

Richard Parker, "The Global HIV/AIDS Pandemic, Structural Inequalities, and the Politics of International Health," *American Journal of Public Health* 93(3):343-346, 2002.

The Global HIV/AIDS Pandemic, Structural Inequalities, and the Politics of International Health

In spite of recent advances in treatment and care available in most developed countries, the HIV/AIDS pandemic continues to spread throughout the developing world.

Structural inequalities continue to fuel the epidemic in all societies, and HIV infection has increasingly been concentrated in the poorest, most marginalized sectors of society in all countries. The relationship between HIV/AIDS and social and economic development has therefore become a central point in policy discussions about the most effective responses to the epidemic.

Important progress has been made in recent United Nations initiatives. Maintaining long-term commitment to initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria is especially important in the wake of September 11 and ensuing events, which threaten to redirect necessary resources to seemingly more urgent security concerns.

Richard Parker, PhD

AS THE HIV/AIDS EPIDEMIC enters its third decade, much of the sense of urgency that accompanied discussions of AIDS only 10 or 15 years ago seems to be disappearing.¹ Thanks to the development of new antiretroviral treatments capable of transforming HIV infection into a chronic but manageable health condition, mortality rates due to AIDS have fallen throughout the industrialized or "developed" world, and even in some of the more privileged "developing" countries.²

The worst types of discrimination and human rights violations against people living with HIV and AIDS (or suspected to be at risk for HIV infection), which occurred regularly during the early years of the epidemic, seem to have declined as well. Legal systems and official structures have been pushed to respond to the epidemic by reaffirming the basic rights of all human beings, independent of serostatus. And both governmental and civil society organizations in countries around the world have gradually mobilized resources and developed programs to overcome what once was described as "AIDS exceptionalism,"³ increasingly mainstreaming programmatic responses to the epidemic at international, national, and local levels. Indeed, as we have turned the page on the past century and entered the new millennium, and as we head into the third decade of the HIV/AIDS epidemic, the progress made in responding to AIDS over the past decade seems to give reason for guarded optimism.

STRUCTURAL INEQUALITIES

When we turn our gaze beyond our own borders to focus on the HIV/AIDS pandemic in the most resource-poor countries of the developing world, however, the picture is considerably worse. The Joint United Nations Program on AIDS (UNAIDS) estimates that by the end of 2000 approximately 36.1 million people had been infected with HIV globally.² Of these, approximately 34.7 million are adults—16.4 million are estimated to be women—and 1.4 million are children. Since the beginning of the epidemic, 21.8 million people are estimated to have died—17.5 million adults (roughly 9 million women) and 4.3 million children. In 2000 alone, 3 million deaths were attributed to AIDS, and 5.3 million new infections are believed to have occurred—2.2 million among women and nearly 570 000 among children.²

These current estimates are enough to give us pause, but it is also important to remember that there is little likelihood that the situation will improve any time soon. On the contrary, UNAIDS and the World Bank predict that HIV, which was responsible for 8.6% of deaths from infectious disease in the developing world in 1990, will be responsible for 37.1% of such deaths among adults between the ages of 15 and 59 by 2020.⁴ If treatment advances and other recent scientific advances give us reason for optimism, there is equally good

reason for concern, as HIV/AIDS continues to stand as one of the most significant global health problems that must be confronted in the new millennium.

Beyond the sheer weight of the numbers, what is perhaps most important about the shape of the HIV pandemic is the fact that the global distribution of infection has been anything but equal. It is estimated that approximately 920 000 people have been infected in North America, for example, with 540 000 infections in Western Europe and another 15 000 in Australia and New Zealand.² In sub-Saharan Africa, by contrast, it is estimated that as many as 25.3 million persons have been infected by HIV. Another 5.8 million have been infected in South and Southeast Asia, and 1.4 million have been infected in Latin America.² In short, the vast majority of HIV infections can be found in the poorest regions of the world, in developing countries already facing a wide range of other serious public health problems.

This concentration of HIV infection in the countries of the developing world becomes even more worrisome if we look again at societies such as the United States,⁵ where disproportionate levels of HIV infection have been documented among racial and ethnic minority populations. Rates are especially high among gay and bisexual men in communities of color and among heterosexual women living in poverty in the inner cities.⁵

Indeed, if we bring together the available data on HIV/AIDS in the developing world with the most recent trends on HIV infection in countries such as the United States, it is impossible not to be impressed by the extent to which a range of structural inequalities intersect and combine to shape the character of the HIV/AIDS epidemic everywhere, both North and South, in developed as well as developing

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countries. In all societies, regardless of their degree of development or prosperity, the HIV/AIDS epidemic continues to rage—but it now affects almost exclusively the most marginalized sectors of society, people living in situations characterized by diverse forms of structural violence.⁶

