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Aids

# Prejudice, Poverty and Aids

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**With over 1.5 million deaths officially estimated in the last 12 months, AIDS is overtaking and interacting with other mass killers. In mid 1996 the United Nations (UNAIDS) estimated that 28 million people had contracted HIV infection world-wide, of whom 6 million had already died. 94% of people with HIV are in Third World countries. Of the 22 million adults now living with HIV, 42% are women, a percentage that is steadily rising.**

Although these global estimates are far more realistic than the official figures the World Health Organisation used to record, they are probably underestimates. As access to health services in Sub-Saharan Africa and South East Asia deteriorates, more and more people become ill and die without treatment or diagnosis. Few countries can maintain comprehensive databases of HIV infection or AIDS mortality, and few can afford effective surveillance testing.

## How Many People Are Affected?

For political and economic reasons, many countries are minimising the dimensions of their problem. Indonesia's official cumulative AIDS mortality is 66, but recently academics at the University of Indonesia published research revealing up to 30,000 unrecorded AIDS deaths each year.

Life expectancy in several countries with well established epidemics has already begun to fall. Life expectancy in Sub-Saharan Africa will decrease from an average of 62 to 47 years by the end of the century. In Zimbabwe, life expectancy for women is expected to fall from 58 years to 30-35 years by the year 2000.

The interaction of HIV infection with tuberculosis (TB) has emerged as a dangerous and key trend in the second decade of the epidemic. TB itself is easily transmissible, particularly to non-HIV positive children and grandparents in the domestic environment. TB can reactivate quite soon after HIV has started to impact on the immune system. The underlying HIV infections often remains undiagnosed in overworked TB wards and clinics. For example, while reports only 235 AIDS cases so far, foreign and local TB specialists maintain that the overwhelming majority of the 13,000 adult TB deaths in the last year have been in people with HIV.

Resources for HIV testing in the Third World have been deployed with little regard as to how testing will benefit affected communities and individuals. Much testing takes place through de-linked surveys, where pregnant women, blood donors or soldiers are tested, often without explanation, and without individuals being told results or offered support. The effect of knowing, as did the pre-massacre Rwandan army, that over 60% of the group will develop a fatal illness, can be disastrous. In some countries, such as Cambodia, those found positive even in individual diagnostic tests are not told, since it is regarded as socially wrong for a doctor to give such bad news to a patient.

## Discrimination against people with HIV

AIDS testing usually means screening out HIV+ applicants for housing, medical aid schemes and insurance, military and police recruits, potential public and private sector employees, applicants for training, and medical patients.

In some provinces of South Africa, one in five applicants for housing loans simultaneously receive news of their

positive HIV result and rejection of their loans. One in ten young men joining the Thai Army are sent home with no ongoing support after their rejection because of HIV.

Several countries use HIV testing as a means of repression against migrant workers, refugees, those suspected of drug use, prostitution or homosexuality. Indefinite detention, or forced relocation are the penalty for testing positive. In 1993 HIV+ Burmese sex workers deported from Thailand were detained and given lethal injections by their country's military regime.

Even in countries with very high rates of HIV and AIDS, there may be very few people publicly known as HIV positive, and those suspected of HIV may be subject to extreme measures of rejection and persecution in their communities. Supportive self-organisations of people with HIV are well-established in some countries of East Africa, and in Thailand, but are at best incipient in most other Asian and African nations.

Organisations of people with HIV in Asia and Africa, dedicated to exercising leadership in AIDS education, or to fighting for basic rights, are even more fragile, despite the efforts of the Global Network of People with HIV (GNP+), the International Council of AIDS Service Organisations, and the repeated manifestos of international conferences since 1983.

## The socio-economic impact

The social and economic impact of the epidemic on several Sub-Saharan African and South Asian countries is already profound. The direct costs of the epidemic include costs of education, testing, the increased use of healers, medicines, clinics and hospitals by people with HIV-related illnesses, funeral and mourning expenses, care of the surviving and now-destitute elderly and orphans. UNICEF estimates there are already 1.5 million orphans with parents lost to AIDS in the most affected African countries.

