# Social inequality and AIDS: the neo-liberal context of the epidemic

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The most recent numbers from the World Health Organization and the United Nations show the magnitude of the tragedy: approximately 40 million people are currently living with the Human Immunodeficiency Virus (HIV) or are suffering from diseases associated with the syndrome. Just in 2003 alone, 5 million people increased the list of those who have tested positive for the Human Immunodeficiency Virus (HIV) test and close to three million die as a result of complications related with AIDS (WHO; UNAIDS, 2003a). Facing the severity of this situation, the WHO and UNAIDS have launched a plan to give antiretroviral treatment to 3 million patients living with AIDS within two years, or about half of those patients who are in need of that kind of treatment. The WHO's strategy is made up of other plans recently proposed by the World Bank and the Washington government (WHO; UNAIDS, 2003b).

At first, the global strategy looks like a humanitarian gesture and decisive intervention by international health organisms and the White House. Their efforts are aimed at controlling the epidemic and also as an incentive to allows for the joint efforts of organizations such as *Doctors Without Borders* and research groups, health workers and activists, that justly claim that besides insisting on prevention, the need for treatment of millions of patients with diseases associated with AIDS must be urgently met (Mukherjee et al, 2003). However, for complete understanding of the true dimension of the pandemic and the real reach that plans by the WHO, the World Bank and the Bush administration may have, it is imperative to consider the world socio-economic context in which the AIDS epidemic has gestated during the last two decades and to place within this context a debate based on new antiretroviral therapies, one aspect of which is the fact that until now, the interests of multinational pharmaceuticals has prevailed over the interest of the patients who should benefit from their medication.

It is the purpose of this article to show that the implementation of neo-liberal economic policies has created the conditions so that the number of infections has not been able to be stopped or reduced despite the work of thousands of scientists, the investment of thousands and thousands of dollars and decades of efforts by an endless number of organizations working on prevention programs.

Within this context, we also examine the philosophy that is guided by the strategy to control the AIDS pandemic, launched by the World Health Organization, the World Bank and the Washington government, and effects that this strategy can have on transnational corporations that manufacture and market the medication.

## The Social Epidemiological Point of View

Initially defined as: "the study of the role of social factors in the etiology of a disease" (Krieger, 2001a), Social Epidemiology has its roots in a study by Frederick Engels in the 19th century concerning living conditions for the English worker (Singer, 1998; Krieger, 2001b). This area of research in public health currently includes different theories that enable us to take on the problem of understanding and managing diseases, particularly pandemics such as AIDS. Within this focus, prevention, treatment and care of an illness cannot be reduced to strictly biomedical or behavioral factors, without considering the way historical, political and economic tendencies influence the distribution of the illness in different populations and the way social acts and factors end up affecting bodies and generate pathologies (Farmer, 1996).

For the case at hand, as Nancy Krieger explained (2003) "of specific concern are neo-liberal economic policies such as the North American Free Trade Agreement – NAFTA – which have resulted in strict economic plans, environmental degradation and an increase in relative social inequalities for health at an intra- and inter-regional level". Also important for epidemiology and social medicine is research about the effects they have on the most vulnerable population of a specific society, organization and coverage of health services and medication manufacturing and marketing systems.

While all the studies agree that the pandemic is concentrated in the poorest countries and in the areas with the highest poverty levels in rich countries, to the degree that you can replace world poverty maps with those of the HIV/AIDS incidences. There are very few researches projects that analyze the tight relation between causes of the socio-economic reality of the nations affected and the as-yet uncontrollable advances of the epidemic during the last two decades. With very few counted exceptions, they are limited in describing the situation without clearly stating the fundamental responsibility that belongs to the economic globalization model that has been imposed on nations during these times of AIDS.

British Epidemiologist, Thomas Mckeown (1914-1988), showed that advances in controlling the diseases of a population couldn't be contributed solely to vaccines, antibiotics and better medical treatments, since general socio-economic conditions and their effect on nutrition become a major health factor. For example, death rates due to tuberculosis were decreasing in Great Britain 100 years before the introduction of the vaccine (Mckeown, 1979).

Currently, without denying the vital importance of progress in biomedicine, epidemiological studies confirm that the health expectations of a population are directly associated with quality of life. At the same time, this one is determined by environmental health, nutritional conditions, water quality, housing, education, working conditions and emotional and psychological factors that benefit human development throughout the entire life cycle. To summarize, the health of the population relies on the economic and social progress of a nation.