It is in the spaces of poverty, racism, gender inequality, and sexual oppression that the HIV epidemic continues today—in large part unencumbered by formal public health and education programs, let alone by the advances in treatment that might otherwise convince us that the emergency has passed. The context in which the HIV/AIDS epidemic continues to expand in countries around the world is one of growing polarization between the very rich and the very poor, increasing the isolation of some segments of the population at a time when others are perversely integrated into the criminal economies of international drug smuggling and the like, and

increasing social inequalities that seem to be an integral part of globalization based on neoliberal economic policies.⁷

These structural factors, which shape the HIV/AIDS epidemic within the contours of specific societies, even in the resource-rich industrialized countries, are the same factors that shape the global epidemic, particularly in the resource-poor and often economically dependent countries of the developing world. Indeed, perhaps no other major international public health problem so clearly reflects the social, political, and economic architecture of what has been described as the new world order: a post-Cold War international system in which, at least until very recently, the gravest threats to human security seemed to stem less from state-controlled and state-inflicted violence (such as the threat of nuclear war) than from the dismantling of previously existing health, education, and welfare systems in many of the most advanced industrial societies and from diverse forms of structural adjustment that have been imposed on many developing countries.⁸

THE POLITICS OF INTERNATIONAL HEALTH

Given these trends, it is worthwhile to note a number of recent developments and to question the ways in which they may continue to evolve, particularly in light of the still largely unpredictable consequences of the post-September 11 world. First, there is the growing role of the World Bank as one of the lead “development” agencies responsible not only for the global response to HIV/AIDS but for international health more broadly.

Established as part of the Bretton Woods accords following World War II, the World Bank has emerged as the most wide-reaching and powerful international development agency in the world. It is responsible for efforts to combat poverty and promote economic development throughout Africa, Asia, and Latin America, as well as in the post-socialist countries of Eastern Europe and the former Soviet Union.

Since the early 1990s, in part as a response to critics who called attention to the frequently negative consequences of structural adjustment programs promoted by the World Bank together with the International Monetary Fund, the World Bank has increasingly focused on health-related issues, opening up new lending programs and expanding the resources available for projects focusing on population, nutrition, and similar issues throughout the developing world.⁹

And nowhere has the institution's growing involvement in health-related work been more visible than in response to the HIV/AIDS pandemic.⁴ By early 2001, a total of US \$1.7 billion had been made available for HIV/AIDS-related work through World Bank loans to developing countries, with significant increases in the commitment of resources in recent years.¹⁰ Indeed, in fiscal year 2001, the World Bank expected to commit an additional US \$744 million for new HIV/AIDS prevention and control efforts, making its loans the single most important source of financial resources for the global fight against the epidemic.

As potentially important as these resources have been, however, the World Bank's growing role in international health has

not gone unquestioned. Precisely because structural adjustment policies have often resulted in greatly reduced spending for health, education, and welfare programs, the role of structural adjustment in contributing to the HIV/AIDS epidemic, especially in sub-Saharan Africa, has been a major focus of debate in recent years.¹¹ The fact that the World Bank seems increasingly to rival the World Health Organization as the most influential international agency involved in health-related work has been cited as a cause for concern.¹

Despite the fact that World Bank loans for HIV/AIDS prevention and control are generally made at the most favorable interest rates possible, there is concern that they are still loans, rather than donations, and thus they contribute to increasing the national debt of many developing countries—countries that are already forced to commit significant portions of their annual gross national products to service existing debt obligations.¹² And although the negative impact of HIV/AIDS on economic development has been clearly articulated by the World Bank and others as a reason for greater mobilization on a global level in response to the epidemic, concern has nonetheless grown about the possibility that relatively crude cost-benefit calculations or overly economic notions of “development” may replace a broader public health framework as the basis for decisions about the design of programs and the allocation of resources.

Equally important, in the effort to develop a fuller understanding of social and economic development in relation to public health within this context, the broader implications and conse-

quences of already existing levels of debt in the developing world must be addressed. Increasingly, treatment activists and others, in both the North and the South, have begun to call for debt relief as the only way to enable many low-income countries to increase their public health budgets to a level that will allow the implementation of adequate care and treatment programs. Without significant reforms in the current global financial system, even the most basic international public health goals may be unattainable, and nowhere are these dilemmas more clearly exposed than in the case of HIV/AIDS.

In light of these concerns, however, it is also important to note some significant progress in recent efforts to build a renewed response to the global HIV/AIDS epidemic. In mid-2001, for example, UNAIDS helped to orchestrate a groundbreaking Special Session of the United Nations General Assembly to reinforce HIV/AIDS as a priority in the international policy agenda. While there is still much to be done to transform policy into practice, the Declaration of Commitment on HIV/AIDS that emerged from that special session marked an important step.