HIV related illness is an extra burden that threatens to overwhelm the health systems of almost every nation in Africa and Asia. A local hospital or clinic will use scarce resources on treatable conditions, rather than deploy medicines and beds for care of patients that cannot be cured. If a person sick with something they believe to be HIV related knows that the local clinic or hospital can offer no treatment or cure, they will not travel or spend money uselessly, and will not even become an HIV statistic. For most of the affected communities, the direct cost of caring for a family member with AIDS is greater than the annual income, and just one AIDS death can plunge the family into irredeemable poverty. In countries where people rely on medical aid or insurance schemes for their health care, families already affected by HIV cannot afford to pay the premiums, and people testing positive for HIV are excluded from voluntary and employment-based schemes.

Because of its predominantly sexual transmission, HIV strikes disproportionately at those of working age. In some countries it has threatened the urban, trained and skilled labour force. In other areas, AIDS has removed tens of thousands of people from agricultural labour. Few countries can afford a drop in productive labour or the reversion of farming methods to below-subsistence levels, as children and the elderly take up the burdens previously born by the parents and young adults.

HIV incurs disastrous indirect costs to the economy through the absence from work, the overall loss of labour productivity and the difficulty in replacing skilled labour. There is a significant loss in school attendance in families with an adult illness or death. Discriminatory responses to people with HIV in the education and health systems and in the workplace also carry an economic burden, through unnecessary screening, premature dismissals and industrial disruption.

In Thailand HIV may cost 20% of the GNP by the year 2000. Kenya's adult HIV rate of 14%, has caused an estimated 15-25% cuts in profits to non-capital intensive businesses over the last 10 years. In Tanzania, the cost of replacing teachers lost to AIDS over the next decade is estimated at USD\$40 million. Zambia relies for 90% of its export earnings on its copper mines (which are now being privatised at the insistence of the IMF), yet almost 60% of the mines' skilled employees have HIV. In 1991 the Zimbabwe Trade Union Congress estimated that over one fifth of its membership had HIV or AIDS.

At a family level, the death of young adults from AIDS disrupts the generational flow and socialisation patterns. At a national level, AIDS deaths undermine the central infrastructure, with the most expensively (often foreign) educated being disproportionately affected and increasingly difficult to replace with experienced cadre. All eleven of Zambia's air traffic controllers have died of the disease. This unwelcome "turnover" of the highest echelons can lead to national destabilisation. Some UN bodies have made HIV rates a key factor in their assessment that some nation states in Africa are becoming "unviable".

Many nations fear that international awareness of their high rates of HIV will affect investment and tourism. The first example of this was Haiti, where the discovery of high rates of AIDS in 1983 resulted in the decimation of tourist income, then that country's major earner.

Civil wars and UN interventions have exacerbated the spread of HIV, with troop movements, sex for money and rape. The UNTAC intervention in Cambodia resulted in an upswing of commercial sex transactions and HIV incidence, with infection of local women and foreign soldiers and officials.

The experience in Mozambique was similar but worse. The escalation of South Africa's HIV epidemic has occurred only in the 90s, much later than the countries to its north. The country now has an estimated 2.4 million people with HIV, which represents an unparalleled socio-economic challenge. The costs of an epidemic of this scope, though well-predicted, were not factored against the virtually-abandoned Reconstruction and Development Program promises of housing, jobs, health care and education, nor have they been accommodated within the current neo-liberal framework of policy making in the new South Africa.

## Failure of international programs

In 1994, the World Health Organisation (WHO) estimated that if global spending on STD and HIV prevention were increased to (USD) \$1.5-2.9 billion per year, that is ten to fifteen times greater than actual spending, 10 million new HIV infections could be averted by the year 2000.

UNAIDS, whose objective is to coordinate the efforts of six UN agencies in combatting AIDS, was launched one year ago. With continuing conflict between the various bodies, lack of commitment by national governments, and without the promised funding, it has been able to channel only minimal resources to HIV programs in the poorest countries, barely able to assemble infrastructure for its own offices, staff and consultants.

