progress that had been made in setting up systems to ensure transparency and accountability, they were also given the freedom to spend it!

Sister Bweupe: Through local committees, often run by women's groups, families were given money—real cash—to look after orphaned neighbours and relatives; to buy new farming equipment, seed, and fertilizer. There was a sea change in thinking. Early experiments in cutting out the 'middle men'—costly and centralized bureaucracy—and minimizing transaction costs had demonstrated real success. In particular, it was women's groups that demonstrated skill in making, managing, and accounting for investment: after all, women have been making household investment decisions for generations. These pilots began to move to scale. In rural areas, small programmes that had started years before really got some muscle and provided large numbers of women with credit, savings, and insurance. By 2020, an evaluation of one such programme running in West and Central Africa found that several million of women were benefiting from partnerships between rural organizations and commercial banks.

In fact, women's issues were receiving more attention in a number of countries—catalysing changes in law and regulation, particularly in relation to discriminatory employment practices; the reallocation of financial and other resources; and the promotion of changes in attitude to gender.

Dr Ibrahim: As I've said, I think that may have been because increasing numbers of women were entering politics: the elections across Africa in the first 10 years of the twenty-first century put more women into parliament than ever before, with 11 countries giving women at least 30% of the parliamentary seats.

At the Third Ordinary Session of the *Assembly of the African Union*, gender mainstreaming was a priority on the agenda and stayed there for a long time, until changes started becoming evident.

Collaboration and coordination

Government ministries, aided by investments in communications technology, began to adopt a more collaborative approach to resolving issues and creating policies! For example, health and education departments began to work with industry departments to make long-term plans about the kinds of training and skills they needed to provide for their people. Each new realization prompted a chain of events that built on the last, helping to create the institutions, skills, programmes, and quality of life that could lift Africa's countries and their people out of poverty.

Steve Phorano: A fine example of what you're described is the way many governments have looked after the homeless and orphaned or vulnerable children in their countries. Taking care of the next

generations became a priority on most governments' agendas—maybe it was the prompting of the 2013 *UN General Assembly* Special Session on Orphans and Vulnerable Children.

Sister Bweupe: "Our children: our future!" I remember the campaign. One of the mobile phone companies provided millions of free text messages to the campaigners...

Steve Phorano: Government policy dictated that children were not to be treated as victims, but given education, love, opportunities, and responsibility to create their own futures. And it was backed up by legal changes. It was not just their physical well-being that was emphasized, but also their mental and emotional health...

Dr Ibrahim: But they didn't work alone—just as with health care, most governments quickly recognized their own limitations. For example, in my country, the government became the coordinator—raising and channelling funds, ensuring standards of care and service, managing information. We made sure that traditional structures of authority and responsibility within African communities were involved in ensuring that all children within communities received services and resources. Cultural and religious leaders encouraged families to take more unrelated children into their homes—helping with costs and other forms of support—and clamped down on the exploitation and abuse of children within the communities they oversaw.

Interestingly, one result was growth in the number of small-scale foster homes, which, in turn, provided the people who ran them, usually women, with valuable income.

Sister Bweupe: The networks caring for these children now extend throughout all levels of African society, and out across the world: funding raised from international bodies by national governments is channelled to local committees, who are trained by the domestic and international NGOs to set up and administer community-driven initiatives.

Dr Ibrahim: And so policy became practice.

3 Working together for development

The Nadeps were followed by money—aid flows were already increasing before the review of the Millennium Development Goals in 2005—and cooperation in how we used it...

Dr Ibrahim: I'd say it was the work on HIV and AIDS itself that accelerated this process. As funding for HIV and AIDS expanded, cooperation around how to use it, rather than waste it, became a significant focus. This kind of discipline gradually spread to all areas of development.

Sister Bweupe: The review of the Millennium Development Goals in 2005 helped: afterwards, people seemed more ready to act on the idea that more resources could only make a difference if they were delivered with better coordination, and better directed by African governments themselves, with clear-cut agendas.

Dr Ibrahim: Whatever the reason... rather than waiting for a disaster to happen and the need for vast sums of humanitarian aid, donor

countries began to make larger sums of development assistance available in advance. You know what used to happen: a paltry US$ 4 million per year was invested in agriculture, and then people acted surprised when US$ 500 million in emergency food aid was needed when the crops failed! Less than US$ 50 million a year was given to prevent HIV, and then more than US$ 3 billion a year was needed to treat the disease—after more than 30 million people had already become infected!

Some real efforts had been made by governments and their donor partners to work together under the plans contained in the PRSPs. However, most governments in Africa, even by 2010, had still found themselves trying to manage a plethora of donors. The political interest in antiretroviral therapy had made things even more complex: no government could easily turn down money for antiretroviral drugs, but for already overstretched ministries of health and finance it just meant more people, funds, and expectations to manage. Perhaps it was the increasing money for HIV and AIDS, together with growing volumes of other aid, that acted as the catalyst for doing things differently. By 2010, Africa was receiving almost a third of all overseas development assistance (ODA) flows—some US$ 36 billion a year and rising rapidly. EMA09 noted that two thirds of donor *Development Assistance Committee (DAC)* countries had achieved 0.7% of GNI, and set a target date of 2015 for the rest.

Dr Ibrahim: There are many and various accounts of how this money was managed. What was clear—and I'm sure someone's made this point before—was that, for the most part, countries were better able to use big investments in social and economic sector spending than people had feared. Gradually, nearly all donors began to appreciate the value of budget support, or sector support, and the need for one national long-term development framework to guide mid-term plans and budgets, with indicative donor commitments set out for each decade, rather than in three-year or five-year cycles.

By 2012 all the major donors in the *DAC* had recognized that parallel projects did little to strengthen national systems. That is not to say that everything was centralized, or went through government budgets alone. Far from it. But the wasteful duplication of earlier days was being phased out.

By 2015, when the review of the Millennium Development Goals took place, there was only one process in each country. It was increasingly usual to find donors sharing staff, back office functions, and representing each other. National programme managers no longer spent incredible amounts of time trying to satisfy dozens of duplicative reporting requirements and hosting repetitive review missions month after month. The result was that careful management of fiscal deficits replaced compliance with fixed expenditure ceilings—and human development programmes began to receive vastly increased funding. Efforts were made to ensure that the external aid to a country rarely went above 30% of GDP, and was always backed by *IMF* sign-off on the macroeconomic feasibility of the scale-up.

Simply put, my friend, aid relationships were transformed: African governments could finally put their long-term national interests ahead of short-term programmes. In 2016 a second wave of countries—including one or two countries with policies that would previously have excluded them from

the aid relationship—signed Nadep agreements with donor partners, followed by a third wave in 2019. By 2020, nearly 30 countries had transformed their international aid partnerships, and significant resources were being handled by African regional bodies.

It had been said before that more aid was not the solution. And, of course, this was right: more aid was not a solution in itself. However, the Nadep process enabled development assistance to be used where it could make the most long-term change—creating a virtuous cycle of funding and development. Money channelled through Nadeps into education, health, agriculture, infrastructure, and communication in turn provided the capacity to implement the Nadeps more effectively.

And of course, all this was a major boost towards achieving the MDGs, although the scale of ambition in the Nadeps meant that the MDGs were no longer the only thing people were working for. Nonetheless, it was clear that real progress was being made. So when the review of the MDGs came in 2015, although few countries had actually already achieved the targets, their trajectories were on the right course and, 10 years later, very few countries had not achieved—or bettered—the targets.

Dr Ibrahim: In addition, slowly, the mechanisms being used to address debt were recognized as being unsustainable and unfair. By 2010, the failure of the *HIPC* process to deliver what it called 'sustainable levels of debt' had discredited the process. Many countries in Africa were still paying more back in debt service than they were receiving in grants and new loans. Moreover, many indebted countries had paid their debt off two or three times over, yet still spent more on debt servicing than on health. Altogether, in 2010, Africa's debt stood at US$ 120 billion, representing both old debts and new ones. In response, the EMA10 process put in motion a mechanism to cancel debt once and for all in the poorest countries, within a two-year time frame, using *IMF* gold sales and *IBRD* resources, and through deeper *G8* commitments. By 2012, most countries had dramatically reduced the burden of debt—and this also helped the financing of the Nadeps. A sizeable chunk of the new resources went into HIV and AIDS prevention and treatment—committed to ending the worst epidemic in history.

To be sure, the bill, across Africa, was a big one. But growing government domestic resources, generous contributions from donors, topped up with individual out-of-pocket spending, meant that we didn't have to compromise, or to make tough choices. Treatment was rolled out to the growing capacity of health systems. And prevention programmes were not compromised. We did everything we could.

4 Trading on strengths

Imagine, we Africans used to trade all we had—and the buyers would decide the price!

But this had changed, too. Over this period, individual African countries became more productive and more competitive exporters. But they also recognized that they needed to work together: when Africa negotiated as a bloc, everyone stood to gain, while when Africa spoke with many different voices, the world was far less likely to listen.

The idea of working together was not limited to the African continent: a new, more equitable era of multilateralism was dawning. It took both African and international efforts to lift Africa out of the 'commodity trap'. It was no longer a case of pursuing open borders at any cost. Full multilateral integration would not bring benefits to Africa: it had to be paced.

Perhaps you can tell this part of the story?

Steve Phorano: Ah yes... This is the story of the birth, in 2010, of the EBA+ (Everything But Arms Plus) initiative. It was during the *G8* meeting in Novosibirsk that Japan and Canada took the decision to provide the least developed African exporters with preferential market access: no tariffs, phasing out of escalation tariffs, and above all, very light and non-restrictive conditionalities, so that *HIPCs* could take full advantage.

The preferential access to *HIPCs* in Africa extended, rather than reduced, the preferential treatment of the poorest countries—attempting to boost these countries' future competitiveness.

It seemed everyone wanted to join in! When the African Growth Opportunity Act expired, the United States offered a low-conditionality preferential trade agreement to African *HIPCs.*

This, in turn, had a series of knock-on effects: for example, the Doha Round of trade talks was salvaged, ensuring a development round that brought real benefits to the world's poorest countries, as well as to middle-income countries. Within Africa, over two decades, rates of poverty decreased, in both relative terms and in real numbers. Across Africa, instead of 300 million people living on less than US$ 1 per day, by 2025 this number had fallen to 220 million. This translates to a remarkable reduction from almost 50% of sub-Saharan Africa's population to just over 20%.

Between 2010 and 2020 there were significant shifts in negotiations at the *World Trade Organization (WTO)*: growing pressure to enable more poor countries to engage in the governance of the world economy helped to shift agendas; and new coalitions of countries providing Africa with support in the new trading rounds.

More sophisticated, fairer, and integrated rules ensured that the poorest countries in Africa did not lose out—who could believe it? By degrees there was a discernable move towards pursuing a global economic agenda that calibrated the freeing of markets with poverty reduction programmes, and balanced the rules of global trade to protect the interests of the poorest and middle-income countries, rather than only the well-being of the richest ones.

There were also developments in the trade-related aspects of intellectual property rights (TRIPS) agreement, further ensuring that it was compatible with public health and welfare, and offering poorer countries the flexibility to decide when, and in what sectors, they wanted to use patent protection.

Will you tell us more?

Steve Phorano: As the new millennium unfolded, there was increasing consensus on the need to overcome the emotive opposition between access to life-saving medicines and the global extension of intellectual property protection. The spirit of social justice and collective global responsibility resulted in landmark arrangements to regulate the supply of medicines. African countries could keep access to low cost drugs!

Over the next decade there was growing international interest in new models of medicine development that maximized poor people's access, while supporting the innovation required to produce new medicines. The success of groundbreaking campaigns—you remember the *Drugs for Neglected Diseases Initiative* and the *Medicines for Malaria Venture*—showed civil society and public research institutes joining forces with private research companies and governments to address the lack of research and development

of medicines for some of the world's neglected diseases. Innovative public/private collaborations began to tap Africa's research potential more effectively, in everything from biodiversity, benefit-sharing agreements harnessing traditional knowledge, and global drug and vaccine development partnerships.

Since around 2020, an international treaty-based framework has been established to provide the legal and financial infrastructure to support the development and manufacture of affordable essential medicines. Many of the compounds of potential use in treating the diseases most affecting the poorest countries are taken forward as 'open source' projects, which enable countries and individuals to offset costs and pool capabilities. Free online access initiatives for academic journals have become increasingly widespread.

Moves to enhance and extend the *Food and Agricultural Organization (FAO)* Treaty of Plant Genetic Resources for Food and Agriculture have continued to gather momentum. In 2021 an international databank was set up to catalogue the geographical sources of genetic resources and traditional knowledge, linked to local libraries of traditional knowledge and minimum search documentation lists of processing patent offices. This provides a valuable source of revenue to some developing countries.

Dr Ibrahim: I should point out that many feel it's the development of an HIV vaccine that is one of the greatest successes of the new international regime. The public–private partnership in vaccine research and development is widely appreciated as the reason, and these collaborative initiatives extend into the manufacture of vaccines—in the burgeoning industrial facilities situated across Africa.

Business far from usual…

Meanwhile, gradually over this period, more companies were becoming more widely engaged in development. Those who ran the big companies moved from following a model of corporate philanthropy or social responsibility to a wider understanding of their role as agents of social change.

By 2019, most multinationals had developed a 'foreign policy', which went beyond public relations to something far more extensive—far-reaching partnerships in a range of activities that helped build communities and even national governance capacities.

Companies aimed to be as transparent as possible in their activities, breaking the silence about how they may have fed conflict in the way they awarded contracts, gained access to land, or dealt with community representatives. In turn, they were—indeed, they still are—increasingly scrutinized by governments and society. The expectation has also developed that they will play a role in helping to create conditions for peace—not just within the countries where they operate, but across the continent.

5 Human hearts and human rights

At the heart of my story are the changes that were taking place in the relationships between men and women. In fact, I think we can say that without this transformation, none of the others would have worked!

Reductions in poverty—and vulnerability to HIV—could not have been brought about without these fundamental changes, without empowering girls and women. But this is not just about one gender: importantly, it is about the new social 'scripts' that were emerging for both sexes in the first quarter of the twenty-first century.

School's in

In 2000 it was already understood that education was probably the single biggest contribution that could be made to improving the life chances of girls, but that education would not, on its own, be enough to tackle all the inequalities

deeply rooted in political, economic, social, and cultural life. Throughout the period 2000 to 2010, the first step—and greatest challenge—was to get girls into school, especially those from poor rural households, and, after they were in school, to keep them there for six years, or even nine. In these early years, enrolment rates were particularly low among rural girls in Islamic countries.

Sister Bweupe: **But we didn't make it for a while, did we? We failed to reach the targets for primary and secondary education by the end of 2005.**

Dr Ibrahim: **Maybe it was this disappointment, together with a reawakening women's movement, that galvanized action: gender and education strategies; national sensitization programmes; the provision of girls-only schools and classes; bursaries and stipends for girls, particularly for secondary and tertiary education; and girls-only education voucher schemes for poor households to send girls to school. An increase in well educated women teachers provided new role models for girls.**

By 2015, most countries were very close to meeting the MDG target.

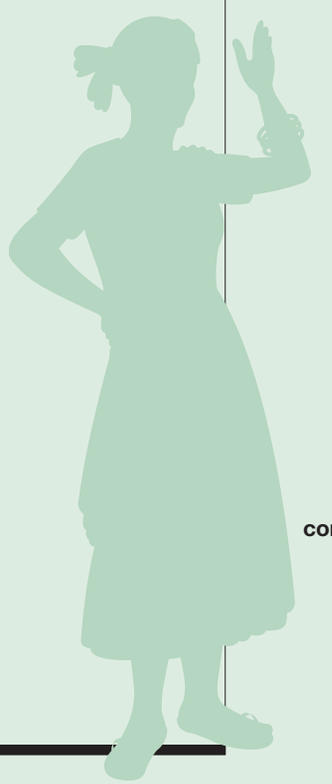
Confidence grew. A new generation of educated girls developed a greater sense of self-worth, a belief in their ability to control their futures. As these girls became mothers, they socialized their sons differently: little by little, expectations about behaviour began to change.

In some countries, new women's movements began to emerge: challenging the existing social order head-on required strength in numbers, particularly when the issue was HIV and AIDS and women's vulnerability. It was a huge taboo to break: for many women, challenging men's behaviour meant questioning male domination—and that was unheard of. But more and more women did. In the past, even educated women had not dared to challenge their husband's behaviour, but over the period 2010 to 2020 something new started to happen.

Dr Ibrahim: **This was undoubtedly related to the major cultural changes that were taking place across Africa and in the Middle East.**

Sister Bweupe: **We've already mentioned urbanization, haven't we? This surely had a part to play, helping new ideas about individual identities to emerge.**

Steve Phorano: **I think we also have to point to the growth in religious revival. Many people argue that the emphasis on personal self-esteem and individuality in many of the new churches tapped into a wave of social change, and mosques, too, were important sources of a sense of community revival. Much of the religious leadership may still be predominantly male, but they did bring new opportunities for women, and certainly a new confidence.**



Leapfrogging communications… and aspirations

World-spanning communications were also playing their part in shaping these new social values. For so long, Africa had lacked so much basic infrastructure—wires, cables, paved roads—but, as prices dropped, African countries were able to leapfrog wire or line-based telecommunications systems. People had ways of communicating that were cutting-edge, cheap, and easy to use. Suddenly, everyone was talking on mobile phones and internet cafés were springing up across the continent—even in remote rural areas!

Steve Phorano: People were connecting with other people across the world. The results were extraordinary—suddenly it was possible to send information, warnings, pleas for help, all instantaneously.

In some areas, these new technologies were used by governments to provide education for their people. Before people could afford their own equipment, they used to set up screens in the village squares… How quiet it was on those evenings when the educational programmes came on!

Other people were buying their own equipment, using microcredit to raise the funds, or teaming up within communities to raise money through social banking.

Dr Ibrahim: Of course, there can be no technology without the energy to power it. An increasing number of modular, decentralized energy systems started to flourish—wind energy, photovoltaics, biomass, fuel cells, small hydroelectric plants…

Again, these were not without teething problems, but lessons were learned and quickly spread… A number of these projects were started or boosted by private sector consortia—for example, energy companies teaming up with development banks and NGOs.

Via all these links, changes flowed—goods, information, music, fashions, ideas, money… People, separated by continents, history, and cultures were brought together by economic supply and demand, by political ideology, by religion. Many religious movements have ties with similar groups abroad, especially in the US. Obviously, these were useful connections through which Africans could raise funds and support, but they also acted as conduits in the other direction, helping those abroad to understand the lives and experiences of their African brothers and sisters.

More and stronger alliances developed, with greater popular involvement, particularly between cities. The *Forum of the World Alliance of Cities Against Poverty (WACAP)*, for example, had grown to include people from cities in 149 countries by 2020, with some 2000 cities forging links with each other to challenge poverty and underdevelopment wherever it was found. Seeing themselves as a laboratory for new international relationships, groups from cities developed remarkable links with partner cities: Marseilles supported Abidjan; Budapest twinned with Addis Ababa; even small rural towns began to join in. City connections spread to other local bodies, as models of governance were shared, and solutions to urban violence, poverty, and slums were explored.

They were little links, but they were many… and remember what they say in Gambia—giant silk cotton trees grow from very tiny seeds. In the same way, each of these thousands of little connections helped to build great chains of understanding—chains strong enough to raise hope and support crucial changes. And these connections reached deep into communities, into the most remote rural villages—bringing information and training about human rights and healthy living, all of which was desperately needed.

Steve Phorano: As I tell my students: this is where Dr Amanzi's 'Virtuous circle of aspiration' comes into its own. Back in 2011, Amanzi described how more and more people across the continent were being exposed to modern values and lifestyles—either when they moved to one of Africa's expanding cities or via the TV, cinema, or internet—and aspiring to them. However, rather than being blocked from achieving them by limited opportunities and becoming frustrated or hopeless, the new possibilities of this era meant that most people

believed that their aspirations could be realized. Every day, they saw and met people who were achieving their goals, and they began to believe that they, too, could do the same.

Dr Ibrahim: But it's important to add that not only could they, but they also believed they had the right to do so. This was catalysed by the increasing emphasis on the importance of human rights—spreading at every level through African society, through the expanding cities, into rural areas, even reaching local community organizations… And when these rights were contravened: well, the spread of new technology meant that national and international opinion could be mobilized—within minutes. We had never seen anything like it!

And it was happening at every level. Whereas before, the deep reluctance of African leaders to speak out against other leaders had hampered collective, pan-African governance, this began to change. Pan-African and international mechanisms that had been largely theoretical began to develop teeth. Tell us, Doctor…

Dr Ibrahim: By 2007, the *Pan-African Parliament* had gathered more signatories across the continent. Two years later, it was not only physically and institutionally established, but its advisory powers were strengthened by legislative powers.

Steve Phorano: Cases began to appear before a reformed, more proactive *African Court for Human and Peoples' Rights*, successfully challenging the persecution of individuals and groups, restrictive legislation, or the violation of human rights by certain African governments. For the first time, international human rights treaty bodies were used when governments failed to comply with international agreements to which they had assented. The growth of a number of talented, pan-African legal activists helped to turn the spotlight on national judiciaries, and the need for reform and investment in these too.

Meanwhile, beyond Africa, the *Global Framework on Arms Sales to Africa*, was brokered by a network of civil society pressure groups under the umbrella of the *Global Network on Arms* and ratified by the UN *Security Council*. Countries that sold arms to African countries, outside of a strict *UN* code, were heavily sanctioned and government individuals and organizations caught selling arms outside of this code now faced the *International Criminal Court* in The Hague.

6

Planting peace

Across regions and the continent

Of course, none of this happened overnight, but gradually, like the cool shade of a tree, peace was spreading over Africa…

Between 2006 and 2010, a coalition of foreign powers wrestled to win the so-called global war on terror. Africa dropped down the international agenda—her leaders were, more or less, left alone to take care of their countries. We've already described how they responded at a national level—now we will turn to how they worked together. Doctor, I know you wanted to tell this part of the story…

Dr Ibrahim: At last! Well, we can summarize it all by saying that these new leaders helped to establish the real political legitimacy and relevance of the *African Union*, replacing rhetoric with action.

Naturally, not all leaders initially subscribed to the ideas of the *AU* or ratified the protocols that gave the *AU* powers over them. But,

in the end, most were too afraid of losing their power—particularly as the *AU* and its agencies grew in power. In turn, the various instruments of the *AU*—such as the *Partnership for Africa's Development (PAD)* (previously called the *New Partnership for Africa's Development, NEPAD);* the *African Peer Review Mechanism (APRM);* the *African Court on Human and People's Rights;* the *Pan-African Parliament* and the *Peace and Security Council*—all helped to promote good governance. It has to be said that the *APRM* had a shaky start, but operational procedures were simplified and members of civil society were included in its process.

On *NEPAD's* tenth birthday in 2012, there was certainly something to celebrate! *NEPAD* was genuinely promoting good governance, development, peace, and security on the continent. It was relaunched as the *Partnership for Africa's Development (PAD)*—an instrument of the *AU* that acts as the development arm. *PAD* remained committed to *NEPAD's* objectives and values, but employed different operational structures and strategies to respond to the continent's development challenges.

Critical to *PAD's* success was Zanzii Bangura—the second woman chairperson of the *AU* (2012–2017). She was able to attract and mobilize resources and people from around the world, helping to reverse the crippling poverty and underdevelopment that had plagued the continent for decades. The inclusion of the *PAD* agenda into public service training and practice, as well as the Nadeps, enabled it to work in tandem with government parastatals and agencies across the continent.

