MAILMAN SCHOOL
OF PUBLIC HEALTH
Columbia University

Introduction to Sociomedical Sciences
PH-P6700
FALL 2003

Nov. 13 Structural Violence and the Global HIV/AIDS Pandemic
Richard Parker, PhD

Teaching Goals
Introduce the concept of "structural violence" and explore how it relates to the HIV/AIDS pandemic.

Required Reading
Hans A. Baer, Merrill Singer and Ida Susser, "AIDS: A Disease of the Global System," in Hans A. Baer, Merrill Singer and Ida Susser, *Medical Anthropology and the World System: A Critical Perspective*, Westport, Connecticut: Bergin & Garvey, 1997, pp. 159-188.

Richard Parker, "The Global HIV/AIDS Pandemic, Structural Inequalities, and the Politics of International Health," *American Journal of Public Health* 92(3):343-346, 2002.

Eleanor Preston-Whyte, Christine Varga, Herman Oosthuizen, Rachel Roberts, and Frederick Blose, "Survival Sex and HIV/AIDS in an African City," in Richard Parker, Regina Maria Barbosa and Peter Aggleton, eds., *Framing the Sexual Subject: The Politics of Gender, Sexuality and Power*, Berkeley, Los Angeles and London: University of California Press, 2000, pp. 165-190.

Paul Farmer, "Invisible Women: Class, Gender, and HIV," in *Infections and Inequalities: The Modern Plagues*, Berkeley, Los Angeles and London: University of California Press, 1999, pp. 59-93.

hat have influenced the nature of this behavior. As a result, the account provided ere differs from that commonly found in the popular press or in the pro- ouncements of policy makers. We have tried to show that illicit drug use is ot a pathology of poor people per se, but rather an unhealthy condition that is haped by the implementation and enforcement of laws, by the character of class nd racial relations in society, and by the effort of the oppressed to cope with he hidden and overt injuries of racism, classism, and other forms of social igotry. In this context, drug use may function as a form of self-medication for he psychosocial injuries of oppression.

Hans A. Baer, Merrill Singer and Ida Susser, "AIDS: A Disease of the Global System," in Hans A. Baer, Merrill Singer and Ida Susser, *Medical Anthropology and the World System: A Critical Perspective*, Westport, Connecticut: Bergin & Garvey, 1997, pp. 159-188.

Chapter 8

AIDS: A Disease of the Global System

AN OVERVIEW OF THE AIDS CRISIS

It has been said that as AIDS has spread "along the fault lines of . . . society and becomes a metaphor for understanding . . . society" (Bateson and Goldsby 1988:2) it has exposed the "hidden vulnerabilities in the human condition" (Fineberg 1988:128). In other words, while certainly a biological phenomenon, AIDS cannot really be understood only in biological or clinical terms. AIDS, the disease, interacts with human societies and the social relationships that constitute them to create the global "AIDS pandemic," that is, the global distribution of the disease and the social response to it in particular groups and populations. By referring to AIDS as a metaphor for society, Bateson and Goldsby draw attention to an issue that will be of central concern in this chapter, namely, the way in which the AIDS crisis exposes the nature and consequences of social inequality within and between nations and groups in the contemporary world.

In exploring the relationship between AIDS and society, it is important to begin by emphasizing that the AIDS crisis is of considerable and growing magnitude. AIDS is now the leading cause of death among men in the U.S. between the ages of twenty-five and forty-four and the second leading cause of death among women in this age group. On a global scale, Jonathan Mann, director of the International AIDS Center of the Harvard AIDS Institute, and his coeditors of *AIDS in the World* report:

> In the first decade of response to AIDS, remarkable successes in some communities contrast dramatically with a sense of threatening collective global failure. The course of the pandemic within and through global society is not affected—in any serious manner—

by the actions taken at the national or international level. . . . As we enter the second decade of AIDS, it is time to ask: Is the AIDS pandemic now out of control? (Mann et al. 1992:1)

The inability of nations, individually and collectively, to respond effectively to the threat of AIDS suggests underlying dimensions of the global system that will be examined in this chapter.

Certainly the sudden appearance of AIDS in the early 1980s was a profoundly unexpected occurrence, "a startling discontinuity with the past" (Fee and Fox 1992:1). Global public health efforts that date to the period before the beginning of the AIDS pandemic, such as the successful smallpox eradication program, "reinforced the notion that mortality from infectious disease was a thing of the past" (McCombie 1990:10). Consequently, whatever the actual health needs of particular populations, the primary concerns of the biomedical health care system have been the so-called Western diseases, that is, chronic health problems, such as cancer and cerebrovascular problems, common in a developed society with an aging population. This surely has been the case in the United States comments Brandt (1989:367): "The United States has relatively little recent experience dealing with health crises. . . . We had come to believe that the problem of infectious, epidemic diseases had passed—a topic of concern only to the developing world and historians."

However, as a result of AIDS, the term *epidemic* has been thrust back into the popular vocabulary in recent years. Many definitions of this term exist. Marks and Beatty (1976), in their history of the subject, adopt a broad approach and include both communicable and noncommunicable diseases that affect many people at one time. Epidemics (a word formed by joining *epi* or "in" with *demos* "the people") are conceptually linked to other words in the "demic" family of terms, including "endemics" (from *en* or "on"), which are nonexplosive, entrenched diseases of everyday life in particular communities, and "pandemics" (from *pan* or "all of"), which are epidemics on a widespread or global scale.

AIDS in this sense is best described as a pandemic. It is now found in every nation on the planet. Further, it has spread, although far from uniformly, to people of every age, race, class, ethnicity, gender, sexual orientation, and religion. By 1992, about thirteen million people around the globe were infected by the human immunodeficiency virus (HIV), the pathogen that causes acquired immunodeficiency syndrome (AIDS), and the number has continued to grow since. Unfortunately, no country or community that has been struck by the pandemic has been successful in stopping the spread of the virus.

With the transmission of the virus to diverse new populations through a number of routes of contagion tied to a range of behaviors, the pandemic becomes ever more complex and can be said to be composed "of thousands of smaller, complicated epidemics" in local settings and populations (Mann et al. 1992:3). These local epidemics reveal that in each setting somewhat different subgroups

are put at risk, but almost always it is those who have the least power in society or are otherwise subject to social opprobrium and public disparagement who are the most likely to be infected.

Throughout its known history, HIV "has repeatedly demonstrated its ability to cross all borders: social, cultural, economic, political," but this often has not brought people closer together to appreciate their common plight and their shared needs as human beings (Mann et al. 1992:3). Rather, the pandemic generally has led to increased conflict and social contestation, usually on preexisting lines of tension. Indeed, AIDS has become probably the most political affliction visited upon the human species in modern times. The disease caused by this "strange virus of unknown origin" (Leibowitch 1985) reminds us, in fact, just how political are all facets of health, illness, treatment, and health-related discourse.

In sum, AIDS has revealed itself as a disease of social relationship—not merely a social disease, but a disease of society as it is constituted as a markedly stratified and widely oppressive structure. This occurs locally within communities, nationally within the social systems of individual countries, and internationally within the global system of nations. The social features of the AIDS pandemic as it reflects and reveals aspects of the global system, as well as social features of some of the local epidemics that comprise the larger AIDS crisis, are explored in this chapter. To help clarify the social dimensions of the AIDS pandemic as a disease of the world system, we begin with a Closer Look at AIDS within a country generally seen as being one of the poorest in the world, and, in part, as a result, one with a well-developed AIDS epidemic.

"A Closer Look"

THE HEALTH CONSEQUENCES OF BEING A PERIPHERAL NATION IN THE GLOBAL SYSTEM: AIDS IN HAITI

As the second New World colonial creation to successfully overthrow European political dominance and the world's first independent black republic, Haiti has long held a special place in Eurocentered global politics and political discourse. This place was defined early in Haitian history. Absorption of the Caribbean island of Hispaniola that Haiti shares with the Dominican Republic into the world system began on December 5, 1492, with the arrival of Columbus. Over the next ten years, the indigenous population of island Arawak and Carib peoples was enslaved and decimated by forced work in Spanish gold mines. To replace this lost workforce, in the 1520s the Spanish began importing kidnapped Africans to serve as slaves. The wealth and pivotal position of the island attracted French pirates and buccaneers, who seized the tiny neighboring island of La Tortue in 1629 and made it their base for preying on the sea trade hauling the extracted wealth of the New World back to the colonial centers of Europe. Based on this foothold, the French were able to claim sovereign control of the

western third of Hispaniola in 1697, known officially as Saint-Domingue. The French colloquially referred to their New World colonial possession as La Petite France (the Little France) or Grande Isle á Sucre (the Great Sugar Island). By the last years of the eighteenth century, the colony, which was seen as a great source of wealth and productivity, accounted for two-thirds of France's foreign trade. At the time, the population was composed of 40,000 white settlers, 28,000 mulattoes of mixed ancestry, and 450,000 black slaves.

