

## GLOBAL NEOLIBERALISM AND AIDS POLICY: INTERNATIONAL RESPONSES TO SUB-SAHARAN AFRICA'S PANDEMIC

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The small trading centre of Lyantonde is located in South-western Uganda on the transnational African highway that begins in Mombasa and runs through Kenya and Uganda to Rwanda. At the height of Uganda's AIDS epidemic, it was a transient community of approximately 5,000 people. Many of its residents worked in restaurants, hotels and kiosks along the main road, while others moved to weekly markets in the local area. Traders and long-distance drivers would stop for rest from their travels here. Cultivators, mostly women, worked on small plots near their homes. The three most common activities for women were subsistence production, selling local produce or produced foodstuffs, and working as barmaids or waitresses.

This region prospered during the height of illegal cross-border trade of the notorious Amin and Obote years, from the early seventies until the mid-1980s, but a dramatic decline followed, associated with many AIDS-related deaths. As I travelled through the area in 1992, some of the former hotels and rest stops were empty and abandoned. Seroprevalence in the Rakai trading centres peaked at 25 percent for males and 38 percent for females in 1989,<sup>1</sup> and in Lyantonde, an estimated 12 percent of children were orphaned.

At the time, Mrs. Muleke lived a few miles from the trading centre with her husband where she cultivated his half hectare of land. They shared a small mud and wattle house with her mother in-law, their four children—age 7 to 17—and her brother's two orphaned children, ages one and three. Her brother had died of AIDS six months prior, and his wife left the children to find work in Kampala. Mrs. Muleke's husband was suffering from AIDS, and her eldest daughter, who worked as a waitress in the trading centre, had also returned home to die. Her daughter's cash income had helped with the children's school fees, and without this income Mrs. Muleke pulled the girls out of school. Their labour

was now needed in the fields and in caring for the younger children. Her coffee plot had been lying fallow since her husband became sick, and the other crops were suffering from neglect, but there was still enough of the perennial staple—matooke—for the family. She had sold the cow to pay for medicines from the pharmacy and the traditional healer so the children had to go without milk, and it had been a month since they had had meat or fish. The only cash income was from the occasional sale of mats and baskets that her mother-in-law produced and sold by the roadside. Ms. Muleke was beginning to feel weak and was losing weight; she feared she too had AIDS. She worried about what would happen to the children when she was gone. Their grandmother was strong, but could not single-handedly care for and support her grandchildren.<sup>2</sup>

In Lyantonde, the formal presence of the AIDS Control Program (ACP) of the Government of Uganda consisted of one woman whose job was to provide counselling to AIDS sufferers and their families. A research project, directed by a Ugandan physician with Canadian funding, had its office on the main road and with the community was designing AIDS education strategies. The Rakai AIDS Information Network (RAIN) had recently begun providing counselling and small grants of Ugshs 500 (the equivalent of 50 cents) to people infected with HIV, through its mobile home care unit that came through the town once a week. The community was struggling to survive through the informal organizing of the grandmothers, who provided what care they could to orphans, of school teachers, who turned down the Parent-Teacher Association contributions to orphaned children, and through community-sharing of local resources; this was in the context of growing impoverishment in Lyantonde related to more general macro-forces of socioeconomic decline, a growing debt burden and structural adjustment. Despite a “rapidly growing economy” and the country’s adoption of a far-reaching economic reform agenda spearheaded by the IMF and the World Bank, rural living standards, life expectancy, and basic social and nutritional indicators were and remain among the lowest in the world.

This is a small snapshot of one town in 1992 Uganda, and of one woman’s life, but it is a story that is repeated in many different towns in Southern and East Africa today that have been hard hit by AIDS. In Uganda, ten years later, the prevalence of HIV infection has dropped, the fall in infections likely the result of a number of factors: the epidemic reaching its saturation point (where so many have died amongst the sexually active population that there is a smaller pool of people still able to acquire the infection); the return of peace and stability to most of the country, and Uganda’s relatively successful prevention

program, considered a model for the continent.

But infection continues to spread, and the effects of the epidemic—falling outside of the health and education box of the hegemonic analytical model—will continue to be felt for decades to come. Lyantonde reflects the broader geopolitical and economic conditions of the small trading centres and villages that have been hard hit by AIDS. Mary Muleke’s circumstances are typical of the thousands of women who shoulder the major burden of the current AIDS epidemic in Africa south of the Sahara. At a macro level, AIDS affects production, the availability of skilled workers and professional personnel and the ability of the social infrastructure to deliver basic health and social services. At a micro level, it has had a devastating impact on household economies, particularly subsistence production, typically the domain of women, which feeds the rural poor. And in many regions, the ability of family members—especially women—to cope with the many burdens associated with AIDS within the family unit has been stretched to the limit.

