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Dialogue

Structural Violence, Poverty and the AIDS Pandemic

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ABSTRACT *Joia S. Mukherjee addresses the linkage between poverty, gender inequality and HIV risk; the worsening of poverty due to the HIV pandemic; and the lack of access to active antiretroviral therapy for the poor. She argues structural violence is connected with a large variety of factors including economic privation, gender inequality, lack of opportunity for education and work, and migration for work increases both the risk of contracting HIV and makes prevention strategies less actionable. Without funding to address economic and educational opportunities, the epidemic can only continue.*

KEYWORDS *economic privation; gender inequality; sex work; sexual rights; intellectual property*

Introduction

Three and a half decades into the AIDS epidemic, prevention programmes are focused on information, education and communication about behaviours that put people at risk for HIV – a sexually transmitted disease. AIDS can be prevented, it is reasoned, through behaviour change. Yet despite prevention efforts, AIDS has continued to spread, particularly among the poor. Today, of the 40 million people worldwide living with HIV, 90 percent of them live in resource-poor countries.

What can be done about the AIDS epidemic? The answer is often simply stated as prevention and treatment. HIV prevention can be viewed as two interrelated entities: risk avoidance such as abstaining from sex and drug use; and harm reduction that is minimizing risk while conducting behaviours that are associated with HIV (this specifically refers to the use of clean injecting needles for drug users and the use of condoms if one is having sex). Prevention is often presented as 'life-style choices', within the control of the individual. Yet those who live in poverty have severely constrained choice. The systematic exclusion of a group from the resources needed to develop their full human potential has been called 'structural violence' (Galtung, 1969). The concept of structural violence is useful to understand the barriers that prevent risk mitigation in the HIV epidemic.

Lack of access to treatment is also intertwined with poverty. 1995 saw the advent of active antiretroviral therapy (ART), after which a combination of drugs or 'cocktail', taken daily, could return even the sickest people with advanced immune

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deficiency to normal health. Availability of treatment, however, actually worsened inequality in AIDS outcomes between the rich and the poor. The poor were systematically excluded from ART as the drugs were thought to be too expensive, too complicated and not sustainable to use in resource-poor settings. This combination of factors has led to a global pandemic in which the poor have excess risk of acquiring HIV and, once infected, have less access to lifesaving ART. As a result, the most heavily HIV-burdened countries have become further impoverished due to the epidemic.

AIDS and structural violence

As mentioned above, 90 percent of the HIV epidemic is concentrated in developing countries. In poor countries, many people are trapped in wage slavery. This type of economic victimization is one of the major factors in the spread of HIV. Girls are often sent to cities to be domestic servants and, as such, are often forced to have sex with their masters. Women unable to support themselves and their children often become reliant on men who are neither economically reliable nor faithful. Finally, prostitution and the sex trade reflects a reality that has been most widely documented in South and Southeast Asia, now home to 6.5 million HIV-positive persons, but that likely occurs everywhere in the world (World Health Organization, 2004a). Women are less likely to be educated and less likely to find paying work. When working, women earn two-thirds of what men earn. Women also bear the enormous burden of uncompensated work, including caring for children and sick relatives, feeding the family and managing the home. As a result, women spend twice as much time performing unpaid work than do men (International Labour Organization, 2004, http://www.ilo.org/public/english/bureau/inf/download/women/pdf/factssheet.pdf, accessed 10 December 2004). Men are far from immune, however, to the crushing poverty of the developing world. They, too, suffer from desperation, depression, anger and emasculation, all of which have been linked with resultant so-called 'social ills' such as substance abuse, domestic violence and other criminal activities (Kawachi and Kennedy, 1997). But we must ask: what really is the fundamental 'social ill'? Such social ills are rooted in poverty and inequality. Structural violence, defined as the physical and psychological harm that results from exploitive and unjust social, political and economic systems, is the shadow in which the AIDS virus lurks.

South Africa has the highest HIV prevalence in the world, with nearly 25 percent of its adult population living with the virus. This is hardly surprising, given the legacy of the most carefully crafted structural violence of the twentieth century, apartheid. As recounted in an Paton's 1948 novel, *Cry, the Beloved Country*, the question of whether African men should be allowed to buy land, build homes or bring their families to the mining communities in which they work was one of the hotly debated topics of the original apartheid legislation. Reading this classic now gives one a terrible sense of foreboding of the AIDS epidemic that was then still 45 years away. While many now rightfully focus on the South African government's recent policies of ignoring the impact of AIDS, it is only by understanding history and acting to prevent the systemic disregard of social and economic rights throughout the world that the further disastrous consequences of structural violence can be avoided.

