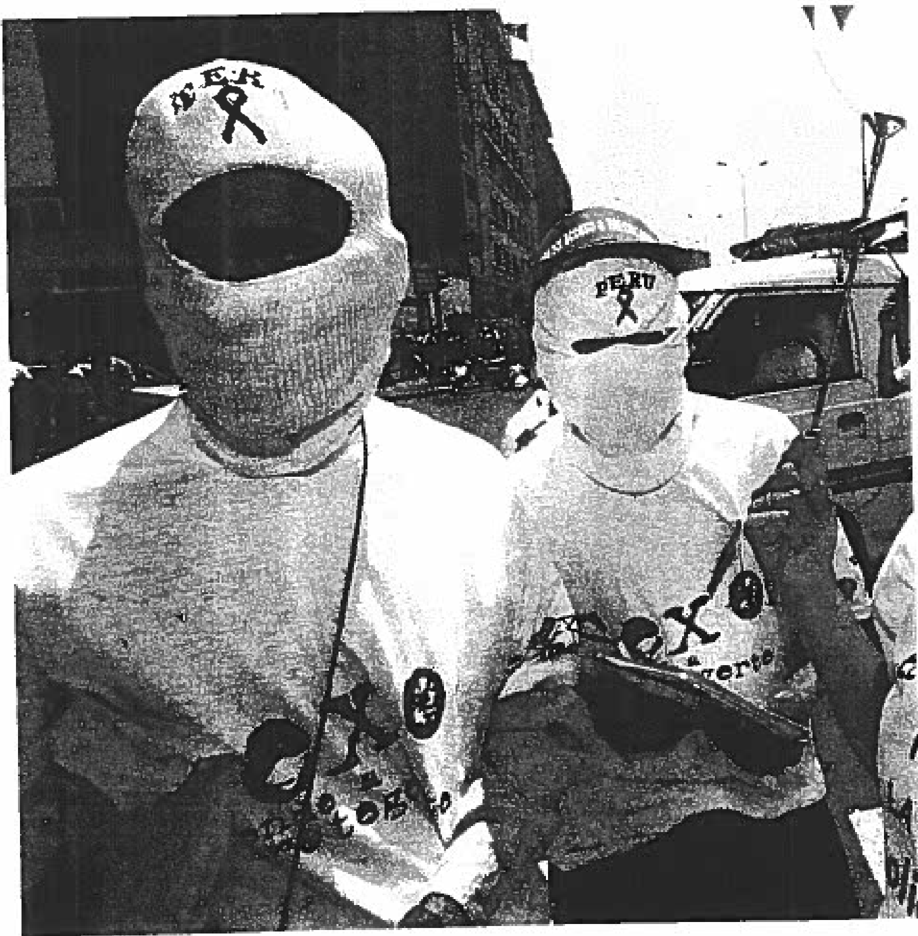


Marchers wear masks to remain anonymous during World AIDS Day events in Lima, Peru.

MYTH ONE: AIDS and Africa

Myth: AIDS is primarily an African problem. The disease exists in many places but is unlikely to affect other regions as it has Africa. In wealthy countries like the US, AIDS has been brought under control and no longer poses a major threat.

Response: Sub-Saharan Africa currently suffers by far the most devastating effects of the AIDS pandemic. Of the estimated 42 million people worldwide living with HIV or AIDS, more than 29 million, some 70 percent, live (and die) in sub-Saharan Africa. Approximately 2.4 million Africans died of AIDS in 2002, and 3.5 million new infections occurred in the region. In 16 African countries, at least 10 percent of people aged 15 to 49 are infected with HIV. The list includes seven countries where infection rates exceed 20 percent of the adult population.[1]

Despite such statistics, however, the automatic association of AIDS with Africa is problematic for two main reasons. First, while the effects of AIDS in sub-Saharan Africa have been brutal, AIDS is not an "African problem," if this means a "problem" for which Africans alone bear responsibility. AIDS in Africa is best viewed as a "transnational" problem. The long history of violence and injustice inflicted on the African continent by colonialism and neoliberal economic and trade policies shaped the socioeconomic context in which HIV proliferates. Second, while so far AIDS has struck hardest

in Africa, today the disease is advancing in many other regions, moving along fault lines of poverty, inequality, and conflict between and within countries.[2] AIDS is not solely an African problem but a global medical and moral crisis that demands a global response. In the following pages, we look first at the historical background of AIDS in Africa. Then we survey the epidemic's spread through every region of the world, paying attention to the increased concentration of HIV/AIDS among poor and marginalized communities within wealthy countries, particularly the US.