According to the UNAIDS Epidemic Update of December 2002, 29.4 million out of the 42 million people globally living with HIV infection are in Sub-Saharan Africa and by 2000 the continent had buried more than 75 percent of the more than 20 million people who had died of AIDS. Women become infected younger and show a higher prevalence of disease. But they also shoulder the main burden of the epidemic. It is this last feature of the epidemic in particular that is erased in the main understandings of the epidemic and in the policy response—women’s labour in caring for the sick and struggling to hold together fragile communities.

**AIDS Knowledges** This paper aims to explain the way in which Sub-Saharan Africa has been cast in the global institutional response to the AIDS pandemic, with particular attention to the cultural and ideological meanings attached to global restructuring, and the ways that they are reflected in the response. I provide a sketch of the competing knowledge systems of AIDS—the predominant understandings that have informed the international policy response to AIDS in Africa, their social conditions and institutional contexts. I suggest that a number of factors have converged to shape the African policy response; a particular “Western” understanding of AIDS deriving from biomedicine, and its articulation with a neoliberal and androcentric human rights discourse — the political counterpart to the economic dimensions of global restructuring. Also informing AIDS policy in Africa have been the ideas and

practices of institutionalized development and public health in the “Third World.”

How do we understand the epidemic, and the policy response, in a country like Uganda? On one end of the spectrum of AIDS knowledges, the human immunodeficiency virus (HIV) which leads to Acquired Immune Deficiency Syndrome (AIDS) is a microbe, understood through the tools of modern virology and immunology; in the middle of the spectrum it is a disease based principally on culturally defined patterns of sexual behaviour; and at the other end, a virus whose prevalence and impact varies according to a country's socioeconomic status and position within the global political economy. Stated simply, the first understanding is grounded in biomedicine, the second in epidemiology and a particular brand of empirical or applied medical anthropology, and the third, to a political economy perspective. Shaping the policy response to the global pandemic are principally the first two understandings, reflecting both the power of biomedical approaches to disease in general, and the boundaries of knowledge set by disciplinary inquiry. But perhaps more importantly, the biomedical approach is entirely consistent and compatible with the ideological hegemony of neoliberalism. A growing number of critics, activists and scholars are illuminating the relationship between the spread of HIV infection and globalization. The current pricing and patent right protection of drugs to treat HIV infection, trade liberalization and the promotion of market-driven monoculture, the privatization of social services including health services, and the devolution of responsibility to the local level, need to be considered in assessing the successes and the failures of HIV/AIDS policy in sub-Saharan Africa. Unequal gender relations, shrinking rural subsistence economies, increased migration and urbanization in the context of insecurity provide not simply a context for national epidemics in SSA, but shape the spread of epidemic disease, as well as the local responses and impacts. Underlying “biological” and “behavioral” factors are the restructuring of markets and states, and laws and ideologies that uphold unequal gender and other power relations and identities.

In the pages that follow I suggest that African AIDS policy reflects the ideological hegemony of neoliberalism. As Marchand and Runyan point out, the discourses on neoliberalism and globalization reflect a “radical individualism” and the valorization of men and masculinity. In their words, “restructuring entails re-workings of the boundaries between femininity and masculinity, which are intimately related to the shifting boundaries and meanings of private and public, domestic and international, and local and global.”<sup>3</sup> We see this too, in

African AIDS policy, which falls squarely under the neoliberal canon. In the current understanding of AIDS in Africa, the structural features of African economies and societies more broadly are considered mere context for national epidemics, rather than important factors shaping the epidemiological pattern of the various epidemics. Furthermore, gender relations are reified into fixed cultural practices with no relationship to broader social and economic forces, and women's “private” and caregiving labour is taken as a given — the “cost effective” underpinning of market freedom.

The neoliberal agenda shapes the direction of AIDS policy formulation to the extent that underlying health policy in particular, and broader decisions about the allocation of state resources in general, in the notion that health is largely a private and individual responsibility regardless of the social and economic conditions in which sick bodies find themselves. Moreover, in today's discourse on AIDS in Africa, people infected with HIV are “clients” who will eventually reap the benefits of globalization though sound economic policies and fiscal management. In the meantime, “gender power” “community empowerment” and “capacity development” at the local level are hallmarks of contemporary policy for coping with the outcomes of disease until the “full growth potential” of African economies can be realized. These terms are used differently by different interests. As Giles Mohan and Kristian Stokke point out, the role of local participation in a globalizing world is fraught with dangers, as the retreat into localism obscures the role of the state and transnational power holders as well as romanticizes a community, which may in fact not exist.<sup>4</sup> This is not to say that local responses have no value, nor to say that communities should not be involved in designing strategies to cope with AIDS' multiple effects. But it is important to look at what is going on at the local level in the context of the broader production of AIDS knowledges, and national/global political economy. I begin with the policy response in the “West.”

