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A Global Political Economy Approach to AIDS: Ideology, Interests and Implications

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The AIDS (Acquired Immune Deficiency Syndrome) pandemic has been, in many respects, unprecedented. The rapid emergence of a new disease and the mobilisation of significant financial and human resources for research, treatment and control strategies has seen no parallel.[1] Given the global spread of infection, and the global nature of the response, AIDS is of clear relevance to scholars of international relations (IR) and international political economy (IPE). Yet little attention has been devoted to health in the IR field, and even less to AIDS.

The bulk of initial research on AIDS in the early 1980s was devoted to understanding its occurrence and presentation within and across populations. In the past 10 years there has been a growing body of research in the medical and social sciences focused at the national or subnational level. These studies have contributed much to exploring transmission of the human immunodeficiency virus (HIV) among particular groups (notably the homosexual community and intravenous drug users in the USA and Europe, and commercial sex workers in sub-Saharan Africa, Asia and Latin America), the historical and cultural factors which have facilitated transmission of the HIV virus, and the economic impact of AIDS on health systems and labour markets. Other studies have examined individuals in terms of their sexual behaviour and awareness of HIV and AIDS. Analyses in recent years have broadened to include women and youth, gender, human rights, the impact of prevention strategies, and the costs of treating HIV/AIDS.

As part of this broadening perspective on AIDS, this article argues that a global political economy (GPE) approach offers further insights for understanding and responding to the disease.[2] First, widening the spatial dimension of AIDS research to the global level is apt, given the spread of the disease across national boundaries and the attempts to tackle it as a global phenomenon. Second, a GPE approach enables us to extend our analysis temporally by locating AIDS within a particular world order of 'transnational neoliberalism' defined below by material, institutional and ideological forces distinct to inter-

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national relations since the late 1960s. After describing the global spread of AIDS, the article suggests that there is growing evidence that this world order has created fertile conditions within which AIDS has spread, particularly among peripheral interests in the GPE. Importantly, this includes 'the way in which ideas about what constitutes the *political* and the *economic* have emerged historically',[3] and it will be shown that policy making on AIDS has been strongly centred on biomedical and neoliberal economic discourses.

The article concludes by arguing for a more critical awareness of the theoretical and practical lineage of existing knowledge of AIDS. Given that the limitations of this knowledge have been part of the conditions within which the disease has thrived, an expanded research agenda is put forth for the study of IPE and AIDS. It is in locating the disease within what Fortin calls a 'longer view', which seeks 'to situate the present disease within the broad historical, social, ecological, cultural, and political relationships that mediate humanity, sickness, and the environment',[4] that the beginnings of a truly global response to AIDS can be built.

The global spread of AIDS

AIDS is a complex of symptoms and signs in infected individuals, ultimately culminating in the fatal depression of the immune response system. The disease was first identified in 1981 among male homosexuals in the USA. Within a remarkably short period the responsible infectious agent, HIV, was identified and the routes of transmission clarified. These were unprotected penetrative sexual intercourse, transfusion with infected blood products, injection using infected equipment, and from an infected mother to her child either during pregnancy, the birthing process or breastfeeding. There are two recognised serotypes of the virus, HIV-1 and HIV-2. HIV-1 predominates worldwide, while HIV-2 has spread since the mid-1980s, notably in west Africa, but by no means confined to that area.

HIV infection has spread rapidly across the globe. In North America, western Europe, Australia, New Zealand and many urban areas of Latin America, it is believed that HIV began to spread from the mid- to late-1970s and early 1980s. This spread occurred initially among homosexual and bisexual men through unprotected sexual intercourse; among intravenous drug users (IVDU); and among the recipients of contaminated blood products. In sub-Saharan Africa, Latin America and the Caribbean, the heterosexual spread of HIV was recognised as a key means of transmission by the second half of the 1980s. Subsequent spread through infected blood products, given a high prevalence among the general population and limited access to technologies for screening and testing, is also likely. The estimated prevalence of HIV infection in these regions is sobering. In Africa, around 10 million adults are believed to have been infected to date, with over three million cases of AIDS. Those at particular risk, such as commercial sex workers without access to condoms, have been found to have HIV prevalence rates as high as 90 per cent.[5] In eastern and central Europe, the Middle East, north Africa, Asia and the Pacific, future increases in HIV infection are likely to be most dramatic, with the number of new cases of HIV

TABLE I. Estimated cases of HIV and AIDS by mid-1994

Region	Estimated total adult HIV infections[1]	Estimated total adult AIDS cases[2]	Cumulative reported AIDS cases (adult and paediatric)[3]	Ratio of HIV infections in men to those in women[4]
Australasia	>25,000	>5,000	5,158	5–6:1
North America	>1,000,000	>450,000	421,418	5–6:1
Western Europe	>500,000	>150,000	111,877	5–6:1
Latin America and the Caribbean	2,000,000	>400,000	102,359	4:1
Sub-Saharan Africa	>10,000,000	2,000,000	330,805	0.8–0.9:1
South and Southeast Asia	>2,500,000	250,000	7,195	2–3:1
East Asia and Pacific	50,000	>2,000	1,073	5–6:1
Eastern Europe and Central Asia	>50,000	>7,000	3,932	5–6:1
North Africa and the Middle East	100,000	>15,000	1,302	4:1
Global total	> 16 million	>3 million	985,119	1.5:1

Source: WHO, *The HIV/AIDS Pandemic: 1994 Overview* (Global Programme on AIDS, 1994).
Notes:
[1]Figures represent cases of HIV infection recorded from the late 1970s to mid-1994.
[2]Figures represent estimated HIV infection which has progressed to AIDS.
[3]Figures represent reported cases of AIDS which, in some regions, are a fraction of estimated cases.
[4]Ratio of male to female infections provides insights into the nature of spread and general impact on a society.

infection in Asia soon likely to surpass those in Africa. Initial cases in Asia have occurred primarily among commercial sex workers and drug injectors. However, this pattern is rapidly changing and alarming increases in transmission and disease have occurred among the general population of both Thailand and India.[6] This looming epidemic is expected to 'ultimately dwarf all others in scope and impact'.[7]

Table 1 shows that there was an estimated 16 million adults infected with HIV worldwide by mid-1994. In some parts of North America, western Europe, Australia and high-prevalence areas of east and central Africa, there is emerging evidence that the spread is stabilising.[8] The number of heterosexual people infected with HIV in industrialised countries is expected to remain stable or increase more slowly as those currently infected die and new cases are averted.[9] In other regions, however, the rate of increase will remain alarmingly high. Table 2 shows the projected number of HIV-infected people in broad continental areas for 1994 to the year 2000. Most notable is the expected increase in Asia, from 2.5 million to between 12 and 45.5 million cumulative cases.