Following on the heels of the American revolution, and certainly inspired by the American victory over British colonialism, a general slave rebellion was launched in Saint-Domingue in 1791. A little over a decade later, rebellious forces under Jean-Jacques Dessalines proclaimed independence from France and adopted the indigenous Indian name of Haiti (mountainous land) for their new nation. The character of its distinctive role in core-periphery relations in the global system was established early in Haiti's history as a free nation. In the first decades after the Haitian revolutionary victory over French hegemony in 1804, a U.S. senator from South Carolina described U.S. policy toward its sister New World republic, saying, "We never can acknowledge her independence . . . which the peace and safety of a large portion of our union forbids us even to discuss" (quoted in Metraux 1972:9). Fearful of the lessons of a triumphant slave rebellion, the West condemned Haiti to the status of an international pariah state, a position that was sustained through the projection onto the former colony of an image of dangerous and bizarre Otherness (e.g., Loederer 1935; Seabrook 1929). In the Western imagination, Haiti was constructed as "another world far from what they know as ordinary" (Barry, Wood, and Preusch 1984:337). Thus, voodoo, the indigenously formed syncretic religious system of Haiti, became synonymous in the West with evil, the epitome of so-called black magic, zombiism, strange trances, unearthly feats, and unbridled animalistic sexuality.

With the appearance of AIDS, this distorted portrayal was generalized and Haitians themselves were represented as dangerously infectious and life threatening by their very nature. By 1982, within a year of the identification of the first cases of what was to be termed AIDS (see below), Haitians were labeled as a "risk group" by the U.S. Centers for Disease Control. As a consequence, it was not long before being a Haitian "meant that you were perceived as an AIDS 'carrier' " and "the fact that AIDS was found among heterosexuals in Haiti . . . [was read as] evidence that Haiti was the *source* of the disease" (Gilman 1987:102). The U.S. press carried stories quoting Dr. Bruce Chabner of the National Cancer Institute, who reported, "We suspect that this [disease] may be an epidemic Haitian virus" (quoted in Farmer 1992:2). The politico-ideological context for these developments lay in the well-established constructed images of Haiti.

> The link between AIDS and Haiti, strengthened in innumerable articles in the popular press, seemed to resonate with what might be termed a North American "folk model" of Haitians. . . . The press drew upon readily available images of squalor, voodoo, and boatloads of "disease-ridden" or "economic" refugees. One of the most persistently invoked associations related the occurrence of AIDS in Haitians to voodoo. Something that happened at these ritual fires, it was speculated, triggered AIDS in cult adherents, presumed to be the quasitotality of Haitians. (Farmer 1990:416)

The link with voodoo was asserted or suggested in both medical and social science texts. In the October 1983 issue of *Annals of Internal Medicine*, for example, two physicians from the Massachusetts Institute of Technology suggested that it was "reasonable to consider voodoo practices a cause of the syndrome" (Moses and Moses 1983:565). Other "bizarre" or "weird" features alleged to be characteristic of Haiti also were implicated.

> Some US researchers proposed that AIDS began with an outbreak of African swine fever in Haitian pigs, and the swine virus had been passed to humans. Others suggested that a Haitian homosexual may have contracted the swine virus from eating undercooked pork, and then passed it on to homosexual partners from the United States during acts of prostitution. . . . Others proposed that Haitians may have contracted the virus from monkeys as part of bizarre sexual practices in Haitian brothels. (Sabatier 1988:45)

As the critical medical anthropologist Paul Farmer notes (1990:438), "Even cannibalism, the most popular nineteenth-century smear, was resuscitated during discussions of Haiti's role in the AIDS pandemic." In the dark light cast by such linkages, in 1990 the U.S. Food and Drug Administration banned Haitians from donating blood.

All along, Haitian physicians studying the disease had produced evidence to support an alternative, more mundane, although no less politically significant explanation of the high prevalence of AIDS among Haitians. Research by these physicians found that most early cases could be traced to Carrefour, a red-light prostitution center on the southern end of the Haitian capitol of Port-au-Prince. Testing of stored blood samples that were drawn from Haitian adults during an outbreak of dengue fever in 1977–1979 found that none carried antibodies to HIV. These data were consistent with the hypothesis that HIV was not indigenous to the country but had been introduced into Haiti in the late 1970s or early 1980s either by tourists or by returning Haitians coming from the United States or Europe (Pape et al. 1986). In addition to seeking an opportunity to purchase inexpensive "ethnic" curiosities, acquire value-gaining primitivist paintings, and take pictures of barefooted women balancing large bundles on their heads as they walked passed traditional-looking thatched huts, it is well known that many foreigners came to Haiti during the 1970s tourist boom seeking sex. Thus, a Club Méditerranée was established in Port-Au-Prince in 1980, and erotic accounts of available fun in the brilliant Haitian sun were common in tourist guides of this period. Not surprisingly, admitting to exchanging sex for desperately needed tourist dollars was quite frequent among early Haitian AIDS patients.

Driven by poverty that was itself the product of Haitian subordination to

external economies and internal stratification, prostitution became a means of survival for some rural migrants to Haiti's crowded capitol city. In short, the politics of AIDS among Haitians and other Caribbean peoples are the politics of political-economic domination and, as a result, "the map of HIV in the New World reflects to an important degree the geography of U.S. neocolonialism" (Farmer 1992:261). But this set of political relations was successfully submerged in more exotic accounts of Haitian AIDS, images that exuded racism while they mystified hegemony. The mundane and age-old tale of political-economic domination leading to sexual domination, which is a good piece of the real story of Haitian AIDS, remained hidden behind buried newfangled renditions of the master's fear of the rebellious subordinate. And, in various guises, this is a significant part of the history and politics of AIDS everywhere, from the preoccupation with "discovering" the African origins of the epidemic to the effort to construct AIDS as a disease peculiar to the bodies of gay men and people of color (see below), a disease of the distant and diminished Other.

Ironically, Haitians have their own theory of how AIDS, or *sida* as it is known in Creole, came to their island and how it spread to large numbers of individuals living throughout Haiti, especially among those in urban areas from the poor and working classes. This theory, while no less a cultural creation than other popular ideas about AIDS, nonetheless reflects a clearer understanding of the global system than is commonly found among North Americans and is an example of the fact that those at the bottom often have a somewhat better and less mystified understanding of the actual nature and structure of oppression than those higher up the ladder of social power.

> Dieudonné [a Haitian AIDS patient] tended to cast things in sociological terms. . . . Dieudonné "wondered whether *sida* might not have been sent to Haiti by the United States. That's why they were so quick to say that Haitians gave [the world] *sida*." When asked why the United States would wish such a pestilence on Haitians, Dieudonné had a ready answer: "They say there are too many Haitians over there now. They needed us to work for them, but now there are too many over there." (quoted in Farmer 1992:242)

The social history of AIDS as an identified disease in epidemiology and biomedicine, the topic examined in the next section, reveals additional dimensions of the politics of AIDS.

THE HISTORY AND BIOLOGY OF AIDS: CONTROVERSIES IN SCIENCE AND SOCIETY

In the highly controversial world of AIDS, there is much about which we still are uncertain. The beginning of the AIDS pandemic—not the point at which the virus began to spread in human populations but the point at which people began to recognize this was happening—is not in dispute, however. During 1980, fifty-five young men in the United States, primarily self-identified gay men, were diagnosed with various diseases that ultimately came to be linked with AIDS. The health problems of these men were noticed because they sought medical care; their physicians, in turn, unable to halt the infection with standard remedies, sought approval to use a second-line antibiotic (pentamidine) from the Centers for Disease Control. The first report of an emergent health problem suggested by the diseases of these men appeared on June 5, 1981, in a widely read public health publication, the Centers for Disease Control's *Morbidity and Mortality Weekly Report (MMWR)*. This article, which focused on five cases from Los Angeles, did not mention that the people who were coming down with an unusual form of pneumonia were gay men. On July 4, 1981, however, the same publication carried a second article entitled "Kaposi's Sarcoma and *Pneumocystis* Pneumonia among Homosexual Men—New York and California." This linkage of a rare cancer with a rare pneumonia (caused by a harmless parasite for those with healthy immune systems) in a geographically dispersed population defined by sexual orientation was startling. The story was picked up immediately in both the *New York Times* and the *Los Angeles Times*, and soon found its way into the mass media throughout the country.