A country's health or geographic area not only depends on the entry of new citizens, (although it as been demonstrated that the lower the number of incoming people there is a larger the index of illnesses and lower life expectancy), but also on the degree of equality present in a specific society. Today it has been proven that better health expectations are greater in countries that show relative lower inequality in income and lower social inequality in its population. This is why there are differences in life expectancies and other health indicators within industrialized countries. For example, Sweden, Switzerland and other developed countries show better health indices and greater life expectancies for its habitants than the United States, a country that has the most powerful economy on the planet. However, the US also shows tremendous social inequalities (Hertzman, 2001) and in which currently 46 million citizens are unprotected because they can't pay their health insurance premiums.

In as much as it becomes impossible to isolate health problems from social inequalities, an ideological dilemma becomes evident: Are the ill guilty of their illnesses or are they a product of social inequality? Regarding this, Daphne Roe (1973) in her research about the social history of pellagra, a nutritional illness that mainly hits farmers that can barely survive only by eating corn, found that in face of the epidemic only two positions are possible:

> *"I came to the conclusion that there are two kinds of observers: those who believe that pellagra is a disease caused by society and the result of the human practice of condemning poor people to a diet that can't keep a dog healthy; and those who think that those who have the disease are guilty of it."*

The social history of AIDS has, for the most part, blamed the victims. In the beginning, AIDS was even defined as the 4H disease: Homosexuals, Haitians, Hemophiliacs, and Heroin Addicts (Grmek, 1990). From the ideological point of view, blaming the victims performs the role of hiding the socio-economic context in the generation and propagation of diseases and places prevention and treatment responsibility solely on the individual, in order to evade governmental obligation in the health care of its citizens. In real life, homophobia and other forms of discrimination are factors that, when intertwined with poverty, favor the advancement of the epidemic and negatively affect the most vulnerable areas of the population (Diaz et al, 2001). "Poverty also causes alienation conditions that make the intravenous drug use culture possible" (Weinberg et al, 2001. p275). In

the concrete case of Haiti, Paul Farmer (1992) was able to establish that contrary to the widely reported stigma that accused Haitians of bringing the AIDS epidemic into the United States, it was actually sexual tourism by Americans to that country that was responsible, combined with unsanitary conditions of poverty-stricken Haitians, that caused AIDS to became an epidemic in this nation.

Consistent with the idea that transmission of the AIDS virus is basically the problem of the individual, during the first 20 years of the pandemic prevention efforts were centered around trying to modify individual risk behavior and attitudes. This unilateral focus on the problem, which doesn't take into account the socioeconomic determiners of AIDS, failed as long as those most vulnerable kept practicing risky sexual behavior and using and injecting drugs; but it prevailed as far as preventing an in-depth debate on the responsibility of the neo-liberal economic model that has been globally implemented during this historic time and whose social consequences are set in the context that has facilitated the advancement of the epidemic.

## Neo-liberalism and AIDS

Neo-liberalism is nothing more than a set of theories and economic policies developed by the contemporary monopolistic capital with the purpose of consolidating its global expansion to take complete control of the world's markets that it needs to survive. After the fall of the Soviet empire and as a result of the American strategy to strengthen and expand its economic, political and military power, the contradictions of the United States with other economic powers and the rest of the nations have become more serious. A new world order has emerged, characterized by the jurisdiction in which the United States can be called the First World, a Second World made up of Europe and other highly industrialized countries including China, Japan and Russia, and a pauperized Third World of Africa, Asia and Latin America.

The distribution of the infection by HIV/AIDS completely agrees with the current socioeconomic world order, confirming the thesis by Paul Farmer which states that the health of the poor is primarily affected by infections and violence, while the rich suffer from chronic illnesses associated with growing old. It is not strange, then, that in the region of sub-Saharan Africa, where the situation is dramatically bleak, (a product of the neo-liberal measures imposed by the International Monetary Fund and the World Bank through its *Structural Adjustments Programs*), that you find 21 nations with the highest incidents of AIDS in the world.

On the African continent, hunger and AIDS go hand in hand. Steven Lewis, a United Nations envoy explains it this way: "Now everyone understands that when the body doesn't have food to eat, the virus eats the body… And of course what is happening is that with weak immune systems because of lack of food, the

progress of the disease is much faster and people are dying in less time." (NPR, 2003).