Colonialism and AIDS in Africa

HIV/AIDS emerged as a major health crisis for Africa less than 20 years ago, yet the stage was set for its explosive dissemination long before. The economic and social roots of the disease date back over 500 years to the European conquest and, later, colonization of the African continent. An examination of the history and political economy of modern Africa shows that, for Europeans and North Americans, the African AIDS crisis is also our crisis, because the policies carried out by our governments, armies, businesses, and, more recently, by the international financial institutions we dominate, helped create many of the conditions that have enabled the rapid spread of HIV infection.

The AIDS epidemic is only one recent chapter in a longer history of health catastrophes that started with the arrival of Europeans in Africa. From the fifteenth century onward, slave-trafficking, military conquest, colonial rule, and sustained economic exploitation undermined Africans' health directly and indirectly. Even after the cessation of more than four hundred years of the transatlantic slave trade, the colonial powers continued to brutalize Africans who resisted their authority. European colonialists imposed forced labor, uprooted families and

communities through involuntary displacements and labor migration, undermined traditional African political and legal systems, and broke down indigenous agriculture, plunging millions into destitution.[3] The socioeconomic and political disarray intensified the susceptibility of African populations to a host of old and new health scourges, including malnutrition, maternal and childhood illnesses, and infectious diseases.

In some parts of Africa, entire peoples were wiped out during the colonial conquest by direct military violence, sickness, or starvation.[4] Contact with Europeans and population displacements during the colonial period unleashed repeated epidemics in local African populations unprotected by immunity. In 1918–19, hundreds of thousands perished on the continent from influenza brought back by Africans forcibly conscripted by Europeans to fight in World War I. As African men were forced into labor in European-owned industries such as mining, indigenous food production declined, leading to recurrent famines.

Hunger further heightened African people's vulnerability to outbreaks of infectious sickness, creating a persistent cycle of deprivation and disease. When the colonial powers established health care systems in their African dependencies, these systems focused first on the needs of Europeans, then on caring for those Africans who were directly useful to the colonial regime, such as soldiers and overseers. Most Africans had no access to this European medical care.[5]

African colonies began to achieve independence in the early 1960s, and several newly independent countries realized impressive health gains in their early years. Yet the political dislocations and social injustices inherited from the colonial period left new African states with daunting challenges. The poverty, weak institutions, and epidemic disease created during colonialism, reinforced each other

and undermined progress. As the post-independence era unfolded, many poor African countries remained economically dependent on their former colonial powers and the international financial institutions those powers controlled. Under this arrangement, often termed "neocolonialism," the new African states were promised economic growth and "development" as rewards for cooperating with Western Cold War political strategies and commercial interests.

Throughout the 1960s and 1970s, many African governments—in some cases oppressive, corrupt regimes—borrowed heavily from foreign sources. European and American banks enticed developing countries with low-interest loans. By the early 1980s, many African countries confronted high foreign debt burdens compounded by falling international prices for key African commodities such as copper, coffee, and cocoa. The countries' leaders appealed for help to institutions such as the World Bank and the International Monetary Fund (IMF), whose response came in the form of Structural Adjustment Programs (SAP's). Indebted countries were obliged to accept these far-reaching economic reform packages in order to qualify for loan rescheduling and continued international assistance.[6]

SAP's mandated a reorganization of poor countries' economic and social policy structures in line with the emergent ideology of economic neoliberalism. The role of the state was to be minimized, the private sector deregulated, and market forces freed. Fundamental features of SAP's included privatization of many government assets, sharp public sector budget cuts (especially on health and education), scaling back of labor protections, the elimination of price controls and subsidies on food, and the imposition of "user fees" for health services and education. In theory, SAP's were intended to stimulate growth and help reduce the burden of debt; in practice, the austerity measures often exacerbated poverty.[7]

The World Bank report laying the groundwork for the SAP strategy in Africa appeared in 1981, the same year American health officials published the first reports of AIDS.[8] The coincidence of these two events meant that SAP-mandated cuts in government spending undermined the viability of health services in many parts of Africa at the moment when AIDS was poised to explode. Massive public-sector layoffs, subsidy cuts, and sharp reductions in nonexport agricultural spending raised unemployment and deepened poverty, while the introduction of user fees often led to sharp declines in the use of health services. Meanwhile, the promised reward of greater economic growth failed to materialize in most cases.