But epidemiologists and other health researchers were puzzled by the epidemic that appeared to be breaking out around them. While it was clear that the disease was linked to a breakdown in the body's natural defense system, the immune system, the cause of immunosuppression (i.e., a breakdown of the immune system) was unclear. Was it the result of environmental conditions, dietary practices, a promiscuous fast-lane gay lifestyle, or the inhalation of amyl or butyl nitrite poppers to enhance sexual or dance-floor arousal? No one was sure. There was less uncertainty, or so it seemed, about who was becoming ill. In December 1981, David Durack wrote an editorial for the *New England Journal of Medicine* proposing a multifactorial disease model that centered on the interaction between recurrent sexually transmitted disease and popper use as the cause of immunosuppression in gay men. Before long, the term *gay plague* had made its way into popular discourse. The new disease complex appeared to single out and attack only gay men, particularly those with a promiscuous lifestyle. Ultimately the term gay-related immune deficiency (GRID) was suggested to label the new syndrome descriptively. In short order, San Francisco, especially the heavily gay-populated Castro Street area, came to be thought of as "AIDS City, U.S.A." (Shilts 1987:268) in the popular imagination. In this way, gay lifestyle became an intensified object of mainstream social derision; not only was it seen by many as being immoral, but now it could be said to be life-threatening as well. Some people began to see the new disease complex as divine punishment for violating religious prohibitions against homosexuality. That the disease appeared to target gay men but avoid lesbian women created a certain dilemma for the divine punishment argument. The rapid appearance of the disease among blood-transfusion patients, individuals who seemingly were not guilty of any known moral transgression, further undercut but has never eliminated the appeal of a punitive view of the disease.

But the narrow focus on gay lifestyle during the early years of the pandemic overlooked a growing body of evidence that immunodeficiency diseases like Kaposi's sarcoma (KS) and especially pneumocystis carinii pneumonia (PCP) also were showing up in increasing numbers among heterosexual drug injectors, their lovers, and their children, especially in New York and New Jersey. In December 1981, for example, when Arye Rubinstein, chief of Albert Einstein's medical college Division of Allergy and Immunology submitted a paper to the annual conference of the American Academy of Pediatrics suggesting that the African-American children he was treating in the Bronx, New York, were suffering from the same disease as immunodeficient gay men, he was rebuffed.

> Such thinking . . . was simply too farfetched for a scientific community that, when it thought about gay cancer and gay pneumonia at all, was quite happy to keep the problem just that: gay. The academy would not accept Rubinstein's abstract for presentation at the conference, and among immunologists, word quietly circulated that [Rubinstein] had gone a little batty. (Shilts 1987:104)

The same pattern occurred among inner-city adult drug injectors, who began exhibiting immunodeficiency disorders in the early 1980s. Consistently, health officials "reported them as being homosexual, being strangely reluctant to shed the notion that this was a gay disease; all these junkies would somehow turn out to be gay in the end, they said" (Shilts 1987:106).

By 1983, however, intravenous drug users (IDUs) constituted the majority of immunodeficiency cases in the Northeast. Still, among epidemiologists focused on the gay-lifestyle explanation, "There was a reluctance to believe that intravenous drug users might be wrapped into this epidemic" (Shilts 1987:83). Nonetheless, the first clinical description of immunosuppression and opportunistic infection among injection drug users appeared in *MMWR* in December 1981, followed by a second report in June 1982 that indicated that 22% of new patients with KS and PCP were heterosexuals, the majority IDUs. Crimp (1988:249), in fact, has suggested that the

> AIDS problem did *not* affect gay men first, even in the US. What is now called AIDS was first *seen* in middle-class gay men in America, in part because of [their] access to medical care. Retrospectively, however, it appears that IV drug users—whether gay or straight—were dying of AIDS in New York City throughout the '70s and early '80s, but a class-based and racist health care system failed to notice, and an epidemiology equally skewed by class and racial bias failed to begin to look *until* 1987.

In fact, IDUs continued not to be counted accurately in the AIDS statistics for several years after 1987 (at least until 1993, when the CDC definition of AIDS changed), and, because they often are not well served by the health care system, are probably still not being counted fully today. As Friedman, Sufian, and Des Jarlais (1990:47–48) note

> a large proportion of the deaths among HIV-infected intravenous drug users in New York City occurs through diseases that are not classified as AIDS under the Center for Disease Control criteria [for defining AIDS]. . . . Many intravenous drug users die of "non-AIDS" HIV-related disease before they develop the specific opportunistic infections that qualify as AIDS, such as pneumocystis carinii pneumonia.

The actual term *acquired immunodeficiency disease* (AIDS) was introduced in 1982, when the growing number of blood transfusion cases made it clear that GRID or other gay-specific terms were problematic. But the cause of acquired immunodeficiency was still not clear. A number of scientists on both sides of the Atlantic became committed to finding the common cause of AIDS among gay men, IDUs, blood-transfusion recipients, and, in Africa, large numbers of non-drug-using heterosexual women and men. Many were now sure that a distinct pathogen had to be involved because AIDS patients did not share a common lifestyle or set of environmental conditions. Blood transfusion cases made it clear that the pathogen in question had to be found in the blood. Cases of sexual transmission suggested that other body fluids harbored the pathogen as well. Then, on April 23, 1984, Margaret Heckler, Secretary of the Department of Health and Human Services, held a press conference to announce that "the long honor roll of American medicine and science" had recorded another miracle; the virus that caused AIDS had been discovered. Flushed with confidence and enthusiasm, she also added that a vaccine to stop the virus would be ready for testing in two years, an achievement that has yet to be added to the "honor roll" of medicine and science. The Heckler announcement created an international stir. For many subsequent years a debate has raged over whether HIV was first isolated in France at the Pasteur Institute laboratory of Luc Montagnier or in the United States at the National Cancer Institute laboratory of Robert Gallo. Both labs were working feverishly on discovering the pathogenic cause of AIDS. Heckler's press conference, in fact, was designed to cut off the French and patriotically to claim American credit for the discovery of HIV as well as the profits to be gained by designing a blood test to detect the virus. Anthropologically, these events are of interest because they reveal the underlying political-economic nature of scientific work. Ultimately, Gallo and Montagnier agreed to share credit for the discovery, but tension continued for years.

The April 11, 1983, issue of *Newsweek* magazine, which carried a cover story labeling AIDS the "Public Health Threat of the Century," signified a new era in AIDS media coverage. Notes Shilts (1987:267):

> In the first three months of 1983, 169 stories about the epidemic had run in the nation's major newspapers and newsmagazines, four times the number of the last three months of 1982. Moreover, from April through June, these major news organs published an astonishing 680 stories.

AIDS was coming to be recognized as a major health problem, one that was not narrowly limited to any specific population subgroup. With this recognition, the level of public hysteria about AIDS began to grow enormously.

In subsequent years, a lot has been learned about HIV. Numerous scientific debates notwithstanding, it is clear that infection by HIV alone or in conjunction with other organisms causes a severe crippling of the body's natural defense capacity, allowing an array of available viruses, fungi, bacteria, protozoa, bacilli, and other microbial parasites to attack several bodily systems. This destruction leads for many—but for not all—to death within about ten years from the point of infection (with the course of infection being conditioned by the viral strain, prior health of the host, living conditions of the infected individual, and a variety of other known and unknown factors). It is clear that HIV thrives in certain body fluids and that the "exchange" of these between people—directly or indirectly (e.g., during sex or through the reuse of hypodermic needles)—is the route of transmission in human populations. There is a range of cofactors, such as prior STD infection, that influence the likelihood of HIV infection should an individual engage in what have come to be labeled "risk behaviors" (i.e., behaviors that allow the exchange of certain body fluids, particularly blood, semen, or vaginal secretion). It also appears that certain powerful drugs alone or in combination hamper the reproductive efficacy of HIV, at least for a period of time. It is also certain that rates of HIV infection, opportunistic diseases, the duration of symptom-free vitality after infection, lengths of survival with infection, and routes of transmission vary across social categories, classes, and groups, as well as geographic regions.

Science, in fact, has produced more knowledge about HIV than any other known virus. Because of AIDS, we now realize that "infectious diseases are not a vestige of our premodern past; instead, like disease in general, they are the price we pay for living in the organic world" (Morse 1992:23). But, because of AIDS we also know that the price of living in an organic world is not paid equally by all of those who live in that world. Indeed, while the virus is a product of the organic world, the AIDS pandemic (i.e., who is likely to become infected and who is not) is a social creation. In other words, as William McNeill (1976) suggests in his book *Plagues and Peoples*, it is important to differentiate between *microparasitism* and *macroparasitism* and to examine interrelations between the two.

Microparasites are tiny organisms like HIV that find the resources for sustaining their vital processes in human tissues and in the process may cause sickness or even death. In the case of HIV, it appears that the virus needs host-cell proteins to be able to transcribe its RNA genome (i.e., its genetic code for making copies of itself), synthesize its glycoprotein outer coat that shields the genome, and assemble new infectious virons that can, in turn, seek out new host-cells for continuing the process of replication. As it invades a host-cell, HIV harvests proteins that it finds there, including cyclophilin A, actin, and ubiquitin. Without these "stolen" proteins, HIV would not be able to reproduce itself or successfully to avoid destruction by the body's immune system (e.g., it is thought that by covering itself in the type of proteins found on the surface of human cells HIV virons may evade the immune system by masquerading as human blood cells).

Macroparasites, by contrast, are larger organisms that prey on humans, "chief among which have been other human beings" (McNeill 1976:5). In the course of human history, macroparasitism has become ever more important in determining human health.

