The AIDS pandemic has laid bare a deceptively simple reality—that economically and socially vulnerable populations cannot sustain what is necessary to improve their quality of life without viable institutional and structural changes both within and outside of their countries. With increased economic polarization, sexual and gender exploitation, political instability, shifting global economies and the like, it is no wonder that “questions of health can never be separated from broader struggles for responsibility, fairness, and social justice” (Parker 2002, 345).

Throughout the history of the HIV/AIDS pandemic, epidemiologists, public health experts, activists, non-governmental organizations (NGOs) and some policy makers have confronted a bio-behavioral approach to disease which posits that disease can be halted by targeting the individual or the risk group. This approach frequently converges with the rational choice paradigm, which posits that transmission rates will decrease once an individual is given incentives and made accountable for his or her choice to engage in risk behavior and understands the availability of alternatives. However, public health has generally been the responsibility of the government, and individual rights historically have been subject to limitation if there is a communicable risk or a severe public risk, such as in the case of drug resistant tuberculosis. The maintenance and improvement of the public’s health requires collective or social action, involves governmental, non-governmental and professional actors, and must operate from the local to the international level (Breslow, et al. 2002, Gandy 2005). Further, many decades of social
epidemiological research have established that social context is a serious component of disease risk, and that choice is mediated by what is available to the individual actor, or to the community in which she lives.

Thus, a more useful analytical strategy is to place the individual actor within a larger social environment in which external variables affecting life chances (whether HIV-specific or not) can be understood. For example, utilizing a social epidemiological approach to HIV allows for the identification of social determinants that affect susceptibility and vulnerability at the population level. By using this approach, one can identify the complex web of intersecting factors that affect HIV/AIDS (Poundstone, Strathdee and Celentano 2004). Some of these factors are at the social level: cultural context, social networks, neighborhood, and social capital. Cultural beliefs and practices can be reinforced by social networks and result in the continued stigmatization of people living with HIV/AIDS (PLHA) and the stigmatization of certain risk behaviors (see Faubion, this volume). Naturally, stigma and fear of discrimination can result in many barriers for people seeking information or health services.

Other factors affecting HIV/AIDS are structural, such as the interaction of poorly functioning social institutions (government, education, and media, for example) and a lack of will result in what Paul Farmer (2003) has termed “structural violence.” Structural violence occurs when harmful or untenable structural conditions persist and result in the undue suffering of groups of people who often are already vulnerable to marginalization due to their race, ethnicity, religion, citizenship status, gender, economic status, or sexuality. Structure refers to phenomena that are “embedded in the political and economic organization of [the] social world: they are violent because they cause injury to people (typically not those responsible for perpetuating such inequalities” (Farmer, Nizeye, Stulac and Keshavjee 2006: 1686). Therefore,
structural violence may be caused by institutional forces, such as forced migration, unequal law and criminal justice processes, and war/militarization. For example, armed conflict and stagnant economies are linked with health crises in developing countries (Epstein 2003) and an absence of political will and rule of law in nations like Ethiopia and Zambia (Mohiddin and Johnston 2006). It is clear that the most vulnerable to disease, whether in the global North (northern hemisphere) or global South (southern hemisphere), are the economically and socially marginalized. Those who are the most vulnerable require structural supports in order to survive. Therefore, the eradication of diseases presumes government effectiveness, the absence of violence, the rule of law, lack of corruption, and civil engagement or the ability to select a government and influence domestic policy (Menon-Johansson 2005; Irwin and Scali 2007). All of these social and structural impacts on HIV/AIDS are systemic rather than merely individual and behavioral in that social and structural factors feed off of each other and shape the lived context of the populations affected by them. Furthermore, other actors such as NGOs, multinationals and the governments of developed nations have influenced the development of responses to the social and structural challenges faced by the governments of developing nations and their citizens.

Engaging in a social epidemiological analysis or structural analysis of the impact of HIV in resource-poor nations requires multiple lenses, such as understanding the social and structural variables within a particular nation while recognizing the impact of systems outside of the country. For example,

As poverty increases so usually do income and class inequality. Mobility increases as people seek to escape poverty and work away from their homes. Increased poverty, inequality and mobility weaken or break up the social framework in which people live – a framework that may have
disciplined sexual relations in ways that reduce disease transmission. This framework may be thought of, in part, as ‘social capital.’ Finally, rapid change and insecurity often increase the incidence of transactional sex as part of women’s livelihoods. When, against this background, a government cuts back spending on health and education, it creates an environment conducive to HIV transmission (Barnett and Blackwell 2004, 4).