By 2015, African leaders regularly took part in *OECD* and *G77* peer reviews under the *PAD* banner. To bolster the work of the *AU* and its bodies, a series of tough anti-corruption commissions and anti-money laundering initiatives were established, along with other transparency initiatives, such as the *Extractive Industries Transparency Initiative,* and its African-led successor, the *African Extractive Industries Transparency Compact*. They have earned much success.

The *Pan-African Parliament*, which had only advisory and consultative powers at its inception, was vested with full legislative powers by the *AU Assembly*. The Africa AIDS Prevention Act in 2009 was one of its major pieces of legislation: this had a profound impact on the response to HIV and AIDS on the continent. It had four strands: first, a series of regional and pan-African measures aimed at reducing poverty; second, the establishment of a series of norms and targets for educating all children, particularly girls; third, strategies for ensuring crossborder health care and the treatment of refugees, including the establishment of health centres providing a full range of services, such as STI treatment, the provision of condoms, counselling, and testing; and, finally, the establishment of a pan-African initiative for the development of new HIV prevention technologies.

Thank you…

Dr Ibrahim: But I don't want to leave you with the wrong impression! Clearly, not every country followed this trajectory. Some countries, particularly in North Africa, looked to Europe and to the Middle East, rather than to their peers in sub-Saharan Africa (SSA). But by 2005, at least 10 or so SSA countries had sorted out many of the governance problems holding them back. By 2015, this number had doubled, and by 2025, it had grown still further.

From war to peace…

Steve Phorano: But none of the governance agenda would have been possible if Africa hadn't dealt with its conflicts. It seems incredible now, but at the turn of the century, 28 out of 48 countries in sub-Saharan Africa were affected by some kind of civil or crossborder conflict. Many had their origins in disputes over access to resources, political power, or historic feuds.

You're right. And conflict threatened to undermine all other development, and intensify the spread and impact of the AIDS epidemic. Thus, inevitably, a vital part of the new African agenda for the twenty-first century was conflict prevention and the promotion of peace and security. Acknowledging the domino effect of conflict—by which I mean the way conflicts in one country fuel insecurity and instability in a neighbouring country—many leaders demanded high levels of international and regional cooperation.

Steve Phorano: In response, the *AU's Peace and Security Council (PSC)* was established in 2004—and this triggered changes in the management of Africa's security agenda and the restructuring of its security architecture. At the same time, a series of *AU-PSC*-backed *National Commissions for Ethnic and Religious Dispute Resolution* were instituted. I think you've been involved in this, haven't you Doctor?

Dr Ibrahim: Indeed. *The AU Peace and Security Council* and the *Pan-African Parliament* have taken the front seat in dispute resolution: they can step in early if there are signs of conflict developing.

In the few instances when conflict has erupted, the *PSC*—with international support and *UN* backing—has deployed the *African Standby Force* to engage in peacekeeping, peacebuilding, and any necessary reconstruction.

As more countries have signed up to the *APRM*, the *African Standby Force* has been increasingly able to intervene in humanitarian disasters, violent conflict, military incursions or coups, and excessive human rights abuses or genocide in other countries. As more African countries have signed the *Common African Defence and Security Pact*, full blown conflict has gradually became a thing of the past.

Sister Bweupe: Meanwhile, antiretroviral therapy has kept the national and regional armies standing, combat ready, and prepared for deployment. Indeed, one of the most effective military programmes has been the HIV-prevention work, managed by coalitions of the military, NGOs, and the *UN*.

Steve Phorano: After all, there was little point in disarming and rehabilitating soldiers merely for them to die from AIDS. For a long time, most armed combatants could see little future outside of the military: an early death from war, from AIDS, or some other cause seemed inevitable.

Sister Bweupe: But as more and more young men and women completed nine years of school, as jobs—real jobs—have become available, their hope has grown. HIV prevention has taken hold; condom use had increased. Ready access to antiretroviral therapy formed another incentive for the army to stay loyal, helping to avert the possibility of coups and politico-military insurrections. The few rebel groups still in existence have high HIV prevalence rates in their ranks and this has weakened both their cohesiveness and their battle readiness.

In the end, the accumulation of development gains has just made conflict too dangerous. The growth of democracy, increased oversight mechanisms, and a strong movement of pro-democratic activism has led to new levels of accountability. Of course, there is still corruption and there are still conflicts—but they are no longer the norm.

Virtuous cycles

So, you see, it's difficult to pin down any first cause, any straightforward chain of events: you could say it was leaders creating democratic structures that helped to strengthen civil society—or that civil society pressure prompted leaders to change their attitudes or remodel their country's constitutions.

You could say it was African governments building their nations, making long-term plans, and being accountable that encouraged donors to provide more aid—or that leaders were able to achieve economic and political reform because they were receiving more resources from abroad. Whatever the first cause, improvement has built on improvement, whichever way you look at it.

Dr Ibrahim: It's true: as peace has deepened, and most countries have established macroeconomic stability, the investors have flocked to Africa. African countries are increasingly integrated into the new international economy—not just as buckets of resources, but increasingly as markets for consumers, with a growing demand for international products. As new business has moved into Africa, so too has the diaspora: there are more and more reasons for returning home.

Meanwhile, even by 2025, aid dependency was levelling off in many countries, even diminishing. The imperative to reduce poverty has gone a long way to do just that in most of Africa. The struggle against HIV and AIDS and for improved economic development has been in line with priorities, agendas, and strategies devised by African countries and regional African organizations, in consultation with both civil society and the private sector. And in partnership with the rest of the world.

HIV has gradually become—to many—an avoidable disease. Greater openness and honesty has grown around the social issues of HIV and AIDS and slowly unlocked changes in behaviour that help to reinforce prevention methods. Stigma dissipated and there was less discrimination; people began to talk more openly about avoiding HIV. The 'ABC' of prevention was reworked: 'A' became "Acknowledgement of the realities of sexuality"; 'B' became "Behavioural change (with a goal of responsible, mutually satisfying, safer sex)" and 'C' stood for "Communicating". In all these areas, people living with HIV and AIDS played—and continue to play—a pivotal role. An increasingly powerful political constituency, they have kept HIV and AIDS, and the context in which it is spread, firmly in the public eye and on the political agenda.

Sister Bweupe: We must say something about the advances in biomedicine... It's hard to imagine a world without the vaccine, for example. And yet, it took much longer to develop than was expected...

After the first vaccine appeared in 2015, a new, improved vaccine was expected to become available by 2020, providing lifetime protection and 80% efficacy. In fact, it took until 2025 for this vaccine to be developed—it worked across all the types of HIV strains in Africa, and needed two doses over one year and boosters every 10. In the last 10 years, it has been added to infant immunization programmes in an increasing number of countries.

Then, of course, there was the microbicide—available in Europe in 2014 and in Africa just a year later (not widely, but certainly for women in high-risk situations). And it was cheap, subsidized by governments anxious to protect their young people. Within five years, microbicides were easy to purchase and easy to use. And by 2025, who could remember life without them, both the contraceptive and non-contraceptive version?

But the focus on tackling HIV and AIDS has not detracted from other health or development issues. Coupled with buoyant economic growth, and the continued large budget support investments from donors, this meant that the total quantity of money going into the social sectors, particularly health and education, was growing every year. Sister?

Sister Bweupe: By 2015, the malaria burden stabilized at a lower level thanks to new forms of prevention—new insecticides and so on; and by 2020, the development of an effective malaria vaccine completely changed the issue. TB presented much more of a challenge, because of the continued coincidence of the TB and AIDS epidemics. But wider access to antiretroviral therapy did lower TB incidence, while TB prophylaxis was also more widely available in areas which antiretroviral therapy programmes still hadn't reached. Between 2010 and 2020, new diagnostic tests and drugs for TB were developed and, in 2016, the new TB vaccine appeared. By 2020, it was widely available. Imagine life without it now!

Growing pains

Dr Ibrahim: But we mustn't forget...

You're right—it wasn't all simple. Some people felt anxious about the cultural changes that were happening: increasing links with international communities, diaspora networks, new religious movements, globalized media, and new communications technologies meant culture was constantly sloughing off its old skin, continuously being redefined. People were developing new values, reaching for new aspirations—especially young people—and more Africans were moving to the cities in search of better prospects.

By 2020, cities and newly urban areas were home to increasing numbers of people aspiring to consumer lifestyles. And, yes, sometimes these improvements had darker aspects… We can see now, from 2030, how dangerous that new wealth could be, how seductive it was suddenly to have money in your pocket.

Dr Ibrahim: We've all seen "*City Slicker*"—it told the story very well: affluent young men, separated from their homes and families, lonely in the big cities, might want, might need, to find pleasure and comfort in the growing red light districts of the towns.

Sister Bweupe: But every cloud... one thing that film didn't point out is that, in some ways, these developments actually made prevention efforts easier: because commercial sex became more visible and easier to make safer.

Dr Ibrahim: Still, there was a point, you have to admit, when it seemed that new resources and growth were making people angrier—those who still didn't have anything were angry with those who were suddenly doing better.

Steve Phorano: But I see that changing now—as more people have benefited from the transitions that are happening, and the gap between rich and poor has narrowed, even though there is still a long way to go.

People were worried—still are worried—about what these changes might mean for our traditional values and cultures. They argue that we have gone too far, too fast—they tell me that no one should test the depth of a river with both feet.

Others have pointed out that it is impossible to hold culture still; and besides, by 2025, these changes were already unstoppable, as more people were living in cities, travelling, changing.

Of course, none of this happened overnight: as they say, the moon moves slowly, but it does cross the town. For the last 30 years, the changes that have taken place have brought peace, even some prosperity, spreading over Africa. This new story is always gaining strength—more and more people are involved in its telling.

They also say on the Zambezi River that if you don't row hard enough up river, the river will surely take you down.

We have rowed hard enough, even if both our feet were wet!

You who have listened are part of this story.

Now the story is yours to carry on. You are storytellers, just as I am.

So… what story shall we create for Africa now?

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In the remainder of this article, and in line with its practice of providing summary historical data, *One World Review* presents an overview of some of the key indicators that help illustrate the progress achieved during the first 25 years of this century.

Times of transition: An overview

The human toll

By 2025 the number of people living with HIV and AIDS had fallen from 25 million in 2003 to 15 million, despite the fact that the population had grown to 1.4 billion from 0.9 billion in 2003. This represented a fall in overall adult HIV prevalence from 5.6% to 1.9%. The number of new adult infections annually had dropped by almost half since 2003.

The gender bias had begun to even out, but women were still more adversely affected. Adult male HIV prevalence dropped from 4.9% in 2003 to 1.6% in 2025, and female prevalence from 6.4% in 2003 to 2.2% in 2025.

The scaling up of antiretroviral therapy provision had been dramatic: from less than 77 000 people in 2003 to 3.4 million by 2025, representing just over 70% of those who needed it.

However, the number of people dying from AIDS, despite the lengthening of their lives with antiretroviral drugs, had continued to climb. By 2025, 53 million adults and 15 million children had died since the beginning of the AIDS epidemic. The annual number of deaths was also still high, reflecting the fact that reducing the rate of infection was taking time to work through the population. In 2025, 1.3 million adults across Africa died from AIDS, and 260 000 children.

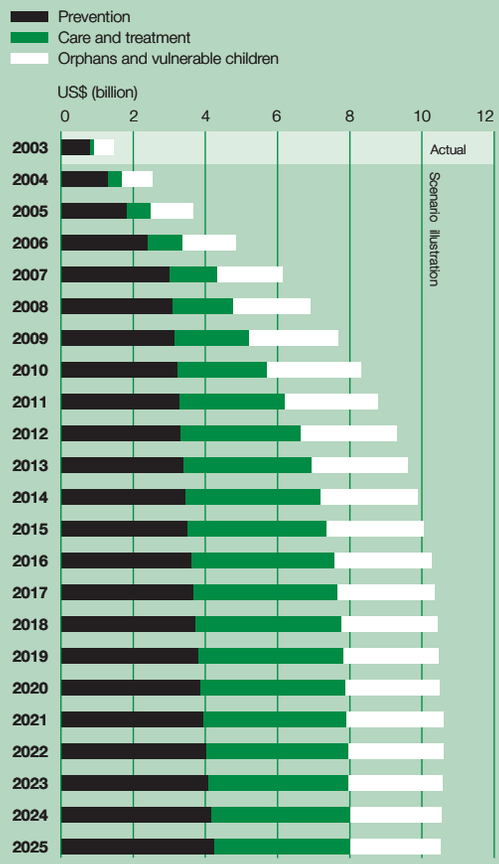
Costing action

Prevention and care initiatives prevented a steep rise in the numbers of children orphaned by AIDS, but a significant problem remained, with the number of children orphaned by AIDS rising from 13 million in 2003 to 18 million at the end of 2025.

Comparing the first and last bars in **Figure 61** illustrates how resource allocation changed between 2003 and 2025. There was a steady balancing of expenditure, reflecting the equal importance placed on each of the three components. The allocation to care and treatment began to decline from around 2015, as the actual number of people living with HIV and AIDS began to fall.

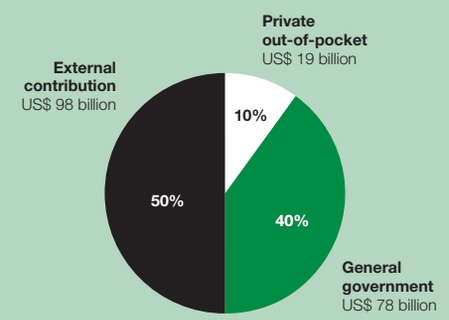
Over the 23 years, responding to the epidemic required investments of nearly US$ 200 billion, within a larger overall package of investment in health, education, infrastructure, and social development. HIV- and AIDS-specific funding increased at a year-on-year rate of more than 9%, and there was a very rapid increase in expenditure on prevention, and orphans and vulnerable children in the initial years, 2003 to 2007. Thereafter, expansion

Figure 61 Annual expenditure on HIV and AIDS, by component, 'Times of transition', 2003–2025



Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 62 Total expenditure on HIV and AIDS, by source 'Times of transition', 2003–2025



Source: UNAIDS AIDS in Africa Scenarios Project.

continued at a more moderate pace. Care and treatment expenditure expanded rapidly to 2012, in order to provide access to nearly 50% of those who needed antiretroviral therapy, and then increased more slowly to achieve more than 70% coverage.

This slower increase reflected the fact that expanding care beyond the capacity of existing health systems was a time-consuming and painstaking process. Expenditure on orphans and vulnerable children levelled off at the rate of population growth after 2012.

The total package, although large, was not an astronomical sum. By comparison, it was less than half of what the United States spent on new vehicles in 2003[1].

During the period, economic growth was 4% (real GDP growth, not taking into account inflation) and the Abuja target was met (15% of government spending is on health). At the same time, overall government budgets grew at 1% per year. Overall, national governments contributed 40% and individual out-of-pocket contributions 10%. External contributions accounted for the remaining 50%. A full explanation of what is included in these expenditures is in **Appendix 1**.

Most *Development Assistance Committee (DAC)* countries did, in fact, reach the 0.7% of GDP target for official development assistance (ODA). Even if the entire budget for Africa's HIV and AIDS programme had been paid for through ODA, the US$ 10.5 billion needed in 2025 would have amounted to

a mere 3% of ODA to Africa in 2025. *DAC* economies had grown strongly, at an average of 3% per year. African economies had also developed, and the decade 2015–2025 saw a gradual transfer of HIV and AIDS costs from external contributions to domestic budgets. Out-of-pocket spending remained steady. In 2003 external contributions to the AIDS sector were estimated to be just over a US$1 billion. Over the next decade this figure grew steadily until 2014, when annual external contributions were estimated at US$ 6.8 billion. Stronger economies, more generous health budgets, and a levelling off of the amount of resources required for programmes meant that, in the years 2015 to 2025, dependency on external aid flows decreased, slowly but significantly.

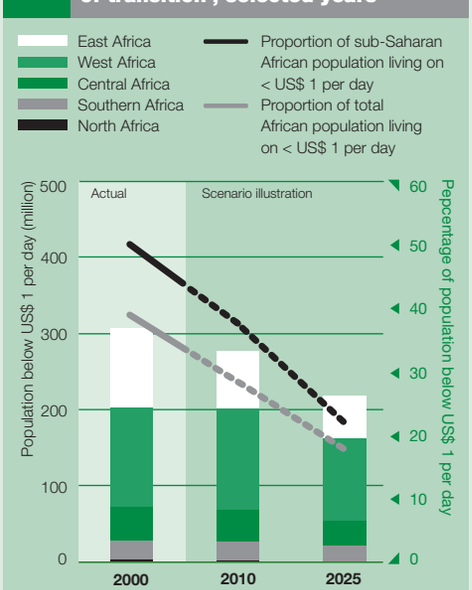
Although the costs of the programme continued to rise, aid dependency decreased over time after peaking in 2014, declining to a little over US$ 1.3 billion once the majority of costs were covered by stronger economies and more generous health budgets. It is true, however, that budget deficits continued to plague governments and individuals. Fortunately, donor countries and international finance institutions took a more relaxed view of these deficits.

Eastern, and West and Central Africa faced the greatest costs, but also received the largest proportion of ODA as the commitments made at Monterrey in 2002 and in the EMAs of 2009 and 2010 materialized.

Southern Africa required 30% of external contributions over the 23 years, but it was in a far better position to cover the remaining costs, thanks to improved economic growth and larger budgets. The region was left with smaller budget deficits than East and West and Central Africa.

North Africa, like Southern Africa, was better able to cover costs through government funds. However, this was primarily due to much lower infection rates and far lower HIV and AIDS programme costs.

Figure 63 **Population living on less than US$ 1 per day, by region, 'Times of transition', selected years**



Source: UN (2003) *World population projections – 2002 revision*. Geneva (2000 data); UNAIDS AIDS in Africa Scenarios Project.

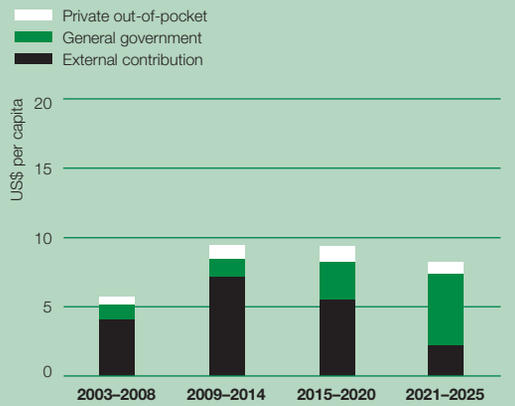
Millennium Development Goals

Most parts of sub-Saharan Africa had significant problems in shifting the trajectory towards achieving the MDGs in the early years of the century. However, the recommitment from African leaders and their international partners in 2005 really did begin to turn things around. The Extraordinary Meetings and Agreements (EMAs) of 2009 and 2010 provided additional impetus, as did the large investment of social sector spending from African governments and their partners. By 2015, it was clear that the trajectory had significantly altered and, while few countries achieved the targets in 2015, across sub-Saharan Africa the targets were met by 2025, with some countries achieving them well before that date. North Africa made rapid progress against some MDGs, and slower progress against others. The ratio of boys to girls in education and the primary school completion targets were achieved by 2015, as was the under-five mortality target.

Poverty

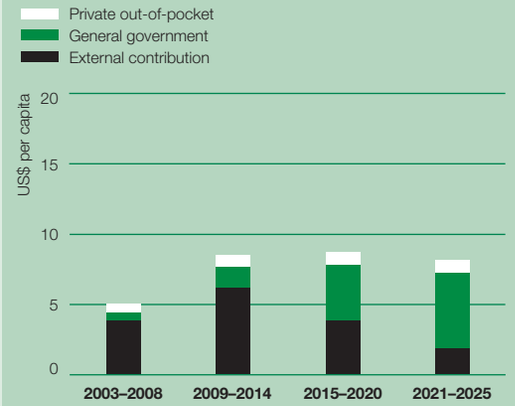
Both the proportion and the actual number of people living on less than US$ 1 per day in Africa reduced in the period 2003–2025: from 40% to 18% (in sub-Saharan Africa: from 50% to 22%) and from 306 million to 217 million. The greatest reduction in poverty was observed in East Africa (down to 56 million), with a 23% reduction in Central Africa (to 34 million) and around a 20% reduction in West and Southern Africa (to 21 million). The number of poor in North Africa reduced most significantly, by over 60% to 1 million.