> In early times, the skill and formidability of human hunters outclassed rival predators. Humanity thus emerged at the top of the food chain, with little risk of being eaten by predatory animals any more. . . . Later, when food production became a way of life for some human communities, a modulated macroparasitism became possible. A conqueror could seize food from those who produced it, and by consuming it himself become a parasite of a new sort on those who did the work. In specially fertile landscapes, it even proved possible to establish a comparatively stable pattern of this sort of macroparasitism among human beings.

The emergence of a class structure, as McNeill shows, institutionalized macroparasitism. Moreover, as the case of HIV suggests, *microparasitism and macroparasitism interact*. As a consequence of the effects of macroparasitism some human beings—those who have less power and resources in society—are put at greater risk for exposure to and infection by various microparasites like HIV. This interconnection explains why poorer, less powerful classes in society and nations in the global system suffer more from disease than their rich, more powerful counterparts.

A GLOBAL PICTURE OF AIDS

AIDS, as we have seen, is a global disease. It is found on every continent and probably in every country in the world. It is believed that the worldwide spread of HIV began in the mid to late 1970s. In North America, over a million people had become infected with HIV by 1992. Many were still symptom-free, while others had progressed through one or more stages in the deterioration of their immune system, allowing opportunistic infection by various progressively lethal pathogens. At the time, there were over 250,000 diagnosed cases of AIDS in North America, about 10% of the world's cases, according to *AIDS in the World* estimates (Mann, Tarantola, and Netter 1992). Across the Atlantic, there were over 100,000 diagnosed cases in Western Europe, while sub-Saharan Africa was rapidly moving toward recording its two-millionth case, over 70% of the diagnosed cases in the world. Latin America accounted for 7.5%, and the Caribbean 2%; Southeast Asia, a locus of new infection, reported about 3% of the world's AIDS cases. Even on the dispersed islands of Oceania, there were about 5,000 AIDS cases. By 1992, AIDS cases had been reported to the World Health Organization (WHO) from 164 countries, including 52 countries in Africa, 45 in the Americas, 28 in Asia, 28 in Europe, and 11 in Oceania. Between

1985 and 1990, there was a sevenfold increase in the number of new AIDS cases reported to WHO (Mann, Tarantola, and Netter 1992). Given the fact that it is generally recognized that WHO only receives partial data from many areas of the world, the number of AIDS cases may have been even higher by 1992 than in those figures. While the numbers have continued to climb since 1992, the trends are clear. AIDS has become a major source of morbidity and mortality on a global scale. Unlike many other diseases, it is a killer of both children and young adults of child-bearing age, and the largest health and social impacts are yet to come.

> Projecting to the Year 2000, the most conservative . . . estimates suggest that a minimum of 38 million adults will become HIV infected: a more realistic project is that this figure will be higher, perhaps up to 110 million. An increase to 119 million adults means that over six times more adults will have become HIV infected from 1995 to 2000 than became infected from the beginning of the pandemic until 1995. In this scenario, the number of cumulative AIDS cases by the year 2000 would reach nearly 25 million. (Mann, Tarantola, and Netter 1992:3–4)

This statement makes it clear that we are far closer to the beginning of the history of the AIDS pandemic than we are to its end. On a global scale, how are we to understand this history? Elizabeth Fee and Nancy Krieger (1993:323) have argued that

> the history of AIDS does not simply present itself as a chronological succession of events. It is a history that necessarily is constructed and that cannot simply be inferred from the biological properties of HIV or the pathological realities of the disease.

The dynamic, still-evolving world AIDS picture, in fact, can only be understood in light of a wide range of cultural practices and in terms of global, national, and local political-economic relations. This is so because *the key dimensions in the spread of AIDS are human behavior and human relations*. Factors that shape the collective patterns of human behavior, from inegalitarian class or gender relations to particular cultural beliefs about reproduction or sexual pleasure, therefore, constitute critical promotors or inhibitors in the spread of HIV. The role played by some of these factors can be seen by examining a few of the local epidemics that comprise the larger global AIDS pandemic.

India and Thailand

There was a dramatic increase in the number of AIDS cases in Southeastern Asia during the late 1980s and early 1990s. Previously, countries in Asia had been labeled "Pattern III." In one of the early epidemiological efforts to organize the global AIDS picture, this meant that rates of HIV infection were quite low and usually were a consequence of recent extensive contact with higher infection "Pattern I" countries (those with high rates of transmission through drug use and homosexual contact) or "Pattern II" countries (those with

high rates of transmission through heterosexual contact). Today, these patterns no longer hold, and this classification system been dropped. Southeast Asia is one of the reasons for this change. In India, HIV prevalence among STD clinic patients in the city of Bombay jumped from 4.3% in 1989–90 to over 30% in 1991. Professional sex workers in Bombay (i.e., those who sell sex for money or other items of desire), a group estimated to be between 100,000 to 150,000 in number, had an HIV seroprevalence (i.e., rate of infection) rate of 1.3% in 1987. A few years later, some studies were reporting rates of infection of 60% this population. In the east Indian state of Manipur, HIV prevalence among IDUs was found to be minimal in 1986. Four years later, over half of IDUs tested in Manipur were seropositive (i.e., infected with HIV). Similar increases also were recorded in Thailand. By 1994, it was estimated that there were over half a million people with HIV infection in the country. Studies in northeast Thailand show that the primary means of HIV transmission is through prostitution. In the provincial capital of Khon Kaen, for example, four hundred professional sex workers, all women, have been identified. These women work out of a variety of sites, including massage parlors, brothels, barbershops, night clubs, restaurants, and short-stay hotels. About 20% of these sex workers were seropositive by 1994. Studies suggest that between a quarter and a half of Thai men have frequented professional sex workers. Nonetheless, a community study of married women in twelve villages in Khon Kaen Province showed that most women do not believe themselves to be at risk for HIV infection. The reason most frequently given by women for not believing they are at risk is that their husbands never frequent professional sex workers (Maticka-Tyndale et al. 1994). As these data suggest, gender relations and gender inequality can be a critical factor in AIDS transmission. Thailand, in fact, is one of a number of sites in Asia where international prostitution or sex tourism flourishes. The practice involves individuals or groups of foreign male visitors booking holiday vacations that include numerous visits to local brothels, x-rated clubs, and massage parlors. These "businessman's holidays" have created a lucrative income for those who run the sex trade business. Girls and young women who wind up in the sex trade often are duped into coming to urban areas from the countryside through bogus offers of legitimate employment or access to education.

AIDS, Crack, and Sex

The impact of gender inequality on the transmission of AIDS is not peculiar to Asia. The spread of crack cocaine use during the 1980s in the United States, for example, has contributed to a significant increase in sex-for-drugs exchanges that has caused a notable rise in HIV infection among poor women. Commonly, these exchanges involve behaviors that place women at high risk for HIV infection. Often, in addition, they involve women in sexual behaviors that violate their values and leave them feeling dehumanized and defeminized. As Lowen and coworkers (1993:97) report,

There is a critical element of coercion involved in the degradation associated with crack addiction. This has parallels with rape and torture, where the victim has been forced to perform acts that violate personal standards for human behaviour. . . . In the case of women driven by crack addiction, the . . . source of their stigmatization is the loss of "womanliness" as defined by cultural ideals.

Lown and coworkers (1993:101) attribute the rise in crack addition, particularly in the African-American community, to radical changes in the economic infrastructure of inner-city communities: "Previously, blacks could compete for unskilled jobs but such employment has all but disappeared from the inner city." The crack industry has emerged as an arena of employment and economic "opportunity" for individuals cut off from the legitimate labor market. Some researchers have even described crack sales as a form of ethnic enterprise among those who are blocked by racism and other structural barriers from legal business ventures. As discussed further below, marketing crack to the poor and to women, however, has contributed significantly to the inner-city AIDS crisis.

AIDS and Urban Policy

Roderick Wallace (1990) has analyzed the social distribution of AIDS in New York City in terms of the social disorganization of poor neighborhoods caused by changes in social policy, such as the withdrawal of essential municipal services like fire protection, implemented with the intention of lowering population densities and achieving planned population shrinkage in targeted neighborhoods. Without public services, areas begin to deteriorate. Fires, of both intentional and accidental origin, destroy building after building, and none are repaired. After service withdrawal by the City Planning Commission and other government agencies, Wallace has documented a subsequent mass migration of people from burned-out areas into nearby neighborhoods, which themselves become overcrowded and are targeted for service reduction and subsequent burnout and migration. In areas undergoing this process of "urban desertification," community life, social networks, and other forms of social support are severely disrupted. These changes are associated with heightened rates of substance use and HIV infection. At the heart of one of the most devastated urban zones studied by Wallace, a section of the South-Central Bronx, 25% of emergency-room patients in the local hospital have tested positive for HIV infection. Wallace concludes that social policies, which are fairly direct expressions of social relations among contending social classes (i.e., those selected to sit on government planning commissions versus those who live in impoverished neighborhoods), propelled the urban environmental changes that produced a skyrocketing of HIV morbidity and mortality rates in parts of New York City.