Social epidemiological analyses also necessitate recognizing that there are moral and ethical concerns that intersect society and structures. Key stakeholders have made decisions which both directly and indirectly affect the development of many nations’ infrastructures. A person’s inability to afford life saving health care obstructs their ability to act as an autonomous being and thus becomes a human rights problem (Hein and Kohlmorgen 2005). As such, it is important to address the ways in which such decisions constrain a nation’s ability to respond to the needs of its citizenry and to what extent multiple actors are culpable in the building of nations’ infrastructures (The Henry Kaiser Family Foundation 2007). The physical health of citizens is directly predicated upon the social health of the nation. The social health of a nation depends upon many factors—political, cultural, and economic. All of these factors shape and are shaped by the AIDS pandemic. Political structures impact the development of public health policy, fiscal decision-making, the building of infrastructures which facilitate health, and the decentralization of power within systems required to provide aid to citizens. Cultural factors such as the influence of gendered and sexual stigma, social norms concerning care giving, and reliance on indigenous spiritual and health seeking practices are influential as well. Movement of capital and labor within and between countries, trends in worker employability, wage
stagnation, and are some of the viable economic factors associated with HIV/AIDS in developing countries. While developing such an extensive analysis is outside of the scope of this framing essay, what is feasible is to provide an introductory sketch of how one of these mechanisms is connected to HIV/AIDS—namely, economic influences.

**Structural Factors and Powerful Stakeholders**

Global gaps in income and investment have been growing over the past 20 years to 86:1 between the richest and poorest 20 percent of the global population. While poor state level economic and political management are implicated in this trend, the influence of bilateral and multilateral financial support cannot be denied. For example, foreign direct investment (FDI) involves the influx of overseas foreign funds into a country to be used in manufacturing or services. The foreign investor retains at least partial control and ownership of this investment (e.g., the increasing trend among US–based multinationals to outsource information technologies). FDI in the global South targeted 10 countries including China, Indonesia, Colombia, Malaysia, and Taiwan.

At the other extreme, the 48 Less Developed Countries (LDCs) received around $800 million in FDI in 1999 – roughly the same size as flows into Brazil, and less that 1 percent of the total transfer to developing countries… This uneven distribution of global investment patterns with its associated selectivity and polarization of societies has given rise to: a growing gap between the rich and poor within and between nations (Commission on HIV/AIDS and Governance in Africa 2004, 5; see also BBC 2005).
Arguably, macroeconomic policy has had a profound impact on the economic viability of developing nations. Macroeconomic policies affect health and development because they alter absolute poverty and the distribution of wealth. As a result, both households and health systems are affected (Federici 2002; Gostin 2004; Poundstone, Strathdee and Celentano 2004). Since the 1980s, the overarching macroeconomic policy that has generated substantial debate concerning its impact on health care provision and on national responses to HIV, has been structural adjustment programs (SAP). The World Bank and the International Monetary Fund were the two key architects of SAPs in the 1980s. SAPs are vehicles for economic stabilization, sustained economic growth, and poverty reduction in developing countries. Eligible countries that receive low interest rate loans agree to satisfy certain conditions including trade liberalization and reductions in state budgets (Abouharb and Cingranelli 2003; Muuka 1998). This economic model and the resulting conditions were predicated on a neoliberal political-economic premise emphasizing the power of the free market to dictate resource mobilization and patterns of consumption. With a reduction in state controls on production and export of goods, economic growth was to be stimulated and all resources needed for the public good would be more efficiently distributed. Stimulating economic growth might necessitate a reduction in investments for the social good, including health care provision, but would promise long-term benefits. Within this framework, responsibility for health care would shift from the state as provider to the individual as consumer (Irwin and Scali 2007).