The exact degree of damage inflicted on African health systems by SAP's is debated. Yet many African and Africanist scholars concur that the consequences of these programs for the health of poor Africans have been severe. SAP's have exacerbated the impact of AIDS directly and indirectly, through health sector budget cuts and user fees that barred access to health services for the poor, and by deepening poverty and social instability, key drivers of the crisis.[9]

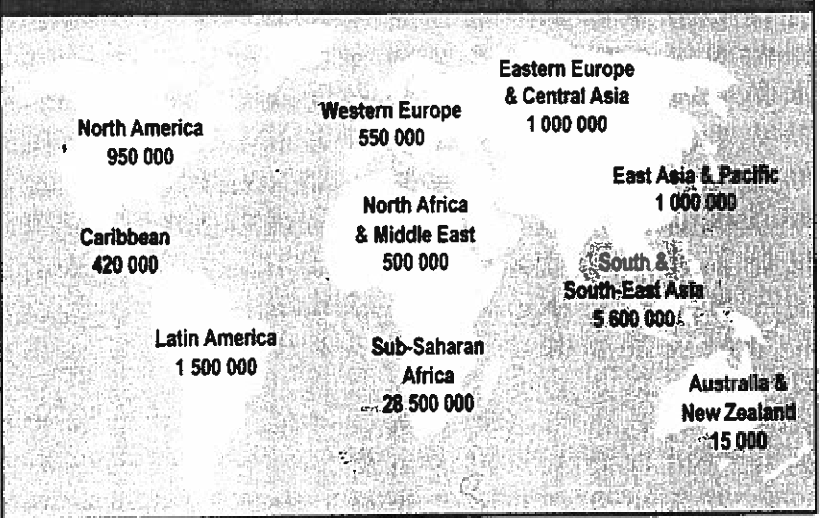
Despite two decades of SAP austerity measures, many poor countries' foreign debt continues to grow. A recent Oxfam briefing paper draws the connections between unsustainable debt and the HIV/AIDS pandemic. It points out that one-third of all people living with AIDS live in countries classified by the World Bank and IMF as heavily indebted. Over half of the countries currently receiving debt relief spend more on servicing their debt than on their total health budgets. With one of the highest HIV/AIDS prevalence rates in the world, Zambia spends 30 percent more on its annual debt payment than it does on health care. Malawi's debt service equals its health spending. In Cameroon, debt repayments are the equivalent of three and one-half times the health budget; while Mali channels $1.60 toward its debt for every $1 that it spends on health.[10]

The SAP policies were designed in Washington boardrooms, just as for centuries Africa's economic despoilment had been supervised from Western capitals. Through these ties of past and current political and economic history, people living today in the wealthiest countries are intimately connected to the pandemic unfolding on African soil.

A Global Killer

To think of AIDS as an exclusively African problem is wrong historically and morally; it is also epidemiologically inaccurate. If Africa's history left the continent particularly vulnerable to the initial onslaught of HIV/AIDS, socioeconomic conditions in many other regions now endanger their populations in turn. Current data show that HIV/AIDS is spreading fast in the Caribbean, Asia, and Eastern Europe, as well as in poor urban neighborhoods in the US.

Some factors influencing HIV transmission patterns, such as the prevalence of injection drug use, vary considerably from region



to region, and from one community to another. Yet the most critical factors heightening vulnerability—poverty, inequality, armed conflict, and the disempowerment of women—pervade many parts of the world. Globalization and increased mobility within and between countries have also hastened the spread of the pandemic. In the following pages, we present epidemiological data to show the worldwide reach of AIDS and highlight the need for a global offensive against the disease.

Eastern Europe and Central Asia

Eastern Europe and Central Asia are now witnessing the fastest growing epidemic in the world.[11] UNAIDS estimates that 250,000 people were newly infected in the region in 2002, bringing the total number of people living with HIV/AIDS there to 1.2 million.[12]

Already at the end of 2002, the adult HIV prevalence in Ukraine stood at one percent.[13] In the Russian Federation, newly reported HIV diagnoses have almost doubled annually since 1998 with actual infections probably far outnumbering official figures. According to US National Intelligence Council estimates, without a greatly expanded response to the epidemic, between five and eight million Russians may be HIV-infected by 2010.[14]

In the Russian Federation and other parts of the former Soviet Union, most reported HIV infections are related to injection drug use, which has become alarmingly widespread among young people during the past decade. One study of Moscow secondary-school students found that four percent had injected drugs. In some countries of the ex-USSR, an estimated one percent of the population is injecting drugs.[15] In Ukraine, while injection drug use is currently responsible for three-quarters of HIV infections, the proportion of sexually transmitted HIV infections is growing, suggesting that the epidemic is moving into the wider population.[16]

Intravenous drug use is widespread among the huge prison population in Russia, where HIV/AIDS overlaps with a tuberculosis epidemic. In the absence of effective prevention and treatment programs, prisoners returning home risk infecting their families and spreading HIV and TB.[17]

The former Soviet Union's transition to a market economy has been accompanied by mass unemployment, heightened economic insecurity, and a sense of exclusion and hopelessness among many young people. These factors appear to spur rising drug use, fueling the spread of HIV.[18] A shortage of available job opportunities and the growing numbers of young people failing to complete secondary school increase the likelihood that many in the next generation will join the ranks of vulnerable groups such as intravenous drug users, prisoners, and sex workers.[19] Moreover, since the breakup of the Soviet Union, Russia and several other newly independent states have implemented harsh austerity measures to meet the demands of international financial institutions and Western governments providing loans and aid during the transition from socialism to capitalism. As a result of budget cuts, public health services have deteriorated in many areas, leaving the newly independent states ill-equipped to scale up HIV prevention and treatment.[20]

Asia and the Pacific

Asia and the Pacific are home to more people living with HIV/AIDS than any other region except Africa.[21] While prevalence rates are lower in Asia than in Africa, such aggregate figures can be misleading. Low overall prevalence rates mask localized concentrations of infection which may spark generalized epidemics.[22] Moreover, low prevalence across very large populations still means massive numbers of people living with HIV/AIDS.