**The Public Health Response in the West** Rather than being separate and distinct from AIDS policy in Africa, AIDS policy in the West has had a not-insignificant role in shaping the policy response in African countries. The fundamental assumptions that underpin the policy approaches to AIDS, far from being objective and value-free, construct the epidemic in certain ways. Research on AIDS has been dominated by the medical sciences, the main informants of the public health response both in the West where most research is carried out, and in the “Third World” where National AIDS programs have largely been the

recipients of the wisdom of Western-based institutions. Competing social and moral understandings have also shaped Western AIDS policy, as have AIDS-specific advocacy movements, particularly those organized by gay men who initially were the main focus of research and public health campaigns. Although recently, more attention is being paid to the gender dimensions and socioeconomic impacts of AIDS by the main institutions involved in AIDS policy and programs, certain givens are generally accepted; in particular, the benefits of markets and “communities” in the delivery of services and the formulation of “coping strategies,” and in mitigating impacts.

Members of the medical and scientific communities were the first to place AIDS in the international spotlight, largely setting the initial research agenda and policy response. According to Gerald Oppenheimer, epidemiologists obtained institutional control over AIDS research early on in the epidemic, as they had the tools to define what was essentially an unknown virus or pathogen in the early 1980s.<sup>5</sup> Epidemiology explains broad patterns of disease seeking to “measure and analyze the occurrence and distribution of diseases and other health-related conditions, acting as both a sentinel who warns of shifts in disease patterns and as a scout who seizes on such shifts to discover their etiology.”<sup>6</sup> As Krieger explains, a complex web of numerous interconnected risk and protective factors explains broad population patterns of health and disease. Through disease surveillance, epidemiologists discern changes in disease distribution within particular populations on the basis of which they formulate hypotheses concerning the relation between the disease and variables that may affect its natural history and clinical course—the objective being to isolate the causal variables of the disease. Contemporary epidemiology incorporates environmental factors into its understanding of disease, but the tendency has been to interpret them in a narrow and selective frame, emphasizing variables that can be linked directly to the disease in question. In the early days of the AIDS epidemic, the focus was overwhelmingly on promiscuity and drug abuse.

When the new disease was first detected in North America, its first sufferers were a small number of gay men. The fact that they were all young male homosexuals suggested to epidemiologists some association between “homosexual lifestyle” and immune dysfunction— such as persistent STD infection, numerous sex partners, attendance at bathhouses, a history of syphilis, and exposure to feces during sex. When similar opportunistic infections began to appear outside of the gay community, the conceptualization of the disease shifted to one based on transmissible agent spread through blood, a model supporting

the introduction of public health measures. Given the high concentration of infection among gay men in North America, women remained invisible in AIDS research well into the epidemic, despite rising levels of infection in women in other parts of the world. After virologists at the Pasteur Institute in Paris and the National Cancer Institute in the US isolated the virus in 1983 and 1984, the understanding of the syndrome shifted from a purely “lifestyle”-based disease to a biomedical problem open to a medical solution. Still, in the absence of a cure or vaccine, behavioural changes were seen as necessary. The bottom line was don't share body fluids.

Isolating a virus did make clinical management possible. The understanding of AIDS in the West shifted from one of “fatal” to “chronic” disease. Drug research and development began to move at a fast pace, but with little interest by the pharmaceutical companies in developing an unprofitable vaccine. Resources were skewed to developing a cure, and to highly effective antiretroviral therapy (HAART) with its huge profits and cost of \$10,000 to \$30,000 a year for the drugs alone. Drugs research has been irrelevant to 90 percent of the World's HIV population, where public health campaigns have focused on behavioural change. As Laurie Garrett has pointed out:

The HAART model opened up a set of profitable doors for the pharmaceutical industry. First, it allowed an acute infection to be treated as a chronic disease, dragging out treatment (and drug sales) for decades. Second, it escalated the level of socially acceptable public health disparity in the world, finding companies and wealthy world governments facing remarkably little criticism for sparing the lives of European and North American citizens while witnessing obliteration of populations elsewhere. Third, the treatment was based on a class of drugs, called protease inhibitors that were very costly and difficult to produce; patent violation was minimized by their sheer scale of production obstacles. And fourth, even an extraordinarily expensive set of drugs could prove profitable within targeted wealthy nations if the sense of urgency was high enough to commit governments to their subsidized purchase.<sup>7</sup>