Low-Intensity Wars and the Spread of AIDS

While most attention on the spread of AIDS has been focused on individual psychological factors, social conflicts, including war, have been shown to have

a significant impact on AIDS risk. Wars disrupt established patterns of social support and subsistence. As these patterns break down, as in the urban desertification example discussed above, new behavior patterns appear, which, under highly strained conditions, may increase the opportunities for AIDS transmission. Baldo and Cabral (1991) have called attention to the AIDS impact of one particular kind of war that has raged in a number of areas of southern Africa in recent decades. This warfare has been called "low intensity" because it involves intermittent periods of open military conflict followed by prolonged periods of economic sabotage, that is, destruction of vital infrastructures like health and education services (e.g., through assassinations of doctors and teachers and the burning of clinics and schools). This type of warfare produces massive numbers of refugees, frequent troop movements through civilian areas, the appearance of bandit groups, forced recruitment of soldiers, and a general impoverishment of the countryside. All of these factors increase the likelihood of prostitution, multiple sexual partners, inability to know about or use safer-sex practices, the spread of STDs and other HIV cofactors, and a lack of medical care. It is important to recognize that low-intensity wars are not sustained without outside economic and political support. In the low-intensity wars that have devastated the southern African countries of Mozambique, Angola, and Zimbabwe, the former apartheid government of South Africa played a critical role in supporting rebel forces. Elsewhere in the world, other governments have supported similar arrangements to promote their political ends. The United States, for example, supported and financed a low-intensity war against Nicaragua during the 1970s and 1980s.

As these examples suggest, the causes of AIDS transmission involve far more than individual psychological factors or intentions. The nature of the interaction of AIDS with social relations and social conditions is further revealed through an in-depth examination of an individual case. In the discussion above, we noted several cases in which unequal social relations—gender relations, racial relations, and class relations—contributed to the spread of AIDS among the urban poor in the United States. We continue that discussion below by looking at AIDS as it interacts with other health and social conditions to create a broader phenomenon that has been called the *inner-city AIDS syndemic*. The term *syndemic* (Singer 1994) refers to a major set of synergistic or intertwined and mutually enhancing health and social problems facing the urban poor. Developing this concept requires a Closer Look at health in the inner city.

"A Closer Look"

THE INNER CITY SYNDEMIC: AIDS AND THE BIOLOGY OF POVERTY

It is widely known that the health status of inner-city communities in the United States is notably worse than that of wealthier population groups. Health

in the inner city is a product of a particular set of closely interrelated endemic and epidemic diseases, all of which are strongly influenced by a broader set of political-economic and social factors, including high rates of unemployment, poverty, homelessness and residential overcrowding, substandard nutrition, environmental toxins and related environmental health risks, infrastructural deterioration and loss of quality housing stock, forced geographic mobility, family breakup and disruption of social support networks, youth gangs and drug-related violence, and health-care inequality. Urban minority communities are known to suffer from disproportionately high rates of preventable infant mortality and low birthweight, diabetes, hypertension, cirrhosis, tuberculosis, alcohol and drug-related health conditions, and sexually transmitted diseases. As a result, as McCord and Freedman (1990) have observed, men in Bangladesh have a higher probability of survival after age thirty-five than men in Harlem. More generally, "The death rate in blacks is higher than that in whites, and for many causes of death mortality differentials are increasing rather than decreasing" (Navarro 1990:1238). However, these differences cannot be understood only in terms of racial inequalities; significant class factors are involved as well. The vast majority of urban-dwelling African Americans, as well as Latinos, "are members of the low paid, poorly educated working class that have higher morbidity and mortality rates than high-earning, better educated people" (Navarro 1990:1240). Indeed, these mortality differentials are directly tied to the widening wealth and income differentials between the upper and lower classes of U.S. society. To clarify these points, we will examine the interconnections between a number of major health problems in the inner city.

Infant mortality, which is often used in public health and epidemiology as a reflection of the general health of a population, provides a good starting point for this discussion. Infant mortality among inner-city African Americans and Puerto Ricans has been called America's shameful little secret. In 1987, the Children's Defense Fund announced that a child born in Costa Rica had a better chance of surviving beyond its first birthday than an African-American child born in Washington, D.C. (Edelman 1987). This pattern is not limited to the nation's capital. Overall,

> African American children are twice as likely to be born prematurely, die during the first year of life, suffer low birthweight, have mothers who receive late or no prenatal care, be born to a teenage or unmarried parent, be unemployed as teenagers, have unemployed parents, and live in substandard housing. Furthermore, African-American children are three times more likely than whites to be poor, have their mothers die in childbirth, live in a female-headed family, be in foster care, and be placed in an educable mentally-retarded class. (Hope 1992:153)

In some inner-city neighborhoods of Hartford, Connecticut, where Singer works, the rate of infant mortality has been found to be between 29 and 31 per 1,000 live births, more than three times the state average. Similarly, in 1985, Boston

experienced a 32% increase in infant mortality, with African-American infants dying at two and a half times the rate of white infants. Rising infant mortality in Boston as elsewhere has been linked to a sharp increase in the percentage of low-birthweight babies, which in turn is seen as a product of "worsening housing conditions, nutrition and access to medical care" among inner-city ethnic minorities (Knox 1987:1). Although these "contributing variables act additively or synergistically," household income stands as the single best indicator of an infant's vulnerability, with poor families having infant mortality rates that are one and a half to three times higher than wealthier families (Nersesian 1988: 374).

Class disparities in mortality rates are not limited to infancy, as substantial differences also have been found among older children. For example, children from inner-city poor families are more likely to die from respiratory diseases or in fires than children from wealthier suburban families. Inadequately heated and ventilated apartments also contribute to death at an early age for poor urban children. Hunger and poor nutrition are additional factors. As Fitchen indicates,

> That malnutrition and hunger exist in the contemporary United States seems unbelievable to people in other nations who assume that Americans can have whatever they want in life. Even within the United States, most people are not aware of domestic hunger or else believe that government programs and volunteer efforts must surely be taking care of hunger that does exist here. (Fitchen 1988:309)

However, several studies have shown that a significant link exists among hunger, malnutrition, and inner-city poverty, especially among ethnic minorities. A study by the Hispanic Health Council of 315 primarily minority households (39% African American, 56% Latino) with elementary-school-age children in eight Hartford neighborhoods found that 41.3% reported experiencing hunger during the previous twelve months (based on having positive answers to at least five of eight questions on a hunger scale), and an additional 35.4% experienced food shortages that put them at risk of hunger (based on having a positive answer to at least one question on the hunger scale) (Damio and Cohen 1990). It should be noted that the 1990 census (as did the 1980 census) found Hartford to be among the ten poorest cities (of over 100,000 population) in the country (as measured by percentage of people living in poverty). Over 27% of the city's residents fell below the federal poverty line, compared to a Connecticut statewide rate of just under 7%, according to the census. Hartford, however, is not unique. Research conducted through the Harvard School of Public Health found that federal cuts in food assistance programs has contributed to significant drops in the number of children receiving free and reduced-price school lunches, producing growing reports of hunger and malnutrition from pediatricians in cities around the country (Physician Task Force on Hunger in America 1985). The study, for example, found reports of marasmus (protein-calorie deficiency) and kwashiorkor (protein deficiency) in Chicago.

Cardiovascular disease commonly has been portrayed as primarily a consequence of either genetic predisposition or "lifestyle choice," including such factors as personal eating or exercise habits. As Crawford (1984: 75) suggests, "Americans have . . . been exposed to a virtual media and professional blitz for a particular model of health promotion: one that emphasizes lifestyle change and individual responsibility." Often these portrayals have had the ring of victim-blaming, implying that individuals personally select their "lifestyle," from a range of equally accessible options. As a consequence, even at the popular level, health comes to be defined "in terms of self-control and a set of related concepts that include self-discipline, self-denial, and will power" (Crawford 1984: 66). Research by David Barker and his colleagues on cardiovascular disease suggests the folly in this line of thinking. These researchers show that the lower the birthweight of a newborn or body weight of a one-year-old infant, the greater the level of risk for developing heart disease or stroke in adulthood. Low-birthweight babies, they report, have higher blood pressure and higher concentrations of the clotting factors fibrinogen and factor VII as well as low-density-liproprotein (LDL) cholesterol as adults, factors associated with susceptibility to cardiovascular disease. Numerous attempts have been made to explain excessive levels of premature morbidity and mortality from cardiovascular diseases, especially heart diseases, stroke, and hypertension. Some have attempted to explain this pattern in terms of racial-genetic predisposition. Research by Barker and others, however, reveals the likely relationship of these diseases to the larger syndemic health crisis and thus to poverty and social inequality. Their work suggests that important factors may be the health status of the mother as well as of the infant during the early years of life, conditions directly tied to the kinds of social forces we have been discussing.