TABLE II. Projection of cumulative adult HIV infections by geographic area to the year 2000

GAA	Low estimate	High estimate
North America	1,811,000	8,150,000
Western Europe	1,188,000	2,331,000
Oceania	22,000	45,000
Latin America	1,599,000	8,554,000
Sub-Saharan Africa	20,778,000	33,609,000
Caribbean	536,000	6,962,000
Eastern Europe	>2,000	20,000
South East Mediterranean	893,000	3,532,000
North East Asia	>6,000	486,000
Southeast Asia	11,277,000	45,059,000
Total	>38,112,000	108,748,000

Source: Jonathan Mann, Daniel Tarantola & T. Netter (Eds), *AIDS in the World: A Global Report* (Harvard University Press 1992), p. 107.

AIDS and the global political economy: an emerging transnational neoliberal order

There are no simple answers to how and why HIV infection has spread in the manner it has. Billions of US dollars have been spent on understanding the HIV virus, the pathogenesis of HIV disease, its epidemiology and clinical manifestations. Between 1982–91, about US$5.63 billion was spent on AIDS-related research worldwide, the vast majority by the governments of the 10 largest industrialised countries and almost all since 1985.[10] In order to broaden our understanding of the AIDS pandemic, this article examines how the study of the global political economy can enhance our understanding of HIV and AIDS. In turn, it is argued that HIV and AIDS can reveal new empirical applications for IPE scholars. Traditionally, the realist—liberal orthodoxy which has dominated the study of international relations has neglected the study of health. As Thomas writes, 'disease is a transnational phenomenon which pays no heed to territorial state boundaries; yet it rarely features in the discussion of International Relations'.[11] Critical or post-positivist approaches, which have emerged in recent years, seek to widen the intellectual boundaries of IR, extending the disciplinary agenda to include gender, the environment and social policy.[12]

Briefly, the GPE approach taken in this article is based on the writings of critical theorists in IR. Critical theorists share the aim of challenging positivist approaches to social science and proposing alternatives. Applied to the GPE, Gill writes that, first, 'there is a relativity in the claim to truth'; and second, that 'social conditions interact with and influence the survival, scientific status and consequences of rival social theories: knowledge is also a process of social struggle, again between hegemonic and counter-hegemonic perspectives and

principles'. Given that all 'thought processes and knowledge systems' are at variance with reality, the aim is not to determine which truth is a true reflection of reality, but 'how and why and with what consequences' these particular 'truths' hold within a given historical period.[13] In this sense, the approach goes beyond the economic determinism found in the early political economy of health literature.[14]

This dialectic between the realms of ideas and material conditions is central to the ontology and theory of GPE put forth in critical theory. Drawing on the writings of Antonio Gramsci, Gill writes that the global political economy 'implies an integrated system of knowledge, production and exchange, and includes the dialectical relations between capital and non-capitalist systems and states, and ecological, ethical and other aspects of the whole'.[15] Central to such relations is the Gramscian concept of *hegemony* which is achieved by core interests (individuals, classes, states or transnational actors) through a mixture of coercive and consensual means. The use of coercion or force to assert leadership is domination. In contrast, the mobilisation of the consent of peripheral groups to a given order is achieved through intellectual, moral and political leadership. This suggests a complex concept of power which can be structurally embedded in historical social constructs (i.e. historic blocs) as well as vested in individual actors.[16]

Applying this GPE approach to the study of AIDS, it is argued that the disease can be located within a particular world order characterised by transnational neoliberalism. Briefly, this world order is defined by unprecedented growth of capital, production and exchange relations across state boundaries, with the effects of this process of globalisation[17] far from uniform. The material basis of this world order is 'a global economic system dominated by large institutional investors and transnational firms which control the bulk of the world's productive assets and are the principal influences in world trade and financial markets'. Its institutional nucleus is comprised of 'elements of the G-7 state apparatuses and transnational capital (in manufacturing, finance, and services)' which have created an 'internationalisation of authority and governance that not only involves international organisations ... and transnational firms, but also private consultancies and private bondrating agencies'.[18] Global governance is thus led by what Cox calls a 'transnational managerial class' and their institutional homes (e.g. ministries of finance, trade and industry, the World Bank and IMF, the Organisation of Economic Cooperation and Development) who increasingly shape policy making on a global scale.[19] Intellectual, moral and political leadership of this transnational managerial class is centred on consent to the ideas of political and economic neoliberalism, an ideology which is 'largely consistent with the world view and political priorities of large-scale, internationally-mobile forms of capital'.

It is within this world order that a fuller understanding of the global spread of AIDS can be achieved. First, the spread of AIDS has been facilitated by resultant changes in the spatial dimension of human relations. Globalisation, as described above, has led to an unprecedented increase in the worldwide movement of people (within and across national borders) in the form of migration and migrant labour,[20] tourism, displacement, occupying military forces,[21] and rapid

urbanisation. Where development strategies have been adopted which seek to integrate a country into the global economy through liberalised markets and rapid industrialisation, pressures of transience on populations have increased at the same time as weakening systems of social support and the increased prices of many products and services. These changes have led to fundamental changes to social structures in both lower and higher income countries which have provided fertile conditions within which HIV has appeared and spread. For example, in Senegal and Uganda, it was found that 'mobility is an independent risk factor for acquiring HIV', noting that 'it is not the origin, or the destination of migration, but the social disruption which characterises certain types of migration, which determines vulnerability to HIV'.[22] Similarly, a study in the USA found that 'the disintegration of minority community physical or social structures has created such turmoil that AIDS spread rapidly to intravenous drug users and their sex partners, and rapidly followed commuting patterns into the suburbs'.[23]

Second, the ability of individuals, societies and countries to adapt to the process of globalisation is unequal, with those less able to adapt engaging in risk behaviours under conditions of poor access to health care that have made them more susceptible to HIV infection. For many low-income countries, the period since the late 1970s has brought rising levels of foreign debt, negative economic growth and declining terms of trade and levels of foreign aid. The introduction of structural adjustment programmes (SAPs) by the World Bank during the 1980s as a response to these macroeconomic problems has, as Asthana writes, 'contributed to an unprecedented decline in the health and living standards of the Third World poor'.[24] The main cause has been reduced public spending on the social sectors which much recent evidence shows has led to a decline in health status among the poorest communities. In Zambia, real expenditure on health fell between 1982–85 by 22 per cent, while in Bolivia per capita expenditure on health by the government declined by 30 per cent.[25] The introduction in many countries of cost-recovery mechanisms, such as user charges for health services, has been found to reduce utilisation despite exemption mechanisms for the poor.[26] It is now widely recognised by the development community, including the World Bank, that, in the mid-1990s, insufficient emphasis on 'poverty alleviation' by SAPs has had detrimental effects on the health status of poor communities.[27]