But we must also look beyond the medical research establishment and pharmaceutical industry; also important in shaping the public health response to AIDS in the West was neoliberalism's triumph, its accompanying moral-political agenda, as well as gay community organizing within a distinct discourse of individual human rights. AIDS emerged in conjunction with the increasing withdrawal of the state from the social sectors, privatization, and the opening

up of economies to global market forces. The two competing discourses that gave AIDS its cultural meaning in the US were both compatible with the neoliberal political agenda: the discourse of the “moral majority” on the one hand, and the counterdiscourse of civil libertarianism on the other. Within the evangelical right wing, AIDS became a major issue through which to challenge the evolving acceptance of sexualities and family forms brought about by gay rights and feminist movements. For the evangelical right wing, AIDS was seen as a punishment from God for those who deviated from the patriarchal monogamous nuclear family. Resistance of the gay community was marked by an explicit discourse of individual rights.

Despite the stigmatized status of gays in North America and Europe, relatively affluent members of the community in particular were able to play an active role in challenging and shaping the public response to the epidemic. Unlike other “risk groups,” (poor women, and intravenous drug users, for example) there was a gay community based on a shared identity, with financial resources to mount an active campaign. The discourse of AIDS activism reflected a conflict between traditional public health approaches and pressure to respect individual human rights and civil liberties—defined exclusively as the rights to privacy, bodily autonomy and freedom from discrimination.

Gay community organizing represented a comparatively successful campaign at a time when few civil society organizations were able to make claims on the state. Despite its relative successes, the application of the Western model of AIDS organizing to Africa was not unambiguous. As this model was imported to African countries, so too was the discourse of AIDS and human rights, which has focused almost exclusively on individual rights to bodily autonomy, privacy, and freedom from stigma and discrimination.<sup>8</sup> This exclusive focus on non-discrimination arises from a conception of human rights that is both liberal and androcentric in that it assumes a level of bodily autonomy that most people, particularly women, do not have; what Scheper-Hughes describes as sexual citizenship, “a broad constellation of individual, medical, social, and legal rights designed to protect bodily autonomy, bodily integrity, reproductive freedom, and sexual equity. Sexual citizenship implies, among other things, the ability to negotiate the kind of sex one wants, freedom from rape and other forms of non-consensual or coercive sex, and freedom from forced reproduction and coerced abortion.”<sup>9</sup> Also absent at the time from the discourse on AIDS and human rights was an understanding of how the denial of the exercise of basic

rights to human survival shaped both the risk of infection, and the ability to cope with its multiple effects. But it was a discourse compatible with a policy response whose main elements are the inaccessibility of treatment to those who cannot pay, individual behavioural change, and strengthening the capacity of local communities to cope with the effects of the epidemic.

**WHO and the Global Institutional Response** The World Health Organization (WHO) spearheaded the policy response to AIDS in the Third World. The WHO's initial approach to disease in the Third World was strongly influenced by wartime advances in chemical disease controls, interventions that had been developed to reduce high levels of sickness among troops in Latin America and the Pacific Region. Broader socioeconomic constituents of health may have been understood, but were rarely taken into consideration. In an in-depth study of WHO conducted by Harold Jacobsen in 1967, all but one of the 33 “core group” of policy formulators within WHO were medical doctors.<sup>10</sup> The influence of national associations of doctors, such as the American Medical Association, ensured that within the WHO all medical assistance be given by, or in the presence of, a fully qualified doctor.

This policy was finally broken in the mid-seventies by which time thirteen newly independent states, mainly on the African continent, became members of WHO. It was increasingly recognized that WHO's programs reflected Western public health practices and did not adequately address the needs of developing countries. The 1960s and 70s saw the development of the principles of Primary Health Care (PHC) and Country Health Programming. PHC was canonized at “Alma Ata” — a major WHO/UNICEF conference in 1978 in Alma-Ata, Kazakhstan, at which the WHO and its member states defined a new constitutional objective: “the attainment by all citizens of the world by the year 2000 of a level of health which will permit them to lead a socially and economically productive life,” and the means of achieving this, primary health care.<sup>11</sup> The WHO's “Health for All” campaign was one among four of the UN's idealist declarations of “new order” formulated in the 1970's, the others being the New International Economic Order of the UN General Assembly and UNCTAD, the New World Information and Communication Order of UNESCO, and an updated World Employment Programme for ILO. The PHC approach embodied the ideas that health depended on improving socioeconomic conditions and alleviating poverty, and that the process should be community-based and

support health priorities at a local level. The emphasis of health planning shifted from the construction of hospitals to primary health care centres, which were to be decentralized, foster popular participation, and use appropriate technology. The birth of Alma Ata, however, was quickly followed by its death barely two years later. Alma Ata's collapse, corresponding to the oil and debt crisis on the African continent, put its political nature in sharp relief. Three major policy shifts undermined the essence of PHC and heralded the beginning of Africa's "lost decade:" the introduction of selective PHC in the early 1980s; the push for cost-recovery and user-financed health services introduced in the late 1980s, and finally, the takeover of Third World health care policy by the World Bank in the 1990s, all three a reflection of underlying macroeconomic and ideological trends.<sup>12</sup>