Gender inequality

Young women have been recognized to be especially vulnerable to infection and the largest number of new cases comes from this group. The 2004, UNAIDS' AIDS Epidemic Update reported that women constitute half of the 37.2 million adults (aged 15–49) globally who are living with HIV. Close to 60 percent of adults living with HIV on the most heavily burdened continent, Africa, are women (World Health Organization, 2004b). Every region of the world has seen an increase in the number of women living with HIV during the past two years (World Health Organization, 2004b).

The differences between the rates of incident HIV infection between boys and girls are staggering. Girls under the age of 15 are five times more

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likely to be HIV positive than boys of the same age group. Part of this vulnerability is biologic, for every sex act, an HIV-negative woman is at least twice as likely to become infected by an HIV-positive man, than an HIV-negative man is to become infected from an HIV-positive woman. We would make a critical mistake, however, to view this heightened threat to women as solely a matter of biology. While part of the greater transmissibility of HIV from men to women can be explained by basic science, biological vulnerability adds little to our understanding of the disproportionate suffering borne by poor women across the globe at the hands of the AIDS epidemic.

When we take a step back from statistics and biology, the bigger picture reveals that AIDS affects women who are struggling under the overarching epidemic of *poverty*, have little control against the factors that put them at risk for this deadly disease. This link, between the economic conditions in which women live, those which make them more vulnerable to all facets of the pandemic, has not been translated into policies to remediate this vulnerability or mitigate the impact of HIV on women even in countries where ART is available. In the United States and western Europe, success stories of the late 1990s, when highly active antiretroviral therapy restored life to the dying, leave poor women in the darkened corner of statistical outliers, victims of the gross inequalities in rich countries. Among new AIDS cases in the United States, approximately half occur in African-Americans; representing only 12 percent of the population, this group's HIV prevalence is eleven times higher than among whites. African-American women, both urban and rural, account for an increasing proportion of new infections, and AIDS is now the leading cause of death for African-American women aged 25–34 in the United States and Canada.

In resource-poor settings the situation is more dire. Clearly, there is a role for AIDS prevention; particularly that which is evidence based such as the use of antiretroviral drugs in pregnant women to prevent HIV transmission to their infants; the treatment of sexually transmitted diseases; the use of harm-reduction strategies such as condom distribution and needle exchange; and most recently, male circumcision. However, in the last five years, HIV prevention has been co-opted by groups promoting moral or religious agendas – particularly in the United States. Today more than half of international funding for AIDS prevention comes from the United States' State Department and relies on a prevention education strategy given the epithet 'ABC' for promoting abstinence, being faithful and condom use. All of these prevention strategies rely on personal choice and the agency to carry out such choices.

Abstinence relies on the ability to say 'no' and to have it be heard. Such personal agency is robbed by violence of both the structural and physical varieties. Gender inequality through laws or practices from unequal access to education, housing, paying work or inheritance continue to place more women than men into destitution. Infidelity more commonly stems from the male partner and is worsened by a shortage of wage-earning jobs available. In such a state, women are more likely to be victimized by rape, or forced to use sex as a tradable commodity for survival. Trumpeting calls for abstinence and fidelity without addressing the economic roots of the commoditization of women's bodies is a cynical dismissal of the lives of the most vulnerable in the epidemic. Such an approach fails to address the fact that violence and brutality rather than love, trust or sexual activity are the forces that put women at risk for AIDS, death and unplanned pregnancy.

Rape is a major factor driving the AIDS epidemic. In political conflicts, rape is a common crime and can even be used purposefully as a tool of war. For example, in Rwanda, the systemic sexual molestation, rape and mutilation of women and girls were an integral part of the Hutu plan to annihilate the Tutsi population (Donovan, 2002; Amnesty International, 2004, http://web.amnesty.org/library/Index/ENGAFR470072004?open&of=ENG-RWA, accessed 13 December 2004). As a result, a total 70 percent of the 250,000 women who survived the genocide but were raped are now HIV positive (Human Rights Watch, 2004: 7; http://www.avega.org.rw, accessed December 13, 2004). Similarly, studies by the United Nations Children's Fund concluded that over 75 percent of girls and young women abducted by rebel forces

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during times of armed conflict in Sierra Leone were sexually abused (Amnesty International, 2000: 2). In Uganda, the Lord's Resistance Army (LRA) continues to abduct children; in this 15-year conflict, thousands of children have been raped and HIV-infected by the LRA. Ninety percent of northern Uganda's 1.8 million people have been internally displaced and are now crowded into refugee camps. Forty thousand children routinely walk up to several kilometres each night to schools, hospitals and shelters in the town of Gulu to protect themselves from abduction. Not surprisingly, the HIV prevalence rate in northern Uganda is at least twice that of the rest of the country.