Alcohol and drug-related problems have been discussed in previous chapters, but it bears repeating that these conditions contribute to poor health generally among the urban poor. As Herd indicates with specific reference to drinking among African Americans,

> Medical problems associated with heavy drinking have increased very dramatically in the black population. Rates of acute and chronic alcohol-related diseases among blacks, which were formerly lower than or similar to whites, have in the post war years increased to almost epidemic proportions. Currently, blacks are at extremely high risk for morbidity and mortality for acute and chronic alcohol-related diseases such as alcohol fatty liver, hepatitis, liver cirrhosis, and esophageal cancer. (Herd 1991: 309)

Of the diagnosed AIDS cases in the United States, 30% are African Americans and 17% Latinos. While these two ethnic groups comprise about 28% of the U.S. population, they account for almost half of AIDS cases. Among women, 51% of all AIDS cases are African American, and another 20% are Latina (Centers for Disease Control 1990). Among children, over 75% of AIDS cases are among ethnic minorities. The incidence of heterosexually acquired AIDS is

almost ten times greater for African Americans and four times greater for Latinos than for whites (Aral and Holmes 1989). Similarly, AIDS is more prevalent among African-American and Latino gay men than among their white counterparts. For example, based on existing patterns of AIDS distribution, the relative risk for AIDS in exclusively gay men without a history of injection drug use is 1.7 times greater for Latinos than for whites, while among bisexual men the relative risk for Latinos is two and a half times the white rate (Selik, Castro, and Pappaioanou 1988). Additionally, a high percentage of adolescent AIDS cases occur among minority youth. The median survival time of individuals diagnosed with AIDS varies by ethnicity as well. In Connecticut, for example, the median survival in months is 11.2 for whites compared to 7.7 for African Americans and 10.2 for Latinos (Connecticut Department of Health Services 1990), reflecting the broader differences in the general health and access to health services of these populations. The transmission of AIDS, of course, has been closely linked to drug use. Drug injection and sexual transmission linked to crack use have become the primary sources of new HIV infection in the United States (Kolata 1995). Among drug injectors with AIDS nationally, about 80% are African American or Latino.

Since the mid-1980s, there has been a dramatic rise in the incidence of syphilis in the United States, "attributable to a very steep rise in infection among black men and women" (Aral and Holmes 1989: 63). While rates of infection dropped below 5,000 cases per 100,000 population for white men in 1985 and continued to decline through 1988, for African-American men the rate began climbing in 1985 and by 1988 was about 17,000 cases per 100,000 population. Among women, in 1988 there were about 2,000 and 13,000 cases per 100,000 for white and African-American women respectively. By 1991, 85% of primary and secondary syphilis cases recorded in the United States were among African Americans (Hahn et al. 1989). In part, this sharp increase has been linked to sex for drugs or money exchanges associated with cocaine use. Blood test data show that low income, urban residence, and lack of education are all associated with positive blood results for syphilis. Rates of gonorrhea infection also show marked racial differences, and these differences have widened noticeably since 1984, when the incidence among African Americans began a sizeable increase. By 1991, of the 544,057 cases of gonorrhea reported to the Centers for Disease Control, 82% were among African Africans (Hahn et al. 1989). Beginning in 1984, another sexually transmitted disease, chancroid, which produces open lesions and has been associated with HIV transmission in parts of Africa, began to appear in a number U.S. inner cities. The total number of chancroid cases reported in the United States rose from 665 in 1984 to 4,714 by 1989 (Aral and Holmes 1989). Similarly, African-American women report 1.8 times the rate of pelvic inflammatory disease as do white women, while herpes simplex virus type 2 is 3.4 times higher in African Americans, hepatitis B is 4.6 times higher, and cervical cancer with a suspected STD etiology is 2.3 times more common among African Americans than whites (Centers for Disease Control 1992).

As this epidemiologic overview suggests, the diseases and conditions that comprise the inner-city "syndemic" are not independent of each other; they are closely intertwined and collectively enhancing. Poverty contributes to poor nutrition and susceptibility to infection. Poor nutrition, chronic stress (e.g., due to being the object of overt and covert racist practices and attitudes), and prior disease produce a compromised immune system, increasing susceptibility to new infection. A range of socioeconomic problems, lack of social support, and various stressors (such unemployment or access to only the lowest-status, most demeaning jobs) increase the likelihood of substance abuse and resulting exposure to HIV. Substance abuse contributes to increased risk for exposure to an STD, which can, in turn, be a cofactor in HIV infection. HIV further damages the immune system, increasing susceptibility to a host of other diseases. While HIV thereby increases susceptibility to tuberculosis, there is growing evidence that the tuberculosis bacterium, in turn, can activate latent HIV.

Locating and reconceptualizing AIDS as part of the broader syndemic that plagues the inner-city poor helps to demystify the rapid spread of the disease in marginalized populations. In this context, *AIDS itself emerges as an opportunistic disease*, a disease of compromised health compromising social conditions, a disease of poverty and discrimination. It is for this reason that it is important to examine the social origins of disease and ill health, whatever the immediate causes of specific health problems (e.g., in the case of AIDS, a particular pathogen). Conceptually isolating AIDS from its wider health environment has resulted in the epidemiological construction of "risk groups" and "risk behaviors" that, rather than unhealthy living and working conditions, discrimination, racism, sexism, homophobia and related issues, have become the primary focus of public health efforts to halt the epidemic in the inner city. Lost in these public health campaigns is an understanding of AIDS as a disease that is spreading under particular historical and political-economic conditions (Quam 1994). It is for this reason that in this chapter we have called AIDS a disease of the global system. Our intention is to refocus attention on the relationship between the spread of AIDS and the particular set of political economic forces that have contributed to the rapid movement of the virus along particular routes of transmission locally, regionally, and globally. When we bring together our discussion of AIDS in Haiti, Southeast Asia, and southern Africa with our discussion of AIDS in the U.S. inner city, we see that poverty, political domination (e.g., across genders, classes, and nations), and other expressions of social inequality are the social engines driving the global pandemic.

ANTHROPOLOGISTS AND AIDS: WORK AT THE FRONT LINES OF THE PANDEMIC

Ironically, in the first volume edited by anthropologists about AIDS (Feldman and Johnson 1986), most of the individuals who authored articles were sociologists. Bolton and Orozco (1994:vi) observe:

> In the early years of the pandemic, anthropologists were slow to respond to this rapidly emerging health problem. After the mid-1980s, however, this initial neglect was followed by serious engagement with the epidemic on the part of a large number of anthropologists. More than two hundred of our colleagues have joined the AIDS and Anthropology Research Group, a [subgroup] of the Society for Medical Anthropology. It is safe to assert that no topic in the entire field of anthropology commands more attention and more scholarly involvement at the present time.

Indeed, a number of anthropologists see AIDS as a litmus test of the relevancy of the discipline in the modern world. Singer (1992) has suggested that because HIV infection is spread through socially structured, culturally meaningful behaviors about which there is much still to be learned, the AIDS crisis presents a historic challenge to anthropology to prove its relevance. "How anthropology responds to AIDS," he asserts, "may be one measure of whether anthropology merits survival as a distinct entity" (Singer 1992:94).

Anthropological "neglect" during the first years of the AIDS epidemic was, at least in part, tied to the lack of funding for social science of AIDS research and applied work. From the beginning of the pandemic, AIDS research dollars have been dominated by biomedical research, while social scientists have been hampered by a limited availability of AIDS funding. For example, at the Hispanic Health Council in Hartford, efforts in the early and mid-1980s by anthropologists on staff to attract federal AIDS funding went unrewarded. As Feldman and Johnson (1986:261) have noted, "in fiscal year 1985, federal spending for [research on] psychological and social factors of AIDS amounted to a meager 2.1% of the $92.8 million actually spent." With almost all federal AIDS dollars being spent intramurally at the time and no foundation support yet available, funding for community-level AIDS work was scarce. Like all nonprofit agencies that depend primarily on project-specific grants as a source of income, the Hispanic Health Council was constrained in the type and extent of AIDS work it could initiate for several years. Finally, in 1986 the Hispanic Health Council held several meetings with representatives of the Centers of Disease Control (CDC) to develop an AIDS prevention effort targeted to injection drug users. Recognizing that among Puerto Ricans and African Americans injection drug users may not be ostracized from their communities, a preliminary plan was developed for a citywide research and intervention program involving a neighborhood-based system for disseminating AIDS educational information to individuals, families, and local groups. However, two developments delayed and almost derailed the thrust of this initiative. First, the CDC questioned aspects of the fairly ambitious program being proposed. Second, during this period, a shift occurred in CDC funding priorities, with commitment moving from the direct funding of community agencies to state departments of health. Consequently, a series of meetings were initiated with the Connecticut State Department of Health Services. During these meetings, the state's need for information on knowledge and practices relative to AIDS was emphasized. As a result, the

character of the proposed effort underwent considerable revision and evolved into several studies of inner-city AIDS knowledge, attitudes, and risk behavior (Singer et al. 1991).