The main cause of hunger with its inevitable under-nourishment and death consequence is not draughts and other natural disasters that frequently hit Africa, but the elimination of agricultural subsidies, the privatization of public utilities and the complete opening of the economy that has become an integral part of the Structural Adjustments Programs required of the African nations by international agencies since 1986. We will use Zimbabwe's case here as an illustration:

According to the study done by the Center for Political and Economic Research in Washington, the average real economic growth of Zimbabwe during the 1980s was 4 percent annually, nourishment security reached a certain level of development and the manufacturing sector became stronger, which contributed to the diversification of exports. At the same time, health services grew and life expectancy rose from 56 to 65 years, while child mortality decreased from 100 to 50 for every 1,000 births. In 1991, Zimbabwe received a loan of $484 million dollars from the IMF conditional to a *Structural Adjustment* of its economy including: reduction of public expending, deregulation of the financial market, the elimination of manufacturing protections, a labor reform to free the job market, lower the minimum salary and eliminate job stability as a guarantee to lower the fiscal deficit. A year later, Zimbabwe's economy went into recession when private per capita spending dropped 37 percent, salaries fell 25 percent, and unemployment rose while food prices rocketed between 1991 and 1996 (Naiman & Watkins, 1999).

The recipe of the Monetary Fund that required the Zimbabwe government to reduce spending by 46 percent and to reduce health care worker's salaries specifically, had disastrous effects on public health. A large majority of the population was left without access to neither health nor medication, and under-nourishment and incidences of diseases such as tuberculosis dramatically increased. It was during these years that the same World Bank calculated that the cost of treatment of new AIDS cases could be the equivalent to four times the total health budget. Currently, life expectancy has been reduced to 38 years of age. It is not strange then that 2,500 people died of AIDS weekly and that during the first quarter of 2004 between 5 and 8 million people (around 70 percent of the population) need international help getting food to survive. Even so, the International Monetary Fund has begun steps to expel Zimbabwe from its organization for not consistently accepting all the economic reforms that have been "recommended" by the IMF.

The situation is similar in other African nations: For example Zambia, a country where AIDS had left 600,000 orphaned children by the year 2001, freed its economy, including its agriculture, in 1991 under the conditions imposed by the World Bank. Today it lives in its fourth consecutive year of hunger crisis with more than 3 million habitants without a thing to eat, while the government tries to

go back to subsidies and loans for the small agricultural manufacturer to guarantee food and stop food imports. Exactly the same thing happened in Malawi and Mozambique, countries that also suffer from chronic nourishment insecurity.

In 1991, the government of Malawi had grain deposits even at the most remote locations in the country and could sell cheap food, therefore saving a great part of the population from hunger. The Monetary Fund "recommended" the sale of "part" of these food reserves to guarantee payment of the debt and at the same time benefit private businesses; Ten years later, food costs 10 times more and with the elimination of agricultural subsidies, corn costs rose 400 percent between October 2001 and March 2002. Farmers started to eat corn while it was not ripe, once again falling back on the diet responsible for pellagra. In a short time, generalized hunger quickly set in: 7 out of 10 million habitants in Malawi suffered from the disease in the year 2002. It is calculated that between 2002 and 2005, 125,000 children under the age of 5 would die of AIDS in Malawi. The requirement imposed by the Monetary Fund and the World Bank to completely abandon the agricultural sector in Zimbabwe, Malawi and Mozambique, was catastrophic.

The situation is similar in the rest of the world. In the United States, where neo-liberal measures also widen social inequalities each day, new HIV infections are concentrated among African-Americans and Latinos, groups whose population is disproportionately represented in poverty indices as well as in HIV/AIDS statistics. In the current neo-liberalized Russia, around 3 million intravenous drug users (one of the important risk factors for AIDS) are estimated to be infected with HIV, and 1.5 million people are confirmed to be infected with the HIV virus.

In China, although national prevalence is very low, a group of serious epidemics are forming in clusters in the poorest regions, the same area where the Severe Acute Respiratory Syndrome, SARS, originated in 2002 (Berger et al, 2004). In Latin America and the Caribbean, "lack of social and economic equality constitutes its own context for the AIDS epidemic to reach disastrous proportions in the next decades," this according Ricardo Garcia, UN advisor for Colombia (eltiempo.com/salud. November 25, 2003). In the region, the most serious situation is found in economically depressed countries: Haiti and the Dominican Republic, and in countries such as Colombia, it is forecasted that by the year 2010, 1.6 percent of the population will be infected with the HIV virus.

## Bush, the World Bank and the fight against AIDS

In the last few years, it became impossible to cover the sun with one hand since the correlation between poverty and AIDS became irrefutable (95 percent of the cases are shown in the pauperized Third World). , The American government and the World Bank, the two entities mainly responsible for neo-liberal reforms that have destroyed national economies and caused hunger in vast areas of the

world to the point that one billion of the planet's inhabitants live on less than a dollar a day, have launched a large world campaign to fight the pandemic.