Figure 64 **Average annual per capita expenditure on HIV and AIDS in East Africa, by source, 'Times of transition', 2003–2025**



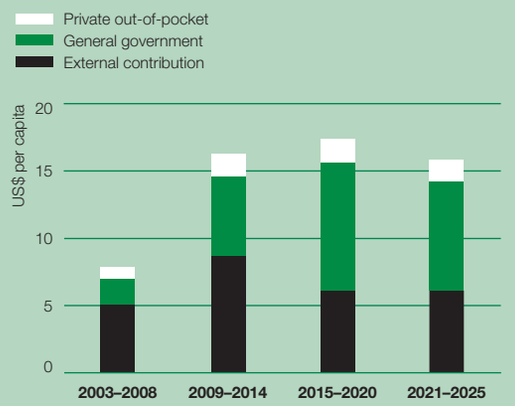
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 65 **Average annual per capita expenditure on HIV and AIDS in West and Central Africa, by source,'Times of transition', 2003–2025**



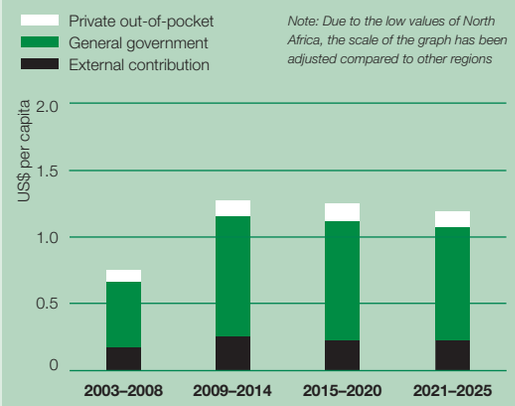
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 66 **Average annual per capita expenditure on HIV and AIDS in Southern Africa, by source, 'Times of transition', 2003–2025**



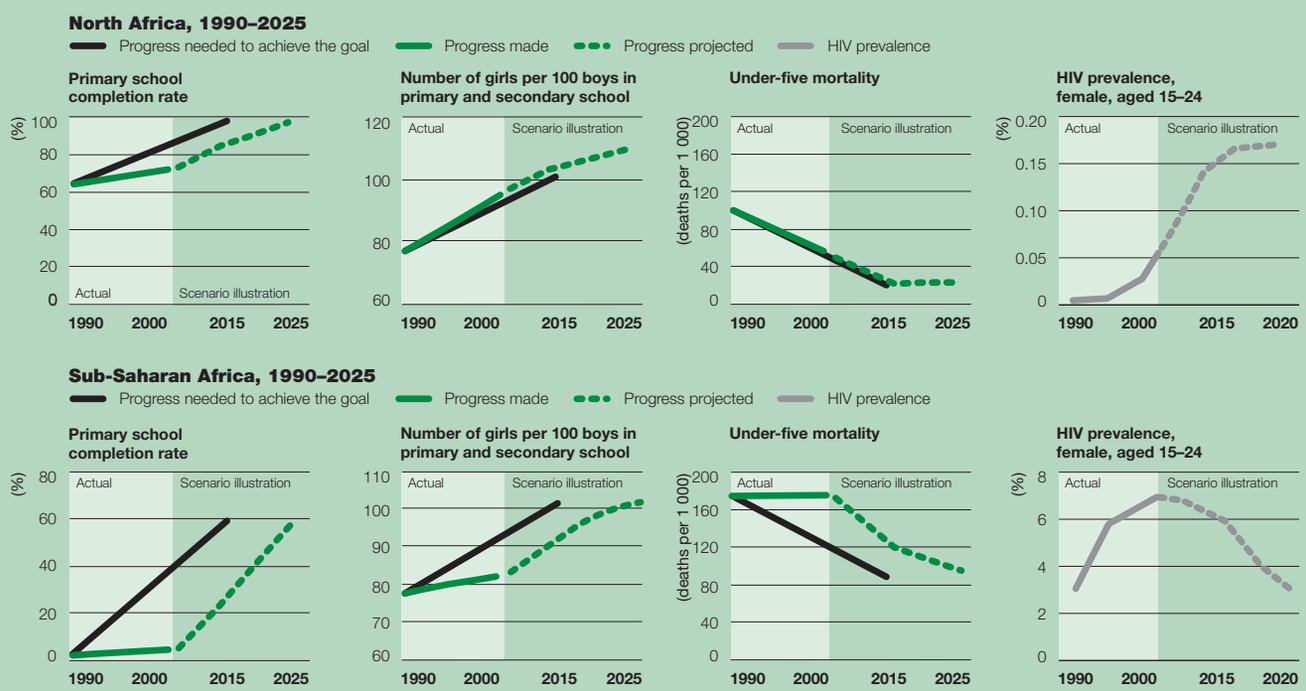
Source: UNAIDS AIDS in Africa Scenarios Project

Figure 67 **Average annual per capita expenditure on HIV and AIDS in North Africa, by source, 'Times of transition', 2003–2025**



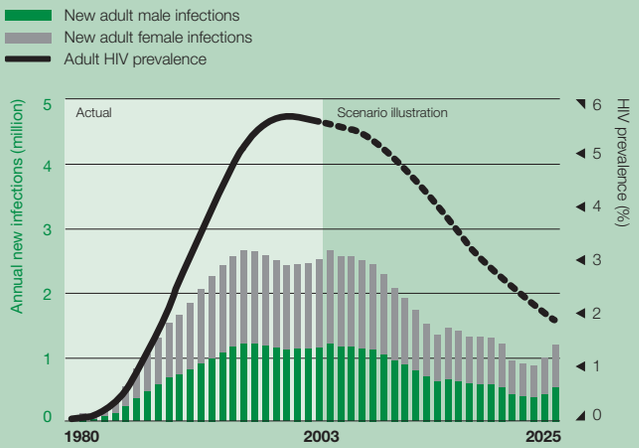
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 68 **Progress made against Millennium Development Goals in North and sub-Saharan Africa, 'Times of transition', 1990–2025**



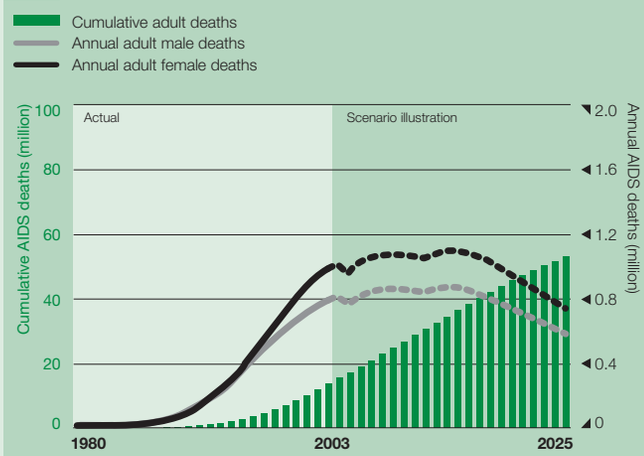
Source: UNDP/UNICEF (2002), *The Millennium development Goals in Africa: promises and progress*, New York; UNAIDS AIDS in Africa Scenarios Project.

Figure 69 Annual new adult HIV infections and adult HIV prevalence in Africa, 'Times of transition', 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 70 Cumulative and annual adult deaths from AIDS in Africa, 'Times of transition', 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

All Africa overview

Adult HIV prevalence across Africa decreased from 5.6% in 2003 to 1.9% in 2025. This was the result of an expanded response to the epidemic, involving different types of prevention interventions, and care and support activities.

The difference between the number of new infections among women and among men was also reduced as a consequence of successful prevention programmes that focused on gender issues. In 2025 there were 650 000 new adult female infections and 540 000 new adult male infections.

Adult deaths from AIDS per year declined from around 810 000 men and 1 million women in 2004 to around 580 000 men and 740 000 women in 2025. The pattern of an initial decline followed by an increase in annual deaths after 2013 was due to the pattern of antiretroviral therapy coverage and roll-out. Antiretroviral therapy coverage increased rapidly until 2010 and then increased much more slowly to 2025. During the rapid increase, many deaths from AIDS were postponed by successful therapy. After 2010, however, people who had been receiving therapy for a number of years begin to fall ill and die. The number of new people beginning therapy after 2010 was not significant enough to balance the increasing number of deaths of those who had been on therapy for a number of years.

Over this period the number of cumulative deaths was still high, despite massive efforts to roll out antiretroviral therapy. Given the high rates of infection at the beginning of the period, the limited effectiveness of therapy, and the time it takes for prevention programmes to reduce overall infection rates, it is difficult to see how these deaths could have been prevented. By 2025, the cumulative number of adult deaths from AIDS since 1980 had reached nearly 53 million.

Antiretroviral therapy was successfully and rapidly rolled out so that, by 2025, 73% of people who needed antiretroviral therapy were receiving it.

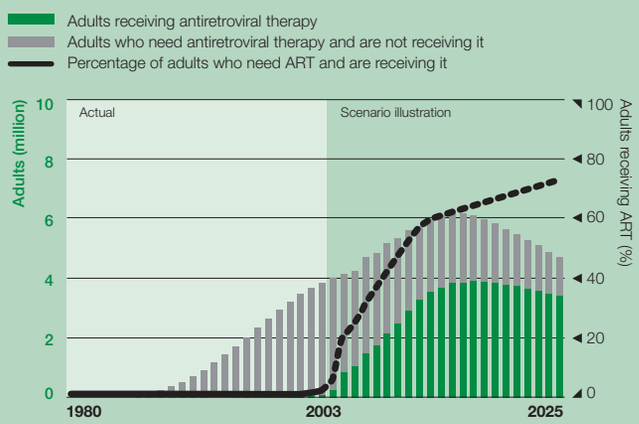
The number of children orphaned by AIDS continued to increase during the period, reaching 18 million in 2025. The total number of orphans (through AIDS and other causes) exceeded 50 million children in 2025, although this was less than in 2015—another indication that the epidemic was in decline.

African regions overview

Figure 73 shows a breakdown of the epidemiology of the epidemic into the geographical regions of East, West and Central, Southern, and Northern Africa.

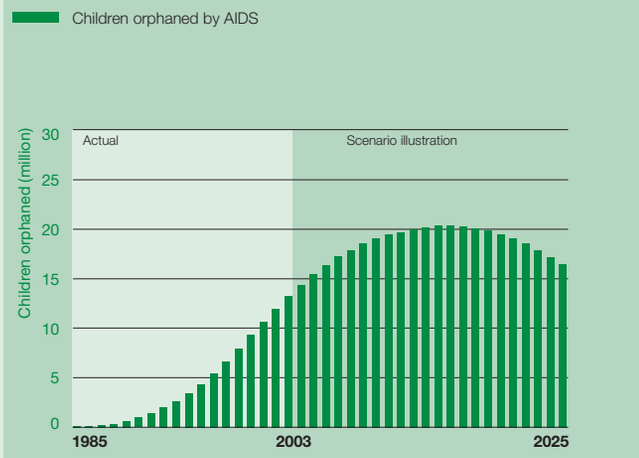
[1] The National Automobile Dealers Association (NADA) reported that total dollar sales of new-car dealerships reached US$ 700 billion in 2003, of which 60% (US$ 420 billion) was through new vehicles departments. *AutoExec Magazine* (May 2004) NADA. Available at http://www.nada.org

Figure 71 **Adults receiving antiretroviral therapy and adults in need of antiretroviral therapy in Africa, 'Times of transition', 1980–2025**



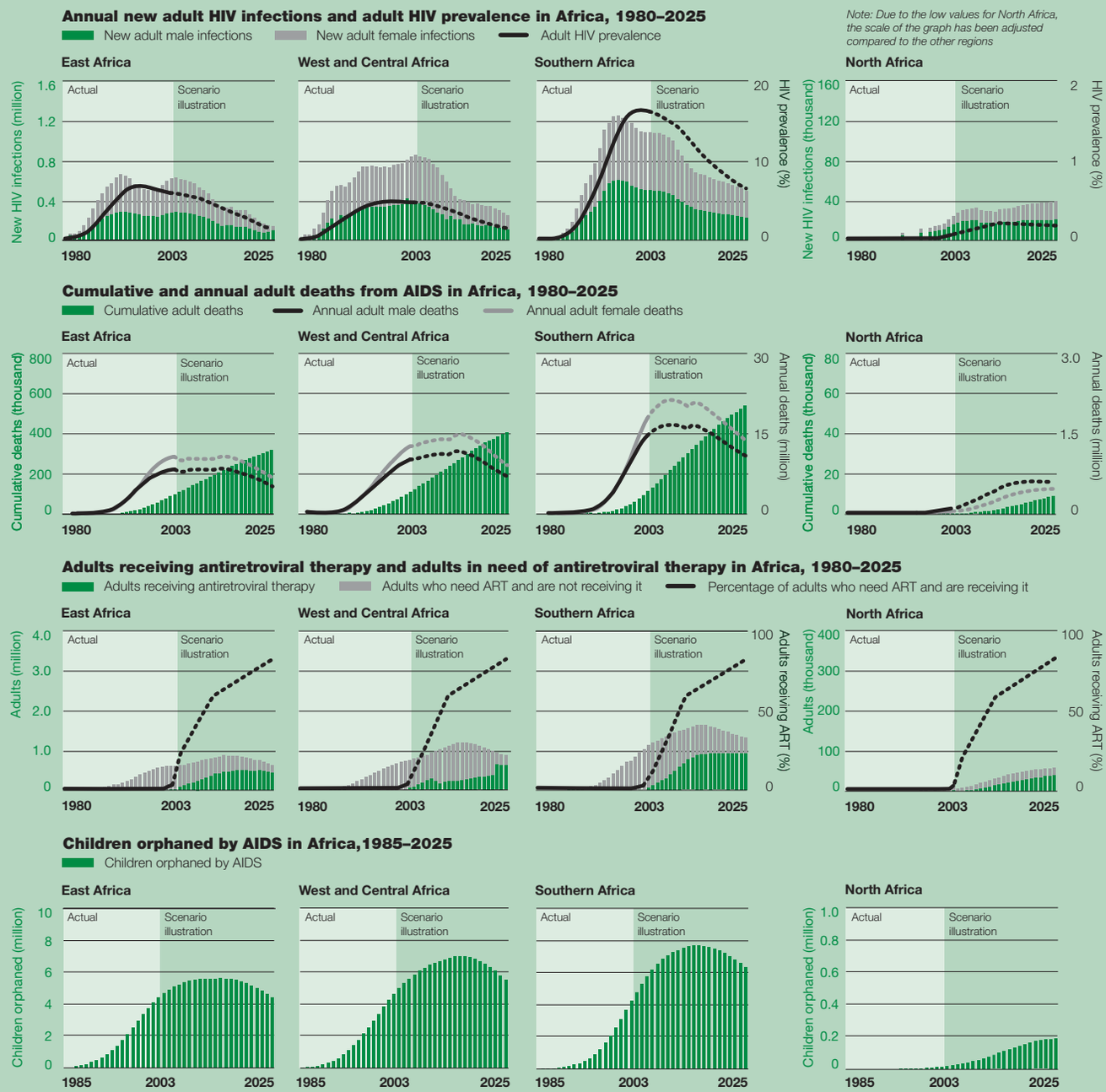
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 72 **Children orphaned by AIDS in Africa, 'Times of transition', 1985–2025**

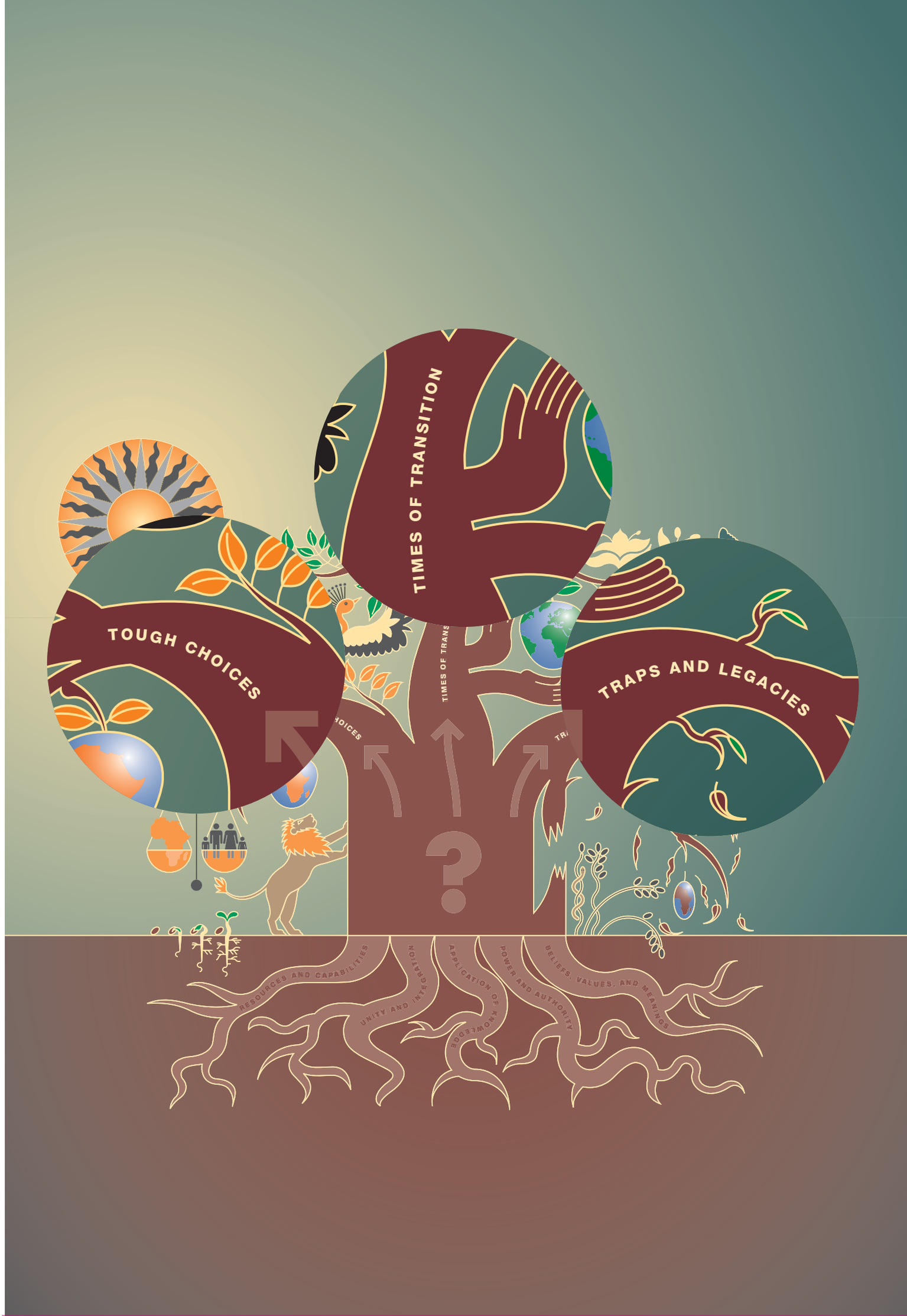


Source: UNAIDS (2004) *2004 report on the global AIDS epidemic.* Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 73 **Times of transition: Regional overview**



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic. Geneva (historical data)*, UNAIDS AIDS in Africa Scenarios Project.


TOUGH CHOICES
TIMES OF TRANSITION
TRAPS AND LEGACIES
RESOURCES AND CAPABILITIES
UNITY AND INTEGRATION
APPLICATION OF KNOWLEDGE
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Section 7 Scenario analysis

> **Knowledge is like a garden: if it is not cultivated, it cannot be harvested.**
> —Guinean proverb.

Section 7 Scenario Analysis

Scenarios are not predictions, but each describes a plausible outcome. Thus, an analysis of them helps us to learn about some of the challenges Africa may face in the future. This section compares the three scenarios by highlighting some of their key messages, and comparing their epidemiological outcomes and the level of resources that are needed to secure these outcomes. The chapter begins with a summary of critical ideas in the three scenarios.

The scenarios

The scenarios initially set out to answer one central question: "Over the next 20 years, what factors will drive Africa's and the world's responses to the AIDS epidemic, and what kind of future will there be for the next generation?" In answering this question, the scenarios pose two related questions: "How is the crisis perceived and by whom?" and "Will there be both the incentive and capacity to deal with it?" The responses to these questions lead us into the three scenarios:

- ***Tough choices: Africa takes a stand***
- ***Traps and legacies: The whirlpool***
- ***Times of transition: Africa overcomes***

Each scenario proposes very different answers.

Tough choices: Africa takes a stand

The key message of 'Tough choices' is that, while there are enormous odds to overcome, there is much that countries in Africa can do with their own strength—and particularly with their collective strength—to grow their economies, to prioritise developmental objectives, to lay the foundation for future growth and development, and to reduce the incidence and prevalence of HIV.

This scenario suggests that it is unlikely that the attitudes of the rest of the world to Africa or the provision they make for Africa will change—but it describes African countries nurturing their domestic resources, including cultural strengths, to find their own way forward. It shows that, with leadership and community mobilization, effective HIV and AIDS responses are possible without huge outlays of resources on stand-alone programming. This scenario ends with declining HIV incidence as the long-term investments in social, economic, and human capital over two decades begin to pay dividends.

This scenario is about identifying the tough choices that state leaders and their people have to make. Leaders make their own priorities for their countries—rather than avoiding or displacing them with externally imposed or suggested priorities, disguised through large amounts of HIV- and AIDS-specific funding and programming. 'Tough choices' demonstrates that it is possible, although not easy, to make tough decisions. Not everything can be done at once, so choices must be made between competing priorities. It may require the sacrifice of more immediate economic comforts for a longer-term sustainable national development.

'Tough choices' includes a stark message that deaths from AIDS will continue to rise. At the end of the period, despite discipline and effort, the number of people dying each year and the number of people living with HIV and AIDS remain the same as at the beginning of the scenario because of population momentum. Admittedly, this is a much better future to be in than the one described in 'Traps and legacies', but nonetheless, it is not a

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pleasant or comfortable world for the near future. However, the foundations are laid for a future that is no longer blighted by AIDS.

Traps and legacies: The whirlpool

The essential message of 'Traps and legacies' is that it will be difficult to make a difference to the AIDS epidemic if HIV is viewed in isolation from its root social, economic, and political context; or if it is seen only as a medical problem or as an issue of individual behavioural change, addressed via programmes that only consider the symptoms. The scenario deliberately does not play out a worsening epidemiological situation—population growth is enough to translate existing rates of incidence and prevalence into a doubling of the numbers of people living with HIV and AIDS by 2025.

'Traps and legacies' is a story of good intentions thwarted by an underlying development malaise, which remains unchanged in the quest for swift dividends. The AIDS epidemic does catalyse people and institutions into responding, but they cannot make sufficient headway in the face of depleted capacity and the spillover impacts from high-prevalence to low-prevalence countries. In this scenario, the continent is gripped in a downward spiral of disunity, denial and stigma, contested knowledge, wasted resources, and competing sources of power and authority. The capacity of systems, people, and institutions to respond to the crises of AIDS and under-development are systematically diminished.

At the start of the 'Traps and legacies' scenario there is a huge emphasis on HIV and AIDS, but the fractured, short-term nature of the response and the failure to make long-term, long-cycle investments result in a failure to deliver a lasting solution. Obviously, there are some winners: enclave economies, based on Africa's mineral wealth, and an élite who continue to live an international lifestyle. However, for the majority at the end of the scenario, demographic, social, and economic impacts have gradually eroded the capacity of high HIV prevalence societies, leading to a collapse in memory, transmission of culture, values, and social meanings, with profound effects.

Times of transition: Africa overcomes

'Times of transition' describes a series of transitions in the way in which Africa and the rest of the world approaches health, development, trade, security, and international relations. The prospect of the collapse of world trade regulation, the failure to meet the Millennium Development Goals, and another century of war leads the continent to draw back from the brink of disaster. The AIDS epidemic mirrors and magnifies a wider crisis and so acts as a catalyst for action—by civil society as much as states. The transitions require sustained social investment and fundamental changes in the way in which donors provide aid and governments deal with it—so that it promotes sovereignty, but does not undermine national autonomy, is not inflationary, and does not promote dependency.

In 'Times of transition', attitudes to Africa are transformed in an increasingly interconnected world and, within Africa, Afro-pessimism, Afro-scepticism, and Afro-exaggeration are replaced by a new understanding of solidarity and citizenship. On the international stage, this requires what has been called a new global covenant, involving security and human rights agendas brought together in coherent international frameworks that encompass economics, trade, social justice, and political equality. These changing international norms are shaped by, and are more responsive to, African needs and perspectives. Within Africa, this scenario requires pan-African solidarity and high levels of regional cooperation. It will need governments that put public good before private office; that direct the benefits of Africa's vast mineral wealth to becoming

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an engine for pan-African good; and that ensure that the state is a resource for all, rather than a prize to be captured. In terms of interpersonal behaviour, this scenario requires that gender relations be transformed, so that women throughout society are able to determine when, where, how, and with whom they have sex.

This scenario suggests that, if these transitions could be made within a generation, they could dramatically reduce the number of people infected with HIV and fundamentally alter the future course of Africa—and the world—in the twenty-first century.

Common challenges

The three scenarios illustrate three possible ways in which Africa and the rest of the world may respond to the epidemic.

Defining the crisis is crucial

How the crisis confronting Africa is defined, and by whom, will make a fundamental difference to the outcome of tackling the crisis. As the three scenarios demonstrate, definitions and explanations of the cause and effect of the epidemic, its magnitude, and the nature of effective solutions may be shared, imposed, ignored, or accommodated. However, a plurality of responses will work only if they are coordinated in the context of an overall shared goal.

The impact of the epidemic is yet to come

Even with the most successful antiretroviral therapy roll-out, treatment will not reach everyone and, in the majority of cases, it may only delay death for a few years. The momentum of population growth means that the number of people in Africa will continue to rise, almost doubling over the next 25 years. Inevitably, this means that the number of deaths over the next 25 years will continue to rise. However, the steepness of the curve on a graph, and the manner in which AIDS illness and mortality is regarded, is far from predetermined.