It has been within communities worst affected by these declining health conditions that HIV infection has gained the biggest foothold. The fastest growing epidemics have been among the most socioeconomically disadvantaged populations within and across countries. In low-income countries, greater human insecurity and social inequities have led many individuals to resort to coping strategies (e.g. migrant labour, commercial sex) under conditions which have placed them at greater risk of HIV infection. In Tanzania, it was found that 70 per cent of commercial sex workers engage in prostitution for economic survival.[28] In west Africa, large numbers of men migrate seasonally to work in neighbouring countries because of poor employment opportunities at home. In a study of Côte d'Ivoire, it was found that an agricultural enterprise provides accommodation for 2000 young male migrant workers in a camp which is visited

after each payday by sex workers. Each sex worker 'services' a 'mean of 25 workers each over a period of two nights'. The study found that it is 'this pattern of mixing, and not the actual number of partners, which is responsible for the extensive spread of HIV among migrant workers'.[29] In India, research by the World Health Organisation (WHO) found that poverty is a key factor contributing to AIDS because financial hardship has forced men to leave their families to find employment. The use of drugs and/or sex workers has often followed suit.[30] An exacerbating factor in the spread of HIV infection among these low-income groups is the inadequate treatment of sexually transmitted diseases (STDs). Conditions such as genital ulceration increase the vulnerability to HIV infection, yet treatment for such conditions has not been forthcoming given limited access to health services. A study in Nairobi showed declines in clinic attendance for sexually transmitted diseases following the introduction of user charges.[31]

It has not only been in low-income countries that deteriorating political economies have increased vulnerability of populations to HIV infection. In the 'economies in transition' of central and eastern Europe, the end of the Cold War, and subsequent pressures to integrate rapidly with the emerging transnational neoliberal order, have brought upheaval to political and economic infrastructures. Health systems have been particularly badly affected, accompanied by sudden rises in such health indicators as infant mortality rate, incidence of infectious diseases and substance abuse. In relation to AIDS, the incidence of high-risk behaviours within unsafe conditions has increased.[32] In Albania, described as the 'bargain-basement brothel of the West', 'sex tourism' has become one of the main sources of income for many women.[33]

Finally, in many Western industrialised countries, globalisation has led to the rise of a disenfranchised, disempowered and impoverished 'underclass'. Individuals and groups within this class are those most adversely affected by globalised economic and political relations: the under- or unemployed thanks to monetarist economic policies; low-skilled labour because of the international mobility of production; small businesses because of the globalised scale of production of goods and services; and women and ethnic minorities who make up the majority of part-time and temporary workers. In the UK this class has emerged amid the widest social inequalities since the 1930s.[34] Similarly, Singer found that urban poverty and socially devalued ethnicity have been contributing factors to the spread of HIV/AIDS in the USA.[35]

In summary, there is much evidence that the emergence of a transnational neoliberal order has widened the health gap between haves and have-nots within and across countries. Within both lower and higher income countries, individuals and groups have had variable capacity to respond to rapidly changing global political and economic relations. Across countries, Figure 1 shows that a small number of countries continue to control the vast majority of global wealth. Over 80 per cent of people estimated to be infected with HIV live in low-income countries.[36] While some have gained access to employment, education and quality health care, others have faced limited employment and educational prospects, social dislocation and limited access to health care. It is within conditions of poverty that low-income groups have been more likely to engage in risk behaviours that heighten their exposure to HIV infection.

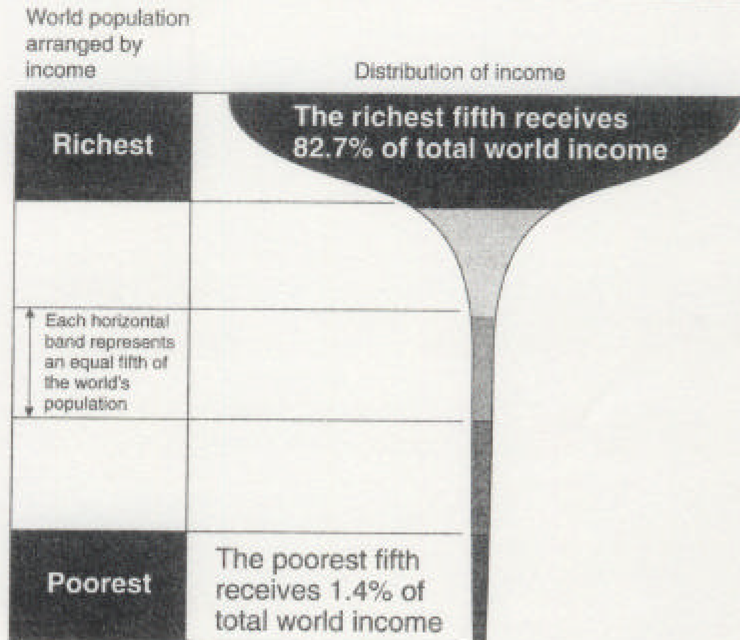

FIGURE 1. Champagne glass of inequality in global wealth.

Orthodoxy and ideology: the discourse of AIDS

It is within the context of the global inequities described above that a critical analysis of the discourse on AIDS can be located. As well as changes in the structural conditions in which AIDS has emerged and spread, a key aspect of the GPE of AIDS is the way in which the disease has been understood by both scholars and practitioners. How AIDS has been theorised has had profound implications, not only for how we understand the disease, but for our responses to it. At the global level two main discourses, biomedical and neoliberal, have dominated.[37]

The *biomedical discourse* has focused on the clinical and epidemiological characteristics of the disease, modes of transmission, strategies emphasising individual risk behaviours, and developing methods of prevention, treatment and care. The proponents of this biomedical discourse have been scientists and medical professionals, trained within the Western medical tradition, who see the origins of disease primarily in terms of individual agents (i.e. viruses, people) and seek solutions through the medical sciences directed at the agents of infection. This tradition, as Doyal writes, is 'hospital-centred, highly technological, and is dispensed on an individual curative basis'.[38] For AIDS, the problem

is seen to be a lack of knowledge and its application. It is held that, with sufficient amounts of the 'right' information, AIDS can be 'solved'. So far, the search for this 'magic bullet' to treat and cure AIDS has been unsuccessful.[39] Policy makers in the meantime have turned to promoting preventive measures, such as education and information campaigns, directed at changing individual behaviours.