During his State of the Union Address in 2003, President Bush announced a $15 billion program to fight AIDS with the objective of: "supplying antiretroviral drugs to 2 million people infected with HIV in 12 African countries and two Caribbean countries: Haiti and Guyana." The World Bank began to finance projects and develop a policy regarding the epidemic in 1986; in the year 2000, the organization joined the IMF, in deciding to integrate its plans to fight AIDS to its "aid for development" programs based on the argument that AIDS increases in poor countries while reducing productivity and the work force causes delays in the economic growth of affected countries. At that time, the Bank demonstrated its point of view with Zimbabwe's case, a country whose one point loss in economic growth was attributed to 25 percent of adults afflicted with HIV.

Finally, in December 2003, the World Health Organization raised the urgency of coordinating these projects with the *United Nations Global Fund to fight AIDS, Tuberculosis and Malaria,* established in 2001 and launched the *"Three million by 2005"* initiative. As its name indicates, the WHO's campaign offers treatment with antiretroviral medication to 3 million AIDS patients in the next two years. It is therefore convenient to analyze the origin, philosophy and economic and political content of these crusades against AIDS to be able to evaluate whether they truly aided the people and regions hit by the epidemic.

## The world backwards: AIDS is the cause of poverty

Mamphela Ramphele (2003), Managing Director for the World Bank categorically expressed on July 1, 2003 at the Lesotho capital: "Our dream is a world free of poverty." But we now know that until the world is free of AIDS, that mission will remain only a "dream." Making a parody of the speech by Doctor Ramphele: "HIV/AIDS: Converting Adversity Into Opportunity," you could say that agencies of the International Capital have found in the AIDS adversity the opportunity to blame the epidemic for the poverty its policies have caused. And worse yet: they condemn poor nations to postpone any hope of economic recovery until AIDS disappears from the planet.

The phrase by the Managing Director is not an isolated comment. On the contrary, it is an insisting idea in the World Bank's documents: "It is still not clear if poverty increases the possibilities of HIV infection. However, there is strong evidence that HIV/AIDS causes and worsens poverty". (World Bank, 2003). AIDS as the cause of poverty is also the position of the government in Washington. US Health and Human Service Secretary, Tommy Thompson recently stated: "Unfortunately, poverty is a common AIDS symptom" (HRSA 2003).

It is not strange then that the introduction to the document in which the World Health Organization announces its strategy to "Treat 3 million people by 2005" establishes in the first paragraph (WHO, 2003b):

*"HIV/AIDS is destroying families and communities and sapping the economic vitality of countries. The loss of teachers to AIDS contributes to illiteracy and lack of skills. The decimation of civil servants weakens core government functions, threatening security.*

*The burden of HIV/AIDS, including the death toll among health workers, is pushing health systems to the brink of collapse. In the most severely affect-ed regions, the impact of disease and death is undermining the economic, social and political gains of the last past half-century and crushing hopes for a better future."*

"Free Trade" defenders want to explain the economy's ruin, loss of political conquests, lack of education, the destruction of health systems and social problems in general, not because of its *structural adjustments*, or privatization and other reforms imposed by them, but for a biological agent's action of a virus...[*]

## Antiretroviral medication and the monopoly of its patients

Hundreds of millions of poor people in the world suffer and die of infectious diseases for which there are neither inexpensive nor effective medication, even though we have the scientific knowledge and the necessary technology to develop them. Likewise, while America, Europe and Japan consume 82.4 percent of the medicine manufactured worldwide; Asia and Africa, with 2/3 of the world's population only consume 10.6 percent of the available medication in the market. The explanation to this criminal inequality lies, as it has been well documented by Patrice Trouiller and her colleagues (2001), in the neo-liberal economy where it is not the health needs of a population but the financial interests of the great pharmaceutical industry that drives research to develop new medicine as well as manufacture and market the available medication.

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[**] This position that tries to explain social, economic and political reality based exclusively on biology not only denies the general principles of history and lets us clear up certain cynical aspects, but forgets that in older poorer countries AIDS has simply worsen disease that like tuberculosis were already in existence.

[*] It is important to insist that antiretroviral medication are not a cure for AIDS and that there isn't complete unity within its defenders because there are many questions as far as the use of this kind of therapy that science has not been able to resolve yet (Volberding, 2003). Even more so: out of all these pharmacological agents that have been approved in the united States, up to now, a little more than 20 show serious problems related to its high toxicity, lack of efficacy due to the resistance the body develops after a time of use and the difficulty patients have to stick to the adequate treatment.