Exceptionalism versus isolationism

HIV is an exceptional disease. In high HIV prevalence countries, it has a unique capacity to reverse decades of development progress. However, a line must be drawn between treating HIV as an exceptional disease (exceptionalism) and paying attention only to HIV at the expense of other diseases (isolationism) or development issues.

In 'Tough choices', the AIDS epidemic is seen as part of the crisis of underdevelopment and actions are taken by each nation—in the context of limited domestic resources and stagnant overseas development assistance flows—to tackle underdevelopment and to find development models that suit their particular needs and environment. The spread of HIV means that difficult choices come into even clearer focus. However, solutions are devised not as a response to AIDS, but with the goal of securing sustained, more autonomous development.

In 'Traps and legacies', AIDS is treated in isolation from its social and economic context. Because of the emphasis on antiretroviral therapy, the overall response focuses on a medical approach: the urgent need to respond to AIDS is translated into a medical emergency. AIDS captures much of the additional money that goes to Africa between 2004 and 2010, and diverts money and capacities from other areas.

In 'Times of transition', the AIDS epidemic becomes a catalyst, helping people and institutions across the world understand that it is a small part of a wider international peace and development crisis. AIDS engenders an exceptional response, but it is not treated in isolation from its wider social and economic context.

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The danger of swift dividends

Although the AIDS epidemic is an emergency, it is essential to develop both short-term pragmatic solutions and long-term strategic responses. Prioritizing only one approach has grave consequences. Unfortunately, current approaches tend towards providing solutions that are short-term in nature.

'Tough choices' responds by accepting short-term hardship for many, in order to achieve longer-term goals; 'Traps and legacies' describes what might happen if the focus is placed on the symptoms of the emergency only; and 'Times of transition' tackles the symptoms and ensures sustainable development by massively expanding the resources and capabilities of the system.

Dependency, independence, and interdependence

As globalization marches forward, it becomes a truism that individuals, communities, nations, and the systems that they create and within which they exist and work are becoming increasingly interconnected. This integration can create both opportunities and constraints.

In 'Tough choices', African nations struggle for autonomy, which provides opportunities for longer-term economic, political, and social reforms, although in the short term it means restrictions and limitations (of financial flows, for instance).

In 'Traps and legacies', integration increases, but it creates dependence among African nations on richer countries and multilateral institutions—and this undermines or blocks the economic, cultural, and political reforms that are needed to ensure more inclusive and sustained development of individual countries, and erodes regional cooperation.

In 'Times of transition', interdependency is achieved, which establishes equal partnerships between African nations and the countries of the rest of the world and sees pan-African rhetoric translated into reality. However, this is only possible with fundamental changes on both sides and, of course, it may also introduce new vulnerabilities to external shocks for everyone involved, such as volatile international financial flows.

The dangers of ignoring local culture and meaning

The meanings attached to sex, death, ill health, HIV, identity, trust, and cosmology play a large part in determining actions in response to the AIDS epidemic. Yet, overall, in current HIV and AIDS policy, too little attention is paid to local culture and meanings. Medical or behavioural models of HIV transmission may have little to do with indigenous views and beliefs, and the mismatch can have profound consequences. The scenarios illustrate how different approaches to meanings may affect the outcomes of HIV and AIDS policies.

In 'Tough choices', national governments focus on using local meanings—whether that means adapting or reinforcing them—in order to introduce and sustain effective policies and programmes. These create powerful platforms for social action, although models of transgression and penance may also evolve with a constraining effect.

In 'Traps and legacies', ignorance of, conflict over, or ignoring the deeper meanings held by local cultures may mean that policies or programmes cannot gain a foothold in a community. These approaches may, in fact, increase stigma, blame, and taboo and lead to suspicion of, or rejection of, prevention technologies and treatments.

In 'Times of transition', there is a change in the conceptual thinking of stakeholders: ways of thinking that are based on risk, vulnerability, impact, and opportunity are effectively adapted to local contexts.

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The problem with policy triage and the public debate

In the face of a crisis that obviously exceeds the current capacity to respond, combined with continuing population growth, not everything can be done at once. Systems are under strain at all levels and resources of all types must be used judiciously. The scenarios explore a range of different approaches to decisions and actions taken around the allocation of scarce resources.

In 'Tough choices', national and state forces are determined to act on their own agendas—and they evolve a system of checks and balances, in order to achieve their longer-term development goals within a context of constrained capacities.

In 'Traps and legacies', there is little or no time for reflection on the extent or use of national or international capacities because events are moving too fast, results are needed too quickly, and the priorities of stronger individuals, countries, or institutions dominate.

In 'Times of transition', in response to more transparent and better governance by governments, multilateral institutions, NGOs, and corporations, financial resources grow, predictably and sustainably. This, in turn, generates further economic and political reforms, which, again, prompt improvements in development governance, including greater transparency and rationalization in decision-making processes.

Leadership is not enough but is important

Leadership in the response to HIV and AIDS is vital. However, leadership without the backing of institutional capabilities and resources, available systems capacity, or effective policy will not be able to deliver a successful response to the AIDS epidemic.

In 'Tough choices', national leadership galvanizes a national, regional, and—over time—pan-African response to the epidemic.

In 'Traps and legacies', there are plenty of leaders speaking out. National leaders declare the AIDS epidemic within Africa as a national emergency, but these statements seldom go beyond rhetoric.

In 'Times of transition', the appeal of overt and high profile leadership takes a backstage role to the deeper leadership challenges of building national and pan-African consensus and exemplary, long-sighted, and committed involvement in new global policy and programming synergies.

There is no magic bullet

Just as the causes of the AIDS epidemic are complex, so are the responses. There is no single policy prescription that will change the outcome of the epidemic. Antiretroviral therapy is not a magic bullet, although it is often presented as such, nor is the wide availability of condoms or voluntary counselling and testing. Not even a vaccine can fulfil this role if it is not available until after 2020, after another 15 years of underinvestment in African national health systems. At this late stage it would be difficult, if not impossible, to administer a vaccine sufficiently widely. However, a vaccine that became available after 2020 *could* make a rapid difference *if* there had been significant investment in human capital and national and health systems in the interim period. Rather than developing an approach that pins all hopes on finding a single magic bullet, the scenarios suggest that it is necessary to accept, and plan for, a wide range of policy interventions.

Bad action may be worse than no action

In 'Times of transition', the epidemic is always viewed in terms of its full human, social, political, economic, and development context. The long-term consequences of actions are always considered to be as important as their immediate impact. This approach involves experimentation—and a willingness to learn from mistakes and start again, using that new learning.

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While 'Times of transition' plays out the full set of actions needed to reduce the spread of the AIDS epidemic significantly, this is not to imply that anything less than this would be a waste of time. This approach could be played out on a smaller scale—at a national or regional level—and it would still make a difference. However, when resources do not permit a full set of actions in a comprehensive response, it is extremely important to tailor prevention strategies to address the local dynamics and impacts of the epidemic, and priorities must be set within this framework. In this context, it is important to recognize that there are diverse AIDS epidemics across Africa.

Approaches and actions of the kind suggested in 'Traps and legacies', such as the inappropriate scaling up of antiretroviral therapy without sufficient checks and balances, may be worse than no action at all. In contrast, 'Tough choices' extols the virtue of careful action: if 'Traps and legacies' is the hare, 'Tough choices' is the tortoise, winning this particular race through careful goal setting and the determination to make the best of scarce resources.

Gender

The importance of paying attention to gender—women's social, economic, and physiological vulnerability to HIV—is well understood, but the policies and actions that might best reduce vulnerability are not.

'Tough choices' shows that, even if gender is not the focus of attention for ideological or human rights reasons, there are entirely pragmatic economic and social reasons to address the status of girls and women in the context of national development and the lowering of HIV prevalence.

'Traps and legacies' describes how there is danger in focusing on women in isolation, without considering the complexity of wider family and community relations. For example, programmes that emphasize individual behavioural change can place the onus for action on women, and yet, in fact, women often lack the power to make or negotiate choices within their sexual relationships.

'Times of transition' shows that focusing on gender issues and their wider ramifications can have immense transformative power, catalysing social, economic, and political reforms.

Taking care of orphans and other vulnerable children

The scenarios show that the number of children orphaned by AIDS will rise, no matter what course of action governments choose, and that the consequences of ignoring the psychological, cultural, emotional, and social needs of those children will be very grave. So far, the resilience of communities to care for these children has been considerable, but the ongoing nature of the AIDS epidemic means that this resilience may be worn away.

'Tough choices' describes how African governments can address taking care of orphans and vulnerable children as a crucial part of building the future of their nations. Several approaches are explored: some view these children as an economic resource; others concentrate on their education or training; some ensure they stay within their community; others build orphanages.

'Traps and legacies' shows how these children might become a driver of social instability and future poverty. A vicious cycle develops where large numbers of children are caught up in a pattern of continuous and traumatic stress, leading to problems ranging from delinquency to depression. These children then grow up to become adults who are chronically traumatized.

In 'Times of transition', children orphaned by AIDS receive more resources, including explicit psychological help, and are not viewed as victims. They are encouraged to play an active role in building their own futures, making choices about their education and about where and how they can live.

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Mental and physical treatment

'Tough choices' and 'Traps and legacies' show the dangers of overlooking mental health in the response to HIV and AIDS. First, there is the individual trauma the epidemic is inflicting. In addition to that, there is trauma at both community and national levels, which is still little understood. One of the problems raised in tackling this trauma is that there is no common, personified enemy for people to see and unite against—there is no one to bring to justice and no mechanism through which justice can be delivered.

'Tough choices' explores some of the ways in which hope might be instilled among people and comfort brought to those who are suffering, but the resources for this are limited. Governments tend to focus on targeting help where it will provide the greatest effect—in many countries, they focus on taking care of the future generation, especially orphans and vulnerable children.

'Times of transition' more explicitly recognizes the importance of offering widespread psychological care—and finds ways to provide this.

Who benefits from social change?

All the scenarios tell stories about responses to rapid social change.

'Tough choices' describes how balancing or tempering rapid social change with other values, such as continuity of culture or identity, can be tough, but can pay dividends in the maintenance of security, autonomy, and social cohesion.

'Traps and legacies' shows how a minority can capture the benefits of social change, with disastrous consequences for the majority.

'Times of transition' reveals some ways in which much larger numbers of people can be caught up in positive social change—and some of the benefits they might access if knowledge, economic growth, and social transformation are shared more widely.

Local responses are critical

For effective responses to HIV and AIDS, local action is critical for sustaining safe behaviours; providing care and, increasingly, treatment to people living with HIV and AIDS; and in mitigating the impact of the epidemic, for example in providing care for children orphaned by AIDS. Nationwide responses to HIV and AIDS require service provision at a local level and the involvement of community organizations (whether quasi-governmental, religious, or communal). The three scenarios explore very different patterns for local organization and its relation to the state and other structures.

In 'Tough choices', the role of the state as arbiter and coordinator of local efforts is paramount and, in some instances, that implies trade-offs in supporting diversity and sustaining the momentum of local efforts.

'Traps and legacies' sees a proliferation of local responses, rarely coordinated and often sustained by direct contact between local organizations in different parts of the world.

In 'Times of transition', civil society is an engine for the transitions that take place, with a sometimes contested, but necessarily robust, relationship with government.

Religious transformation

The role of faith-based organizations in responding to the epidemic has been considerable, but it is rarely examined in relation to the changing dynamics of religion as a social force across the African continent. The scenarios bring to light some of the profoundly different roles that religion might play.

In 'Tough choices', the actual and latent capacity of faith-based organizations is marshalled by national leaders as part of a national HIV and AIDS response.

In 'Traps and legacies', religious institutions provide one of the few refuges available to

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communities suffering from the impacts of AIDS, but the relationship between people of different faiths, and between faith-based and secular institutions, is often uncomfortable and sometimes extremely tense.

In 'Times of transition', religious leaders and their congregations, both within and outside Africa, play a crucial role in shaping new global values and, specifically, the response to the AIDS epidemic. Collaboration between religious groups grows. These developments require a willingness to set aside doctrinal differences, in favour of cooperation.

The significance of time

Time itself has different meanings in the three scenarios.

'Tough choices' tells us that time is intergenerational and that the past matters—the value of ancestors, family history, and identity profoundly shape the present, and actions in the present have consequences not just for those alive today, but also for generations yet to come.

In 'Traps and legacies', time is short and returns need to be immediate; targets are time-bound and action is measured out in political terms of office. Long-wave events such as an AIDS epidemic do not respond well to such short-termism.

'Times of transition' tells us something about the depth of time, rather than simply its length. The transitions and transformations envisaged in 'Times of transition' could take generations if they only occurred sequentially, with each one having to complete before another could begin.

'Times of transition' tells of a world in which leapfrogging and synergy are dominant metaphors; where rapid transition is possible because it rides on the back of a series of other transitions, all taking place simultaneously.

Development responses too rarely take account of time, other than to measure it out in conventional three or five-year project cycles. While any action is already too late for the millions who have already died from AIDS, there is a need to take time—and human experience of time—as a significant factor in the response to HIV and AIDS, or else the same mistakes will be repeated.

Funding the necessary response

Indicators of progress in responding to the AIDS epidemic are closely tied to the amount of resources spent on HIV and AIDS programmes and services. In particular, the scenarios suggest that, to produce better epidemiological outcomes or even to prevent significant deterioration, spending on HIV and AIDS prevention, care, treatment, and mitigation will have to be scaled up substantially from current levels.

The scenarios investigate the resources required for AIDS programmes.

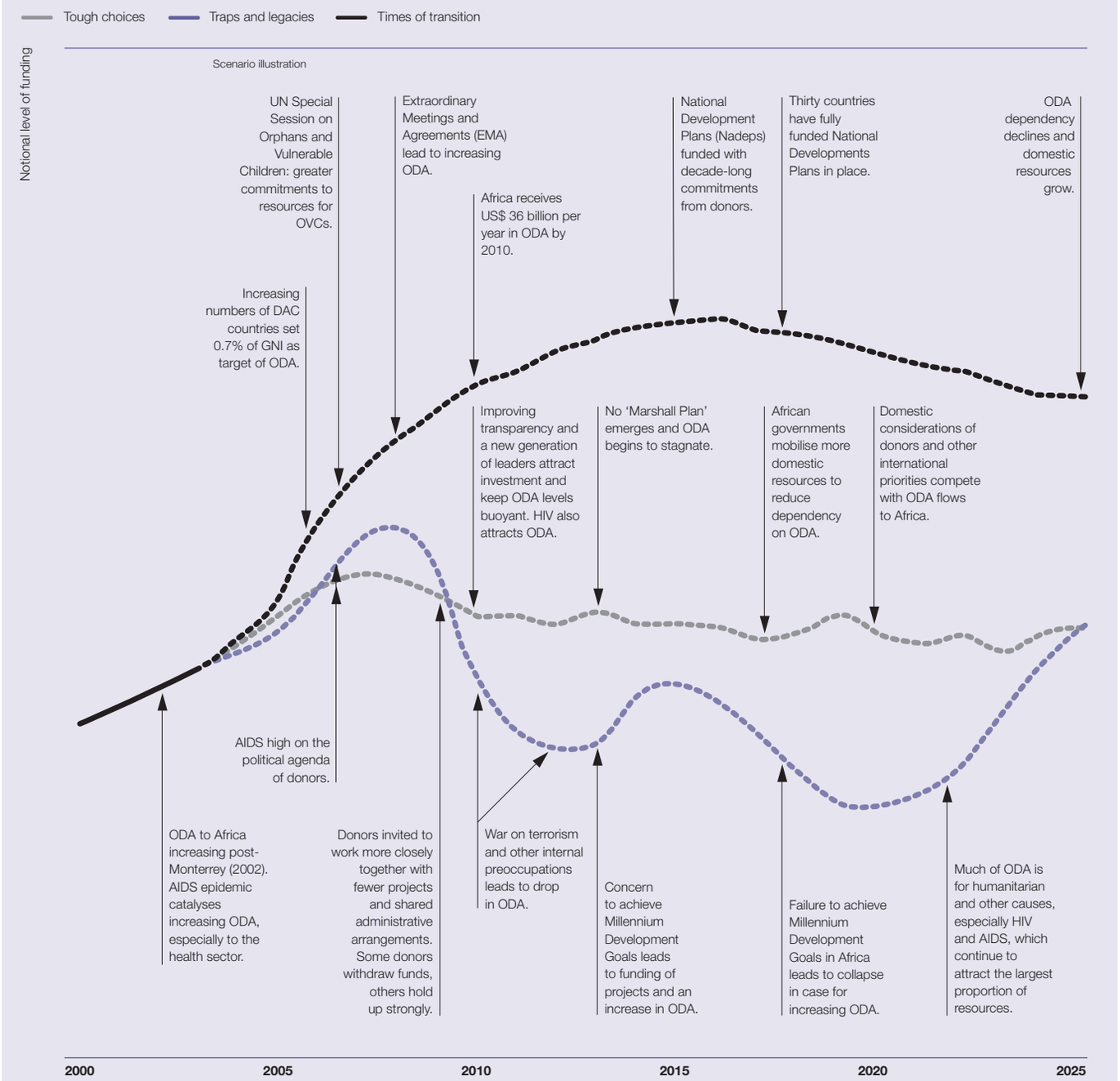
In 'Tough choices', aid remains largely stagnant after an initial surge of donor interest. The large spending recommendations of the *Millennium Project* do not happen. Nonetheless, African governments seek to maximize investments through well developed domestic policies.

In 'Traps and legacies', there are substantial increases in aid over an initial period of growth and much of this is captured by HIV and AIDS programming in isolation from other development issues. Thereafter, aid is volatile and unpredictable.

In 'Times of transition', it is assumed that significant and sustained increases in aid are made, much in line with the recommendations of the *Millennium Project*, and that HIV and AIDS funding occurs in that broader development context.

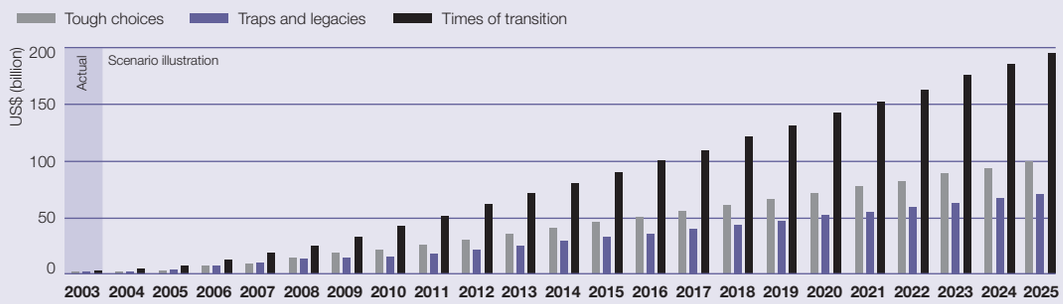
The scenarios make it clear that it is not only *how much* that is spent on HIV and AIDS programming that counts, but also *how effectively* those resources are used and what other development goals are financed at the same time.

Figure 74 **Comparison of ODA to Africa, by source, 2000–2025**



Sources: UNAIDS AIDS in Africa Scenarios Project.

Figure 75 **Cumulative expenditure on HIV and AIDS in Africa, 2003–2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

The impact of the AIDS epidemic will play out over a long period—it can be described as a silent explosion, followed by a series of shockwaves—and policy responses also take time to show their impact. Short-term projects may have local and individual benefits, but measuring out the future of the epidemic in three-year time horizons will not have a significant overall impact. Short-term solutions can cause the very thing they are meant to prevent.

'Tough choices' describes how, within African nations, policy perspectives could be lengthened—even when those of foreign governments or institutions remain short or narrow.

'Traps and legacies' describes the consequences of policy restlessness, when action is tied to political terms of office or expectations of swift returns.

In 'Times of transition', everybody's perspective lengthens, both within Africa and outside, with donors making 10-year and 15-year funding commitments, and African leaders being able to, and willing to, make long-term plans.

For the purposes of these scenarios the project has drawn on work done on costing the response to the epidemic over the last decade (**Appendix 1** and **Appendix 2**) . This includes extrapolating the costs and likely effectiveness of some 26 interventions. These include 18 specific prevention interventions, ranging from mass media campaigns and voluntary counselling and testing, to work with specific vulnerable populations (including young people both in and out of school); and service delivery ranging from condom distribution to universal precautions in health care settings.

The package of interventions also includes care and treatment, ranging from palliative care to the roll-out of antiretroviral therapy. Under this component, costs include laboratory services for monitoring treatment and toxicity of drugs; nutritional support for patients; and drug costs. Costs have also been included for the care of orphans and vulnerable children. However, costs such as additional training for health personnel are not included, nor expanded infrastructure.

The benefits of paying for a scaled-up response to the AIDS epidemic should substantially exceed the costs incurred. Under the 'Times of transition' scenario, donors, governments, and the private sector in Africa spend US$ 195 billion in the fight against AIDS in the first quarter of this century. Under the 'Traps and legacies' scenario, they spend about US$ 70 billion[i] . Total spending under 'Tough choices', with its slower expansion of antiretroviral therapy, is intermediate between 'Times of transition' and 'Traps and legacies' at around US$ 98 billion.

The resources required are not astronomical. To put them in context: the cost of a full response to Africa's AIDS epidemic (US$ 195 billion) is less than half of what the United States spent on new vehicles in 2003[2].

HIV and AIDS programme expenditure by source

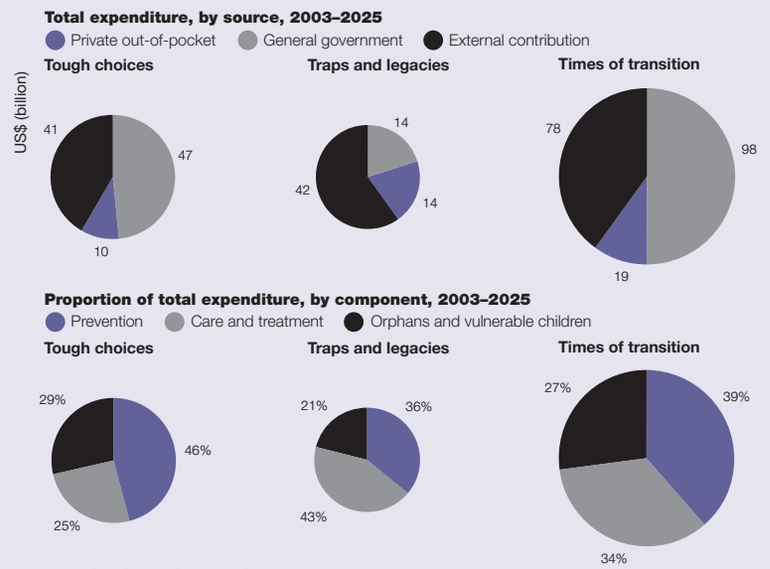
Each scenario envisages different epidemiological outcomes. This is mainly due to the distinct HIV and AIDS programmes that are implemented in each scenario. Not only do these programmes differ in their epidemiological outcomes, but also in their programme content, costs, and sources of funding.

The lowest-cost programme, rolled out in the 'Traps and legacies' scenario, requires governments and individuals to each contribute 20%, with external contributions providing the remaining 60%. Although this scenario plays out the lowest-cost option, it also requires the greatest relative external contribution.

The 'Tough choices' scenario rolls out an intermediate-cost programme option and requires the smallest relative proportion of external contributions (48%) and the greatest domestically

[i] The cumulative expenditures of the more expensive scenarios hide a reduction in cost increases over time. Beyond 2025, the early expenditure, more costly paths eventually lead to falling costs of response to the epidemic. In later years, the positive effects of spending more, sooner will become increasingly evident.