Under SAP guidelines, countries with a high debt burden would garner restructuring of debt as long as they satisfy certain requirements. These included the reorganization of their

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1 Neo liberalism is a policy geared to the expansion of global economies. It presumes that free private enterprise should be encouraged (allowing for the flow of capital, goods, and services), that reduction of public expenditures frees up revenue to be invested in production of goods, government deregulation of policies that might obstruct profits, privatization of enterprises and infrastructures (like water, highways, telecommunications, and electricity), and a focus on individual responsibility for solving societal problems (Martinez and Garcia 2000).
economic system and social policy initiatives to focus on privatization of goods and services, reduction of price controls on goods, a focus on exporting goods, and the use of fees for social goods such as education and health care (Irwin, Millen and Fallows 2003, Barnett and Blackwell 2004, Heimer 2007). An unintended outcome was the reduction of spending in the social sector at the same time that the HIV pandemic was emerging (Irwin and Scali 2007). Ironically, alongside the expansion and popularization of neo-liberalism there was an increase in available medical technologies to wealthy nations, liberalization of trade, increased economic vulnerability and marginalization of the already vulnerable, and increased intervention by non-state actors as problem solvers (Hein and Kohlmorgen 2005). All of the societal tools needed to confront the pandemic were weakened exactly when they were most needed by the governments of developing countries to launch effective, strategic and long-term responses to HIV. There were limited resources for AIDS education through traditional and non-traditional outlets, infrastructures for health provision had been stripped, and thus developing nations faced the reality of borrowing more to offset the cost of care. While the SAPs and related neoliberal policies did not cause the rapid transmission of HIV in developing countries, particularly in sub-Saharan Africa, they inadvertently diverted resources that could have been used by poor nations in response to the pandemic. It would be problematic to argue that poor nations would have been equipped to contain the prevalence of HIV but it is possible that such macroeconomic policies weakened those nations with some modicum of infrastructure (Federici 2002; London 2007).

The economic destabilization of developing nations was so profound that by the end of the 1990s the debt to foreign aid ratio reached a high of 1.5-to-1 in sub-Saharan Africa, where expenditures on debt service outpaced health care by 2-to-1 (Harris and Siplon 2001). Among the many outcomes of this debt load is that the provision of proven treatments such as
antiretroviral drug therapies (ARVs) were too costly for countries to afford. (Krieger 2001) Access to ARVs is literally a life and death issue since taking these drug cocktails makes the difference between HIV being a chronic disease and a fatal one. Along with the increasing demand for ARVs is the need for health care providers, educators, and other health workers necessary to the provision of care. “This increased demand is putting pressure on the limited health resources in many developing countries…. As more and more people turn to the public sector to help pay for health services after their own resources are depleted, governments will be faced with important choices regarding responses to HIV/AIDS” (The Henry Kaiser Family Foundation 2007, 5).

A lack of infrastructural support has also been linked to an increased likelihood of structural violence within societies. Such violence is defined as the impact of both intentional and unintentional processes of institutional forces that constrain agency. Some scholars, such as Farmer (2003) and Poundstone, Strathdee and Celentano (2004), have viewed the impact of SAPs and other institutional forces on the provision of care to individuals in resource poor countries as a form of structural violence. One of the outcomes of this structural violence and public health debate is a new human rights and health discourse which calls for a renewed commitment to providing for the sustainability of health care and the reduction of rates of HIV transmission. Within this discourse what comes to the fore is that developing nations may be resource poor but asset rich (Mohiddin and Johnston 2006). This shifts the health-as-social-problem debate from a pathologizing discourse to a collaborative problem solving approach.

International law and human rights law have provided useful guideposts to this asset rich, collective problem solving strategy. What is especially instructive is that the application of a human rights orientation facilitates the leadership of developing nations to confront their
HIV/AIDS crises with the help of both wealthy nations, NGOs and other international actors. Responding to structural violence and the legacy of neoliberal economic policy demands the integration of human rights law in a way that addresses the importance of socioeconomic rights (Ammann 2002, Patterson and London 2002). Some scholars argue that the right to health is a binding component of international law extending to essential medicines\(^2\), a system of health protection and various other goods, services, and facilities allowing for the enjoyment of the highest possible level of health (Blaylock 2006, Hein and Kohlmorgen 2005). One of the most visible applications of the human rights discourse has concerned access to affordable ARVs. Even the most affordable ARVs are prohibitively expensive for the average person in a developing country, where the average daily wage might be no more than $1USD. Institutional conflicts between nations becomes evident when the World Trade Organization (WTO). In 1995 WTO drafted the agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) which was intended to protect the intellectual property of corporations (e.g., the patent rights of pharmaceuticals) to promote further incentives to advance R+ARV therapies for those pharmaceuticals operating in market-based economies. All WTO member nations, including developing ones, were obligated to alter their state laws so they paralleled the TRIPS agreement. But paying full price for medicines protected by patent law is untenable for most developing nations (which Craddock expands on in this volume). A logical alternative would be the production or import of generics or a pricing structure that would relieve poorer nations of this untenable economic burden. (Perry 2002, Blaylock 2006).