It is not only political violence itself that threatens to spread the virus. While official statistics have not been released, it is now widely recognized that UN peacekeeping forces can contribute to the spread of HIV, often through unprotected contact with commercial sex workers and by the the simple fact that they themselves may come from countries with high prevalence rates; for example, in Sierra Leone in 2001, 32 percent of the 16,630 UN peacekeepers were from countries with prevalence rates greater than 5 percent (General accounting Office, 2001: 11). In Haiti, since the overthrow of the democratically elected president, Jean Bertrand Aristide, on 29 February 2004, utilization of one rape crisis centre has increased five-fold. Because the *de facto* government has no control over the heavily armed rebels, backed by US-based groups, the rule of law has broken down to such an extent that women most frequently do not report rape to the police for fear of reprisals.

A similar lack of real choice or agency faces women in monogamous relationships who are encouraged to rely on 'being faithful' as their means to prevent HIV infection. This strategy, of course, withers against the backdrop of structural violence, as most women are infected as a result of their partners' infidelities, not their own. In fact, in many locations, the main HIV risk factor for a woman is the simple fact of having a stable sexual partner (World Health Organization, 2004b: 7–12). One study reports that HIV infection rates were 10 percent higher for married than for sexually active unmarried girls aged 15–19 years in Kenya and Zambia (Glynn *et al.*, 2001). A study in rural Uganda found that 88 percent of HIV-infected women aged 15–19 years were married (Kelly *et al.*, 2003). Because young women in many societies often have significantly older men as their partners, the men are more likely to have had other partners and are therefore more likely to have been exposed to HIV. Additionally, while infidelity is as old as the human species, structural violence often forces men living in poverty to leave their homes to search for work in cities, factories and mines where there are no provisions for family life. Such necessary migration for meagre wages, resulting in long absences from the family, sets the stage for multiple sexual partners.

Condom use is rarely under the control of women and access is limited in resource-poor settings. While 'success stories' of commercial sex worker labour unions demanding condom use of their clients do exist, few would argue that a society that affords women no option but prostitution should be considered a 'success' (Crossette, 1995; Hanenberg and Rojanapithayakorn, 1996; AIDS Weekly Plus, 1999; Cohen, 2003, 2004). Collective bargaining around the terms of the commercial exchange of sex only highlights the marginalization of women in a society where sex is their only marketable resource. Women in stable relationships may fare even worse than single women in terms of their ability to use condoms for HIV prevention. Many couples decrease condom use because of greater trust, or in an attempt to conceive children, or because the man holds economic sway and refuses to use a condom. Often, if a woman within a stable union demands that her partner use a condom, she is accused of infidelity, physically abused or even thrown out of the house (van der Straten *et al.*, 1995; De Zoysa *et al.*, 1996; Piot, 1999, http://www.thebody.com/unaids/women_violence.html, accessed 3 December 1999).

Worsening poverty

AIDS is making the world's poorest countries poorer. One only needs to look at the salient economic indicators of family income, food, security, education and health care to see the impact of AIDS in sub-Saharan Africa. In Zambia, two-

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thirds of families who lose the head of the household experience an 80 percent drop in monthly income. In the Ivory Coast, families who lose an adult to HIV experience a 50 percent decrease in household income. Agricultural productivity in Burkina Faso has fallen by 20 percent because of AIDS. In Ethiopia, HIV-positive farmers spend between 11.6 and 16.4 hours a week farming compared with 33.6 hours weekly for healthy farmers (FAO, 2001).

As more adults perish, the education of children is compromised. In Swaziland, school enrolment fell by 36 percent, mainly because girls left school to care for sick relatives. The International Labour Organization estimated that in sub-Saharan Africa, 200,000 teachers will die from AIDS by 2010 (Bennell *et al.*, 2002). A report from the Ivory Coast indicated that in the 1996–1997 academic year, more than 50 percent of deaths among elementary school teachers were from AIDS and 280 teaching hours a year were lost because of teacher absences (Dzisah, 1999, www.aegis.com/news/ips/1999/IP990103.html, accessed 16 Oct 2003). HIV is also having an effect on healthcare workers. In Malawi and Zambia, the death rate of healthcare workers has increased six-fold since the early 1990s. In Southern Africa, 25–40 percent more doctors and nurses will need to be trained during 2001–2010 to compensate for deaths from AIDS.

Access to treatment

Current global inequalities are often the legacies of oppression, colonialism and slavery, and are today perpetuated by radical, market-driven international financial policies that foment poor health. Neo-liberal economic 'reforms' imposed on poor countries by international financial institutions such as the International Monetary Fund and the World Bank force poor governments, as the recipients of qualified loans, to decrease their public sector budgets, privatize health services and, when they would rather invest their minuscule capital to protect their vulnerable citizens and educate their children, these recipient countries are instead forced to march in lock step toward the 'free' market, enforcing policies such as user fees for health and primary education.