In a world were there aren't patients but clients and where the government abandons its responsibility with public health, medicine manufacturers don't invest in medication to treat the illnesses of the poor who don't have money to pay for them and their manufacturing and sales strategies are aimed at the market's sector that can get it the highest profit margins (the medication business sold $337 million in 1999).

Although there isn't any medicine that cures AIDS currently, anti-HIV drugs have been developed that are considered by scientists and members of the medical community to have the capability of slowing down the AIDS progress and reducing its mortality by up to 80 percent (The Durban Declaration, 2000)**
The same "free trade" policies that have allowed medicine manufacturers to make a great business deal; have also intensified the misery of those who need them. It can then be said that in the case of the AIDS epidemic, neo-liberalism has contradicted itself in a capitalistic economy by creating a large potential market for the new antiretroviral drugs (42 million people with HIV/AIDS) but who don't have any way to purchase them.

Currently, only 8 percent of the 6 million AIDS patients that require medication to improve their heath conditions have access to antiretroviral medication, an amount that in countries like South Africa is reduced to less than 1 percent. Today it is calculated that in the United States, the cost of treatment for one person with HIV/AIDS comes to around $20,000 per year if you keep in mind the cost of antiretroviral therapy, laboratory tests, medical visits and medication to prevent or treat opportunistic illnesses. To pay for the treatment of around 180,000 people who are not covered by health insurance (one out of every five diagnosed with HIV) would cost $3.6 billion per year (Heubeck, 2003).

For the WHO (2003b), this situation can now be overcome:

***"The prices of antiretroviral drugs, which until recently put them far beyond the reach of low-income countries, have dropped sharply. A growing worldwide political mobilization, led by people living with HIV/AIDS, has educated***

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*communities and governments, affirming treatment as a human right. The World Bank has channeled increased funding into HIV/AIDS. New institutions such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and ambitious bilateral programs, including the*
*United States Presidential Emergency Plan for AIDS Relief, have been launched, reflecting an exceptional level of political will and unprecedented resources for the HIV/AIDS battle. This unique combination of opportunity and political will must now be translated into urgent action."*

However, the economic context must be analyzed to evaluate if the suffering of those people infected with AIDS can be relieved and deaths decreased with a campaign like the one by the WHO, the UN and the United States government to deliver antiretroviral therapy to 3 million people with HIV/AIDS. Since 1995, patents for AIDS medications basically depend on *Trade Related Aspects of Intellectual Property Rights* (TRIPS) established by the World Trade Organization – WTO (Velasquez & Boulet, 1999).

In practice, these TRIPS are the tools that support transnational companies which manufacture pharmaceuticals and guarantees them a monopoly of the market and therefore, exuberant profit margins. In line with neo-liberal strategies aimed at eliminating competition of national products to benefit big capitalism, namely the American system, the WHO initially allowed member countries to manufacture generic drugs during the first years of intellectual property rights. A few countries, like South Africa, India and Brazil, that were covered by this regulation, started to manufacture generic versions of the medication to treat AIDS and showed that government companies or those with national capital could substantially reduce prices and produce profits while at the same time serve the health needs created by the epidemic in those countries.

Soon, the United States government and representatives from pharmaceutical companies started pressuring for the "respect" of the patent's monopoly. Thirty-nine of these companies sued the South African government in the year 2000 (Velasquez, 2003). Massive protests on behalf of the citizens came quickly and the rejection of transnational companies that sell medicine while millions of poor people around the world died without having access to them was felt during the 14th International AIDS Conference in Barcelona 2002. It was there that activists confronted the US Health Secretary. On August 30' 2003, in a preventive measure aimed at the upcoming WHO summit in Cancun, Mexico, the Bush Administration and representatives of the pharmaceutical industry temporarily conceded that poor countries could keep purchasing generic drugs. A clause was of course included that requires all member countries to only use patented medicine manufactured by the transnational companies in the future.

As the United States is promoting its trade interests with the WHO, it continues negotiating regional treaties such as NEPAD in Africa or ALCA in Latin America or bilateral agreements always trying to impose its neo-liberal policies and in

those, demand that patents by the monopolies that manufacture and market medication be respected. President Bush's initiative against AIDS was launched as an independent plan from the one already launched by the *Global Fund for the Fight Against AIDS, Tuberculosis and Malaria* with the clear purpose of being able to directly control the project's philosophy as well as the moneys that will be invested in the campaign by the government in Washington. If it were only about strengthening programs against the epidemic, it would have been enough for the White House to increase the fund created by the United Nations as was expected by the international community. Although the U.S. has distributed $1.5 billion in 2 years to finance 160 projects in 85 countries, the money available in the fund are by all accounts insufficient.