The earliest anthropological publication on AIDS was written by Douglas Feldman (1985). This article presents a pilot study, carried out between August 1982 and April 1983, on social changes in response to the AIDS pandemic in a convenience sample of gay men in New York City. In some ways, this study was a harbinger of many anthropological studies on AIDS that were to follow. First, it reflects fact that gay anthropologists were the pioneers of AIDS work within the discipline and have continued to be strong voices promoting AIDS research and applied work using anthropological models. Second, like others who were to follow, Feldman encountered a number of methodological problems carrying out his study, most notably an inability to construct a random sample because the precise size and demographic characteristics of the gay population in New York were not known. Feldman sought creatively to overcome this limitation by using various strategies to construct as broad and diverse a sample as possible. For data collection, he used a questionnaire. Given the sensitive and socially defined private nature of sexual behavior, Feldman could not use traditional ethnographic approaches in his study. This remains a significant problem for anthropologists working in the pandemic. While some innovative and sometimes controversial strategies have been developed (see below), for the most part anthropologists, like other social science researchers, have had to rely on the self-report of study participants for gaining information about sexual practices. However, anthropologists have stressed the importance of conducting open-ended, in-depth interviews within individuals in their natural social contexts rather than always bringing them into unfamiliar office settings for formal structured interviews or the administration of questionnaires. With other kinds of AIDS risk behavior, such as drug injection and crack use, anthropologists have been able to conduct field observations, which have contributed to significant insights about the nature and context of risk.

Bolton and Orozco (1994) have compiled a bibliography of over 1,500 publications and conference presentations by anthropologists (although related items by nonanthropologists are included in these figures). This number indicates the significant attention AIDS now receives within the discipline. As the number of anthropologists working in AIDS has grown, there has been a considerable diversification in the research problems they have tackled and in the ways they have contributed to AIDS work. Anthropological research on AIDS has include numerous topics including

symbolic analyses of AIDS discourse; surveys of adolescent attitudes toward sexuality and AIDS; the response of health-care personnel toward AIDS patients; [studies] of general population knowledge, attitudes, and risk behaviors; ethnographies of drug using populations; . . . experimental evaluation of the effectiveness of culturally specific prevention programs; and [analyses] of societal responses to the epidemic

among a wide spectrum of other topics (Bolton and Singer 1992:1). This research has been carried out in many locations around the world, with most work to date being done in North America, Africa, Asia, Europe, and South America. In the applied arena, anthropologists have filled a number of roles, including health educators and developers of AIDS education materials; AIDS outreach workers; peer counselors and case managers for people with AIDS, their families, and partners; designers and administrators for prevention programs in community, national, and international organizations; evaluators of AIDS program effectiveness; advocates seeking to set or change social policies related to AIDS services and funding; and advisors to health care organizations and institutes. Applied work by anthropologists has addressed a variety of issues, including the use of needle exchange programs as a means of preventing the spread of AIDS among injection drug users; the development of socially and culturally sensitive approaches to AIDS vaccine testing; the incorporation of indigenous and traditional healers in condom promotion; the design of community-based outreach to out-of-treatment injection drug users; the testing of the female condom in specific populations; and the creation of intervention models targeted to changing risk behavior in the social networks of drug injectors. Two of the authors of this volume (Susser and Singer) have been very involved in AIDS prevention work. Susser (Susser and González 1992:182), for example, has worked with shelter residents in New York on a video project designed as a self-help initiative to empower the homeless to reshape "their conscious views of themselves and their potential to confront hazards such a HIV infection along with the numerous other issues with which they are forced to battle."

While anthropologists have made a variety of contributions in the AIDS field, probably the most important have been in the area of understanding AIDS risk. Much of this research has a very significant applied dimension. In other words, it is research designed not only to understand the social nature of viral transmission but, in addition, to understand it in a way that will contribute to AIDS prevention. Parker (1992:226) has pointed out that "if we are to understand the radical difference that seem to characterize the epidemiology of AIDS in different areas, we need data that will allow us to compare and contrast not only distinct societies but also distinct social groups within any given society." Socially grounded data of this sort is needed to design targeted intervention programs that are appropriate for specific populations. Several examples of anthropological research designed to provide this kind of data are described below.

Studying Private Sexual Encounters

Given the importance of sexual behavior in the transmission of AIDS, we need to have a clear understanding of what actually happens when two (or more) people have sex in diverse cultural settings. However, the privacy of sex in most cultures makes it difficult to collect this kind of observational data. One inno-

vative response to this dilemma was undertaken by Ralph Bolton in his study of AIDS risk among gay men in Belgium. He reports,

> I spent most of my time, at all hours of day and night . . . in settings where gay men in Brussels hang out: bars, saunas, restaurants, parks, tearooms [public bathrooms where sex occurs], streets, and privates homes. . . . My presentation of self was simple and straightforward: I was a gay man doing research as a medical anthropologist on AIDS and sex. . . . In my casual sexual encounters with men I picked up in gay cruising situations, my approach during sex was to allow my partner to take the lead in determining which sexual practices to engage in. Low-risk activities posed no problem, of course, but to discover which moderate and high-risk behaviors they practiced, I assented to the former (oral sex, for example) while declining the latter (unprotected sexual intercourse). (Bolton 1992:133–135)

Through this strategy, Bolton was able to determine that high-risk sexual behavior was quite common and quite accepted in the privacy of the bedroom among gay men in Brussels. This finding was of importance because health officials in Belgium had come to the conclusion, based on several surveys, that gay men had significantly curtailed risky sexual behavior and that it was no longer necessary therefore to focus prevention efforts on the gay community.

Another approach for going beyond self-reported sexual practices was developed by Terri Leonard in her study of male clients of street sex workers in Camden, New Jersey. Leonard conducted her research by hanging out at an inner-city "stroll" area (a street where sex workers seek business among pedestrians and the drivers of passing cars).

> All men who attempted to solicit my services, assuming I was a sex worker, were invited to participate in a "sex survey." Men initiated contact using several approaches. Some pulled up alongside the curb or onto a side street and, with engines idling, engaged me in conversation. Some men parked alongside the street and got out to make a phone call or have a drink in a nearby bar, initiating conversation en route. Some men "cruised" by several times per day, several days per week, or once every few weeks before approaching. (Leonard 1990:43)

Leonard found that twenty men out of the forty-nine she was able to interview reported that they used condoms during commercial sex. However, despite this self-report, only five of the men actually had condoms with them at the time they solicited sex with Leonard. Like Bolton's work, Leonard's shows that ethnographic approaches can produce data that reflects actual rather than idealized behavior.

Risky Behaviors among Drug Injectors

Ethnography has also been used effectively by anthropologists to describe AIDS risk among drug users. In the early years of AIDS prevention among drug

injectors, primary focus was on providing education about the risks of "needle sharing." But other routes of infection in contexts of drug injection often were ignored. Based on ethnography among drug injectors in Miami, Bryan Page has identified several other possible routes of AIDS transmission in this population. For example, Page found that in Miami water that is used to liquify drugs is referred to as "clean water" (as opposed, ironically, to water used to unclog needles, which is referred to as "dirty water"). Liquification usually occurs in a metal container, usually a spoon, a bottle cap, or even a cut-off soda can.

> Drawing the desired amount of water from the clean water into the syringe, the user squirts ("skeets") this water into a bottle cap onto the drug powder that has already been dumped into the cap. If the drug is cocaine, the water is then stirred, usually with the tip of the syringe or the plunger. (Page et al. 1990:65)

As Page and coworkers (1991:76) indicate, so-called clean water may in fact harbor pathogens.

> As most Miamian drug injection behavior involves cocaine, which is not "cooked" during the mixing process, whatever microbes are in the clean water will be injected into the shooter. Even if the client uses a new set of works to inject the drug, the water mixed with the drugs could be contaminated by exposure to [other injectors'] contaminated syringes.

Risk for HIV transmission through water also occurs during needle rinsing. Explain Page et al. (1991:76),

> The small, diabetic-gauge disposable syringes and needles preferred by IVDUs [intravenous drug users] inevitably become clogged and inoperable after repeated injections. To forestall this condition, the house rules in all houses [i.e., shooting galleries] observed in Miami dictates that after each use of a set of works [a syringe and needle], the customer must clean the set with "dirty water" (water provided for cleaning purposes) before returning the syringe and needle to the storage container. Every needle returned to the container is supposed to be returned after this kind of "cleaning."

In the process of "cleaning" their needles, injectors, in fact, may be infecting them with virons in the rinse water that has been used by other injectors. Ethnographic studies of drug injectors, like those Page has conducted in Miami and a growing number of anthropologists have carried out in other cities in the United States and in other countries, have identified a range of risks for HIV infection faced by street drug injectors.

Muddles in the Models

In order to track and predict the course of the AIDS pandemic, public health workers attempted to identify groups of people at heighten risk for infection.

Various risk groups have been identified and referred to in the AIDS literature. Anthropologists, however, have challenged risk group categories based on their ethnographic experiences. For example, one group that commonly is listed in AIDS surveillance reports from city and state health departments and the national Centers for Disease Control and Prevention is referred to as "sex partners of injector drug users." Kane (1991) has emphasized that being the sex partner of a drug injector is not a natural category, it is not a social group, nor is it necessarily part of an individual's identity. Indeed, many people are sex partners of injection drug users and do not know it. Others may suspect but fear knowing the full truth. Needless to say, this makes prevention efforts targeted to individuals at risk in this way very difficult. Moreover, as Herdt (1990:13) has written, "Though the notion of sexual partner may seem obvious, it varies across cultures and is probably the source of significant error in research design. Whether a partnership is sexual and/or social, culturally approved or disapproved, voluntary or coercive, is of real import." In questioning the epidemiological categories that have been used for studying AIDS, anthropologists have argued that better and more useful data will be collected if we use natural social categories rather than categories that are constructed by researchers.