Within bilateral aid packages, a very small percentage actually provides resources for care or prevention at a community level in the most needy countries. For most donor countries, 90% of aid money is spent at home, purchasing testing kits or advice on training, needs assessments, planning or evaluation from profiteering pharmaceutical or development consultancy corporations. At the increasingly large and expensive international Aids conferences, those on A-list circuit of "technical advisers" grow ever richer, while the rhetoric grows more hollow, and the inaction by governments more criminal.

The recent success of anti-retroviral combination therapies among many people with HIV in the imperialist nations throws into stark relief the almost complete lack of access to any but the simplest treatments for symptoms or common opportunistic infections for people with HIV in the Third World. The lives of people with HIV are being squeezed out in a vice. On one side are the very opulent profits of the major drug companies, (Glaxo-Wellcome, Ciba-Geigy, Roche, Abbott, etc), and on the other, the enforcement by the imperialist financial institutions of debt repayments and the structural adjustment plans.

Precisely at the point at which HIV emerged as a large scale epidemic in Sub-Saharan African nations, governments were implementing "as demanded by the IMF" major cuts to public health spending, and dismantling primary health care services. In Zambia per capita annual expenditure on health fell in the 1980s from US\$23 to \$5. Where only user-pays or private health care exists, AIDS victims will only present themselves at a very late stage of the disease, and after the main bread-winner dies, families affected by HIV will be unable to access any care.

While there has been some progress, hopes for effective, cheap and available vaginal viricides, female condoms, and vaccines are a long way from being fulfilled.

## Women's rights

Sexual inequality is a key factor behind the HIV epidemic.

Since more than three-quarters of HIV transmission world-wide occurs during heterosexual sex, the rights of women are a key determinant in for the epidemic. In the long term, women in Africa and Asia will bear a greater AIDS burden than men. In response to HIV, many men select younger partners. In Zimbabwe, five times more women than men under the age of 20 are HIV positive.

It is utopian for AIDS campaigns to encourage women to negotiate condom use with their male partners outside of the context of struggles against rape, sexual and domestic violence, female genital mutilation, struggles for sexual and reproductive self-determination, and for reforms to marriage, divorce, inheritance and property laws, and struggles to increase access by women to health services, basic and technical education, and employment opportunities.

## Commercial Sex

AIDS has occasioned increased repression of women in the commercial sex industry in many countries. Governments and religious NGOs have assumed that women and girls "trapped" in prostitution can be tested, gaoled, retrained or relocated and the problem of infecting heterosexual male clients with "innocent families" will be eliminated. But none of the moralistic or anti-prostitution programs have been able to cut the overall numbers of commercial sex transactions. Every time the Cambodian, Vietnamese, Thai or Filipino governments have declared war on the brothels, they have reopened in increased numbers soon after. For every ex-prostitute retrained in craft and sent home, a younger woman replaces her on the street.

Much more effective in curtailing HIV incidence have been projects which assist sex workers organising for their rights, educating each other, increasing access to non-judgemental sexual health services, standing up to employers, and enforcing safe standards in their working lives. Sex worker organisations have achieved inspiring successes in cities from Nairobi and Durban to Mumbai (Bombay) and Phnom Penh.

# Third World gays struggle for survival

Sexual transmission of HIV between men makes up a relatively small part of overall HIV incidence in the Third World, but amongst homosexual and transgender sub-cultures in many countries, infection rates are devastating.

In many cities, organisations of sexual minorities pre-date AIDS. In Burma, China, Malaysia, Taiwan, Singapore and other countries tentative gay rights organising grew out of youth upsurges in the 80s for democratic rights. But in other Asian and African nations, the advent of HIV has allowed activists from homosexual and transgender communities to claim space and resources. [1]

Traditional transgender identities and sub-cultures are undergoing transformations because of imperialist economic, ideological and cultural expansion, but also because of threats of decimation due to AIDS. The \*leiti\* in Tonga have their own association under patronage of the royal household. Indian \*hijras\*, \*baklas\* in Filipino barrios, \*waria\* in Indonesia and \*kathoey\* in Thailand receive small international grants for AIDS peer-education. From Soweto to Suva, drag beauty contests are being transformed into health education rallies.