Equally important, as part of this process, United Nations Secretary-General Kofi Annan has exercised leadership in international policy debates about HIV/AIDS and global health more broadly. Annan's role has been crucial in launching a broader debate about the social and economic roots and consequences of AIDS, as well as in supporting an innovative new funding mechanism that may have a long-term impact on restructuring financial support for the response not only to HIV/AIDS

but to other serious international health problems: the Global Fund to Fight AIDS, Tuberculosis and Malaria. With Annan's active backing, the creation of this special fund received widespread international support in June 2001, when representatives from more than 50 countries, multilateral agencies, and nongovernmental organizations met at the Special Session of the United Nations General Assembly.¹³

The specific details of the governance, administration, and underlying principles of the Global Fund to Fight AIDS, Tuberculosis and Malaria are still being finalized. However, early signs suggest that the fund may offer important advances in terms of better coordination of efforts to confront disease, greater transparency in relation to the distribution of resources, and greater decentralization of decision making in relation to program design and implementation than has been the case in previous multilateral agency responses to HIV/AIDS and related issues.

Unfortunately, the initial response in terms of commitment of resources to the fund has been disappointing. Although Annan originally estimated that US \$7 to \$10 billion would be needed by 2005 to meet expected demand, as of November 2001 only slightly more than US \$1.5 billion had been committed by governments, nongovernmental organizations, and private donors. This amount includes only US \$300 million committed thus far by the government of the United States.¹⁴

The relatively disappointing response of the United States should be cause for alarm for anyone concerned about HIV/AIDS or issues of international health more broadly. As the richest nation in

the world—and as one of the chief beneficiaries of the current global economic order, which has done so much to shape the HIV/AIDS pandemic as a product of structural inequalities both within and between nations—the United States is unquestionably the key point of reference for other nations, as well as for private-sector organizations and individuals, in evaluating their own contributions to the global effort to respond to HIV/AIDS and other major international health problems.

Without renewed and expanded commitment from the Bush administration and the US Congress, the likelihood is that the Global Fund to Fight AIDS, Tuberculosis and Malaria will fall far short of its goal, and one of the most innovative opportunities in the response to HIV/AIDS globally will be lost. At a time when health care around the world is increasingly privatized, and when banks have increasingly become the arbiters of international health policy, losing this chance to reaffirm a vision of health as a fundamentally public good would be a terrible loss—not only for those who are living with or vulnerable to HIV infection, but for all who understand that questions of health can never be separated from broader struggles for responsibility, fairness, and social justice.

MAINTAINING COMMITMENT

The risk of a lack of ongoing commitment to HIV/AIDS internationally, and to the Global Fund to Fight AIDS, Tuberculosis and Malaria in particular, has of course become all the more serious in the wake of the terrible terrorist attacks on September 11

and the ensuing military response of the United States. As the international system struggles to come to grips with the many changes that have been brought about by these events, public attention has understandably turned to questions of our immediate security in a world that now seems physically unsafe in a new and very different way, and our ability to maintain interest in the seemingly more long-term and distant security concerns of issues such as HIV/AIDS is threatened.

Although the United Nations leadership has stood firm in emphasizing the continued importance of the Global Fund and the high priority that must be given to struggles against infectious diseases, issues such as terrorism and bioterrorism have understandably taken precedence in many of the most recent debates about human well-being and safety within the broader context of international relations. Within this rapidly changing context, we can only hope that new concern will emerge, as well, with the fundamental inequities that have been such an integral part of recent processes of globalization—in particular, with the ways in which such inequities have contributed to the terrible new forms of risk and insecurity that confront us today in a world that often seems to be spinning out of control.⁷

Now, more than ever, it is crucial that we work to analyze and understand the social and economic processes that have not only produced extreme forms of physical violence, but that have exacerbated the health threats that face so much of the world's population on a daily basis. Clearly, public health research

and analysis has a key role to play in building the intellectual bridges that will be necessary to understand the health consequences of the development models that have been pursued in recent decades—and the ways in which these models may have contributed to new forms of insecurity that are omnipresent in today's world.

In a policy context that is increasingly conditioned by fear—and, because of this fear, by urgent demands for immediate solutions—one of our greatest challenges is to build an understanding of the broader structural forces that have shaped not only the first epidemics of a truly globalized world, but also its most recent political and ideological challenges.¹⁵ And in a historical moment in which our most pressing dangers have come so close to home, one of our most urgent priorities must be to keep alive, as well, the broad range of public health issues that must be confronted as we march into the new millennium. The future of the global HIV/AIDS epidemic, and of the millions of lives affected by it, will depend on the ways in which we confront these dilemmas. ■

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This commentary was accepted November 30, 2001.

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