Critiques of the biomedical approach to health are not new. Of particular note has been Lesley Doyal's *The Political Economy of Health* (1979) in which she argues that the legacies of early capital accumulation, social inequalities, colonialism and racism laid the foundations for ill-health in both developed and developing countries. Other writers, such as Vincent Navarro, David Sanders and Meredith Turshen,[40] have raised similarly important questions for social scientists seeking to understand the relationship between medicine, health and society. These ideas have increasingly been applied to HIV/AIDS, albeit with emphasis on the national and subnational levels.[41]

In relation to AIDS, there are three main shortfalls to the biomedical discourse. First, by focusing on the biology of the individual, it neglects potential explanations of disease and its treatment within wider social, economic and political contexts which create conditions of risk. Second, the discourse conceives the major response to health problems in terms of medical care, and thus fails to recognise the key importance of power in shaping policy responses to AIDS. Third, because medicine is seen as essentially 'good', the problem is perceived in terms of insufficient amounts of medical knowledge rather than any shortfalls in the knowledge itself.

A second, and increasingly powerful, AIDS discourse since the mid-1980s has been based on the principles of *neoliberal economics*. The ascendance of neoliberalism within the health sector has been part of the wider global shift in ideology, interests and institutions described above. Neoliberalism argues that the causes of ill-health are allocative and technical inefficiencies, and that health can be improved through, for example, reducing corruption and waste, supporting cost-effective interventions and increasing the operation of market forces in health-service delivery and financing.[42] Like the biomedical discourse, it implicitly assumes that ill-health is primarily a resource issue, in this case making better use of health resources. Applied to AIDS, this discourse has focused on the financial implications of the disease for national economies, with direct costs estimated at US$11 billion worldwide in 1993.[43] Costing studies have thus been carried out, for example, on the impact of AIDS on patterns of health care expenditure, and the cost-effectiveness of different control strategies.[44] Other studies have examined the effect of the disease on local labour markets, given that, in many countries, AIDS has affected people in their most economically productive years.[45]

The main shortfall of the neoliberal discourse has been the legitimation of economic above other criteria (e.g. moral, ethical, clinical) in the allocation of resources for AIDS. Within the context of seeking greater 'value-for money', an increasing number of national and international policy makers have placed financial considerations foremost in the selection of control and treatment strategies. The promotion of equity, human rights and gender issues have

received lower priority. This is perhaps best illustrated by the World Bank's *World Development Report 1993: Investing in Health*, which puts forth the concept of the 'global burden of disease' measured by 'disability-adjusted life years' (DALY). A DALY is calculated by 'the present value of the future years of disability-free life that are lost as a result of the premature deaths or cases of disability occurring in a particular year' (p. x). Importantly, this formula is based on the normative assumption that individuals in economically productive age and socioeconomic groups are of higher value. AIDS is calculated to cause a heavy burden of disease and, hence, should be given high priority by policy makers, because it has 'powerful negative economic effects on households, productive enterprises, and countries' (p. 100).

Together, both the biomedical and neoliberal discourses have framed the AIDS debate in apolitical terms, legitimised by the claim that they are confined to non-normative issues. Little discussion has taken place within these discourses of the role of power, and particularly how AIDS can be located within changing structures of global political and economic power. Furthermore, the dominance of these discourses has not been limited to an intellectual exercise, but has directly shaped the global response to AIDS.

The global response to AIDS: policy making and the biomedical discourse

National and international policy makers were initially slow to respond to AIDS as a public health issue. In high-income countries this was largely the result of its characterisation by the medical community as being limited to, and controllable within, particular 'risk groups' (i.e. homosexuals, IVDUs, certain geographical regions). Between 1981–85, researchers focused on gathering clinical, albeit vital, information on the disease. This slow response by public health officials was exacerbated by distrust within affected communities. Within the Afro-American community, which has suffered disproportionately from HIV infection in the past decade, efforts by public health officials were looked upon with suspicion because of historical experiences of unethical medical research practices. Most notorious was the Tuskegee study on syphilis in which researchers left people untreated to allow for observation of longer-term effects.[46] In sub-Saharan Africa, apparent Western preoccupation with the alleged link between Africa and AIDS was seen by many as racist and delayed recognition and public acknowledgement of the importance of HIV infection in some regions.[47]

It was not until 1985 that the first International AIDS Conference was held, after which there occurred a mobilisation of expertise and other resources with unprecedented speed. Soon afterwards the international community began to discuss AIDS as a serious global issue and, in February 1987, the World Health Organisation's Global Programme on AIDS (GPA) was created as the main multilateral channel for Western aid.[48] This was followed by a high-level consultative meeting on AIDS and Development held in Talloires, France, whose attendance included the heads of WHO and the UN Children's Fund (Unicef), senior aid officials, and the Minister of Health for Uganda, a country where AIDS was already well established. In 1987 AIDS became the first disease to be

discussed at the UN General Assembly, which prompted Resolution 42/8 to mobilise the entire UN system in a worldwide campaign to control the disease. A World Summit of Health Ministers on AIDS was held soon after in January 1988 and put forth the London Declaration on AIDS.

Financial resources for AIDS have reflected this rapid growth in international attention. In 1987 US$30 million was allocated by GPA; by 1990 this had grown to $109 million. Total external aid flows for AIDS and STD reached $185 million in 1990, more than 10 times that for tuberculosis and 20 times that for intentional injuries, conditions responsible for a similar 'burden of disease'.[49] By 1991 global spending on AIDS reached 10 per cent of total investments in health and population, with development agencies contributing some $250 million annually.[50] Notably, 95 per cent of annual global AIDS budgets has been spent within high-income countries.[51]—

Bilaterally, the USA has spent the largest sums on AIDS. By the end of 1993, the US government had spent over $17 billion, with nearly $1 billion on basic scientific research by the Public Health Service in 1993 alone.[52] Abroad, the US Agency for International Development (USAID) has made the highest financial contributions to HIV prevention activities in low-income countries. Initially officers were advised to minimise their involvement in HIV/AIDS, given limited available resources and sensitivity over the distribution of condoms. It was only after recognition of the impact of AIDS on other development efforts (e.g. child survival) that the USA played a more active role in the creation of GPA, providing $88.5 million of funding from 1986–91. This was in addition to $79.5 million allocated by USAID for bilateral projects, and another $68 million worth of other USAID activities supporting HIV prevention.[53]

