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A political economy perspective on prevention of HIV infection

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When the human immunodeficiency virus (HIV) was first discovered over 20 years ago, there began a huge effort to educate people about the risks associated with HIV infection, and promote abstinence, condoms and clean needles as ways to curb the growing rate of infection. Despite the massive effort and expenditure put into prevention of HIV infection, the global infection rate has increased, not decreased. Researchers and the medical community have had to take a closer look at the problem to realise that prevention of HIV infection is more complex than just giving people education about the disease or providing resources in the form of condoms or clear needles. Cultural, racial, economic and gender barriers put people at risk for HIV infection. As such, HIV programmes turned their focus to 'empowering' disadvantaged groups (e.g. women, drug users, the destitute poor)—people who may be taking risks because of oppressive conditions regardless of what they know about how the virus is transmitted. Empowerment programmes, for example, have attempted to address issues related to HIV infection by investigating cultural taboos regarding sex or those related to the standard of living of marginalised populations. Even with programmes that acknowledge and address the complex and social nature of HIV transmission, the epidemic continues to rise. This article explores ideas about the broad social, political and economic factors that affect HIV prevention and highlights some ideas about alternative ways to understand the root cause of the spread of HIV infection.

Linking illness with social conditions of oppression

Education regarding prevention of HIV infection has developed from what modern medicine has told us about the characteristics of the virus. Yet there is an important contradiction in modern medicine. Its underlying philosophies and research are supported by the advancement of industrial society despite the fact that industrialisation is an exploitative practice that creates conditions of poverty and marginalisation. It is an approach that strives to prevent, treat and cure illness without accounting for the broader social, political and economic forces that create vulnerability to disease. This was clearly shown by Engels in his study, *The Conditions of the Working Class in England.* There existed an exceptionally high incidence of disease, including typhus and tuberculosis, in the working class population of Manchester. Engels uncovered that the poor health of this population was directly linked to their position in the emerging industrial society. While medical research attempted to find cures by focusing on the biology of disease, Engels noted that overcrowding, poor ventilation, stagnant sewers and polluted water were the root causes of the problem and the real cure was to improve the standard of living among this population (1). Similarly, in the case of HIV infection, a medical perspective assumes that the virus is the agent of disease, lack of hygiene is the basis of the problem and behaviour modification is the way to reduce the rates of infection. However, addressing the issue at the level of biology does not challenge the imbalance of power embedded in political and economic systems that put people at risk in the first place. People who participate in high-risk activity often do so under adverse conditions. As such, HIV infection-prevention practitioners need to incorporate a perspective that broadens the focus from individual risk-taking behaviour to studying the social forces that put people at risk. This would assume perhaps that while the virus is the agent of the disease, poverty and exploitation is the basis of the problem and resistance to this exploitation is the way to reduce infection.

HIV, industrialisation and development

One approach to understanding the challenges of prevention is to understand its relationship with the forces of industrialisation and development. Until the mid 1990s, HIV infection was treated as a health issue addressed by AIDS organisations and public health departments at the local, national and international levels. However, by the mid 1990s, concern was raised that AIDS was not being adequately addressed through health programming and was put on the international development agenda. As such, the World Health Organization's Global Programme on AIDS was shut down and replaced by UNAIDS. The logic behind the marriage of AIDS and 'development' was made clear: because the epidemic is affecting large populations of young employable men and women in parts of the developing world, the future survival of nations and their economies are at stake.

It is commonly believed that industrialisation and development help to stimulate economic growth, create jobs, raise the standard of living, and improve the quality of life of people living in so-called 'developing' countries. Thus, proponents of development, such as the World Bank, suggest that economic stimulation is the way to eradicate the HIV epidemic. I suggest that the opposite is true—that international forces pushing for development and industrialisation of the non-industrial world have exacerbated the spread of HIV and promoted the development of an HIV-prevention industry. Lurie *et al.* (2) examined the impact of the International Monetary Fund and World Bank structural adjustment policy on risk factors for HIV transmission in developing countries. They found that structural adjustment programmes required developing countries to reduce government spending on health and social services, increase personal income tax, devalue currency, provide concessions to foreign investors and increase the price of goods and services. Following these shifts they noted declining sustainability of rural subsistence economies as economic activity shifted to the export sector, increasing levels of poverty and landlessness, development of a transportation infrastructure to serve export economies and increasing urbanisation. These factors have contributed to the disruption of family life as rural dwellers have left rural areas for the city in search of employment. The risk of contracting HIV infection has increased substantially along transportation routes and drug trade has emerged in many urban centres.

A good example of how industrialisation affects the spread of HIV infection is the World Bank's Chad–Cameroon Oil Pipeline Project. Beginning in 1998, this 30-year, US$ 3.5 billion project involves developing oilfields in southern Chad and the construction of a 1,100 km pipeline to port facilities on the Atlantic coast of Cameroon. During peak construction, the project will draw over 2,500 construction workers and truckers to areas where poverty, prostitution and HIV infection are high (3). While the Bank claims that the project will provide substantial economic benefits to both the countries, critics are concerned that the migratory labour force will exacerbate the spread of HIV/AIDS in the project area.

Given the complexity of the HIV epidemic, powerful institutions that promote industrialisation are taking a more aggressive approach to solving the problem. For example, the president of the World Bank, James Wolfsensohn, recently made an historic appearance before the United Nations Security Council calling for a 'war on AIDS'. He urged the Council to allocate more money to AIDS efforts because the epidemic is turning back the clock on development by increasing cross-border conflict, destabilising economies and undermining large portions of the labour force. Funds taken from the Council would be used to develop an 'AIDS technology and surveillance infrastructure.' The World Bank's approach to prevention relies heavily on technological advance. Yet Clark and Boyles (4) note that World Bank HIV prevention programmes are failing to curb the high rate of infection in India and that funds 'are spent on activities like information and communication and importing expensive blood banking equipment, most of which is lying unused for lack of basic infrastructure like a steady power supply'. This approach taken to solve the problem of the epidemic is far from realistic. However, it allows the technical industries to profit by developing technologies that promise to solve the problem. Waring (5) points out that the 1989 Exxon Valdez oil spill, in which 11 million gallons of heavy crude oil spilled in waters near Alaska, stimulated the economy through the creation of thousands of jobs to clean up the mess. Similarly, the clean-up of the AIDS crisis will require more jobs and more loans. If the World Bank is generating income from the interest of HIV infection-prevention loans, and if profit is being made off technological advance in the name of HIV prevention, then money is being made off the backs of those suffering the effects of the epidemic. How can we be assured that global development efforts in prevention will be effective if HIV is of value in the global economy?

In examining the medical basis of prevention of HIV infection as well as the industrial response to the epidemic, it is clear that the layers of inequity and of inequitable power relations create vulnerability and that industrialisation impedes real measures to reduce the rates of HIV transmission. HIV infection-prevention efforts must incorporate an awareness of the effects of industrialisation and development and must be aligned with anti-development movements that are restoring dignity, human rights and power to marginalised people. It is through resistance to globalisation and development that communities can reduce their vulnerability and develop immunity to disease. From this perspective, we can begin to understand what is really needed to end the AIDS epidemic.

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