Gay organisations have gained some level of official recognition, at least with government health departments, through being able to initiate grassroots AIDS education and support, and provide input to AIDS policy development and planning. Examples of this limited legitimation are Citra Usada in Bali, Gaya Nusantara in Surabaya, Bombay Dost, Pink Triangle in Kuala Lumpur, Library Foundation in Manila, and FACT in Bangkok. In other centres, such as Fiji, Hong Kong and Singapore gay activism has been able to clothe itself in the garb of general AIDS service NGOs.

Last year's Ninth Conference on AIDS and STDs in Africa, held in Kampala, allowed a ground-breaking meeting of lesbians and gay men to establish an information network across dozens of African countries.

The added urgency of organising against HIV among homosexual sub-cultures, and the need for more open discussion of sexual behaviours has led to demands for the repeal of colonial laws against homosexual activities still retained in countries such as India, Singapore, Zambia.

In China and Vietnam, local pragmatism about AIDS prevention has allowed small, and discrete gay groups to form in major cities. In Beijing local health officials worked with a small gay group to produce a leaflet about HIV and safe sex to be distributed to men meeting for sex in parks.

## Golden Triangle?

The "War on Drugs" makes HIV spread faster.

As rural populations in the Mekong are forced to cut opium production, scarcity causes local modes of consumption to switch from traditional smoking, to injection of the "value-added" heroin, often with shared and contaminated injecting equipment. The most dynamic axis of the epidemic is a South-East Asian "corridor" stretching from North East India, across Burma (where 70% of drug injectors are HIV positive), Thailand, Cambodia, Laos, Yunnan and Vietnam. This HIV axis thrives on two economies, the trafficking in opiates and in women.

International and domestic political pressures have led several countries to intensify repression of drug-using groups. In Vietnam, the "struggle against social evils" â€” officially reinvigorated this month in the lead up to the lunar new

year "cleansing" period " targets drug abuse, prostitution, pornography and gambling as the unwanted side-effects of the reintroduction of capitalism.

The strategy in Ho Chi Minh City, where most HIV in Vietnam is centred, has been to round up all drug users and sex workers, confining them to two large "rehabilitation" and detention centres. Inmates are HIV tested, and those found positive cannot be released. Many are newly infected through sexual or drug using activities inside the centres. For the majority of people detected with HIV in Vietnam, the future holds only incarceration until death.

Yet also in Vietnam there have been experiments in allowing the training and development of peer education programs for injection drug users, sex workers and gay men " though more recently these peer groups have become more controlled by local Party cadre. There are trial needle exchange schemes in three districts of Hanoi, and pilot projects in care of HIV positive drug injectors in their family homes.

Similar "harm minimisation" and peer-organising projects for drug injectors have been operating in Nepal, Manipur, Cape Town, Malaysia and Thailand. Even in Yunnan, where China's HIV epidemic is centred, highly repressive responses alternate and co-exist with some more effective and pragmatic interventions.

To effectively minimise HIV transmission through drug injection requires the abandonment of repressive measures against drug users, and the civil space for users to organise themselves.

## Censorship

Northern governments and international institutions boast of the resources they have committed to prevention and education campaigns worldwide. The reality is that, in country after country, explicit information about HIV transmission has been prevented by censorship.

Governments as diverse as Vietnam, Indonesia and Zambia say that condom promotion offends national morals, and that all resources should be devoted to promotion of abstinence, monogamy and family values.

Effective AIDS education includes solidarity with people with HIV. It also requires the widest possible distribution of empowering sex-positive messages. Unfortunately, religious influence over government and NGO programs often prevent or hinder this.

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[1] see Peter Drucker's article in IV no 282, November 1996