From a GPE perspective, this growth of international effort to control AIDS from the early to mid-1980s was firmly located within the biomedical discourse. Internationally, GPA was designated as the lead organisation to mobilise resources and promote the development of national AIDS control programmes. Nationally, governments worked closely with GPA to initiate and implement their own strategies. These strategies were centred on the screening of blood products, clinical care for those affected, education and information campaigns, social marketing of condoms, and peer education among commercial sex workers. The screening of blood products was particularly emphasised during the early years, despite being the least common route of infection.[54] As a technical intervention, it was seen as less controversial than, for instance, the promotion of condom use. Improving the safety of blood supplies also had other potential benefits, such as safety from other blood-borne infections. By no means insignificant were the concerns among travellers from high-income countries to the developing world.[55] Information and education campaigns warning of 'risk behaviours' have also been an important component of prevention strategies. In these campaigns, emphasis is placed on informed individuals taking responsibility for not engaging in such behaviours. AIDS was seen, in this context, as a disease of poor technical capacity, clinical practice or personal knowledge, and less a disease of broader structural features within and across countries.

As national AIDS control programmes became widely adopted by governments, and resources began to flow to support their implementation, many policy

makers turned to the development of appropriate drugs to treat the disease—and a vaccine to prevent HIV infection—as key components of a global AIDS policy. With the prominent success of WHO's Intensified Smallpox Eradication Programme still in recent memory, and other campaigns such as the Polio Eradication Initiative underway, many believed that the AIDS pandemic could also be defeated if the right technologies were available. Thus the race to develop such technologies has led to a massive effort by researchers worldwide. In a survey of 'leading [vaccine] researchers, public health officials, and manufacturers' carried out by the magazine *Science* in 1994, a vaccine for HIV infection was ranked first as the 'most urgently needed vaccine' in both high and low-income countries.[56]

While biomedical research has, and will continue to contribute, vital knowledge in the treatment and control of AIDS, social scientists have played a prominent role in pointing to the need to take account of broader political, economic and social factors behind the AIDS pandemic. In the mid-1990s, there is much concern that biomedical interventions alone have failed to halt the alarming spread of the disease. Policy makers have responded by reassessing the global AIDS strategy. In January 1996 GPA was replaced by UNAIDS, a joint and cosponsored programme of the WHO, Unicef, UN Population Fund (UNFPA), UN Development Programme (UNDP), UN Educational, Scientific and Cultural Organisation (UNESCO) and the World Bank. Foremost among the new programme's goals is to develop a multisectoral and multidisciplinary approach to HIV/AIDS, drawing from a broader range of knowledge and expertise. How this will be achieved, amid uncertainty and rivalry among UN organisations, is unclear. Yet it reflects a recognition that the biomedical discourse alone cannot provide a complete global policy response to AIDS.

The global response to AIDS: policy making and the neoliberal discourse

As well as the biomedical discourse, the global response to AIDS has been strongly shaped by neoliberalism. As described above, neoliberal economic principles such as market-driven resource allocation, privatisation, deregulation and free trade have influenced national and international health sector reform since the 1980s. In relation to AIDS, it is argued that the neoliberal discourse has legitimised certain institutions, interests and ideas in the setting and evaluation of policies according to economic criteria. First, the rise of neoliberalism within the health sector during the 1980s was accompanied by the increased prominence of the World Bank in international health policy. Since 1980, when the Bank began to lend specifically for health projects, it has become the largest source of external health financing for low-income countries. This financial clout has been followed by a greater voice in policy development, with Bank publications having widespread influence on the international health policy agenda.[57]

World Bank lending for AIDS projects began in 1986, and by 1993 it had loaned a cumulative total of US$500 million.[58] One of the key activities supported by the Bank has been research on the economic effects of HIV and the cost-effectiveness of alternative interventions. Lending policies for AIDS

programmes, in turn, have been based on the argument that prevention among 'high-risk groups' is one of the most cost-effective health interventions in the 'global burden of disease'.[59] For example, in India the Bank has worked with the government to study the cost of health care and the indirect national income loss from AIDS. As part of a US$84 million 'multi-pronged prevention strategy', the Bank has combined this research with biomedical interventions emphasising 'behavioural change and condom use, control [of] STDs, strengthen[ing] blood safety, rais[ing] surveillance and clinical management capacity, enhanc[ing] national and provincial capacity for managing HIV/AIDS control activities, and ensur[ing] humane treatment of people with AIDS or HIV infection'.[60] Similar studies have been carried out in the worst affected countries in sub-Saharan Africa, and in Thailand. Overall, the World Bank's lending policy on AIDS has been strongly informed by the neoliberal discourse. Neoliberal economic principles have been foremost in the allocation of resources for AIDS over other health needs, and for the selection of specific interventions. These criteria have been backed by large amounts of financing by the Bank.

Second, the neoliberal discourse has led to an increased emphasis on non-state health care financing and service delivery as viable alternatives to nonexistent or weakened government institutions. As part of a broad shift in the 'public—private mix' within the health sector of many countries, there has been a marked increase in the role of both 'for-profit' (e.g. transnational corporations) and 'not-for-profit' institutions (e.g. non-governmental organisations) in health since the mid-1970s. In low-income countries, this trend has been partly fuelled by an increase in health sector aid through NGOs. Between 1975–85, total official development assistance (ODA) grew by 115 per cent with the amount channelled through NGOs increasing by 1400 per cent. By 1990 NGOs accounted for 17 per cent of the US$4800 million disbursed as external assistance,[61] and about 13 per cent of health sector aid.[62] The rationale for this support includes the belief that NGOs can enhance political and economic pluralism (i.e. civil society), work more closely with local communities and marginalised groups, and fill gaps in service provision. NGOs are also seen to encourage greater cost-effectiveness by offering alternatives to inefficient public health care, and even creating a competitive market where greater choice and competition will improve services.[63] There is no doubt that NGOs are playing a vital and, in many cases, ground-breaking role in the field of AIDS. NGOs have, for example, been at the forefront in drawing attention to human rights issues. The effective implementation of community-based strategies will also depend in large part on NGOs. However, questions have also been raised about the lack of accountability of these organisations and their financial links with traditional donor agencies. There are also concerns of duplication or the establishment of parallel structures, some of which undermine the central role of government.[64]

Third, the neoliberal discourse has strongly defined the race for biomedical technologies to treat and prevent AIDS. The key players in this race have been large pharmaceutical and biotechnology companies, such as the US companies Repligen Corporation, Merck & Company and MicroGeneSys Incorporated, which have spent billions of dollars since the 1980s on research and development. While public subsidies helped to motivate companies into establishing

research programmes,[65] the main spur has been the prospect of a profitable payoff should an effective treatment or vaccine be found. A similarly lucrative market for blood-testing equipment and storage has already emerged.