Figure 76 Expenditure on HIV and AIDS in Africa, by source and by component, 2003–2025



Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 77 Comparison of expenditure on HIV and AIDS and new infections in Africa, by scenario, 2003–2025

Indicator (US$ billion except where marked)	Scenario: Tough choices	Times of transition	Traps and legacies
Total expenditure on HIV and AIDS	98	70	195
Prevention	45	25	75
Care and treatment	25	30	67
Orphans and vulnerable children	28	15	53
Cumulative new infections (million)	65	89	46

Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 78 Incremental cost of prevention in Africa, over and above the 'Traps and legacies' scenario, 2003–2025

Incremental cost (US$)	Scenario: Tough choices	Times of transition
Per infection averted	800	1 160
Per QALY saved[a]	20	29

[a]The QALY calculation is based on the incremental or additional number of infections averted in each scenario, using 'Traps and legacies' as a baseline. The calculation assumes that a typical HIV infection occurs at age 25, and average life expectancy is 65. One infection averted thus yields an additional 40 years of working life. Because the calculation was based only on infections averted and not on years of life gained through antiretroviral therapy, only prevention costs are taken into account.

Source: UNAIDS AIDS in Africa Scenarios Project.

financed proportion with government spending of 42% and individuals' out-of-pocket costs of 10%.

The most cost-intensive programme, in the 'Times of transition' scenario, requires 50% from external contributions, 40% from government, and the remaining 10% from individuals, and shows the growing engagement of African governments in responding to HIV and AIDS and the reduced dependency on aid.

Figure 76 also provides a breakdown of the cumulative expenditure by component in the three scenarios. It shows that in 'Tough choices', the key priority is prevention; in 'Traps and legacies', care and treatment are prioritized, within a much smaller overall resource 'pie'; and in 'Times of transition', with a much larger overall expenditure, a good balance is achieved between prevention, care and treatment, and support for orphans and vulnerable children.

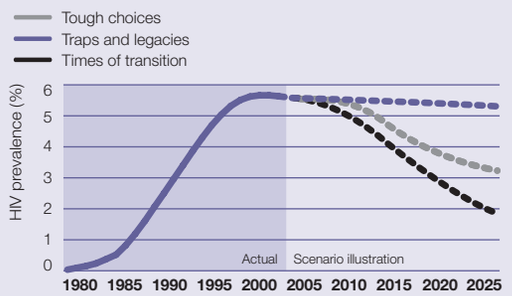
Spending more buys better health and more years of life

What, then, does spending an additional US$ 125 billion 'buy' for Africa, if it follows the 'Times of transition' path rather than the 'Traps and legacies' path?

First, the additional money buys fewer HIV infections and extra years of life. How many fewer infections? How many extra years of life? One way to answer these questions is to compare the results of the more optimistic scenarios to the less optimistic 'Traps and legacies' scenario.

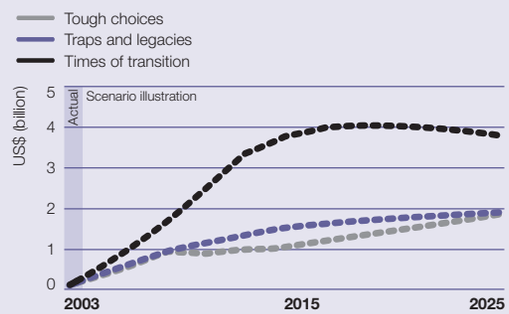
For example, over the period 2003 to 2025, there would be 43 million fewer people infected with HIV under the 'Times of transition' scenario than under 'Traps and legacies' (**Figure 77**). The additional spending required for the HIV prevention component under the 'Times of transition' scenario—around US$ 50 billion—may reasonably be considered as a key component contributing to the lower number of infections (though the 'Times of

Figure 79 Adult HIV prevalence in Africa, by scenario, 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data), UNAIDS AIDS in Africa Scenarios Project.

Figure 80 Annual expenditure on care and treatment in Africa, by scenario, 2003–2025



Source: UNAIDS AIDS in Africa Scenarios Project.

transition' scenario makes it clear that substantial social and economic change are also required).

Taking 'Traps and legacies' as a baseline, the additional costs for 'Times of transition' and 'Tough choices' can be presented as an incremental cost per infection averted (**Figure 78**). This analysis shows that the 'best buy' in terms of greater cost-effectiveness of the proposed interventions can be attributed to the 'Tough choices' scenario, reflecting the 'tough choice' approach of that scenario. In 'Tough choices', the easy-to-reach groups are covered, rather than the hard-to-reach groups, and the incremental cost of achieving one fewer infection, compared to 'Traps and legacies', is US$ 800. The cost per infection averted under 'Times of transition' averages nearly 50% more than under the 'Tough choices' scenario, due to higher costs in preventing HIV infection in populations that are more difficult to reach.

Epidemiologists and health economists often estimate the cost-utility of an intervention by calculating the number of additional years of life attributable to a health intervention. In this case, each infection saved under 'Times of transition' and 'Tough choices' can be compared to 'Traps and legacies' with each infection avoided assumed to be equivalent to 40 additional years of life.

Cost-benefit analysis is only one, narrow, way of interpreting the benefits of responding rigorously to HIV. Beyond these calculations, there is a far broader benefit from the concerted response to HIV and AIDS explored under the 'Times of transition' scenario. Spending directed at controlling the epidemic serves, in effect, to so marginalize the disease as to gradually end the need for maintaining a high level of spending beyond 2025. Also, in the years beyond, both lives and money would be saved in substantial numbers and amounts. Diminishing the impact of the epidemic could more than make up for earlier expenditures by increasing growth and stability in African countries.

Spending money to save money

Prospective spending in the 'Times of transition' and 'Tough choices' scenarios would likely be substantially lower than the costs the spending would avert. A widespread and unchecked epidemic would persist under the 'Traps and legacies' scenario, even with expenditures that total US$ 70 billion in a quarter century and amount to US$ 4 billion annually by 2025. Under the 'Times of transition' scenario, spending in 2025 will be US$ 11 billion, almost three times the level under 'Traps and legacies', but with a vast difference in terms of potential outcomes.

Under 'Traps and legacies' in 2025, HIV would remain a clear and present danger, with more than 40 million adults and children infected, amounting to 3% of the population (or over 5% of adults, see **Figure 79**). Under 'Times of transition', the African AIDS epidemic should be in decline, with only 2% of adults infected.

The balance between prevention and care

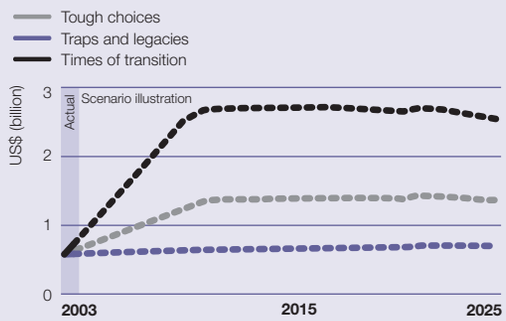
When HIV prevalence stabilizes or drops, the first positive financial effects of earlier resource expenditure become noticeable in declining costs for care and treatment. Care and treatment costs in the 'Traps and legacies' and 'Tough choices' scenarios grow steadily throughout. Alternatively, annual costs for care and treatment in 'Times of transition' begin to decline as early as 2017.

The rapid roll-out of antiretroviral therapy under 'Times of transition' shows the greatest overall spending on care and treatment, providing 57% coverage by 2012. This scenario also presents the most dramatic evidence of a decrease in absolute demand for antiretroviral therapy.

Orphans and vulnerable children

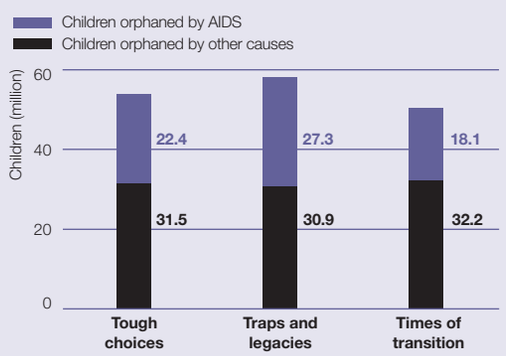
Resources expended on orphan support services remain constant at 2003 levels for the 'Traps and legacies' scenario throughout the period of the

Figure 81 **Annual expenditure on orphans and vulnerable children in Africa, by scenario, 2003–2025**



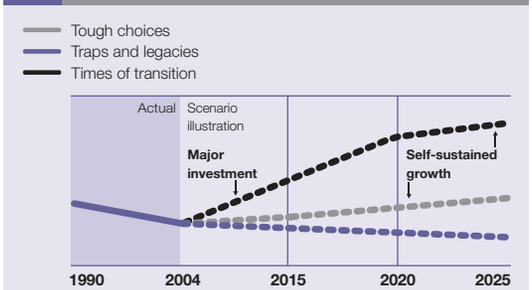
Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 82 **Children orphaned in Africa, by scenario, 2025**



Source: UNAIDS AIDS in Africa Scenarios Project.

Figure 83 **Per capita income in Africa, by scenario, 1990–2025**



Source: Adapted from Sachs J (2004) *Millennium development compact.* Commissioned by the UN Secretary-General and supported by the UN Development Group as part of the Millennium Project. Washington DC, Communications Development Incorporated; UNAIDS AIDS in Africa Scenarios Project.

scenario. Under 'Tough choices', expenditure is double that of 'Traps and legacies' by 2010 and remains at just under US$ 1.5 billion annually through to 2025. Under 'Times of transition', spending on orphans and vulnerable children is much higher, rising to and remaining above US$ 2.5 billion per year throughout the period.

The number of children orphaned by AIDS continues to grow under 'Traps and legacies', reaching more than 27 million by 2025. That number could already be in decline at the end of the period for both the 'Tough choices' and 'Times of transition' scenarios. After 2025, the number of orphans and vulnerable children and associated costs are expected to decline further under both these scenarios, unlike the 'Traps and legacies' scenario.

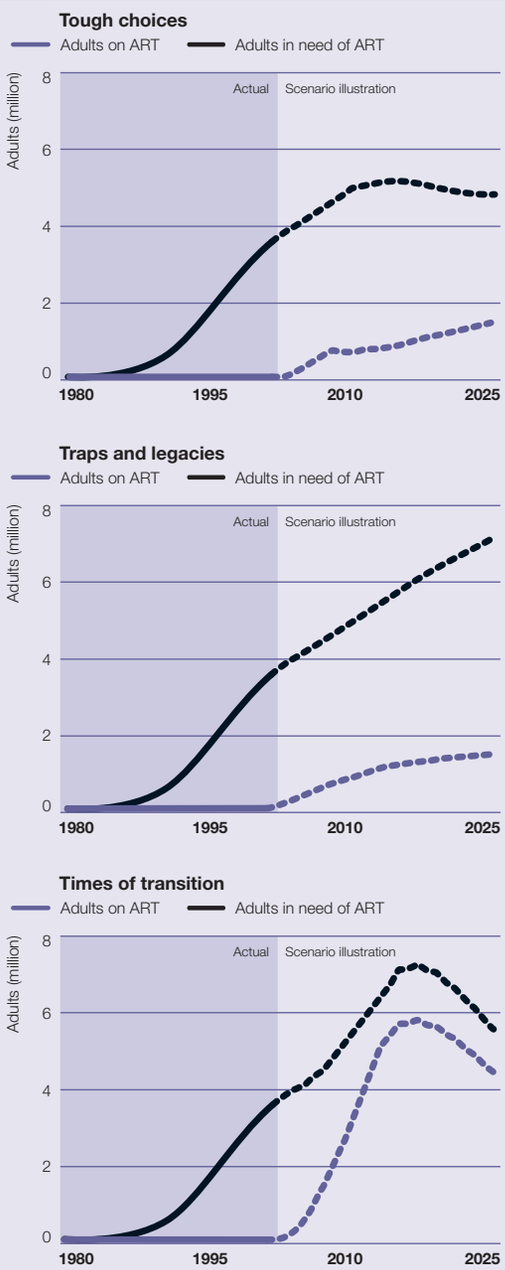
Per capita income in Africa

This section provides an analysis of how the different scenario paths interact with per capita income.

In 'Tough choices', the average aggregate economic growth is in the region of 2% per year, slightly exceeding the rate of population growth in some regions. Up to 2015, aid is accompanied by significant amounts of foreign direct investment (FDI) from within Africa itself, enabling improvements in infrastructure. Later, this, along with more beneficial international trade agreements, prompts a return of overseas FDI. Growing confidence is promoted by a local environment that is better able to sustain its own economic growth thanks to the investments made by African governments in setting their house in order.

In 'Traps and legacies', FDI into, and aid to, African countries drops, and African countries fail to secure improved multilateral trade conditions. The long-term aggregate result is a reduction in per capita incomes. Moreover, because economic growth does not keep pace

Figure 84 Adults receiving, and in need of, antiretroviral therapy in Africa, by scenario, 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

with the demands of the growing population, most of the economic gains made in some parts of Africa disappear.

In 'Times of transition', an average economic growth of 4% per year exceeds population growth and results in increased per capita income. Until 2020, massive investments, through large injections of aid and the facilitation of trade, mean that greater investments can be made in human capacity and infrastructure. Importantly, investments over the longer term are aimed at making Africa a more competitive producer and a more diversified exporter. This means that more funds generated by trade can be reinvested to strengthen economies after 2020, when they become increasingly self-sustaining.

Success stories of early interventions

The relative success of the more expensive scenarios should be evident by 2025, perhaps even by 2015. Differences in mortality between the three scenarios are directly related to the number of people receiving antiretroviral therapy. In 'Traps and legacies', the antiretroviral therapy roll-out fails, while in the 'Times of transition' scenario the roll-out has a significant impact on mortality.[ii]

These impressive achievements serve as indicators that substantial early spending can have timely and positive effects on the epidemic. Costs are still relatively high by the end of the scenarios—but the higher the spending at 2025, the faster the costs can be reduced in subsequent years.

The likely increases in societal well-being achieved by these changes promise to more than make up for the costs incurred as one looks beyond 2025 into a future in which AIDS is no longer an unstoppable epidemic impacting the future development of Africa.

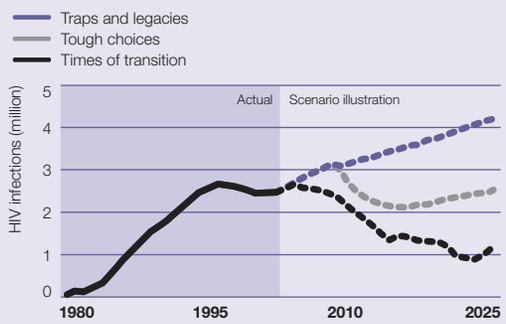
[ii] Those people in need of ART in any year are defined as those people becoming newly eligible for ART, plus those people already on ART in the previous year who will successfully continue on ART in this year. In the 'Times of transition' scenario, there are many more people on ART and many of them continue on ART in the following year. Thus, the total need is higher than for a scenario where only a few people are already on ART and the need is mostly for those newly progressing to AIDS. Most of the people defined as needing ART in the 'Times of transition' scenario are not defined as needing ART in the other scenarios because they have already died.

Figure 85 Population in Africa, by region and scenario, 2004 and 2025

	Year							
	2004		2025					
			Scenario					
Region			Tough choices		Traps and legacies		Times of transition	
Africa	813		1 230		1 220		1 240	
East Africa	195	24%	325	26%	322	26%	329	27%
West and Central Africa	314	39%	501	41%	501	41%	504	41%
Southern Africa	130	16%	176	14%	172	14%	179	14%
North Africa	174	21%	226	18%	226	19%	226	18%

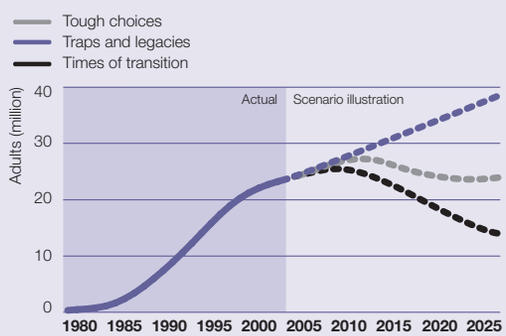
Source: UNDP Population Division; UNAIDS AIDS in Africa Scenarios Project.

Figure 86 Annual new adult HIV infections in Africa, by scenario, 1980–2025



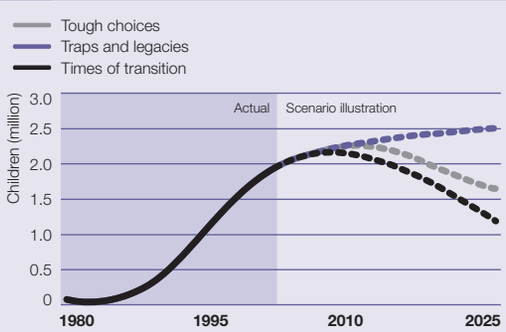
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 87 Adults living with HIV and AIDS in Africa, by scenario, 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 88 Children living with HIV and AIDS in Africa, by scenario, 1980–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

The AIDS epidemic

The continent's total population grows from over 810 million to 1.22 billion in 'Traps and legacies', to 1.24 billion in 'Tough choices', and to 1.24 billion in 'Times of transition'. The data are calculated using the *UN Population Division's* medium fertility variant, and the resulting population differences are exclusively due to the impact of the AIDS epidemic (increasing deaths and fewer births) and of the AIDS programmes (lives extended, infections averted, and consequently more births).

The number of people in each region and the relative percentage of the total population are indicated in **Figure 85**. West and Central Africa increase both in actual number of people and relative proportion of the population of Africa. By contrast, Southern Africa, shows an increase in the actual number of people, but a reduction in the percentage of its population relative to that of the continent.

People newly infected with HIV

One of the more dramatic differences between the scenarios is the picture of the number of people newly infected with HIV. The 'Traps and legacies' scenario shows a rapid rise in HIV incidence throughout the period, and by 2025 there are more than 4 million new adult infections per year. 'Times of transition' shows a significant decline in HIV prevalence, but the actual number of people newly infected begins to rise again towards the end of the period, because the population continues to grow.

Incidence is tied to prevention spending, so, for example, the incidence numbers for 'Tough choices' and 'Traps and legacies' diverge shortly after 'Tough choices' shows a marked increase in prevention spending over 'Traps and legacies'.

Adults living with HIV and AIDS

Reflecting differing levels of commitment to prevention programmes and changes in incidence, the number of adults living with HIV and AIDS diverges considerably for the different scenarios.

AIDS erodes the human capacity of health care systems and significantly increases the burden of disease, as AIDS-related illness both prevents patients with other conditions receiving the care they need, and prompts the resurgence of other diseases, such as TB and pneumonia. **Figure 89** shows how trends in TB incidence follow close behind trends in HIV incidence in the three scenarios.

Children living with HIV and AIDS

The number of children living with HIV and AIDS also begins to diverge early across the three scenarios, reflecting prevention and treatment roll-out.

People dying from AIDS

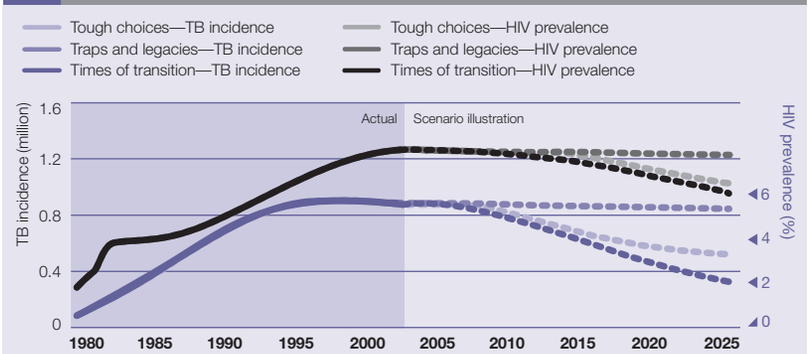
The 'Traps and legacies' scenario results in 66 million cumulative adult deaths from AIDS by 2025. In 'Tough choices', the cumulative total will be 60 million, and in 'Times of transition', the total will be 53 million. This is perhaps the harshest message of these scenarios: that no matter what policy direction is followed, the death toll will continue to rise over the next 20 years. However, there are many millions of deaths from AIDS that can be prevented.

Scaling up prevention

Both 'Tough choices' and 'Traps and legacies' expand prevention spending only slowly from the 2003 level of about US$ 0.8 billion per year (**Figure 92**).

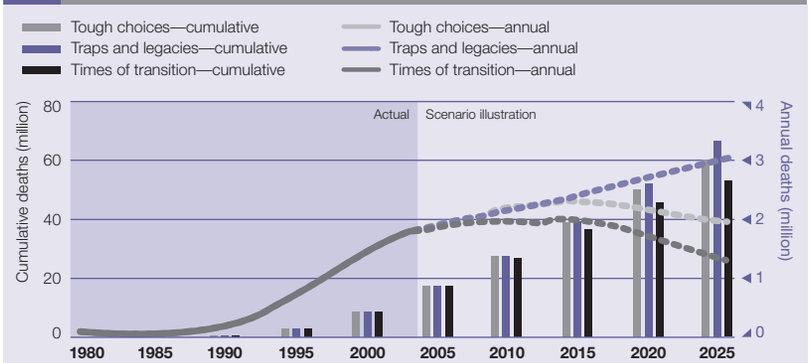
In 'Traps and legacies', the average annual rate of growth of spending is 2.6%, which is only the same as the growth rate of the population.

Figure 89 Trends in adult HIV prevalence and TB incidence per 100 000 adults per year in Africa, by scenario, 1980–2025



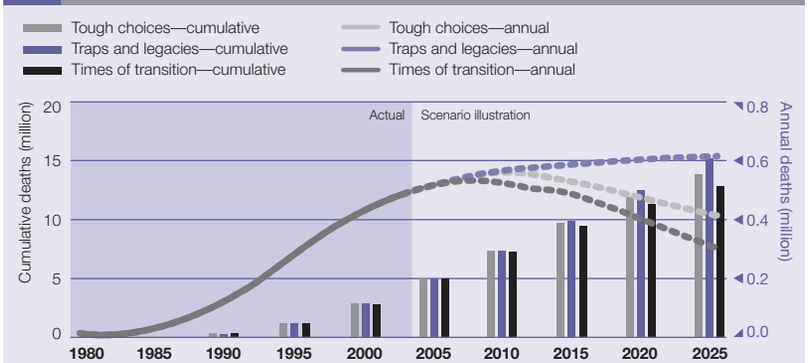
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 90 Cumulative and annual adult deaths from AIDS in Africa, by scenario, 1980–2025



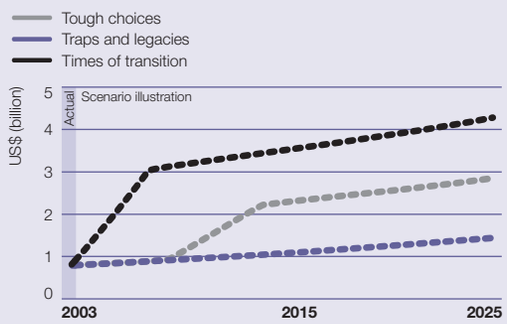
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 91 Cumulative and annual child deaths from AIDS in Africa, by scenario, 1980–2025



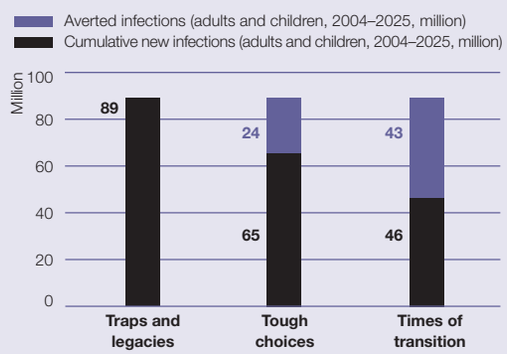
Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 92 Annual expenditure on prevention in Africa, by scenario, 2003–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data); UNAIDS AIDS in Africa Scenarios Project.