In poor countries, revitalizing the public health infrastructure and improving the delivery of essentials such as vaccination, sanitation and clean water are critical aspects to remediating the structural violence that underlies disease. It is only with ongoing, large-scale international assistance that poor governments will be able to address the right to health in a sustained way. Advocacy to redress the violations of the basic right to health must recognize that more money is needed for health now, and for decades to come. Furthermore, the coercion by international financial institutions of poor governments to restrict health spending only serves to deepen inequalities in health care and perpetuate social injustice.

The advent of highly active antiretroviral therapy (HAART, now called ART) in 1996 has caused AIDS mortality to plunge sharply in industrialized countries. The results of ART in the initial studies in 1995 and 1996 were nothing short of miraculous. People who were nearly dead became healthy and strong in a matter of months. So commonly did patients 'rise from the dead' that ART, it was said, had the 'Lazarus effect'. In this time of great promise, the theme of the XI International Conference on AIDS held in Vancouver in 1996 was 'One World, One Hope'. However, while the miracle of Lazarus, a poor leper, was invoked, the poor, who constituted 90 percent of the global AIDS sufferers even then, were not considered for the miracle. In fact, in resource-poor settings, the prospect of initiating ART was summarily dismissed. In effect, once effective therapy for HIV was introduced, treatment and prevention began to be presented as discrete and dichotomous interventions; the argument of limited resources was used to support a prevention-only approach even in the face of the destabilization of families, communities and economies.

Finally, five years and at least 15 million unnecessary deaths later, Kofi Annan, the Secretary General of the United Nations, held a General Assembly Special Session on AIDS (UNGASS). At UNGASS, the Secretary called for the creation of a novel funding mechanism to slow the rapid decimation of the African continent. This multilateral

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mechanism is called the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Since 2003, the GFATM has dispersed three billion dollars to prevent and treat AIDS to more than 150 projects in low- and middle-income countries.

Drugs and intellectual property

While treatment costs were upwards of ten thousand dollars per patient per year in 1998, that same year in which the Global Fund was called for saw the entry of generic antiretroviral drugs onto the market. Advocacy by groups of people living with AIDS, as well as by international groups such as Medicines Sans Frontiers (MSF) and Partners In Health (PIH), was critical in assuring generic companies that if the drugs were cheaper, more patients could be started on therapy. The call for the money assured companies that there would be a 'market' for such drugs. However, efforts at the rapid scale-up were hampered. Pharmaceutical companies, concerned about protecting their intellectual property, invoked patents as well as the World Trade Organization (WTO) agreements that bound signatories to respect patents from any country in which they were issued. AIDS activists, most notably the Treatment Action Campaign (TAC) in South Africa, MSF, Gay Men's Health Crisis and ACT-Up, have continued to fight for the protection of intellectual property in the climate of this global emergency. Within the WTO language, a clause called TRIPS (trade-related aspects of intellectual property) outlines the mandated adherence to intellectual property with a provision for national emergencies that allows for (1) parallel importing – importing the generic version of patented drugs and (2) compulsory licensing – the local development of drugs through a low-cost licensure agreement with the proprietary company. After many rounds of trade talks, it appears finally that this clause will be allowed for countries facing a national emergency due to the AIDS epidemic.

The road block to accepting that AIDS was indeed a national emergency for heavily affected countries was led by the United States under both the Clinton and Bush administrations. Most recently, the President's Emergency Plan for AIDS Relief has mandated that the billions of dollars pledged by President Bush to a US-based programme, rather than the international GFATM, should be used only for branded drugs. Most countries, thankfully, have been able to avoid this issue and purchase generic drugs through other sources. Generic competition has now led to a 100-fold reduction in the price of antiretroviral therapy. Now, at just $150 per patient per year, treatment can be greatly expanded.

Conclusion

Poverty is intimately connected with the HIV epidemic. Structural violence connected with a large variety of factors including economic privation, gender inequality, lack of opportunity for education and work, and migration for work increases the risk of contracting HIV and makes prevention strategies less actionable. Meanwhile, effective, life-prolonging treatment has been available for 12 years, yet the access to this treatment, while being scaled up in resource-poor settings, is yet to reach the poorest. The approach to AIDS therefore must be targeted at the addressing the root causes of the epidemic. New funding through multilateral and bilateral agencies for treatment and prevention must also address economic and educational opportunities, the lack of which will continue to foment the epidemic.

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