Leaving the development, and presumably the eventual allocation, of potential treatments and vaccines to the private sector raises several concerns, including the question of access. Private companies have clearly identified their key markets to be in high-income countries where individuals and governments can afford to pay the expected price. An estimate put forth in 1990 of the potential market for vaccines in the USA and Europe was 67 million people. It was calculated that, if 15–20 per cent of these people paid US$150, this would create a market of over US$1.6 billion.[66] From the companies' perspective, it would require such a large return to pay for the huge sums that pharmaceutical companies invest in the research and development of new products. As argued by the Vice President for Scientific Affairs of the International Federation of Pharmaceutical Manufacturers Associations (IFPMA), Margaret Cone, 'if companies are going to invest enormous sums to develop a vaccine, they have got to get a good return on their investment. And an AIDS vaccine is not going to be cheap. The manufacturing procedure is likely to be long, complicated and expensive'.[67] In low-income countries, however, where more than 80 per cent of people infected with HIV currently live, and where 90 per cent of new infections currently occur, this 'market price' lies beyond the reach of the vast majority of people. For example, Uganda is among the countries so far worst affected by HIV and AIDS. An estimated 1–1.5 million people are HIV-infected and GNP per capita is US$170.[68] For many Africans, a vaccine costing US$150 will clearly be economically inaccessible.

A related concern is the danger of overreliance on market-driven research should the perceived market prove unprofitable. Indeed, in the mid-1990s, some private companies have begun to reassess the investment potential of AIDS vaccine research in the light of new estimates of market potential in high-income countries. Recent evidence has shown that rates of HIV infection have stabilised in some high-income countries,[69] while they continue to rise in many low-income countries. In July 1994 the US biotechnology company Repligen Corporation announced the cancellation of its AIDS vaccine programme for financial reasons. Many are concerned that public health priorities, rather than profits, need to be behind decision making over research.

A further concern lies in the clinical appropriateness of the research being carried out in meeting the needs of countries worst affected by HIV and AIDS. In the report of a meeting on HIV vaccines held by the Rockefeller Foundation at Bellagio, Italy, in 1994, concerns were expressed that companies are 'catering to the needs of the developed world' by focusing on 'a small number of the potential vaccine approaches.'[70] This has included an emphasis on the HIV strain, the B subtype, which predominates in Europe and the USA but not in low-income countries. One notable example has been trials in China and Thailand beginning in June 1993 of a potential HIV-B vaccine. In China the trials have been carried out by the US company United Biomedical with the agreement of the Chinese government, while in Thailand it has been a joint project between the US and Thai armies. Grady writes that governments and

private companies have been under pressure to 'do something ... do anything' in the development of an AIDS vaccine.[71] However, both projects have been criticised on the grounds that the HIV-B virus generally does not occur in Asia.

In summary, the global policy response to AIDS from the mid 1980s has been strongly informed by a neoliberal discourse. As well as conceptualising the problem of AIDS in economic terms, neoliberalism has privileged the needs of certain interest groups, including private companies, and has defined the criteria by which policy responses have been evaluated and implemented.

Towards an expanded understanding of AIDS: a global political economy research agenda

The purpose of this article has been to bring the study of the GPE and AIDS closer together and to show how each can be more fully understood through the other. We argue that, while social sciences have made vital contributions to the study of AIDS over the past decade, scholars of IR have largely neglected global health issues. This is beginning to be addressed,[72] but there are several avenues of research to be explored that would enrich our understanding of both the emerging GPE and the AIDS pandemic.[73]

First, there is a need to explore more fully the relationship between the emerging structure of global economic and political power, and the epidemiology of AIDS. As Porter writes, 'the profile of the epidemic is increasingly one of poorer people in developing countries ... [yet] resource allocations are declining in many quarters'.[74] The link between structures of national political economy and health has been increasingly explored, for example, in relation to the debt crisis, urban decay and perceptions of personal responsibility for health.[75] These analyses must now be extended to the global level by pulling together existing studies, as well as studying AIDS as a transnational and global phenomenon. What has been the relationship between the spread of AIDS and levels of foreign debt in low-income countries? Has there been a link between the employment practices of transnational corporations and the global pattern of AIDS? What impact has the movement of armed forces had on the spread of HIV infection? What aspects of globalisation must international organisations, like the World Health Organisation and the World Bank, recognise as contributing factors to the spread of AIDS? Are existing AIDS policies focused at the national level, sufficiently taking account of global factors? What can AIDS tell us about the winners and losers of globalisation? Have changes in international relations since the end of the Cold War, such as a potential growth in global civil society, and the rise of ethnic and territorial tensions, influenced policy making on AIDS? How has the transformation of production relations, including the reorganisation of labour and technological change, affected the health status of workers worldwide?

Second, more detailed and critical analysis of the epistemological and ontological lineage of policy responses to AIDS so far is clearly needed. This article has begun to show how the biomedical and neoliberal discourses have strongly informed the AIDS debate within key institutions since the early 1980s. Further study of the GPE of AIDS would show more precisely how these discourses

have been located within, and disseminated by, the many other individuals and institutions that have become involved in AIDS research, treatment and control, education and policy making. This includes the impact of global telecommunications and the mass media on how we think about and respond to AIDS. Identifying emerging contradictions between such thought, and actions intended to prevent and control the disease, forms a key part of this critical analysis. Furthermore, there is a need to consider what other discourses, from the rich history of political and social thought, can be explored to broaden the AIDS debate methodologically, theoretically and conceptually. Accompanying the existing orthodoxy has been limited recognition of the structural and historical roots of the pandemic, and hence the more fundamental social and political changes needed to address it effectively. AIDS, in short, teaches us about the current limitations in thinking about health, development and international relations.