Figure 93 Cumulative new infections and cumulative infections averted in Africa, compared to 'Traps and legacies', adults and children, 2003–2025



Source: UNAIDS (2004) *2004 report on the global AIDS epidemic*. Geneva (historical data), UNAIDS AIDS in Africa Scenarios Project.

'Tough choices' increases prevention resources at more than twice that rate: rising slowly at first, accelerating for a number of years, and then levelling off at the growth rate of the population. Under 'Times of transition', prevention spending rises by a significant 40% per year for the first four years, to reach US$ 3 billion per year by 2007, and then continues to expand at the rate of population growth to maintain per capita services at a constantly high level. This early commitment of funds contributes to the powerful impact on incidence in this scenario. Spending on prevention early on leads the 'Times of transition' scenario to yield fewer than half the number of new HIV infections per year in 2025 when compared to the 'Traps and legacies' scenario.

Figure 93 illustrates the number of new infections averted across the three scenarios. 'Traps and legacies' indicates that, as prevalence remains more or less constant over the years of the scenario and population grows, there are some 89 million new HIV infections across Africa. In 'Times of transition', with maximum roll-out of prevention interventions and high levels of antiretroviral therapy roll-out, 43 million new HIV infections are averted when compared to 'Traps and legacies'. In 'Tough choices', with its more limited expenditure on all interventions, 24 million infections are averted when compared to 'Traps and legacies'.

[1] Dye C, et al (1998) Prospects for worldwide tuberculosis control under the WHO DOTS strategy, *The Lancet*, 352:1886.

[2] The National Automobile Dealers Association (NADA) reported that total dollar sales of new-car dealerships reached US$ 700 billion in 2003, of which 60% (US$ 420 billion) was through new vehicles departments. *AutoExec Magazine* (May 2004) NADA. Available at http://www.nada.org

Figure 94 **Comparing key elements across the scenarios**

Key issue or theme	Tough choices	Traps and legacies	Times of transition
Education	High prevalence countries (HPCs) recognize the need to rebuild capacity rapidly: emphasis on secondary and technical education, not universal primary education. Impact of schooling on epidemic effectively leveraged. Teachers seen as key and receive antiretroviral therapy.	Education for All and Millennium Development Goals not met; considerable impact of epidemic on teachers who, in many countries, receive only limited access to antiretroviral therapy. Education not used effectively to respond to the epidemic. Large percentage of children in HPCs, especially orphans and vulnerable children, fail to complete basic education. Education infrastructure fails to keep pace with population growth.	Sufficient political will and finance leads to maximum leveraging of education system in response to HIV. Major efforts to educate girls. Teachers gain effective access to antiretroviral therapy, rapidly change behaviour, and lead by example.
Health sector development	Ill health and malnutrition seen as a major economic burden, constraining national development. Different diseases prioritized in different countries; malaria gains in status. Health care provision in small urban centres concentrated and rationalized; rural work given to faith-based and NGO providers. Some traditional practices leveraged in national interest. No parallel HIV- and AIDS-specific structures.	Growing external funds for health sector development—but not used effectively. Growth in antiretroviral therapy leads to parallel systems, draining key public-sector staff into externally-financed HIV and AIDS projects. In HPCs, rural primary health care systems collapse. Increasing use of traditional medicine. Immunization rates do not keep pace with growing populations.	Best use of increasing external aid flows in HPCs to kick-start health systems. International commitment to Millennium Development Goals increases overall funding for health sector, largely through sector-wide and budget-wide mechanisms. Effective use of managed networks of providers, with government setting standards and directing efforts. Brain drain managed.
HIV prevention	Emphasis on AIDS-free future drives vigorous prevention campaigns in most countries. Some adopt high rates of condom use, legalize and regulate prostitution, and emphasize STI treatment. Others hold more conservative ethos, which can lead to coercive and sometimes counterproductive approaches. Generally, collective good supersedes individual rights and choice. Falling incidence overall.	AIDS policy increasingly focused on treatment. Continued lack of agreement or coordination around effective HIV prevention and emphasis on 'high risk behaviour and personal behavioural change' renders increasing resources and efforts ineffective. Little emphasis on context driving risk behaviour. Major initiatives in voluntary counselling and testing not pursued and new infrastructure wasted.	Best use made of lessons of previous 20 years of epidemic. Strong synergies achieved between treatment and prevention approaches, and the number of people knowing their HIV status rises. Imaginative application of a variety of strategies means maximum appeal to many different audiences. Mother-to-child-transmission therapy effectively rolled out in HPCs and becomes a gateway for further prevention and treatment efforts.
Impact of the epidemic	Awareness of future impacts drives efforts to retain a minimum of skilled essential personnel and to create long-term strategic approaches. Largely successful, but with some short-term cost. Improving food self-sufficiency improves nutrition of general population.	Some countries and sectors do better than others, but overall efforts to address impact are sporadic and uncoordinated, with short-term time horizons. In HPCs, the long-term impact continues to be underestimated and psychological impacts rarely effectively addressed. By 2025 HPCs hard hit at all levels, with impacts spilling over into lower prevalence countries.	Availability of sufficient funds means that short-term, pragmatic responses to immediate needs do not sabotage longer-term efforts to mitigate impact. Full understanding of impacts, shared with wider community of actors, leads to joined-up, effective, strategic approaches, tailored to context and involving relevant communities.

Comparing key elements across the scenarios *(Continued)*

Key issue or theme	Tough choices	Traps and legacies	Times of transition
Biomedical approaches	Gradual progress in biotech research and clever use of scientific advances. Microbicide use is encouraged in some countries, viewed with suspicion in others. Investment in tertiary and technical education means more local capacity. Growth of biotech industries in some countries leads to local breakthroughs.	Development of microbicide, vaccine, and new therapeutics proceeds, but slowly, hampered by underfunding, competition, and redundancy. Competition over Phase III clinical trial sites limits opportunities. Poor health systems and inadequate preparation mean that even major breakthroughs are inadequately rolled out.	Significant funding increases for international public goods leads to rapid breakthroughs in drugs and other approaches to malaria, TB, and HIV. Consolidated, international approaches lead to an HIV vaccine with an improved version by 2025, delivered with childhood immunization. Widespread availability of microbicides. Biomedical approaches matched with social and systems developments, improving their accessibility and use.
Overall focus on HIV and AIDS	Political rhetoric not matched by sustained increases in resources by external partners: Africa must seek its own long-term solutions to HIV and AIDS. HIV seen in many countries as indication of overall crisis of underdevelopment, poverty, and poor governance. Governments look for cost-effective ways of managing this larger agenda.	At the start, HIV and AIDS are the major focus of national and international efforts, but efforts are uncoordinated, and competition for scare human and systems resources leads to waste and burn-out. Solutions imposed on, rather than owned by, African partners. Failure to tackle the epidemic effectively leads to political disengagement; resources fall. By 2025, AIDS has become normalized, much like malaria, but far more catastrophic. Poorer people are far more vulnerable to the epidemic.	Spread of HIV is seen as a metaphor for global injustice and inequality and is addressed as a priority by the international community, under the leadership of African countries. Fundamental changes in international architecture enable Africa to address deep-seated structural problems that are the wider cause of the epidemic.
HIV and AIDS programme governance	Seen as part of larger governance agenda and resourced appropriately. Decentralization via traditional authority structures leads to mixed outcomes: some highly effective. In HPCs, strong central control of resources to ensure maximum leverage. Governments impose discipline on donors.	Generally contested and confused (but with important exceptions). Large external resources fuel competition between government departments, resulting in wasteful duplications. Control either over-centralized or decentralized, without adequate structure or accountability.	Strong central leadership, with government acting as coordinator, standard-setter, and facilitator of a plethora of initiatives. Major emphasis on synergy and harmonization, from largest to smallest partners. HIV and AIDS seen in context of overall national budget and sector priorities, though with some ring fencing of HIV- and AIDS-specific funds.

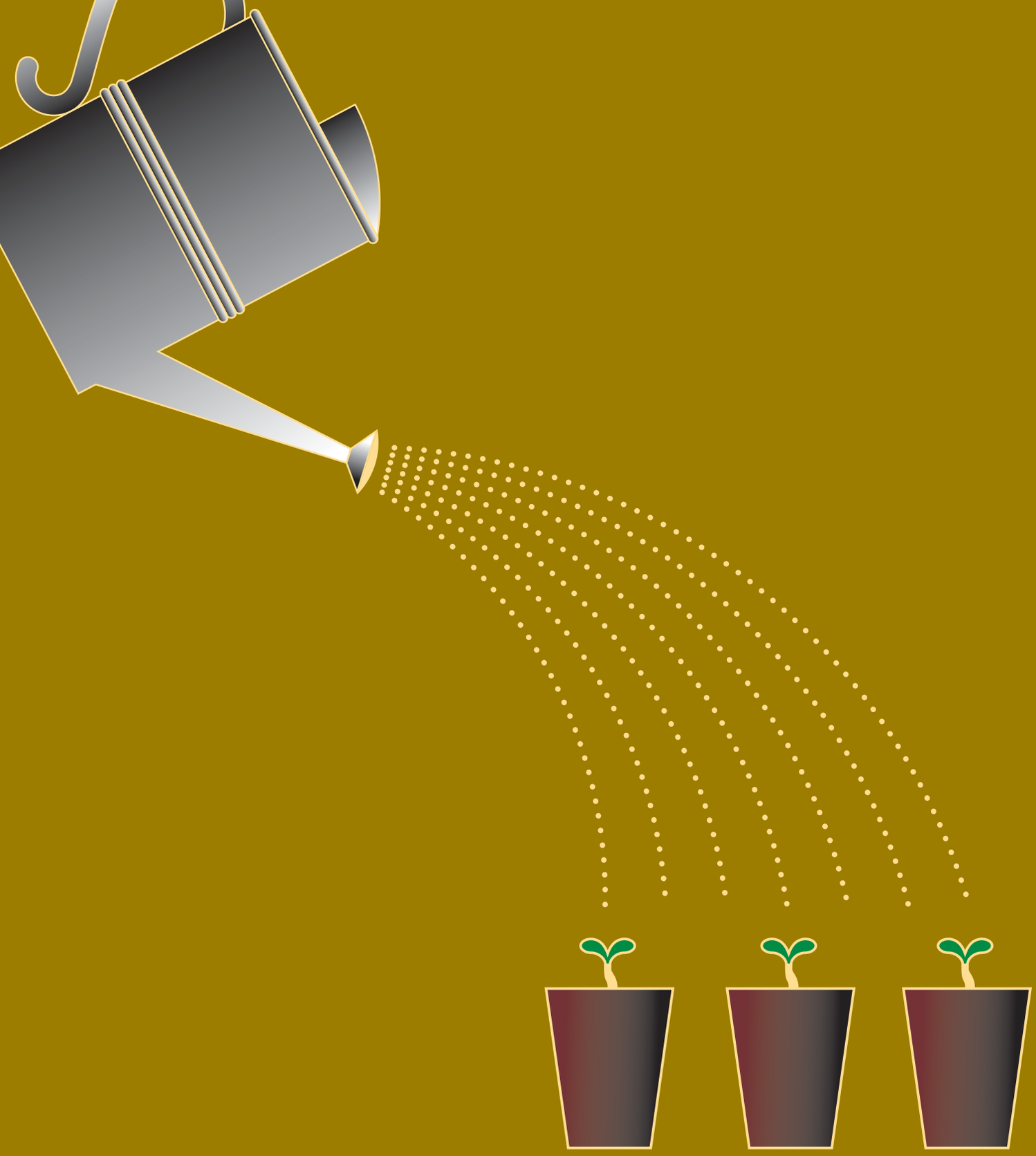
Comparing key elements across the scenarios *(Continued)*

Key issue or theme	Tough choices	Traps and legacies	Times of transition
National leadership and governance	The AIDS epidemic plunges Africa into social, political, and economic austerity. African governments are forced to make tough choices. Approaches and perceptions of crisis are disparate, but innovative and often collaborative approaches are employed. Governments build alliances across society, mobilize private sector support, and coopt civil society and traditional leaders. Resources from within and outside the continent used more efficiently.	The social, political, and economic strains of AIDS begin to fragment society and reverse advances in governance, human rights, and the rule of law. The epidemic undermines democratic institutions, public service parastatals, and security agencies; and disrupts social, political, and economic processes. It triggers unrest and exacerbates existing tensions, as groups compete for increasingly scare resources and power. As the epidemic worsens, regime security begins to supersede human security—even as the legitimacy and relevance of the state erodes. African governments lack concerted or coordinated response. Several states collapse or fragment into ethnic, class, or religious enclaves; conflict is rampant.	Characterized by new leadership, alliances, and global partnerships and rules. Partnerships between governments, civil society, and the private sector help build capacity, not only to combat the virus, but also to ensure the functioning of institutions and delivery of public services, and facilitate sustainable economic growth and development. Good governance, vibrant civil society, and more equitable international systems help Africa rebuild its social, economic, and political structures.
Poverty	More inclusive labour markets and other activities to tackle underdevelopment. Poverty reduction is quite swift in relative terms, with the proportion of people living on less than US$ 1 per day falling from 50% in 2000 to 33% in 2025 in the sub-Saharan Africa region; and the actual number increasing only slightly, from 303 million to 323 million. Also, as more people are put to work (often through government schemes), poverty in monetary terms may not preclude access to services.	Maintenance of existing revenue allocation structures and economic strategies mean that, in sub-Saharan Africa, the proportion of people living on less than US$ 1 per day decreases negligibly from 50% in 2000 to 49% in 2025. As population grows, the actual number of absolute poor increases by 50%, from 303 million in 2000 to 458 million in 2025.	National and international imperative to reduce poverty and improve human development. Governance improvements pay off and sub-Saharan African poverty is reduced, in both relative and actual terms, to 22% of people living on less than US$ 1 per day in 2025, equivalent to 216 million people.
Orphans and vulnerable children (OVCs)	Long-term view of OVC issues dictates rapid implementation of policies designed to improve their life chances in most HPCs. Financial constraints mean institutional approach not an option; emphasis instead on strengthening family and community capabilities, and ensuring all children have access to an education. Task forces develop subnational and community efforts, with the aim of bringing OVCs together in community-led groupings. Faith-based groups and community women's organizations play major role. Large numbers of OVCs absorbed into public works programmes.	Emphasis on issues caused by OVCs rather than on the plight of children. Legislation to protect OVCs in some countries, but not translated into policy or practice. Extended family increasingly unable to cope, receiving no additional support. Orphan-headed households show courage and resilience, but lack of socialization inevitable, perpetuating intergenerational poverty. Many children turn to gangs and rebel armies for survival. Many infected with HIV while young.	Civil society pressurizes state and international bodies. UN Special Session on OVCs provides focus for global process; action plans built into national development plans of most African countries, guided by African Union Commissioner. Desire for AIDS-free generation demands special efforts for the most vulnerable. Governments expected to be accountable, providing leadership and policy. Highly decentralized service delivery leads to appropriate resources for community-level programmes, etc. Widescale roll-out of antiretroviral therapy leads to less morbidity and fewer orphans.

Comparing key elements across the scenarios

Key issue or theme	Tough choices	Traps and legacies	Times of transition
Gender	Gender relations begin to change, under the twin demands of economic development and lowering HIV prevalence. Reform of property rights plays fundamental role. The growing integration of women is pragmatic, rather than ideological, as female education and training opportunities open up. In some countries, limited electoral reform allows women to play a greater role in government. However, in other countries, ideological opposition to women's equality prevents substantial change.	Existing gender relations continue: women continue to bear the burden of coping with the epidemic, both in terms of living with the virus and caring for the infected. Young women continue to have higher rates of HIV infection than their male peers. Élite women continue to do well. Poorer women, on coming of age, find they have fewer opportunities than their mothers and grandmothers. Current negative masculine behaviour is reinforced, as scarcity of money, food, employment, and hope drives aggression and conflict.	Major efforts to educate girls lead to a gradual shift in expectations among educated women, which is increasingly reflected in the socialization of their sons. Rapid modernization and urbanization provides new scripts for male behaviour and attitudes. In rural areas, increasing flows of funding for community development go through women's collectives, as their track record of investment decisions is excellent. Within a generation, many women are more able to change their behaviour rapidly than their male counterparts.
People living with HIV and AIDS (PLWHA)	PLWHA are involved in HIV-prevention programmes, though not without tension. More open approach to HIV reduces stigma in some countries and PLWHA are less afraid of disclosure, though antiretroviral therapy is limited. In other countries, stigma still prevalent. More efforts to ensure roll-out of cotrimoxazole, TB prophylaxis, morphine, and other simple drugs.	Stigma persists: social costs of admitting to being infected continue to outweigh the perceived benefits. Few medical advantages: few PLWHA can access antiretroviral therapy. In policy terms, stigma leads to a failure to involve PLWHA in prevention. Even where PLWHA are consulted, they are excluded from key programme decisions.	PLWHA are catalysts for broader transformation. Integrated approach to HIV and AIDS brings benefits ranging from better psychosocial support to more opportunities for treatment. Growing community cohesion means less stigmatization. Improved service quality includes increased respect for confidentiality.

Source: UNAIDS AIDS in Africa Scenarios Project.



Section 8 Using scenarios

> **Since men have learnt to shoot without missing, the eneke bird has learnt to fly without perching.**
> —Nigerian (Igbo) proverb.

Section 8 Using scenarios

Building the AIDS in Africa scenarios

Over three years ago, *UNAIDS* and *Shell International Limited* made a groundbreaking decision: to work together to develop a scenarios project exploring some of the possible long-term impacts of the AIDS epidemic. Since Africa was so badly affected by the epidemic, it was decided to create scenarios exploring the future of AIDS in Africa, looking forward over 25 years.

A number of other organizations were also invited to join the project, including the *United Nations Development Programme*, the *World Bank*, the *Africa Development Bank*, and the *UN Economic Commission for Africa*.

The project aimed to bring together a wide group of stakeholders from across Africa to create a shared and deeper understanding of the drivers, impacts, and implications of the AIDS epidemic in Africa. It is hoped that this might lead to a more coherent and sustained policy response across different sectors, institutions, and countries.

The AIDS in Africa scenarios project was launched in February 2003. Over the following 18 months, a series of workshops were held across the African continent: participants came together to raise and explore the crucial questions and to build scenarios. Supporting analysis and research continued throughout the project, gathered through interviews, symposia, focused research, and commentary—all helping to shape the scenario stories.

More than 150 people have given their time, experience, knowledge, and expertise to this project. The names of all contributors can be found in **Appendix 3**.

And there is more to come: the creation of the scenario stories is only a beginning. It is hoped that they will set a provocative and productive stage for further thinking—and effective action.

Tools for understanding

Like all tools, scenarios are only valuable when they are used effectively. The success of a scenario project rests not only on building a set of scenarios, but in their widespread communication and use.

It is important that the scenarios are considered as a set, since the learning and insights come as much from comparing and contrasting them, as from exploring the implications of each. As a set, they also highlight key driving forces that, irrespective of which future unfolds, will influence the evolution of the AIDS epidemic.

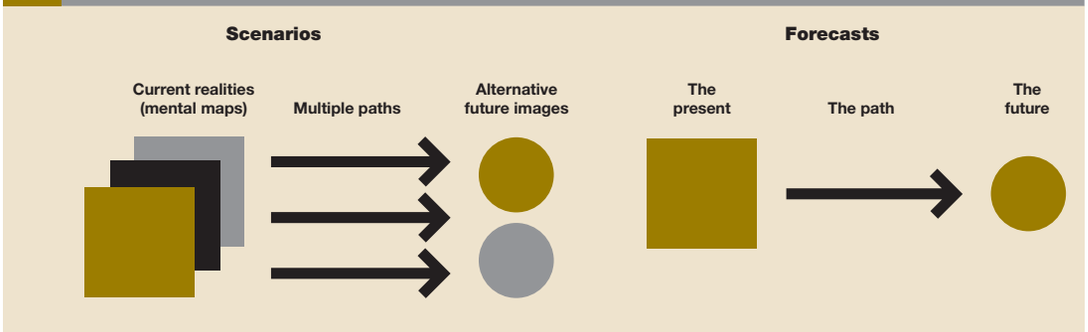
Building scenarios can help us to better frame the questions and challenges we face and promote the generation of ideas across disciplines, rather than simply going over old ground. The building process encourages the involvement of different perspectives and helps ensure that important ideas are not excluded simply because they can't be 'measured'.

Scenarios may be used for a variety of reasons, ranging from individual learning, through awareness raising, to the testing of key collective decisions, strategies, and policies. They can be used to consider potential future developments and their implications and for preparing possible responses.

Scenarios provide their users with a common language and concepts for thinking and talking about current events and 'what really matters'. Building and using scenarios provides a solid, shared basis for making more successful decisions, by, for example:

- Confronting assumptions: our decisions about the future depend on how we think the world works. We (individuals, governments, corporations, institutions, and groups) all face decisions that prove to be turning points in our lives. At times, we regret that we missed something that, if we had only known, might have changed our decision—and our future—for the better. Using scenarios can help us explore the assumptions we currently hold—individually and

Figure 95 **A comparison of scenarios and forecasts**



Source: Shell International Limited.

collectively—about the future and can help us to act more effectively in the present. Scenario thinking can help us to understand our own aspirations more clearly and examine whether these are rooted in a realistic understanding of our current position and capabilities.

- Recognizing uncertainty: scenario planning provides a method for acknowledging, and working with, what we don't know (and even what we don't know we don't know!) Uncertainty makes many people profoundly uncomfortable and many of us prefer to ignore it. However, using scenarios can help us explore and identify the opportunities and the risks contained in uncertainty and help us prepare for when the unexpected or unimaginable happens.
- Widening perspectives: scenarios can help us address 'blind spots'. These may be whole areas that we know nothing about and issues that—individually or collectively—we fail to recognize as important to our aspirations. Scenarios help us expand our vision and combine information from many different perspectives and disciplines. When we plan for the future we need to build a more comprehensive picture of the wider context in which we are acting. We cannot do this alone and our blind spots leave us exposed to unanticipated developments. We need to combine our knowledge and thinking with that of others.
- Addressing dilemmas and conflicts: scenarios can help clarify or even resolve conflicts and dilemmas confronting their users. Action plans and decision processes can get stuck. Sometimes it is because a situation demands a difficult compromise, or because colleagues or wider stakeholders hold different opinions about how the future might unfold, or have conflicting values and disagree about what should be done.