\(^2\) Essential medicines are defined by the WHO as “[T]hose that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford” (World Health Organization 2007).
Despite the aggressive resistance to these affordable alternatives launched by some pharmaceuticals and the United States government in particular, poorer nations could employ other options. There was a clause in TRIPS that granted countries a grace period before full application of intellectual property protections was expected. Initially, this grace period was slated to expire in 2005. Also, since the 2001 Doha WTO-TRIPS meeting there is some authority for developing nations to suspend patent protection due to national emergencies (Calfee and Bate 2004). Further, a number of state actors, with the support of the World Health Organization and other United Nations organizations and activists, have explored the definition of “national emergency” with reference to the AIDS pandemic. In response to the overwhelming global public criticism, the TRIPS council has extended the transition period to 2016 during which less developed nations do not need to guarantee patent protection. Developing nations can utilize either parallel imports (drugs purchased in countries where manufacturing costs are low and resold in countries where costs would have been too high) or the manufacture of generics for domestic use but not imports. This means that countries with the technological capacity to manufacture generics can do so; both Brazil and South Africa took advantage of the grace period and produced generic versions of ARVs. However, many other poor nations are not able to do the same and are also unable to afford the cost of the imported drugs.

**Implications for Future Collaborative Efforts**

SAP and neoliberal social and economic policies have contributed to the destabilization of developing nations (Epstein 2003; Gandy 2005; Avafia and Narasimhan 2006). These are coupled with the impact of the AIDS pandemic which has contributed to the reduced life expectancy rate in many developing nations, weakened the economic viability of nations and become a national security risk (Parker 2002). It is important to recognize that some research
indicates no causal relationship between SAP and the growth of HIV/AIDS, but rather a
correlation (Barnett and Blackwell 2004). Even so, SAP and other policies created before the
advent of HIV/AIDS could be modified to become more responsive to the ways in which HIV
and structural factors are related.

The evolution of international policies allowing for the manufacture of affordable ARVs
makes clear the relevance of structural human rights-oriented approaches to health care access
(Beyrer 2007, Gandy 2005). It also highlights the importance of collaborative initiatives that use
a multi-sectoral approach which is both vertical (focused on disease control) and horizontal
(capacity building) (The Henry Kaiser Family Foundation 2007, Poundstone, Strathdee and
Celentano 2004). NGOs and other international actors do have an important role to play in
devising useful strategies to confront the AIDS pandemic—both vertical and horizontal (Menon-
assistance totaled $5.6 billion USD (Kates, Izazola, Lief 2007). The United States contributes
47% of all donor nation funds committed to HIV/AIDS programs. They are followed by the
Netherlands (16.7%) and the United Kingdom at (14%). When based on the proportion of
national wealth, The Netherlands, Sweden and Ireland are the three leading government donors
for global programs.

The most successful collaborations between NGOs, international interests and state
actors include strong state-level leadership and political will, a national health care regulatory
strategy, the incorporation of indigenous health provision; all of these encourage the capacity-
building support of NGOs, private donors, and other international funds.

[S]olutions and measures—money, expertise, technology—are readily
available in countries with the ability to supply them (most often the
world’s wealthy countries). Moreover, doing so does not significantly harm those providing the aid (and may indeed benefit them materially in the long term, for example when those aided become trading partners). Therefore, those with the ability to provide the necessary aid ought to administer it even if they are not directly complicit in causing the problem—but the obligation is much more profound if they are (Harris and Siplon 2001, 9).