Third, there is an urgent need to apply an expanded understanding of the GPE to develop ethical and practical approaches to AIDS. National and international policy makers are presently seeking to widen the AIDS agenda in recognition that biomedical and economistic responses alone are insufficient. As Mann and Tarantola write, 'it is now clear that HIV/AIDS is as much about society as it is about a virus. This new understanding of the societal basis for vulnerability to HIV/AIDS has the potential to provide a strategic coherence to efforts in HIV/AIDS prevention and control'.[76] Public health experts are looking to social scientists to contribute to a new policy agenda,[77] with hopes that there will be a move in focus 'away from science to issues of sociology and sexual behaviour, organization and management of programs, NGOs, and Government relations and the epidemic's economics'.[78] A key part of this new agenda must be the impact of globalisation on health. It is on this subject that scholars of the global political economy can offer much. As part of our efforts to redefine the concept of security in a post-Cold War world, issues concerning global human security (e.g. health, environment, migration) need to be given far greater and urgent attention.

Notes

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1. The other notable global effort to control or eradicate a specific disease is the World Health Organisation's Intensified Smallpox Eradication Programme (1967–80). The total cost of this programme was US$81 million. In comparison, the budget for WHO's Global Programme on AIDS was about US$100 million in 1989 alone.
2. This article uses the term '*global*' rather than '*international*' political economy because, as Gill & Law argue, 'political economy analysis should not be narrowly limited to relations between nation-states and their governments. It needs to be global as well as international in character'. Stephen Gill & David Law, *The Global Political Economy: Perspectives, Problems and Policies* (Harvester Wheatsheaf, 1988), p. xxii.

3. *Ibid.*, p. xviii. Emphasis in original.
4. A. Fortin, 'AIDS, development, and the limitations of the African state', in: B. Misztal & D. Moss (Eds), *Action on AIDS: National Policies in Comparative Perspective* (Greenwood Press, 1990), p. 217.
5. S. Hawkes & Keith McAdam, 'AIDS in the Developing World', *Medicine International*, Vol. 21, No. 2 (1993), pp. 69–72.
6. N. Ford & S. Koetsawang, 'The Socio-Cultural Context of the Transmission of HIV in Thailand', *Social Science and Medicine*, Vol. 33, No. 4 (1991), pp. 405–14; and 'AIDS: The Third Wave', *Lancet*, Vol. 343 (1994), pp. 186–88.
7. Michael Merson, 'Slowing the Spread of HIV: Agenda for the 1990s', *Science*, Vol. 260 (1993), pp. 1266–68.
8. Stabilisation is defined as the number of deaths from AIDS over the past year being roughly equal to the number of new cases of HIV infection. However, it is important to note that this measure may hide disproportionate increases in certain groups within a national population. World Health Organisation, *The HIV/AIDS Pandemic: 1994 Overview* (Global Programme on AIDS, 1994), p. 4.
9. John Caldwell, 'Understanding the AIDS Epidemic and Reacting Sensibly to it', *Social Science and Medicine*, Vol. 41, No. 3 (1995), p. 301.
10. Figures of amounts spent by pharmaceutical companies are not readily available. Jonathan Mann, Daniel Tarantola & T. Netter (Eds), *AIDS in the World: A Global Report* (Harvard University Press, 1992), p. 263.
11. Caroline Thomas, 'On the Health of International Relations and the International Relations of Health', *Review of International Studies*, Vol. 15, No. 3 (1989), p. 273.
12. Craig Murphy & Roger Tooze, *The New International Political Economy* (Lynne Rienner, 1991).
13. Stephen Gill, *Gramsci, Historical Materialism and International Relations* (Cambridge University Press, 1993), p. 45.
14. Lesley Doyal, *The Political Economy of Health* (Pluto Press, 1979); and Vincent Navarro, *Imperialism, Health and Medicine* (Baywood, 1981).
15. Gill, *Gramsci*, p. 45.
16. Kelley Lee, 'A neo-Gramscian approach to international organization: an expanded analysis of current reform to UN development activities', in: John MacMillan & Andrew Linklater (Eds), *Boundaries in Question: New Directions in International Relations* (Pinter, 1995), pp. 144–62.
17. It is recognised that the concept of globalisation has been applied with 'casual abandon' by scholars and policy makers. It is defined here as a process of intensified social, political and economic relations on a global scale. For a fuller conceptual discussion, see R.J. Barry Jones, *Globalisation and Interdependence in the International Political Economy: Rhetoric and Reality* (Pinter, 1995).
18. Stephen Gill, 'Globalisation, Market Civilisation, and Disciplinary Neoliberalism', *Millennium*, Vol. 24, No. 3 (1995), pp. 399–423.
19. Robert W. Cox, *Production, Power, and World Order: Social Forces in the Making of History* (Columbia University Press, 1987), p. 359.
20. Mary Bassett & M. Mhloyi, 'Women and AIDS in Zimbabwe: The Making of an Epidemic', *International Journal of Health Services*, Vol. 21 (1991), pp. 143–56.
21. The Civil—Military Alliance to Combat HIV and AIDS was established in November 1994 in recognition that the military tends to have sexually transmitted disease rates of two to three times that of civilian age group counterparts. This rate multiplies even further in wartime. Sven Groennings, 'Civil—Military Alliance to Combat HIV and AIDS', *AIDS in Asia*, No. 4 (1995), p. 8.
22. J. Decosas, F. Kane, J. Anarfi, K. Sodji & H. Wagner, 'Migration and AIDS', *Lancet*, Vol. 346 (1995), p. 826; and F. Kane, M. Alary & I. N'Doye, 'Temporary Expatriation is Related to HIV-1 Infection in Rural Senegal', *AIDS*, Vol. 7 (1993), pp. 1261–65.
23. R. Wallace & D. Wallace, 'US Apartheid and the Spread of AIDS to the Suburbs: A Multi-City Analysis of the Political Economy of Spatial Epidemic Threshold', *Social Science and Medicine*, Vol. 41, No. 3 (1995), pp. 333–45.
24. Sheena Asthana, 'Economic crisis, adjustment and the impact on health', in: D. Phillips & Y. Verhasselt (Eds), *Health and Development* (Routledge, 1994), p. 51.
25. Asthana, 'Economic crisis,' p. 59; and Frances Stewart, 'Can adjustment programmes incorporate the interests of women?', in: H. Afshar & C. Dennis (Eds), *Women and Adjustment Policies in the Third World* (Macmillan, 1992).
26. Lucy Gilson, Steven Russell & Kent Buse, 'The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy', *Journal of International Development*, Vol. 7, No. 3 (1995), pp. 369–401.