Economic Determinants of Sexual Risk

While the examples of anthropological work in AIDS discussed above are all drawn from Western cases, anthropologist have worked in other parts of the world as well. Janet McGrath, a biological anthropologist, and her colleagues at Makerere University in Uganda, for example, have studied the cultural rules that shape sexual behavior among Baganda women. Uganda is a country that has been hit particularly hard by AIDS. It is estimated that well over a million Ugandans have been infected with the virus, and the highest rates of infection are among women between twenty and thirty years of age. For example, in the capital of Kampala, 28% of mothers attending a prenatal clinic were found to be infected (McGrath et al. 1992). The Baganda are the largest ethnic group in Kampala. To better understand cultural practices associated with Baganda sexual risk behavior, McGrath and her coworkers interviewed sixty-five seropositive and sixty-five seronegative Baganda women. They found that the infected women had more sex partners than uninfected women but that all women reported they are limiting the number of partners they have to avoid AIDS. However,

> there are situations, such as economic need, when it is acceptable in Baganda culture for a women to have a partner outside of her primary union. If sexual partnerships involve financial gain or increased financial security, then simply advising them to reduce their sexual contacts without recognizing the potential economic harm that may result is problematic. (McGrath et al. 1992:158–59)

This case shows the critical importance of understanding pressing economic factors that contribute to AIDS risk. Failure to recognize such factors could doom an AIDS prevention project to failure because people may be unable to heed AIDS prevention information if it puts their economic survival at risk.

AIDS Risk and the Cultural Construction of Sexuality

The sexual identities that have been dominant in the discussion of AIDS, heterosexuality and homosexuality, have not been found to be the dominant categories of sexual identity in many locales. In Brazil, for example, Richard Parker (1987:160) has found that the structure of sexual life is organized around a distinction between activity and passivity, with males being identified with the former attribute and females with the latter.

> The outlines of this cultural configuration emerge clearly in the language that Brazilians use to describe sexual relations—in their verbs, such as *comer* (to eat) and *dar* (to give), as metaphors for forms of sexual interaction. *Comer* describes the act of penetration during sexual intercourse. Used in a variety of context as a synonym for verbs such as *vencer* (to conquer, vanquish) and *possuir* (to possess, own), it clearly implies a form of symbolic domination, as played out in either vaginal or anal intercourse. Just as *comer* suggests an act of domination *dar* implies some form of submission or subjugation.

This model extends to sexual intercourse among men who have sex with other men. The individual who is penetrated during anal intercourse is seen as playing the passive role, while his partner is viewed as fulfilling a masculine role. In Brazilian society, the former are subject to considerable social stigma while the latter are "reasonably free within the context of this system to pursue occasional or even ongoing sexual contacts with both males and females without fear of severe social sanction" (Parker 1987:161). Similarly, based on his research in Mexico, Joe Carrier (1989:134) has noted that males who play the penetrative or insertive role

> are not stigmatized as "homosexual". . . . The masculine self-image of Mexican males is thus not threatened by their homosexual behavior as long as the appropriate role is played and they also have sexual relations with women. Males playing this role are referred to as *mayates*; and may be called *chichifo* if they habitually do so for money. Although involved in bisexual behavior, they consider themselves to be heterosexual.

By contrast, in the United States, men who have sex with other men are defined by society as being homosexual regardless of the role they play during anal intercourse. Moreover, among self-identified gay men in the United States, mutual penetration is common while distinct active and passive roles, to the degree that they exist, tend to be constructed as personal preferences rather than distinct or enduring sexual identities. These examples show that not only are sexual

identities constructed somewhat differently in different societies but that AIDS prevention must be sensitive to these differences if it is to be effective in reaching individuals who—whatever their specific sexual identities—are at risk for HIV infection because of their sexual behaviors.

As seen in the examples described above, in their AIDS-related studies, anthropologists have stressed the importance of (1) gathering data in natural social settings; (2) paying keen attention to the role of culture in shaping behavior; (3) looking at insider understandings and identities; (4) maintaining a holistic approach that recognizes the influence of range of social factors on risk behavior; (5) paying attention to gender issues in social life; and (6) using information gained through ethnographic approaches to build culturally targeted AIDS prevention programs.

To this set of anthropological approaches to AIDS risk research, critical medical anthropology draws attention to the importance of political-economic factors. As seen in the discussion of AIDS risk in southern Africa, oppressive political and economic relations can be seen as macroparasitic causes of new infection. The failed effort by South Africa to maintain its internal system of apartheid exploitation as well as its regional dominance by promoting a series of low-intensity wars of destabilization against its neighboring countries produced social conditions that significantly increased opportunities for HIV infection. In another African case, that of Zaire, Schoepf notes:

> Disease epidemics generally erupt in times of crisis, and AIDS is no exception. Zaire, like most other sub-Saharan nations and much of the Third World, is in the throes of economic turmoil. Propelled by declining terms of trade and burdensome debt service, the contradictions of distorted neocolonial economies with rapid class formation have created what appears to be a permanent, deepening crisis. . . . In Zaire, as elsewhere in the region, economic crisis and the structure of employment inherited from the colonial period shape the current configuration, contributing to the feminization of poverty and consequently to the spread of AIDS [e.g., through prostitution or multiple partner sexual relationships associated with smuggling networks developed to contend with the worsening economic conditions]. (Schoepf 1992:262)

A number of parallel examples also have been noted in this chapter, including McGrath's study of the role of economic subordination of women in AIDS risk in Uganda, the role of international relations on tourism and commercial sex in Haiti, and the contribution of unequal social relations on the syndemic of the urban poor in the United States. As these examples show, while the human immunodeficiency virus has a material existence independent of social factors, its role and importance as a source of morbidity and mortality among humans cannot be understood in isolation from political economy. Placing emphasis on the social origins of disease does not constitute a denial of the biotic aspects of pathogens, hosts, and environments. Rather, it is an affirmation of the critical importance of adopting a holistic and historically informed biopolitical economic approach to health. In this view, AIDS emerges as a disease of the global system of oppressive political-economic relationships.

CONCLUSION

John (a pseudonym) commented:

> I'm completely different than I was prior to getting sick. I'm much more who I always wanted to be, who I always imagined I'd be. I just didn't know when to begin getting serious about my life. AIDS has made that very clear to me. (quoted in Rabkin, Remien, and Wilson 1994:i)

This striking statement by a man with AIDS raises an important issue. As AIDS spreads through a population and as the statistics begin to spiral upward, there is a tendency to lose sight of the people behind the numbers. Unless it strikes someone in our family or circle of friends and acquaintances, it is still possible to believe that AIDS is a distant phenomenon, one that does not affect "people like us." This attitude has been found, for example, among college students, many of whom do not believe they are at risk for AIDS despite being sexually active. This kind of distancing behavior allows us to avoid thinking about the actual people who die of AIDS or suffer with its painful symptoms. Consequently, one of the thrusts of what has come to be called the AIDS community—those whose lives have been significantly affected by the disease—has been to avoid submerging the names, the distinctive life stories, and the poignant social memories of all of the individuals who have died of AIDS. The Names Project, which began in San Francisco, for example, created a giant AIDS quilt with hundreds of panels, each devoted to the unique memory of a single person who died of AIDS. Each panel of the quilt was created by friends and loved ones grieving the loss of an individual who was special in their lives. In addition, the stories of many people with AIDS (PWAs) have been recorded and inscribed in what has become a fairly extensive personal AIDS literature.

Efforts like this are designed to keep a human face on the AIDS crisis, never to forget that AIDS kills people, not numbers. As Farmer (1992:262) notes, "One way to avoid losing sight of the humanity of those with AIDS is to focus on the experience and insights of those who are afflicted." This is an extremely important point. While the thrust of critical medical anthropology is to understand human health issues in their sociohistoric and political-economic contexts, it also has been emphasized in the CMA literature that we must pay close attention to sufferer experience and agency. Sufferer experience, an arena long neglected in the social science of health, increasingly has become a topic of research interest. From the perspective of CMA, sufferer experience is a social product, one that is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the contexts of daily life. Recognizing the powerful role of such forces,

however, does not imply that individuals are passive and lack the agency to initiate change, and it certainly does not mean that they are insignificant. Instead, it meant that people respond to the material conditions they face in terms of the set of possibilities created by the existing configuration of social relations and social conditions. Within this framework, it is vital that we remain sensitive to the individual level of experience and action so that we never forget that the ultimate goal of critical medical anthropology is to contribute to the creation of a more humane health care system and more humane lives for all people.

Part III

Medical Systems in Social Context