By building sets of scenarios, we assemble different versions of the future simultaneously, working with both analysis and intuition, and not seeking to force consensus. Scenarios enable us to respect and accommodate differences, seeking only to define them more clearly. The origins of conflicts and dilemmas often lie in what we don't know about a situation. Scenarios can help in such situations. They can bring greater clarity to difficult areas of decision-making because they acknowledge and focus on what we don't know, encouraging us to explore the nature of uncertainties. The surfacing of conflicts and dilemmas highlight the judgement required of decision-makers and allows us to take constructive action.

It is important to recognize the difference between scenarios and forecasts.

How to use the *AIDS in Africa* scenarios material

Writing scenarios is only a first step: they can then be explored and applied through interactive processes that encourage users to reflect on their individual and collective assumptions and understandings.

Clarifying assumptions, identifying goals, agreeing success

It is important to recognize that those using the scenarios may be doing so out of choice or perhaps because they are required to do so, and that people's reasons for wanting to engage with the scenarios may vary. In any situation, it is essential that people are able to relate the scenarios to their own views and be clear about what they want to achieve. To that extent, it is useful to allow people time to explore their assumptions and what they think might actually be happening before they listen to a new set of scenarios. This can help them more effectively relate new ideas and information to their own concerns and decisions.

In addition, what constitutes success will vary among the participants according to their purpose. If

possible, these different success factors should be considered and, where relevant, be agreed in advance. These can provide a valuable guide for preparing the engagement session and serve as a basis for evaluating the session afterwards.

These scenarios can be used as a basis for exploring a range of different objectives. Some examples are listed below, and **Appendix 6** provides additional information on making use of the scenarios.

1. Raise understanding of HIV and AIDS and the forces shaping their future in Africa.
2. Raise awareness of (and possibly challenge) the perceptions, beliefs, assumptions, and mental maps held about AIDS and its possible future.
3. Increase mutual understanding between various stakeholders, through the creation of a common language for discussions about HIV and AIDS in Africa.
4. Raise awareness and understanding of the factors, drivers, and fundamental uncertainties (and the systemic relationships between them) that determine the HIV and AIDS future(s).
5. Raise awareness of dilemmas and choices that may need to be made.
6. Identify what gaps need to be addressed, and in what sequence, in order to get an organization or country from where they are now to where they want be.
7. Generate and develop plans, strategies, and policies, and test or challenge the validity and robustness of any vision or strategy.
8. Analyse specific situations for a given country or region for specific risks and opportunities.
9. Provide a backdrop to a specific story that needs to be told, and create passion and support for a specific policy.

It may seem obvious, but it is important to take into account the different languages, as well as the preferred working and learning styles, of the participants before designing or selecting an exercise. For example, the scenario materials can be customized to the needs and interests of the intended audience (although care should be taken to ensure that this does not mean the omission of key information).

Finally, it is important to remember that this process can take time: for some participants, new actions and decisions may be identified by the end of a session, but often people need time to digest the scenarios before they are ready to act on them.

Appendix 6 contains a range of interactive processes, ranging from simple exercises intended to raise awareness of the scenarios (that can be done quickly and with few resources), to more complex workshops for testing organizational policy and decision-making or for developing specific scenarios for individual countries. A companion CD-ROM containing additional resources is available from *UNAIDS*.

204 Appendix 1: Costing and coverage estimations
204 Prevention
205 Care and treatment
205 Orphan care
205 Policy, management, administration, research, evaluation, and monitoring
206 Training and infrastructure
208 Appendix 2: Modelling assumptions
208 Data
208 Handling the data and terminology
210 Appendix 3: List of contributors
212 Appendix 4: Glossary
214 Appendix 5: Bibliography
219 Appendix 6 Exercises to support the scenario process
219 Exercise 1: Short overview presentation of the scenarios
219 Exercise 2: Telling your own stories
219 Exercise 3: Developing country-specific scenarios
220 Exercise 4: Test or challenge a vision or strategy

Section 9 Appendices

Appendix 1: Costing and coverage estimations

This appendix summarizes the procedures used to estimate HIV and AIDS spending under the scenarios that support the project *AIDS in Africa: Three scenarios to 2025*. For more details on each of the 26 interventions analysed, related documents are available[1]. The text summarizes the approaches taken for each of the areas of intervention: prevention; care and treatment; and orphans and vulnerable children support.

Prevention

The resources required for an expanded response were estimated for each intervention as the number of people in need of the service multiplied by the coverage (the percentage of the population receiving the service) multiplied by the unit cost (the cost to provide an individual service).

In the analyses for the project, population numbers and unit costs for each of the sub-regions of Africa were not varied by scenario. Only coverage rates vary between scenarios. Basically, the analyses assumed rapid scale-up to full or nearly full coverage under 'Times of transition'. Scale-up under 'Traps and legacies' is much slower and less complete: per capita coverage rates do not increase, programmes expand only at the rate of population growth. Expansion of coverage under 'Tough choices' is at the mean level of coverage each year that lies between 'Traps and legacies' and 'Times of transition'. The prevention activities in this analysis consist of 18 specific interventions, detailed below.

Population sizes

The population in need is different for each intervention. For some services the population in need is a segment of the general population, such as school children or pregnant women. These populations are calculated from demographic estimates and projections from United Nations Population Division (2003) *World population prospects: The 2002 revision*. These data are supplemented with social and economic indicators, such as the percentage of school age children in school and the percentage of pregnant women accessing antenatal care (World Bank (2004) *World development indicators*).

The sizes of some special populations (sex workers, men who have sex with men, injecting drug users, prisoners, truck drivers, and others) derive from recommendations made by country specialists to a series of UNAIDS regional workshops on costing of HIV and AIDS programmes. The country HIV prevalence, HIV incidence, and AIDS mortality estimates and projections use the end of 2003 latest available data from *UNAIDS/WHO* (UNAIDS, *2004 global report on the AIDS epidemic*).

Coverage

The percentage of the population in need of a service that receives it is estimated separately for each intervention. Information on coverage levels in 2003 is available for most countries from a global survey of coverage of essential interventions reported in *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*, the Futures Group/POLICY Project, June 2004, available at http://www.futuresgroup.com/.

Coverage targets for 2007 for each intervention under the 'Times of transition' scenario are:

- 100% of those needing the service by 2007 in high-prevalence countries for mass-media, education, post exposure prophylaxis, and safe medical injections;
- 75% for harm reduction;
- 70% for prevention of mother-to-child transmission;
- 60% for condom use when at least one partner may have been exposed to HIV; and
- 50% for workplace interventions, voluntary counselling and testing, and out-of-school youth.

In the case of universal precautions in health care settings (i.e., gloves, gowns, etc.) and safe medical injections only, the costs in those countries with an adult HIV prevalence of over 1% are included as an HIV-related cost for the purpose of this analysis. The country-specific costs for safe medical injections are estimated from previously published WHO estimates.

Resources required for orphan support are estimated for orphanage support, community support, and school fees. Targets for 2007 are orphanage support for 5% of orphans, regardless of country HIV prevalence level. Targets for community assistance and school fee support vary by prevalence setting, beginning at 5% of orphans in low prevalence settings and rising to 20% in high prevalence settings.

As described above, coverage for the 'Traps and legacies' scenario is assumed to be at current levels, with provision expanding only at the rate of population growth, and 'Tough choices' is at the annual mean level between 'Times of transition' and 'Traps and legacies'.

The 18 interventions included, and the coverage and other assumptions associated with them, are as follows.

General population interventions

- Mass media[2]
- Voluntary counselling and testing[3].

Vulnerable populations

- Youth in school[4]
- Youth out of school[5]
- Sex workers[6]
- Men who have sex with men
- Injecting drug users
- Informal sector employees
- Special populations such as prisoners, truck drivers, and uniformed services personnel[7]
- People living with HIV[8]

Service delivery

- Condom distribution: public sector[9]
- Condom social marketing
- Blood safety[10]
- STI treatment[11]
- Prevention of mother-to-child transmission[12]
- Post-exposure prophylaxis[13]
- Safe medical injections[14]
- Universal precautions[15].

Unit costs

For most interventions, the unit costs are taken from information provided by country specialists in the series of workshops noted above. These unit costs are used for all years. They could change over time as programmes expand. For example, unit costs might decline as coverage expands, due to economies of scale or new ways of delivering services. However, this seems unlikely for most prevention services. Some services are already provided on a national scale, such as school-based AIDS education, condom provision, mass-media, and blood safety. Some unit costs might rise as populations that are more difficult to reach begin to be covered. Finally, other costs are based on outreach models (such as sex workers programmes) or patient visits (such as STI treatment) where there is little reason to expect unit costs to change with scale. Newer programmes, such as voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT), could become more or less expensive as service providers learn how to best deliver services.

Unit costs for the provision of orphan support are also derived from country-level workshops and general literature, where available. When these specific costs are not available, regional averages are used.

Detailed descriptions of calculations for each intervention are given on the companion CD-ROM, available from *UNAIDS.*

Care and treatment

Under 'Times of transition', a high level of HIV treatment coverage is achieved, reaching 60% of those who need antiretroviral therapy by 2013, and over 70% by 2025. Care and treatment coverage is far lower under 'Traps and legacies'; coverage for these interventions under 'Tough Choices' is intermediate between the other two.

The cost estimation methodology is presented in detail by Bertozzi et al[16].

Resources required for care and treatment are estimated for the following five interventions:

- Palliative care[17]
- Diagnosis of HIV infection (HIV testing)[18]
- Treatment for opportunistic infections[19]
- Prophylaxis for opportunistic infections[20]
- Highly-active antiretroviral therapy (HAART), which includes:
  – Laboratory services for monitoring treatment success/failure[21]
  – Laboratory services for monitoring toxicity
  – Nutritional support for malnourished patients
  – Drug costs[22].

The resources required for each intervention are estimated by multiplying:

(i) The total population in need; by
(ii) The coverage (percentage of the population in need that receives the service); by
(iii) The unit cost of providing the service.

Population in need

The *population in need* is defined as those HIV-positive individuals who show symptoms of AIDS. As there is not an accurate registry of this, the number is estimated based on the assumption that, in the absence of treatment with antiretroviral drugs, an individual transitioning from HIV to AIDS in the developing world has a life expectancy of 2 years. The WHO/UNAIDS country-specific epidemiological models generate estimates of the annual incidence of AIDS (in the absence of antiretroviral drug treatment) and those estimates were used here.

Coverage rates

The initial coverage rates for HAART, prophylaxis for opportunist infections, and testing for HIV were taken from AIDS-related services coverage data published by WHO, when available[23]. For those countries for which all data were not available, the missing values were imputed based on the available country data and the data from the other countries. For the countries for which no coverage data were available, the regional average was used.

For palliative care, the initial coverage is estimated as the median of the coverage of a set of basic health services (antenatal care, attended deliveries, DPT3 immunization coverage, and coverage of directly observed therapy for tuberculosis [DOTS]). For treatment of opportunistic infections, the initial coverage is estimated as a fraction of the palliative care coverage.

For coverage rates in subsequent years under 'Times of transition', the initial coverage rate was increased using a growth rate[24] that is a function of the country's wealth, adjusted by the current burden of HIV (HIV prevalence) and the country's previously demonstrated ability to increase health services coverage (estimated as the difference between the observed immunization coverage and the coverage predicted by the country's wealth). The growth rate adjusts the coverage for each year, adding a percentage (the growth rate) of the uncovered population. Using this methodology, coverage rates per intervention per country per year were estimated. To maintain consistency, a constraint was imposed that the HAART coverage rate ≤ opportunistic infection (OI) prophylaxis coverage rate ≤ OI treatment coverage rate ≤ palliative care coverage rate.

Per capita intervention costs

Per capita intervention costs use unit costs for interventions that have been estimated in the literature, adjusted by recent information on new prices negotiated with providers of drugs and diagnostics, in particular for HAART treatment and laboratory monitoring.

Orphan care

A large number of children have been orphaned in recent years. Many of these children are cared for by family members, but a significant number require some sort of public assistance. Some children may be placed in orphanages while others may be offered assistance in the communities where they live. This analysis considers three types of orphan care: orphanage care, community care, and subsidies for school attendance. The number of orphans is estimated by UNAIDS for each country on the basis of the estimated number and pattern of adult deaths. An orphan is considered to be a child under the age of 18 who has lost one or both parents due to AIDS or other causes.

In countries with high levels of HIV prevalence, children orphaned by AIDS account for a significant proportion of all orphans, while in countries with low levels of HIV prevalence most orphaned children will have been orphaned due to other causes. As with safe injection and universal precautions, the costs of orphan care are included in this analysis only for countries with national adult HIV prevalence of 1% or greater.

Policy, management, administration, research, evaluation, and monitoring

There are many support functions required to implement an expanded response that are not related directly to the number of people receiving specific services. The cost of these support functions is estimated as 5% of total requirements for prevention, care and treatment, and orphan support.

Training and infrastructure

Additional resources may be required for training and infrastructure. For example, training for teachers and system strengthening for condom logistics and PMTCT programmes are explicitly included in the cost of prevention. For other interventions (such as VCT, STI treatment, and outreach programmes for vulnerable populations) the costs of training and facilities may be included in the unit cost. The costs of training for health care workers to provide advanced treatment are not explicitly included, but should be small compared to the overall costs of treatment.

Two types of training and infrastructure costs are not included. One is degree training for health personnel, such as medical school for those training to become physicians and nursing school for those training to become nurses. Such training, if started now, would have little effect on a country's ability to meet the coverage targets by 2010, but would be crucial to achieve longer-term goals. Similarly, these estimates do not include the costs of expanding infrastructure so that a larger percentage of the population has access to schools and health facilities. Such expansion would take too long to have much of an impact in the next four years, but would be crucial to expanding services in the longer term.

[1] For an intermediate-length treatment of the rapid scale-up of interventions through 2007, see the Futures Group and UNAIDS, Methods: Prevention, Care and Treatment, and Orphan Support, available through j.stover@tfgi.com.

[2] The number of national campaigns needed per year multiplied by the cost per campaign.

[3] VCT services (not including diagnostic testing that may occur as part of care and treatment services) assuming annual testing for the highest risk populations (sex workers, MSM, and IDU in countries where HIV prevalence in these groups is 5% or greater); testing every 10, 7, 3, or 2 years depending on the level of HIV prevalence in the country for medium-risk populations (sex workers, MSM and IDU in countries where HIV prevalence in these groups is less than 5% plus all men and women with multiple sex partners) and testing once at age 20 for people in populations at lower risk.

[4] The number of youth in primary and secondary school is estimated as the population aged 6–11 and 12–15 multiplied by the primary and secondary gross enrolment rate (World Bank, *World development indicators*). The number of teachers required is estimated by dividing the number of students by the average number of students per teacher. The number of teachers needing training in a given year is the total number of primary and secondary school teachers multiplied by the coverage and divided by the frequency of training. It is assumed that teachers need to be trained or receive refresher training every three years.

[5] The number of youth out of school is the difference between the total number of youth aged 6–11 and 12–15 minus those in school. These youth need to be reached through peer counselling outreach programs.

[6] For all vulnerable populations including sex workers, men who have sex with men, and injecting drug users, the number of people in the group is multiplied by the coverage to determine the number receiving services and by the unit cost to determine the resources required. For sex workers and men who have sex with men, we also calculate the number of condoms required and the cost of providing those condoms.

[7] Identified by country specialists for each country. No estimates are made for countries not providing data on special populations.

[8] Only for those who are not in treatment, estimated as the number newly identified as HIV-positive through VCT (the number of people tested multiplied by the prevalence rate) multiplied by the average time from VCT until treatment is required (assumed to be three years).

[9] Condoms may be provided through public sector distribution programmes or through condom social marketing. The need for condoms is the total number of high-risk sex acts. High-risk sex acts are defined as those involving sex workers and clients, men who have sex with men, and casual partnerships, plus all marital acts where one or both partners also have outside partners. Data on men and women with multiple partners are from MEASURE Demographic and Health Surveys (http://www.measuredhs.org) and the UNICEF Multiple Indicator Cluster Survey (MICS) (http://www.childinfo.org) surveys. The need for condoms is increased by 10% to account for wastage and spoilage. Female condoms are assumed to account for 10% of condoms distributed through social marketing and 5% of condoms used in commercial sex.

[10] The number of units of blood needing screening is based on per capita transfusion rates from the WHO reference blood safety database.

[11] The need for STI treatment consists of men and women with symptomatic STIs and access to health care services plus the number of syphilis cases among women that are detected through antenatal screening. Access to health care in 2003 is defined as the median of four indicators: the percentage of pregnant women who had some antenatal care, the percentage of births attended by health staff, childhood immunization (the percentage of children under the age of 24 months receiving a full course of immunizations), and the percentage of the population with access to Directly Observed Therapy Short-Course (DOTS) for tuberculosis treatment (WHO). Data are from the World Bank, *World development indicators*, and WHO, *Global tuberculosis control: Surveillance, planning, financing*, *WHO report 2003*. Access increases in the future based on the ability of a country to expand its health system rapidly given political will and the necessary resources. For coverage rates in subsequent years the initial coverage rate is increased using a growth rate that is a function of the country's wealth, adjusted by the current burden of HIV (HIV prevalence) and the country's previously demonstrated ability to increase health services coverage (estimated as the difference between the observed immunization coverage and the coverage predicted by the country's wealth). The growth rate adjusts the coverage for each year adding to the previous coverage a percentage (the growth rate) of the uncovered population (100% = the coverage rate in the previous year). Using this methodology, coverage rates per intervention per country per year are estimated.

[12] Resources needed for PMTCT programmes include the costs of counselling and testing for pregnant women, the costs of strengthening antenatal and delivery services to provide PMTCT, the costs of antiretroviral therapy for those women who are HIV-positive, and the costs of milk formula for those women who choose not to breastfeed. The programme used here is based on current WHO recommendations which include counselling and testing for pregnant women, antiretroviral therapy for HIV-positive women (daily doses of AZT starting at 28 weeks plus a single dose of Nevirapine for the mother at the onset of labour and a single dose for the infant within 48 hours of birth), formula for those who choose not to breastfeed, and family planning counselling to allow couples to achieve their future fertility intentions. Coverage rates are applied only to women attending antenatal services to determine the number of women receiving counselling and testing. The estimated costs of system strengthening are based on the number of HIV-positive women. The acceptance of family planning is based on unmet demand for family planning as measured by various national surveys. Lack of availability is only one reason that couples have an unmet need for family planning. Therefore, it is assumed that 25% of those attending PMTCT services with an unmet need for family planning would accept it if family planning were easily available at PMTCT sites.

[13] Assuming every country would use at least 50 kits in a year plus an additional kit for every million population.

[14] Estimates of the number of unsafe injections and the costs of making all injections safe have been prepared by WHO (Dziekan G, et al (2003) The cost-effectiveness of policies for the safe and appropriate use of injection in health care settings, *Bulletin of the World Health Organization*, 81(4):277–285). Unsafe injections are estimated as total injections multiplied by the regional estimates of the proportion that are unsafe. The total number of injections is estimated from the regional number of injections per capita (including childhood immunizations) and the total population of each country.

[15] Calculated as an annual cost per hospital bed. Data on the number of hospital beds per capita are from the World Bank, *World development indicators*. As with safe injections, the costs of universal precautions are only included for those countries with national adult prevalence of 1% or more.

[16] Bertozzi S, et al (2004) Estimating resource needs for HIV/AIDS health care services in low-income and middle-income countries. *Health Policy* 69(2):189–200.

[17] Palliative care is assumed to occur in the last two years of life. In the event that the patient has access to antiretroviral drugs, palliative treatment is postponed until antiretroviral treatment fails.

[18] Initial and confirmatory testing performed when there is clinical suspicion of HIV infection.

[19] The cost of treating opportunistic infections over the lifetime of an HIV-positive adult. As with palliative care, this is assumed to occur during the last two years of life. HAART is not assumed to change the overall cost of OI treatment, but rather to postpone it for the incremental survival time conferred by antiretroviral therapy. The cost of treatment postponed is discounted with the result that the net present value of OI treatment for a patient newly enrolling in HAART is lower than for a patient who will not receive HAART.

[20] Both the drug costs and the service delivery costs. Half of the population on HAART is assumed to have a sufficiently good immunological response to therapy to be able to discontinue OI prophylaxis.

[21] Assume cost reductions for CD4 and viral load tests to the level negotiated with the diagnostics manufacturers by PAHO for Latin America.

[22] Differential pricing for antiretroviral drugs with the minimum price applying to all low-income countries, and the maximum price in the wealthiest middle-income country, with a linear increase in price for the other middle-income countries in proportion to their GDP per capita. In addition, the minimum price was applied to all middle-income countries with an HIV prevalence in excess of 5% (i.e. South Africa and Botswana). Cost of care for children living with HIV is estimated to be 70% of the country-specific adult cost.

[23] WHO (2002) *Coverage of selected health services for HIV/AIDS prevention and care in less developed countries in 2001*. Geneva.

[24] Even without major changes in infrastructure, access to HIV- and AIDS-related health services can grow within the current constraints. The same installations and personnel used to provide general health care can be used for AIDS-related disease care. To model the increase in coverage within the current constraints, a growth rate was estimated for each country.

Appendix 2: Modelling assumptions

Data

- HIV and AIDS programme data were calculated and supplied by the Futures Group (see **Appendix 1** for assumptions on programme components). It was assumed that:
  – Approximately 80% of the programme costs would be likely to fall under national health budgets, while the remaining 20% would be split between other ministries, with education taking a large share.
  – The proposed HIV and AIDS programme costs would be additional to other national health commitments and financial demands.
- Health spending data drew on the WHO *World health report* (2004 report containing 2001 data: available at http://www.who.int/) providing information for:
  – Total expenditure on health as a percentage of GDP;
  – General government expenditure on health as a percentage of total expenditure on health;
  – Private expenditure on health as a percentage of total expenditure on health;
  – External resources for health as a percentage of total expenditure on health.
- Economic data (GDP) for 2001 was taken from the World Bank *World development indicators* and used to calculate monetary per capita amounts for health sector expenditures (available at http://www.worldbank.orgl).
  – Economic growth—real gross domestic product (GDP) growth—has been calculated and expressed without consideration of inflation, exchange rate fluctuations, etc. The figures express aggregate economic growth, not per capita growth.
- Population growth data was based on the medium variant projection of the UN Population Division (see *World population prospects: the 2002 revision*, available at http://esa.un.org).
  – Population data varies between the scenarios, reflecting the impact of proposed HIV and AIDS programmes and the epidemic's effect on the number of deaths and births.
  – 'Traps and legacies' shows the lowest estimated relative population due to high AIDS death rates and fewer births. 'Times of transition' has the highest population, since more deaths are prevented and more births registered. The population numbers in 'Tough choices' are between those of the other two scenarios—higher death rates than 'Times of transition' are balanced by successful efforts at prevention.
- From existing data, it is not clear how HIV- and AIDS-associated health expenses will be divided between government, external, and private contributors, as well as out-of-pocket contributions, although some regional and country-specific data can be employed for making assumptions.
  – Data from southern Africa[1] (excluding the Republic of South Africa) suggests that 10–15% of total expenditure on HIV and AIDS comes from core government spending, with the rest from official development assistance (ODA) sources. Estimations from work in Senegal[2] suggest that the population's contribution to total health spending is approximately 10%, while data from Rwanda suggests that over 90% of spending on HIV and AIDS is private[3].
  – The working assumption for this model was that, in aggregate terms, 'Tough choices' and 'Times of transition' would both see 10% of HIV and AIDS programme spending coming from private contributors, while in 'Traps and legacies' it would be higher—around 20%.
- In all three scenarios, in aggregate terms, ODA is assumed to cover 80% of HIV and AIDS programme costs in 2003 and gradually fall until 2025.
  – In 'Tough choices' and 'Times of transition', national health budgets grow, sometimes as a result of government budgets increasing, and ODA is gradually reduced. Because the proposed HIV and AIDS programme costs are additional to basic health expenditures, ODA continues to play a significant role in financing the general health sector, as well as HIV- and AIDS-specific programming.
  – In 'Traps and legacies', the sluggish economies fail to grow sufficiently to continue taking over an increasing share of the HIV and AIDS programme costs. ODA and private expenditures continue to be the main source for funding.