27. Anthony Ugalde & Jeffrey Jackson, 'The World Bank and International Health Policy: A Critical Review', *Journal of International Development*, Vol. 7, No. 3 (1995), pp. 525–42.
28. Panos Institute, *AIDS and the Third World* (Panos Institute/Norwegian Red Cross, 1988), p. 88.
29. Decosas *et al.*, 'Migration and AIDS', p. 827.
30. Shiv Lal, 'The HIV/AIDS Situation in India', *AIDS in Asia*, No. 4 (1995), p. 6.
31. F. Moses, F. Manji & J. Bradley, 'Impact of User Fees on Attendance at a Referral Center for Sexually Transmitted Diseases in Kenya', *Lancet*, Vol. 340 (1992), pp. 463–66.
32. See, for example, Renee Danziger, 'HIV/AIDS in the former Soviet Union', unpublished paper, London School of Hygiene and Tropical Medicine, February 1996; and M. Field, 'The Health Crisis in the Former Soviet Union: A Report from the "Post War" Zone', *Social Science and Medicine*, Vol. 41, No. 11 (1994), pp. 1469–78.
33. B. Einhorn, *Cinderella Goes to Market: Citizenship, Gender and Women's Movements in East Central Europe* (Verso, 1993), p. 136.
34. N. Timmons, 'Inequality is worst for 50 years', *The Independent*, 10 February 1995; and Will Hutton, *The State We're In* (Jonathan Cape, 1995).
35. Singer found that almost half of people in the USA who have been diagnosed with AIDS are African-Americans and Latinos from impoverished urban neighbourhoods, M. Singer, 'AIDS and the Health Crisis of the US Urban Poor: The Perspective of Critical Medical Sociology', *Social Science and Medicine*, Vol. 39, No. 7 (1994), pp. 931–48.
36. World Bank, *World Development Report: Investing in Health* (IBRD, 1993), p. 99.
37. For a discussion of how the biomedical and economistic discourses have shaped policy making at the national level, see G. Seidel, 'The Competing Discourses of HIV/AIDS in Sub-Saharan Africa: Discourses of Rights and Empowerment vs Discourses of Control and Exclusion', *Social Science and Medicine*, Vol. 36 (1993), pp. 175–94.
38. Doyal, *The Political Economy of Health*, p. 255. See also Ivan Illich, *Limits to Medicine* (Penguin, 1976) and G. Moon & R. Gillespie (Eds), *Society and Health: An Introduction to Social Science for Health Professionals* (Routledge, 1995).
39. Lesley Doyal, Jennie Naidoo & T. Wilton (Eds), *AIDS: Setting a Feminist Agenda* (Taylor & Francis, 1994).
40. Navarro, *Imperialism, Health and Medicine*; David Sanders, *The Struggle for Health: Medicine and the Politics of Under-development* (Macmillan, 1985); and Meredith Turshen, *The Politics of Public Health* (Zed Books, 1989).
41. David Sanders & A. Sambo, 'AIDS in Africa: The Implications of Economic Recession and Structural Adjustment', *Health Policy and Planning*, Vol. 6, No. 2 (1991), pp. 157–65; Anthony Zwi and A. Cabral, 'Identifying "High Risk Situations" for Preventing AIDS', *British Medical Journal*, Vol. 303 (1991), pp. 1527–29; John Caldwell, 'African Families and AIDS: Context, Reactions and Potential Interventions', *Health Transition Review*, Vol. 3 (1993), pp. 1–16; and C. Evian, 'AIDS and the Socio-economic Determinants of the Epidemic in Southern Africa—A Cycle of Poverty', *Journal of Tropical Pediatrics*, Vol. 40 (1994), pp. 61–2.
42. The seminal publication is the World Bank, *Financing Health Services in Developing Countries: An Agenda for Reform* (IBRD, 1987).
43. Jonathan Mann & Daniel Tarantola, 'Preventive Medicine: A Broader Approach to the AIDS Crisis', *Harvard International Review*, Vol. 17, No. 4 (1995), pp. 46–9, 87.
44. Margaret Ainsworth & Mead Over, *The Economic Impact of AIDS: Shocks, Responses, and Outcomes*, World Bank Technical Working Paper 1, Africa Technical Department, Washington DC, 1992; J. Cuddington, 'Modeling the Macroeconomic Effects of AIDS, with an Application to Tanzania', *World Bank Economic Review* (1993), pp. 173–89; and Susan Foster & Anne Buve, 'Benefits of HIV Screening of Blood Transfusions in Zambia', *Lancet*, Vol. 346 (1995), pp. 225–27.
45. World Bank, *World Development Report: Investing in Health*, p. 100.
46. S. Thomas & S. Quinn, 'The Tuskegee Syphilis Study, 1932–1972: Implications for HIV Education and AIDS Risk Education Programs in the Black Community', *American Journal of Public Health*, Vol. 81 (1991), pp. 1498–1504.
47. Richard Chirimuuta & Rosalind Chirimuuta, *AIDS, Africa and Racism* (Free Association, 1989).
48. Jonathan Mann, 'The Global Picture of AIDS', address to the Fourth International Conference on AIDS, Stockholm, 12 June 1988, pp. 4–5.
49. C. Michaud & C. Murray, 'External Assistance to the Health Sector in Developing Countries: A Detailed Analysis 1972–90', *Bulletin of the World Health Organization*, Vol. 72 (1994), pp. 639–51.

3. *Ibid.*, p. xviii. Emphasis in original.
4. A. Fortin, 'AIDS, development, and the limitations of the African state', in: B. Misztal & D. Moss (Eds), *Action on AIDS: National Policies in Comparative Perspective* (Greenwood Press, 1990), p. 217.
5. S. Hawkes & Keith McAdam, 'AIDS in the Developing World', *Medicine International*, Vol. 21, No. 2 (1993), pp. 69–72.
6. N. Ford & S. Koetsawang, 'The Socio-Cultural Context of the Transmission of HIV in Thailand', *Social Science and Medicine*, Vol. 33, No. 4 (1991), pp. 405–14; and 'AIDS: The Third Wave', *Lancet*, Vol. 343 (1994), pp. 186–88.
7. Michael Merson, 'Slowing the Spread of HIV: Agenda for the 1990s', *Science*, Vol. 260 (1993), pp. 1266–68.
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11. Caroline Thomas, 'On the Health of International Relations and the International Relations of Health', *Review of International Studies*, Vol. 15, No. 3 (1989), p. 273.
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14. Lesley Doyal, *The Political Economy of Health* (Pluto Press, 1979); and Vincent Navarro, *Imperialism, Health and Medicine* (Baywood, 1981).
15. Gill, *Gramsci*, p. 45.
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26. Lucy Gilson, Steven Russell & Kent Buse, 'The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy', *Journal of International Development*, Vol. 7, No. 3 (1995), pp. 369–401.