Ideas of cost-recovery, privatization and "self-reliance" found their ultimate expression in The World Bank's 1993 World Development Report (WBDR) *Investing in Health*. This report signalled the World Bank's emerging interest in global health policy. More significantly, it marked the hijacking of the global health agenda from the WHO. It specifically proposes: 1) the reduction of public expenditures on tertiary facilities, specialist training, and interventions that are not "cost-effective;" 2) the financing of a select package of public health interventions dealing with infectious disease control and environmental pollution; 3) the financing of a package of essential clinical services for the poor; 4) the promotion of private finance of all clinical services outside of the essential package, and 5) the encouragement of private suppliers to compete for both the delivery of clinical services and the provision of inputs such as drugs to the public and private sectors, with the protection of domestic suppliers from international competition.<sup>xiii</sup> Kenna Owoh argues that WBDR not only endorsed the pervasive global strategy of IMF/WB-led structural adjustment programmes, but also contributed to that strategy through the "systematization of global social welfare." Absent from the report is a consideration of how political and economic interests tied to the global adjustment regime contribute to the African health crisis. Owoh states:

The WB and the IMF are restructuring African economies under SAPs to ensure the ease of entry of TNCs, and to realign African economies in the direction of the new global order. Second, under 'second order' adjustment, social unrest is brought under the global agenda. The areas of state autonomy vis-à-vis global institutions have been progressively limited, starting with the

economic and moving to the social, and the role of the state is reduced to overseeing the implementation of the global agenda at the local level.<sup>14</sup>

The World Bank's health strategy is one instrument for bringing global health policy into line with the neoliberal canon that ascribes health mainly to the private domain, through the introduction of market forces into the health sector, and the allocation of public resources according to criteria of technical efficiency and cost-effectiveness. The role of government becomes one of investing in low-cost actions that target those living in critical poverty, and promoting diversity and competition by facilitating and overseeing private sector involvement — a policy consistent with the notion that social welfare is the responsibility of the individual. Throughout these watersheds, WHO has more or less consistently put forth a view of health that transcends curative medicine and incorporates an understanding of the wider social constituents of health; within the field of international health many institutions still attempt to practice certain principles of PHC in their programmes and projects, such as decentralized health service delivery, and community participation. But the links between the capacity of "local communities" to guarantee access the basic constituents of health, and the circumstances within which those "local communities" find themselves are not made.

**The Institutional Response in Africa** As early as 1985, the possibility of widespread heterosexual transmission of HIV infection was taken more seriously. The spread of HIV in central Africa posed a direct challenge to the "gay lifestyle" model of HIV transmission. As the epidemics in African countries worsened, attention shifted to AIDS outside of North America and Western Europe. The WHO's Global Program on AIDS (WHO/GPA) led the global institutional response from 1986 onward. The GPA became the coordinating and funding mechanism for countries receiving development assistance, making its financial support conditional on each country developing a plan, program and staff committed to AIDS. The Director General of WHO, Hafdan Mahler stated in 1987:

A global problem of this magnitude and broad impact — social, economic, demographic, cultural and political — such a global problem requires a global response...Just as smallpox eradication only became a reality when the nations banded together under the banner of WHO, so aids will require global mobilization around a global strategy.<sup>15</sup>

The growth of the GPA was unlike any in the history of the WHO, evolving from a staff of two and a budget of \$1 million in 1986 to a staff of 400 and a budget of nearly US\$100 million by early 1990.<sup>16</sup> The GPA's first Director was a physician with close ties to the American Centers for Disease Control and the US Public Health Services, who created a strong epidemiologic-based team. Despite his strongly biomedical approach he challenged WHO protocol by trying to bring a broad range of civil society institutions around the table to help shape policy. And indeed, the issue of the relationship between HIV infection and "poverty" was aired early on in the epidemic, although in a way that remained largely pedantic and under-analyzed. Jonathan Mann was replaced in 1990 by a much less controversial figure.