Handling the data and terminology

- The simple partial equilibrium model developed for this project is not intended to be exhaustive, and does not reach the complexity and comprehensiveness achieved with a general equilibrium model.
- The numbers described in each scenario are the result of linear extrapolations of trends within that scenario. They are to be taken not as predictions, but as one, plausible, attempt to model and explain the cost of HIV and AIDS programmes in each scenario.
- All resulting US dollar (US$) amounts are expressed in terms of 2002 dollars, but based on 2001 GDP data.

Figure 96 Modelling assumptions and their impact

Variable	Baseline	Assumptions and impact		
		Tough choices: Africa takes a stand	**Traps and legacies: The whirlpool**	**Times of transition: Africa overcomes**
Economic growth	Per capita GDP has declined by around 20% to around US$ 460 per head in SSA[a] since 1990. It is less in W and E Africa and more in Central Africa.	2% mean GDP growth per annum, not taking into account inflation, population growth, etc. GDP grows by 60%. 10% increase in per capita income in NA and SA, stagnation in per capita incomes in WCA, and loss of 10% in EA due to sustained population growth.	1.5% mean GDP growth per annum, not taking into account inflation, population growth, etc. GDP increases by just under 40%. Stagnation in per capita income in NA and SA, nearly 20% per capita income loss in WCA and EA due to strong population growth.	4% real per capita growth per annum, not taking into account inflation, population growth, etc. GDP grows by a factor of 2.5. Per capita income grows by 70% in NA and SA and by about 40% in WCA and EA.
Growth in public expenditure	Currently 30% of GDP in EA, 20% in WCA, 24% in SA and 19% in NA.	0.75% annual increase in share of GDP. (Public expenditure increases through public sector–led growth and some increases in aid.) 2025 levels: EA 36.4% of GDP; WCA 23.9%; SA 28.5%; NA 22.5%.	Stagnation in share of GDP going to budget. (Public expenditure remains a constant proportion of GDP.)	1% annual increase in share of GDP[b] in SA and WCA, 0.5% increase in EA, and 1.5% increase in NA until 2014, then 0.5%. (Public expenditure increases through increased tax base, more aid, and more relaxed fiscal policy.) 2025 levels: EA: 33.9% of GDP, WCA 24.8%; SA 29.5%; NA 22.1%.
Growth in domestically-financed public expenditure on health	Public expenditure on health baseline as a percentage of government budget (aggregates): EA: 6.55% WCA: 9.46% SA: 10.16% NA 8.9%.	Share increases by 1% per annum from 2014 until health budget reaches 13.2% of government budget.	Share increases by 0.5% per year. Share of public expenditure to health increases to following percentage of public expenditure by 2025: EA: 9.9% WCA: 10.6% SA: 11.3% NA: 9.9%.	Share of public expenditure to health increases to 15% of public expenditure by increasing shares as follows: EA: 1% until 2014, then 4% WCA: 1% until 2014, then 3.5% SA: 1% until 2014, then 3% NA: 1% until 2014, then 3%.
Growth in externally financed public expenditure on health	External aid as a proportion of public health expenditure (aggregates): EA: 51% WCA: 46% SA: 44% NA: 12%.	Initial increase then decline for HIV- and AIDS-specific programmes. Gradual build-up post–2015 for interventions additional to HIV, e.g. malaria, childhood diseases, TB, etc.	Erratic. Initial growth and then decline. Increase in run-up to 2015 then decline. Proportions of contributions in terms of percentage of GDP constant but decrease in US$ per capita terms as GDP fails to keep pace with population growth.	Rapid increase to 2015, then levels are maintained.

[a]Note: EA: East Africa; WCA: West and Central Africa; SA: Southern Africa; NA: North Africa; SSA: sub-Saharan Africa.
[b]1% of baseline, not 1% of GDP.

Source: UNAIDS AIDS in Africa Scenarios Project.

Scenario and topic-specific assumptions are indicated in the table above.

[1] Martin HG (2003) *A comparative analysis of the financing of HIV/AIDS programmes in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe*. Research Programme on the Social Aspects of HIV/AIDS and Health. Cape Town, Human Sciences Research Council.

[2] Vinard P, et al (2003) Analysis of HIV/AIDS expenditures in Senegal: from pilot project to national program. In: Agence Nationale de Recherches sur le Sida (2003) *Economics of AIDS and access to HIV/AIDS care in developing countries, issues and challenge*, pp.459–482. Paris, France, ANRS.

[3] Schneider P, et al (2000) *Rwanda national health accounts 1998*. Technical Report No. 53, Partnerships for Health Reform Project. Bethesda, MD, Abt Associates Inc.

Appendix 3: List of contributors

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Appendix 4: Glossary

Acquired immunodeficiency syndrome (AIDS)
AIDS is a fatal disease caused by HIV, the human immunodeficiency virus. HIV destroys the body's ability to fight off infection and disease, which can ultimately lead to death. Currently, medication can slow down replication of the virus, but it does not cure AIDS.

Adherence
The extent to which a patient takes his/her medication according to the prescribed schedule (also referred to as 'compliance').

Antiretroviral therapy (ART)
A treatment that uses antiretroviral drugs to suppress viral replication and improve symptoms. Effective antiretroviral therapy requires the simultaneous use of three or four antiretroviral drugs as specified in the WHO 'Guidelines for a public health approach, scaling up antiretroviral therapy in resource-limited settings' (June 2002). These guidelines (available at http://www.who.int/) are intended to support and facilitate proper management and scale-up of antiretroviral therapy, providing recommended first and second line treatment for adults and for children, reasons for changing ART, monitoring patients, the side-effects of ART, and specific recommendations for certain patient subgroups.

ARV
Antiretroviral (drug).

Epidemic
A disease that spreads rapidly through a demographic segment of the human population, such as everyone in a given geographic area; a military base, or similar population unit; or everyone of a certain age or sex, such as the children or women of a region. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Epidemiology
The branch of medical science that deals with the study of incidence, distribution and control of a disease in a population.

Faith-based organization (FBO)
A term to describe organizations such as churches and other religious organizations.

Gross domestic product (GDP)
The value of all final goods and services produced in a country in one year (see also gross national income). GDP can be measured by adding up all of an economy's incomes—wages, interest, profits, and rents—or expenditures—consumption, investment, government purchases, and net exports (exports minus imports). Both results should be the same because one person's expenditure is always another person's income, so the sum of all incomes must equal the sum of all expenditures.

Gross national income (GNI)
Previously known as 'gross national product', 'gross national income' comprises the total value of goods and services produced within a country (i.e., its 'gross domestic product'), together with the total income received from other countries (notably interest and dividends), less any similar payments made to other countries.

Highly active antiretroviral therapy (HAART)
The name given to treatment regimens recommended by leading HIV experts to aggressively suppress viral replication and progress of HIV disease. More recently, drugs have been developed to prevent the virus from entering the cell. The usual HAART regimen combines three or more different drugs, which may be combined into a single 'fixed-dose combination' (FDC) formula. These treatment regimens have been shown to reduce the amount of virus so that it becomes undetectable in a patient's blood (although they cannot yet completely remove the virus from the body and are thus not a 'cure' for HIV).

HIV incidence
HIV incidence (sometimes referred to as cumulative incidence) is the proportion of people who have become infected with HIV during a specified period of time. UNAIDS normally refers to the number of people (of all ages) or children (0–14) who have become infected during the past year.

HIV-infected
As distinct from HIV-positive (which can sometimes be a false positive test result, especially in infants of up to 18 months of age), the term HIV-infected is usually used to indicate that evidence of HIV has been found via a blood or tissue test.

HIV prevalence
Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15–49.

Human immunodeficiency virus (HIV)
The virus that weakens the immune system, ultimately leading to AIDS. Since HIV means

'human immunodeficiency virus', it is redundant to refer to the *HIV virus.*

Opportunistic infections
Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs.

Orphans
In the context of HIV and AIDS, it is preferable to say 'children orphaned by AIDS' or 'orphans and other children made vulnerable by HIV and AIDS'. In this publication, the term is used to describe a child that has lost either one or both parents.

Official development assistance (ODA)
In the context of this book, the following definition applies:
Grants or loans to countries and territories on Part I of the Development Assistance Committee List of Aid Recipients (developing countries) which are: (a) undertaken by the official sector; (b) with promotion of economic development and welfare as the main objective; (c) at concessional financial terms [if a loan, having a grant element of at least 25%]. In addition to financial flows, technical cooperation is included in aid. Grants, loans, and credits for military purposes are excluded. Transfer payments to private individuals (e.g., pensions, reparations or insurance payouts) are in general not counted.

Pandemic
A disease prevalent throughout an entire country, continent, or the whole world. Preferred usage is to write pandemic when referring to global disease and epidemic at country or regional level. See EPIDEMIC.

Quality-adjusted life year (QALY)
A quality-adjusted life-year (QALY) takes into account both the quantity and the quality of life gained through health care interventions. It is the arithmetic product of life expectancy and a measure of the quality of the remaining life-years. If a person's life is shortened or affected by ill health (such as AIDS) that could be avoided or ameliorated through adequate treatment, the QALY provides a certain measure of the value of the treatment in terms of improved years of life.

Scenarios
A scenario is a story that describes a possible future. It identifies some significant events, the main actors and their motivations, and conveys how the world functions. Scenarios always come in sets of more than one to express the uncertainty of the future. Scenarios are not stories about what should happen, but describe what might happen. They are not predictions, projections, or extrapolations of the present. Good scenarios are plausible, internally consistent, and both relevant and challenging. A set of scenarios is a tool that can be used to improve decision-making by confronting assumptions, recognising uncertainty, widening perspectives, and addressing key dilemmas and conflicts.

Surveillance
The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. The diagnostic study of blood samples for the purpose of surveillance is called serosurveillance.

Vaccine
A substance that contains antigenic components from an infectious organism. By stimulating an immune response—but not the disease—it protects against subsequent infection by that organism. There can be preventive vaccines (e.g. measles or mumps) as well as therapeutic (treatment) vaccines.

Old usages and current preferred usages

Old	Preferred
Developing countries	Low- or middle-income countries
Fight against AIDS	Response to AIDS
High(er) risk groups	Key populations at higher risk
HIV/AIDS	HIV and AIDS
HIV/AIDS	HIV disease or AIDS
HIV/AIDS epidemic	AIDS epidemic
HIV/AIDS prevalence	HIV prevalence
HIV/AIDS prevention	HIV prevention
HIV/AIDS testing	HIV testing
Most vulnerable to infection	Most likely to be exposed to HIV
People living with HIV/AIDS	People living with HIV and AIDS
Prevalence rates	Prevalence
Vulnerable groups	Most likely to be exposed to HIV

Appendix 5: Bibliography

Hundreds of documents were consulted in the course of this project. The full bibliography is available on the project website (http://www.unaids.org/aidsscenarios) and on the companion CD-ROM (available from UNAIDS). Listed here are documents that were particularly useful, together with reference material, and the papers that were specifically commissioned by the project.

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Appendix 6 Exercises to support the scenario process

Exercise 1: Short overview presentation of the scenarios

A short presentation will need to touch upon the scenario method and the five driving forces, along with an introduction to the scenarios themselves and a short summary of each. It can be helpful to break up each scenario presentation with a discussion to help the audience assimilate and orient themselves in each scenario future. After each scenario, ask participants to discuss the scenario by, for example: asking what key words they might use to describe this future; what they like or dislike about this future. Invite the participants to share the outcome of their discussions in plenary before moving to present the next scenario.

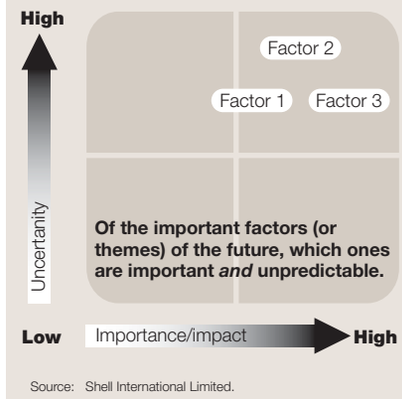
Time needed: At least 20–30 minutes.
Materials: Microsoft PowerPoint presentations on the companion CD-ROM, available from UNAIDS.

Exercise 2: Telling your own stories

Ask participants to write stories about particular characters, or about themselves, as if they were living within different scenarios. This can increase their awareness of the factors, drivers, and fundamental uncertainties (and the systemic relationship between them) that determine the future of HIV and AIDS. Because the exercise demands that people think about living within a scenario, it will deepen their understanding of the threats and opportunities that each future may present. By sharing the stories, this can lead a group to articulate, share, and map their individually-held or group-held expectations about the future of HIV and AIDS, and can increase mutual understanding between various stakeholders.

At the Affirmation Workshop in Johannesburg, the participants created a number of stories, describing people's lives in each of the scenarios. The people they wrote about represented a wide range of different social groups. They described their lives over the course of each scenario, starting from the present. They provided details of important events within their characters' community or country, within Africa or within the world that affected the lives of their characters. Each story ended with a description of what their character was thinking about his or her future. These stories are on the companion CD-ROM, available from *UNAIDS*.

Figure 97 **Exploring what matters most**



Source: Shell International Limited.

Exercise 3: Developing country-specific scenarios

The process that was used to create the *AIDS in Africa* scenarios can also be employed to build scenarios for a particular country. Country-specific scenarios can help in the development and testing of national policies and plans. The scenario-building process was as follows.

- **Step 1: Explore different perspectives to determine what really matters**

The aim of this first step is to explore the range of issues relevant to the future of HIV and AIDS in a country, using open-ended interviews, meetings, and a workshop process with key decision-makers and opinion-formers. It is also important at this stage to identify what time horizon this project needs, that is, will the new scenarios look out across 10 or 20 years?

Using the five key drivers of change identified by the initial project can help the participants identify the critical issues relevant to the future of HIV and AIDS in a particular country. The range of relevant issues is likely to include many different areas. It is important to consider influences that are both domestic and foreign or international in origin.

Develop a synthesis of the issues that surface in the preliminary interviews and meetings. This will provide the process with a solid foundation for future research, establishing what really matters. In addition, a start can be made on thinking about how each issue might play out. The interviews can also prove invaluable for helping to identify workshop participants and key expert perspectives.

- **Step 2: Identify important and uncertain factors**

Bearing in mind the range of key relevant issues that have been identified, this step focuses on identifying the key factors that will shape each of these issues. Clustering these key factors can help to reveal the forces driving change. Are any key issues or perspectives still missing? (**Figure 97**).

- **Step 3: Identify predetermined and critical, but uncertain, driving forces**

Explore two key questions:

- Which key forces are 'predetermined'—that is, are relatively immutable and carry a clear impact?
- Which key forces will both carry most impact and are most uncertain?

A matrix can be used to classify and prioritize the key driving forces in terms of their impact and uncertainty.

- **Step 4: Characterization of driving forces**

This step explores how the driving forces might play out. For each driving force, it is important to identify both the current situation and how it might change in the future. What are the different alternatives that can be envisaged and what is the range of possibilities? By the end of this step the scenario builders should have reached agreement on the set of key outcomes (both predetermined and uncertain) that need to be reflected in the final set of scenarios.

- **Step 5: Develop sketch scenarios**

Create two or three sketch scenario stories, setting out how the driving forces could play out, as well as how they could interact. Describe the logic of each scenario—this will provide an outline of the events that make up that story; the driving forces that are crucial to making those events happen; and the roles of particular players. Establish the branching points that differentiate the scenarios—what are the crucial differences between the scenarios that cause them to develop differently? The participants should find memorable names for the scenarios that resonate with meaning for them and encapsulate the essence of the stories. This step can be carried out by getting different groups to develop sketch scenarios in parallel, before presenting and combining their outputs.

- **Step 6: Agree scenarios**

Develop a common set of scenario stories by sharing, comparing, and contrasting the scenarios developed by different groups. Compare the final stories to the issues raised at the beginning of this process—are they relevant? In addition, the stories should be plausible and internally consistent. If necessary, further discussion and analysis can be used to improve the plausibility, challenge, and relevance of the individual scenarios and the scenarios as a set.

- **Step 7: Explore implications**

Once the stories are agreed, they can be explored: users can reflect on the opportunities, constraints, and threats that each scenario presents.

Exercise 4: Test or challenge a vision or strategy

- **Step 1: Present the existing strategy**

Present and discuss the strategy in question: this will ensure that everyone is familiar with its details. It is critical to explore the assumptions that underpin this strategy.

- **Step 2: Present the *AIDS in Africa* scenarios**

Using the five key forces driving change that were identified during the *AIDS in Africa* project, explore the strategy in question and how it might play out.

Present the scenarios: discussions should follow the presentation of each scenario. Workshop participants may want to consider how the threats and opportunities presented in each scenario would affect their existing strategy. After each discussion, try to reach agreement on the set of key issues for that scenario.

- **Step 3: Agree a list of issues across the three scenarios**

Reflect on the issues that have emerged in discussion and consider if any additions or changes need to be made. Sort the list of issues into those that are common to all scenarios and those that are specific to a particular scenario or pair of scenarios.

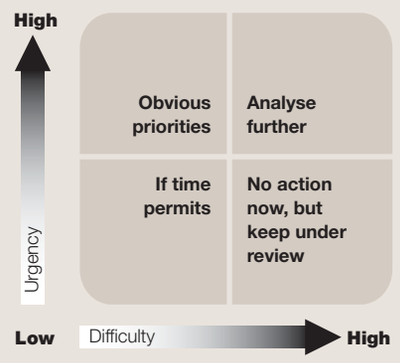
The threats and opportunities that are common across all the scenarios are likely to represent issues that must be addressed whichever future unfolds. The issues that are specific to one scenario or a pair of scenarios represent strategic options—choices that may need to be made, depending on the risks they represent.

- **Step 4: Prioritize strategic issues and decide what to do**

Prioritize the issues based on how difficult they will be to tackle and how urgently they need to be addressed (**Figure 98**). Those issues that are both most urgent and most difficult to deal with will require further analysis. If they are common to all three scenarios, then they represent fundamental challenges to the existing strategy. If they are specific to one scenario then they represent a strategic option (as before).

In the case of issues specific to one scenario that are both very urgent and very difficult, the participants will need to explore possible responses, and then rank them according to preference and what can be done. Identifying barriers that might block progress in acting on each response will help to establish the role that other stakeholders might play.

Figure 98 **Identifying options**



Source: Shell International Limited.

AIDS in Africa: Three scenarios to 2025

Joint United Nations Programme on HIV/AIDS

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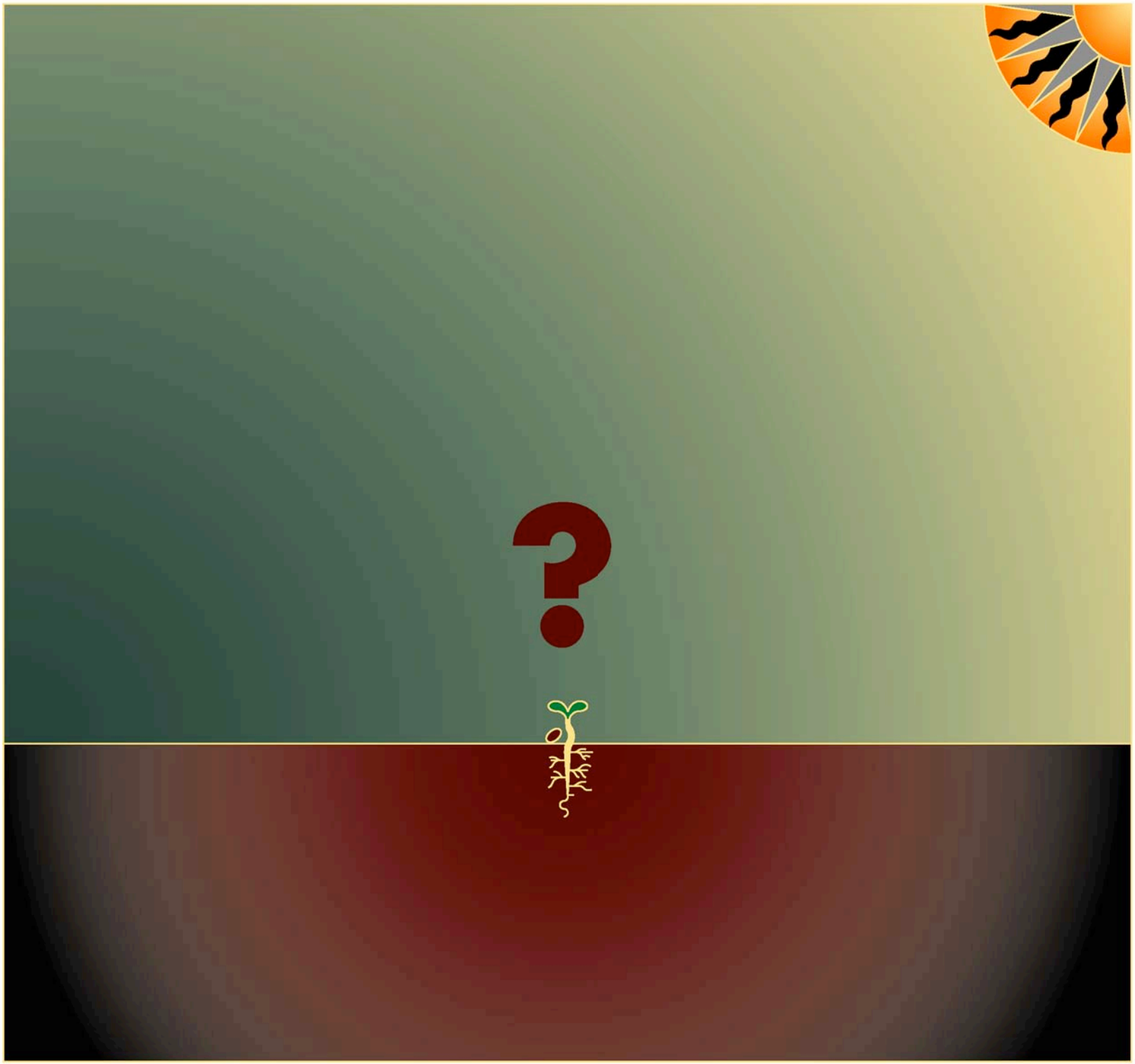
The decisions we make about the future are guided by our view of how the world works and what we think is possible. Scenarios are stories about the future; but their purpose is to help make better decisions about the present. People can use them to challenge their assumptions and implicit beliefs, and look beyond their usual worldview.

This book and the accompanying CD-ROM are intended to deepen people's understanding of the possible course of the AIDS epidemic in Africa over the next 20 years, its context and impacts, and how particular policies may shape Africa's future.

"No progress can be made by any nation unless serious attention is given to the control of malaria, TB and HIV/AIDS.
—President Obasanjo of Nigeria, May 2004.