To manage the program in Africa Bush named Randall Tobias, a person with neither the work experience in this region of the world nor in managing programs related to AIDS. Tobias, in addition to being a large contributor to the Republican Party, represents the interests of the great pharmaceutical industry, having been the General Manager of Eli Lilly, a powerful medication manufacturing company. In practice, the Bush plan is going to work to subsidize the large amount of capital it invests in medication against AIDS, since the government will buy the drugs the companies can't sell to the poor nations in Africa and the Caribbean. As it was not so diplomatically stated by the South African Finance Minister, Trevor Manuel, we run the risk that most of the promised $1.5 billion dollars will end up directly in the American pharmaceutical companies' coffers (World Bank, 2003). Is not unusual then that large labs such as Bristol-Myers Squibb, which controls the patent to the antiretroviral drug Stavudine (Zerit®), support the initiative and compete to get their share of the $1.5 billion and that the lobby in the US congress to support the White House's plan against AIDS be extinguished by corporations that manufacture drugs to fight HIV (Van De Hei, 2003).

The Bush Administration's initiative against AIDS is managed by its globalization policy of the free trade agreements that benefit it. This has been made clear by US Trade Representative Robert Zoellick when he recently expressed that new models for economic development will not be discussed for African countries. Rather, it is simply about finding a way for development, based on the laws of the market, to occur in very poor regions. Surely in this context AIDS assistance will be based upon whether nations accept economic measures imposed by the World Bank and the Monetary Fund. There is no other way to understand the "altruism" displayed by large consortiums that have joined the campaign against AIDS. To not fall behind, after having made a cost-benefit study, these groups have started to pay for the cost of their employees' treatment, establishing some prevention programs in the community and creating a Global Coalition against the epidemic which now includes 130 transnational companies.

## Sexual abstinence and social control

Plans to fight AIDS currently underway and particularly the initiative by the U.S. government to take antiretroviral medication to Africa and the Caribbean are not exempt from a strong ideological component to promote sexual abstinence as a way to prevent new HIV infections. On May 1' 2003, the U.S. Congress introduced a Bill pushed by President Bush, which requires spending one-third of the millions of dollars destined to prevent new cases on projects whose only objective is chastity. And here is another neo-liberal paradox: Those defenders of economic policies that leave millions jobless end up prostituting themselves to survive, are the same defenders of a sexual practice impossible to follow by a huge part of the population in real life but one which they proclaim to be the most effective way to fight the AIDS pandemic.

In order to try to solve this apparent contradiction, it is first necessary to clarify some elements about the role of sexual intercourse with respect to HIV transmission and then try to explain those powerful reasons behind the "abstinence only" campaign as means of prevention.

Except for instances like that of Paul Duesberg, for whom AIDS is not transmissible but a combination of illnesses caused by malnutrition, drug addiction and toxicity caused by drugs prescribed against HIV (Duesberg, Koehnlein and Rasnick, 2003), scientists consider that sexual activities with an infected person are the main way to transmit HIV (Way, Schwartlander, Piot, 1999). Ever since the discovery of the virus, it has been established that anal homosexual or heterosexual intercourse is the riskiest conduct and that in the case of vaginal intercourse the virus is more easily transmitted if the man is the one infected. Research also consider that variables such as the number of sexual partners, frequency of sexual activity with new sexual partners and number of sexual partners, highly increase the likelihood of transmission (O'Reilly, Islam, Sittitrai, 1999).

The AIDS epidemic in America was mainly identified in homosexual men who used recreational drugs. By 2003, it was calculated that in the United States and Canada, "a third part of new infections are caused by heterosexual contact" while 25 percent are due to intravenous drug use in which needles are shared. (UNAIDS, 2003). The opposite was the case in Africa, where from the beginning the epidemic was defined as being transmission through heterosexual sex and in 2002, the World Health Organization estimated that 99 percent of the HIV/AIDS cases in that continent were sexually transmitted. However, this pronouncement started to be refuted when no studies that strongly supported these estimates could be found. Possible means of transmission were underestimated like use of dirty needles and other medical instruments and equipment that didn't meet basic biosecurity measures due to continued deterioration and terrible health services conditions (Gisselquist et al, 2003).