When AIDS was first recognized as a potential health crisis in Africa, scientists looked to parallels with the Western experience to guide research on the epidemiology of AIDS. The first policy responses in countries like Uganda and Tanzania very much mirrored the basic trajectory of the Western response—epidemiological surveillance, increased resources for patient care, cleaning up the blood supply, properly sterilizing syringes and providing protective gloves to health care professionals. But policies were implemented with little emphasis on the general strengthening of, and investment in, basic physical and social infrastructure or human resource development. In Uganda, for example, the medical response was severely hindered by the virtually non-existent health care system in many parts of the country: lack of electricity or generators for proper refrigeration of blood and sterilization equipment, the absence of the basics for patient care such as painkillers, antibiotics, protective gloves and bedding, and shortages of qualified staff for clinics and sentinel surveillance sites across the country.

Halting the spread of the epidemic through public education became the main focus of public health campaigns. AIDS education campaigns were formulated to be "culturally specific and appropriate" and it was the role of applied medical anthropology to explain the specific nature of spread amongst the population. Survey research was conducted among designated "high risk groups;" in countries like Kenya, Tanzania and Uganda, popular cohorts were prostitutes, pregnant women, long-distance lorry drivers and patients at STD clinics. Within some of the early explanations of AIDS in Africa, rapid spread was seen as a consequence of traditional ritual practices, young age at first sexual activity, high levels of premarital sex and extramarital sexual relations, polygamy, wife-sharing, widow inheritance, funeral rights, scarification and circumcision with dirty instruments. Anal intercourse and "dry sex" also received attention—practices

that had less explanatory power when, by the late 1980s, the link between high levels of chronic and untreated STDs among the adult population and ease of viral transmission was established, in large part a consequence of the absence of public health services. Particular vectors of transmission that set apart the "general population" were young single women who worked in bars as prostitutes, and long-distance lorry drivers. Factors contributing to high levels of "promiscuity" were alcohol consumption, migration, and the breakdown of traditional moral codes with increased urbanization and modernization.

Knowledge, Attitude, Practice (KAP) surveys were carried out to obtain information on "sexual risk behaviour." Stated elegantly by Dominique Frommel:

The research done by UNAIDS, coupled with the experience of the WHO and UNICEF in the field of human reproduction, will undoubtedly reveal how diverse sexuality is, but can all this information pinpoint what is needed to motivate men and women who have been warned about HIV to change their behavior and sexual practices? Or will it just lead to pointless arguments that conceal the scale of the social and economic factors which impeded changes in sexual behavior?<sup>17</sup>

Given that sexual behaviour was understood as autonomous from other social forces and relations, it was logical that the main prevention strategy be mass media campaigns and community-based education of a voluntary nature. But the mass education approach underwent a shift as time went on given that campaigns were having a limited impact on HIV spread. Helen Epstein comments on the effectiveness of prevention programmes in Uganda, pointing to the emergence of two schools of thought: "Either people's beliefs about condoms, fertility, and disease prevent them from practicing safe sex or they are constrained by the larger social conditions in their lives, such as poverty and unemployment, that result in a kind of resignation, a feeling that HIV is inevitable, and beyond one's power to prevent."<sup>18</sup>

Sex was increasingly understood in the context of broader factors: single-gender labour migration, the separation of household members, and gender/patriarchal relations, particularly women's economic dependence on men and the cultural imperative to have children. In the early 1990s, "Women and AIDS" became somewhat of a growth industry within AIDS research and the institutional response, the WID directorates of many multilateral and bilateral institutions carving out a space for themselves among the medical doctors and public health specialists. Studies on the social, economic and legal status of women

and its relationship to risky sexual behaviours began to appear. Survey research pointed to women's lack of decisionmaking power in sexual relationships, and the difficulty of practicing "safe sex" in a context where a woman's self worth was largely measured by her capacity to reproduce, and where children provide some measure of security in an unstable economic environment. Research also pointed to the particular problems of AIDS widows who would find themselves destitute when they lost rights to children and property upon the death of their husbands, as well as the limited income-earning options of women who were selling sexual services. Added to the goals of many AIDS prevention strategies on the African continent was the "empowerment of women," a phrase one prominent AIDS activist labelled a linguistic icon in AIDS policy. Today, a more common term is "gender power." Interventions focus on educating marginalized women on matters of sex and HIV/AIDS, basic literacy, and nutrition. Economic autonomy of women also became a goal of AIDS projects; local income-generating strategies were added to the itinerary of AIDS projects.