The Global Fund to Fight AIDS, Tuberculosis and Malaria was developed as a multilateral funding mechanism in 2002 and thus far has received financial commitments exceeding US$4 billion from over 50 countries and numerous foundations such as the Bill and Melinda Gates Foundation (Feachem and Sabot 2007, Hein and Kohlmorgen 2005, The Global Fund 2007). Its governance structure consists of 14 nation states (seven each from the North and South), NGOs foundations, and companies. The WHO, World Bank and UNAIDS are non-voting members. Any country applying for programmatic funds must establish a nationwide coordinating structure that enables the participation of public and private partners. When compared with other stakeholders, the Global Fund represents a multi-sectoral partnership with tangible global power and influence plus an effective strategic approach to prevention (Wornham 2005). For example, funds have been dedicated to voluntary counseling and testing (VCT) for over three million people and the ARV provision to over 300,000 individuals globally. While the United States has been recognized as a leading contributor to the Global Fund, much of these dedicated funds have now been earmarked for the Presidents Emergency Plan for AIDS Relief (PEPFAR). In 2003 President Bush introduced PEPFAR as a mechanism to distribute US$15 billion dollars over five years to existing bilateral programs, the Global Fund, and fourteen target
There is a debate among scholars (Pope and White 2006, see also Blankenship, et al. 2006 for a review of the impact of other contingent funding on international reproductive health programs) regarding the extent to which PEPFAR will engender innovative programs or whether it is merely an ideological policy to promote a singular prevention and treatment agenda. In the meantime, the United States remains the biggest contributor to the Global Fund program, comprising 28% of its funds from donor nations, even with the PEPFAR mechanism (Global Fund 2006).

There are other innovative strategies which have been developed in response to the stated structural barriers faced by developing nations. The Essential Drugs Program of the World Health Organization, adopted in 1978 is one example that may enhance access to ARVs. International clinical research is another vehicle for the distribution of drugs in developing nations (Heimer 2007). The Clinton Foundation and the Bill and Melinda Gates Foundation have been instrumental in brokering tiered pricing of drugs (where cost is adjusted to reflect the financial viability of the recipient nations) and bulk purchases at reduced cost. NGOs such as the Treatment Action Campaign (TAC) in South Africa have actively engaged in public debates about policies concerning access (London 2007, Treatment Action Campaign 2007). TAC coordinates a treatment literacy campaign that provides accurate information—at various reading skill levels—about access to and use of ARVs. They have utilized mobilizing strategies to demand transparency and accountability from the South African Minister of Health and to encourage voluntary counseling and testing at the national level. On May 2, 2007, they issued a press release describing their “National Strategic Plan on HIV/AIDS: A New Opportunity for a Fairer South Africa” in which they commit to advocating for human rights protection, widespread access to ARVs, increased voluntary testing, and endorsing policies mitigating the
impact of HIV on the citizens of South Africa. They call upon state actors to work in collaboration with other national and international interests in their realization of their vision.

As explorations of effective ways to develop new alliances continue, the continuing impact of the AIDS pandemic on developing nations remains unchanged. Given the possible ways that some wealthy nations may have benefitted materially from these policies, the ensuing focus of public health policy researchers and ethicists is likely to be whether wealthier nations have a moral and structural obligation to facilitate both vertical and horizontal forms of prevention (Wornham 2005). “History shows the vulnerability of social determinants policies [policies addressing the social roots of health inequality and disease] to resistance mounted by national and global actors concerned with maintaining existing distributions of economic and social power” (Irwin, Millen and Fallows 2003, 251). Strategic structural interventions will need to be more explicitly linked with the goal of HIV treatment and prevention. Such interventions include innovations in research and technology, structural policy reform, public-private partnerships and above all, recognition that the social and political will must be embraced by all if such change is to become a reality (Feachem 2001; Myer, Ehrlich and Susser, 2004). It has been demonstrated that there is some ideological incompatibility between governments, NGOs and global actors that embrace a structural or social epidemiological approach to HIV and those focused on international financial and development (Blankenship, Friedman, Dworkin and Mantell 1006; London 2007). Perhaps the divide can be breached by recognizing that moral, ethical, human rights and fiscal goals can be simultaneously achieved. There is an implicit profit for all actors involved, whether based on humanitarian and human rights discourse or human and labor capital investment. Employing strategies that encourage economic growth in developing nations without causing undue burdens on social goods and services may result in economic
stability, profit for foreign investors and international and enhance the life chances of the citizens (Gruskin, Mills and Tarantola 2007; Lee 1988). Ultimately, responding to the chronic and institutional impact of HIV/AIDS will continue to require navigation through the rough waters of ideology, geopolitics, transnational economies, and social justice.

References