A study done by Gisselquist & Potterat (2003) estimated that, in Africa, only 19 to 25 percent of male HIV cases and 30 to 35 percent of female HIV cases could be attributed to sexual transmission (unsafe/unprotected-sex). The same investigative team showed some possible reasons for not taking into account those factors other than heterosexual transmission: bias about the alleged promiscuity of Africans, wanting to reinforce pre-existing programs that use contraceptives to decrease population growth, and wanting to show that the epidemic was not just limited to homosexual men and intravenous drug users.

Prevention programs that only promote sexual abstinence are currently prominent in the sexual education offered to young people in the United States without having been able to definitively show their effectiveness. A systematic evaluation of these programs done by Douglas Kirby (2000:87) concluded: "evidence weighs that programs that promote abstinence don't postpone the start of sexual relations". One clinical observation that frequently surprises health care workers is instances in which only one partner in a couple is HIV positive. Surprisingly, the fear of infection does not drive them to stop sexual relations. Even more surprising is that, like in some kind of Russian roulette game, some groups intentionally practice unprotected sex with very high probability of infection. This phenomenon, knows as "barebacking", consists of practicing homosexual anal intercourse with HIV positive partners or with an unknown status without a condom.

Two thousand years promoting the western culture of sexual abstinence and strict monogamy in marriage have proven to be futile. In contemporary market societies this it follows that this failure to universalize abstinence excludes the human need for pleasure and intimacy that characterize eroticism. But because sexual expressions are determined by the contradictions of a social life, the neo-liberal type society creates conditions of prostitution, that all sexual expressions be marketed and creates new cultures and life-styles that revolve around sexual experimentation.

As an example, studies that try to explain *"barebacking"* have found that, in addition to emotional satisfaction and erotic gratification, people practicing this behavior cite what is now called the "health market", or the perception resulting from intense marketing of antiretroviral medication that insists AIDS is no longer deadly and the fatigue cause by constant and aggressive ads by condom manufacturers. The market exploitation of Internet sites for finding sexual partners, the increase in the number of clubs and other businesses that offer a place and an opportunity for anonymous sexual activity and the increase use of "recreational" drugs, are other factors of the current market society that make barebacking possible (Halkitis, Parsons and Wilton, 2003).

What is the reason, then, for the United States government to be set on a campaign to impose a repressive sexual practice when its economic policy drives the accelerated increase of prostitution and the marketing of expressions and

aspects of sexuality? The answer can be found in the ideological and political field. The control of something so intimate as an individual's sexual life acts as a general behavioral control mechanism and the social control of the sexual life of a community eases the control of the general behavior of this community.

The first centuries of the Christian people were centuries of resistance to wild persecutions by the Roman Empire, including the most cruel of all, that of Emperor Diaocletianus. Christians, as well as other patriarchal societies in ancient times tended not to discriminate against women and condone homosexuality, "the naturally accepted the search for sexual pleasure". The sexual moral that glorifies abstinence until marriage and between married couples and then intercourse only for reproduction purposes was established by Saint Augustine at the time when Romans needed to dominate Christians once and for all and concentrate their power in facing the threat by the Barbarians. In this little known but well document story, Bishop Saint Augustine decided to interpret the *Book of Genesis* and state that not only did Adam's sin corrupt our sexuality, but "made us incapable of genuine political freedom" (Pagels, 1988). The Empire, under Constantine understood the importance of one religion in the consolidation of the Government, and knew then how to combine military campaigns with the promotion of a new doctrine of sexual resignation and abstinence. The result: Soon Christians were truly conquered and their beliefs turned into the Empire's official religion.

## Conclusion

Neo-liberalism represents the interests of great capital concentrated in giant monopolistic corporations; based on the premise that the neoclassic economy proposes the Government become "smaller and stingy" each time and sets off to eliminate public services, government workers and government housing, education, nutrition and health programs. Globalization through neo-liberal principles has been promoted by the U.S. government and its closest allies during the last decades and has been mainly implemented by international agencies under its control like the International Monetary Fund and the World Bank that impose economic "free trade" policies on world nations as some sort of universal cure for all social problems.

The neo-liberal ideology found its prefect diligence in *Structural Adjustment Programs* by the World Bank and the International Monetary Fund that have devastated Latin America, Africa, Asia and the Caribbean during the last 20 years. Characterized by the push for privatization, fiscal strictness, deregulation, opening the market and government cuts, these programs have increased and globalized poverty, migration, unemployment and temporary job contracts and have created an extreme polarization of income and life conditions around the world that exclusively benefit big capital.