These developments corresponded to the formation of UNAIDS, a reorganization of the global program to more closely integrate other UN-sponsored initiatives with those of the WHO/GPA. In January 1996, UNAIDS became officially operational, combining WHO's program with those of Unicef, UNESCO, UNDP, ILO, and the World Bank. With a \$60 million annual budget and a staff of 129 professionals, UNAIDS role is one of "catalyst" or coordinator of action on AIDS rather than a direct funding or implementing agency. "As the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens, and supports an expanded response aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS and alleviating the impact of the epidemic."<sup>19</sup>

In the meantime, it was becoming clearer that AIDS was having an impact in countries reaching far beyond family tragedy and strains on the health care sector. The ILO estimated a drop in growth of 25 percent over a 20-year period in high prevalence countries, with labour forces in the year 2020 estimated to be between 10 and 22 percent smaller. AIDS was also seen as a threat to enterprise and macroeconomic performance.<sup>xx</sup> In the agricultural sector, AIDS was having an impact on labour supply and remittance income, and leading to significant declines in household production.<sup>21</sup>

At the close of the decade, there were echoes in the media of the impending AIDS "crisis" in Africa, corresponding to a heightened sense of urgency in the

international community. At the same time that Stephen Lewis, the UN Special envoy on HIV/AIDS in Africa, pointed out that the total spent on every aspect of AIDS treatment and prevention in Africa was approximately five percent of global spending for 95 percent of the pandemic, sub-Saharan Africa was sliding deeper into debt and disorder. The total foreign debt owed by Africa was \$304 billion, of which \$175 billion was owed by sub-Saharan Africa. sub-Saharan Africa's debt burden was 123 percent of its GNP, and its ratio of external debt to exports 340 percent.<sup>22</sup> Even Uganda, the IMF's "star pupil" and Africa's "success story" with regard to lowering HIV sero-prevalence, had begun to falter. Under the Heavily Indebted Poor Countries (HIPC) initiative, Uganda obtained substantial relief, and was able to divert significantly more resources toward health and education, poverty-related expenditures increasing from 18 percent of the budget to 35 percent in 2002. But the 60 percent fall in coffee prices that Uganda's liberalized economy has seen over the past two years has meant that Uganda has had to borrow more to make up the shortfall, and is sinking deeper and deeper into debt. Uganda's debt-to-export ratio was 210 percent in 2000-2001 and is projected at 250 percent for the next two years.<sup>23</sup>

Two significant institutional mechanisms were recently set up to deal with the crisis in Africa. The Annapolis Declaration was issued through UNAIDS, pledging to create an International Partnership against HIV/AIDS in Africa. A second initiative is the establishment of the Global AIDS Fund to fight AIDS, Tuberculosis and Malaria, meant to mobilize billions of dollars from governments, corporations, charities and individuals for the global pandemic, much of which would be disbursed to African countries. The projected need for HIV in Africa alone was estimated to amount to between \$7 and \$10 billion.<sup>24</sup> The money is to be targetted at prevention, basic medical care and research. Despite the hype, contributions from Western nations have been paltry, totalling just over \$2 billion over five years, with the Bill and Melinda Gates Foundation matching Canada's contribution of \$100 million. Both of these initiatives call on an increased role for the private sector, and on private-public sector partnerships. After all, AIDS is bad for business.

At the same time, the issue of access to anti-retroviral (ARV) drugs took centre stage, with US foreign policy blatantly asserting the primacy of TRIPS and the rights of pharmaceutical companies to protect their patent rights. All but a tiny wealthy urban elite of Africans had access only to the most basic palliative care drugs such as aspirin and antibiotics, if even that. *Medecins sans*



Frontiers spearheaded the global campaign to put access to lifesaving medicine as a human right on the international political agenda, negotiating price breaks with the main producers of ARV drugs on an individual-by-country basis. As Grey and Smit argue, improved access to HIV drugs has become the “vanguard” struggle: “It has raised world consciousness of the fundamental contradictions between the interests of people in both developed and developing countries and those of transnational drug manufacturers, between the goals of health and profits.”<sup>25</sup> Still, reducing the cost to the patient from \$10,000 to \$300 has effectively left out the vast majority who live in countries where per capita health spending remains about \$5-\$10 per person. The campaign has pointed out in blatant terms the global cost of the mammoth disparities in basic drugs provision between the West and the Third World, the immorality of the current WTO regime, the inherently problematic nature of market forces driving pharmaceutical research and development, and the failure of the market in providing essential drugs. Zimbabwe is the first country in Africa to make the decision to override patent protection on ARV drugs and use generics, declaring the epidemic a national emergency. Yet the cost of generics is still out of reach to the majority of the population.