AIDS has incubated and spread in this social unequal ecosystem and it will be impossible to prevent or defeat it effectively if we don't aim to change the conditions that cause the pandemic and its expansion throughout the entire world. The initiative against AIDS that has been set by the Bush Administration and the World Bank are set within the neo-liberal globalization strategy of the United States government; this strategy also guides projects by the United Nations and the World Health Organization. These plans basically consist of0 creating funds through which to funnel money donated by governments of developed countries and charitable organizations from big corporations as humanitarian aid, money that will be mainly used in the purchase and distribution of antiretroviral medicine and AIDS prevention programs that include sexual abstinence. AIDS programs of this nature will also serve to reinforce the implementation of neo-liberal policies in those countries that are offered "aid".

An alternative proposal to face the AIDS epidemic with probabilities of success should include the following fundamental points:

1. Defend work and production, thereby agreeing with the independent economic development of nations and guaranteeing its nutritional security and with it, the adequate nutrition of its population. A population with severe under-nourishment is easy prey for those diseases that are characteristic of AIDS.

2. Stop and reverse privatizations, particularly those that have eliminated public services and Health Systems so the government can meets its responsibility of offering care and services to those affected. “Control of the HIV epidemic requires large scale investment in the public health structure of countries with poor resources as well as actions to face poverty and external debt” (Mukjerjee et al, 2003).

3. Allow the manufacturing of generic medicine, thereby eliminating patent monopolies that, with the excuse of respect to intellectual property, the World Trade Organization has given to transnational pharmaceuticals (TRIPS). “Instead of abandoning them as trivial consumer goods in a global free trade economy, essential medications deserve a special status according to their crucial role in the global well being” (Trouiller et al, 2001).

4. There is enough scientific evidence to show that addiction to recreational drugs is directly associated with AIDS, whether it be by its method of use like such as drugs that are injected, through continuous use that causes clinical immune-depression frames or contribute to the deterioration of the organism caused by AIDS, or because it is part of the poverty culture. Therefore, prevention and treatment of these types of drugs must be an integral part of AIDS prevention and treatment (Amaro et al, 2001).

5. Guarantee the necessary debate about the causes of AIDS, its prevention and treatment. The claim by Duesberg and his colleagues that his hypothesis hasn’t been empirically refuted and therefore, to benefit all patients, should be put to the test in control studies, should be taken seriously by the scientific community.

6. Research can’t be limited to the market interests of a few companies that invest more money on advertising the few products that are extremely profitable than in basic research to develop needed medicine.

7. Patients who require it, including the majority from poor countries, should have access to the most advanced medicines. However, as is indicated by the same defenders of antiretroviral therapy: the severe toxicity of these pharmacological agents is a fundamental factor to be considered when prescribing its use. “HIV management is complex. Although improvements have been noticeable, the population of treated patients is accumulating a resistance to the drugs and toxicity due to treatment (Volberding, 2003).

8. Resist the discrimination and stigma of those persons and communities affected by the epidemic because this must be an integral part of the calls and actions aimed at social change. It is necessary to fight discrimination and stigma of people with HIV/AIDS since said stigma “feeds, strengthens

and reproduces inequalities of social class, race, gender and sexuality present" (Parker, Agleton, 2003).

9. Prevention programs must be based on scientific knowledge of AIDS and not sexuality biases or the behavior of those people who serve re-colonizing purposes. As expressed by American Lorraine Cogan, who has educated health professionals in 11 African countries on issues about AIDS, when finding that one-third of the money in the Bush initiative for prevention will be invested in programs that impose sexual abstinence:

> *"It is not appropriate for the United States to establish standards that govem the lives of the entire world. Shouldn't each country, culture or society have its own standards, rules, regulations, taboos and life styles? (Cogan, 2003 p. 41A).*

In conclusion, after 20 years of the epidemic in which systematic quantification and analysis of the relationship between poverty – economic models – AIDS epidemic was abandoned, we can now count on empiric studies that show AIDS cases increase economic deprivation. (Zierler et al, 2000) In order to decrease AIDS incidences, it is essential to expand and strengthen public health systems (Smith Fawzi et al, 2003). This is why, as Paul Farmer (2001) presented it in his report in front of a US House Subcommittee; the fight against AIDS is a fight against poverty. And given that poverty in the contemporary world comes from neo-liberalism, the demise of AIDS will not be possible without the demise of the neo-liberal model.

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