But perhaps more importantly, the biomedical focus to AIDS in Africa is one-sided. It does not address the factors that continue to put people at risk nor does it come even close to mitigating the devastating impacts on the hardest-hit communities. AIDS has articulated with other structural and social forces within communities to create the present “crisis.” Recently, attention has been focused on the relationship between AIDS and famine, AIDS constructed as a cause of famine in the region. But what is left unanalyzed is the role that three decades of agricultural restructuring has played in the undermining of women’s capacity to fulfill their role as subsistence producers. Also receiving scant attention are the local and gendered effects of labour productivity decline, losses of income, and caring for the sick at home. The evidence suggests girls being pulled from school, severely limiting their life chances and placing them at risk in the future; the movement of widows and orphans to urban areas in search of income where many resort to “high risk behaviour” out of economic necessity, and the physical and psychological exhaustion of women living in critical poverty left behind to care for orphans and the sick. At a macro level, the declines in productive capacity mean that social expenditure, already woefully inadequate, will continue to be so. The real costs of the epidemic, couched within the discourse of

“empowerment” are borne by women who take on the lion’s share of the caring burden. The WHO’s own research points to the “harsh realities” faced by those carrying out this largely invisible labour. A recent case study of Zimbabwe concludes that older women constitute 60 percent of those caring for orphans and people with AIDS, and that they are unrewarded, unsupported, lacking the very basics in terms of food, clothing medical care, and economic support.<sup>26</sup> The biomedical focus effectively sidelines this reality.

For those who can’t afford treatment, coping strategies are to be strengthened. The second emphasis of the policy response, the one that receives little in the way of financial investment, is on community-based “culturally specific” interventions, relevant to the local pattern and impact of the epidemic. The new discourse resonates with the discourse of PHC, and also reflects the focus in development circles on both gender and localism. Indeed, it is difficult to find a policy document that does not include some reference to the necessity of “women’s empowerment,” or the importance of “local, culturally relevant interventions.” Corresponding to UNAIDS, and the new global multisectoral strategy, it has been acknowledged that AIDS programs must move beyond conventionally defined public health interventions. Added to the list of strategies are programs targetted at orphans such as school-fees relief, income generation, and support for extended families, as well as projects aimed at “empowering” people and communities to better cope.

With UNAIDS playing the coordinating and catalyzing role, it is up to the largely underfunded NGO sector and local communities, with the assistance of the private sector, to implement programs and projects at the community level. The lion’s share of financial resources continues to be targetted at prevention programmes and medical interventions. What does “women’s empowerment” mean in this context? As communities are articulated as the solution to the epidemic outside of the orbit of ARV provision, the principal focus of policy, women’s “private” domestic labour, has intensified. People within communities experience the effects of AIDS differently, on the basis of economic and social status and gender relations. Women, for the most part, continue to shoulder the responsibility for feeding and caring for their families, while current processes of economic restructuring which contribute to the undermining of health and the destruction of the social and economic fabric of communities, continue underanalyzed and unabated.

**Conclusion** The ideological partner to the globalization of finance and production has been the undermining of collective responsibility for the social and economic well being of society, of the principles of universality, and of the exercise of basic human rights. In this context, the failures of the system are viewed as the sole responsibility of the individual, no longer the system or collectivity. Intrinsic to both neoliberalism and biomedicine is an individualistic view of humans, a view that is reflected in the policy response to AIDS in Sub-Saharan Africa. The largely biomedical policy response fits nicely into the neoliberal agenda, to the extent that the factors that fuel the spread of HIV are not considered proper targets for intervention. In essence, policies are designed to counter the destabilization caused by AIDS — biological, social, economic — to “empower” the individual to better cope with his or her infection and imminent death, or to protect him or herself from infection. But these policies have limited effect.

The understanding of AIDS has to move outside of the health box of the analytical model, to address the macroeconomic and political factors that deprive communities of the basic constituents of health, including the means for providing for their own subsistence or, more specifically, the gendered crisis of care at the community level. In so doing, there is a need to understand “the community” in terms of the gendered power dynamics that underpin the division of household and caring labour, access to vital resources and the exercise of rights basic to human sustenance — rights to land, labour, food, security, bodily autonomy — as well as to vital treatment and health services.

The hegemonic biomedical understanding of African AIDS fails to acknowledge the vested interests that underlie the current global order, an order that contributes to the pattern and spread of disease, and the ability of “communities” to cope. It also fails to address the gendered power dynamics that not only render women more vulnerable to infection, but that render poor women’s vital role in providing care and holding together fragile communities invisible and unsupported. The hegemonic understanding of AIDS effectively normalizes the confluence of disease and famine as the inevitable outcome of viruses, drought, and “culture.” Contained within the international policy responses to the pandemic is a set of practices which inevitably determine who should live, and who should die.

## Notes

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