In China, the number of people living with HIV/AIDS was estimated at one million by mid-2002, and projections indicate that the number could rise as high as 10–15 million by 2010.[23] China faces, in certain regions, high rates of injection drug use, poorly monitored blood supplies, high population mobility, and a burgeoning sex industry. Yet despite signs of an epidemic on the brink of eruption, the country's AIDS prevention programs are years behind those of many African nations. The marked lack of AIDS education has allowed widespread ignorance about the disease to persist.[24] One journalist visiting China found:

> With only scattershot education programs, even those at very high risk of getting AIDS often do not know how to protect themselves; many have never even heard of HIV. In a country where patients generally receive no counseling after testing positive for HIV, known carriers often have only a vague idea of how [the virus] is transmitted, and they inadvertently infect others.[25]

HIV levels in specific population groups like injection drug users are rising in several Chinese provinces, with prevalence rates as high as 70 percent reported among drug users in some areas.[26] A devastating epidemic is occurring in central China's Henan province, where hundreds of thousands of poor rural farmers have been infected by the unsafe blood collection procedures commercial blood processing companies used in the early 1990s.[27]

Many researchers foresee an explosion of HIV/AIDS in India. Projections from the US National Intelligence Council panel indicate that 20–25 million Indians may be infected by 2010.[28] Local epidemics, initially concentrated in highly vulnerable groups (e.g., sex workers, truck drivers, injection drug users), are beginning to cross over into the broader population. India's adult (defined as 15–49 years) HIV prevalence is currently less than one percent. Yet, given the country's vast population, this means more than 3.8 million

Indian adults were living with HIV/AIDS at the end of 2001—more HIV-positive men and women than in any other country except South Africa.[29] Prevention efforts have been hampered by widespread poverty, illiteracy, and inequalities based on caste and gender.[30]

In Indonesia, the world's fourth most populous country, HIV/AIDS prevalence rates among injection drug users were not even measured until 1999–2000. When measurements finally began, a staggering 38 percent of injection drug users were found to be HIV-positive in the capital city of Jakarta.[31] Screening blood donations is one way to monitor levels of HIV/AIDS in the general population. Between 1999 and 2000, a surge in HIV infection among blood donors was observed, indicating that the disease may no longer be confined to the most vulnerable groups, such as female sex workers and injection drug users.[32]

The Caribbean and Latin America

While the Caribbean epidemic has not yet reached the devastating proportions seen in Africa, current trends show an accelerating spread of infection. AIDS is now the leading cause of death among men aged 15–44 in the English-speaking Caribbean.[33] More cases of HIV were reported in the Caribbean between 1995 and 1998 than had been identified in the whole period from the early 1980s up to 1995.[34] Although there is some transmission among injection drug users and among men who have sex with men, (MSM), HIV in the Caribbean is spread mainly through heterosexual sex.

At 6.1 percent, national HIV prevalence in Haiti is the highest in the Western hemisphere and the highest of any country outside sub-Saharan Africa.[35] Together, Haiti and the Dominican Republic account for 85 percent of HIV/AIDS cases in the region.[36] Not

coincidentally, Haiti is also the Western hemisphere's poorest country. As in the case of Africa, studies of Haitian history show how the military, political, and economic agendas of foreign powers (in the 20th century, primarily the US) have fostered immiseration, extreme economic inequality, political turmoil, and recurrent violence: all factors that facilitate transmission of HIV.[37]

The contrast between Haiti and Cuba is instructive. Cuba is also a relatively poor country, but one whose government has prioritized equitable access to education and high-quality health care. Adult HIV prevalence in Cuba stands at only 0.03 percent.[38] When HIV was first detected on the island, Cuban health officials moved to place AIDS patients in specialized sanitoria, drawing international criticism. In large part because the first cases of HIV infection were diagnosed among soldiers and aid workers returning from Africa, the problem was managed initially by the Ministry of Defense. After the management of the centers passed to the Ministry of Health, however, restrictions on patients' movements were relaxed. The Cuban government's multidimensional response to the AIDS threat has included HIV education and testing for wide segments of the population, substantial government-funded AIDS research, and advanced medical care (including certain antiretrovirals, or ARVs) supplied free of charge to HIV-positive people.[39]

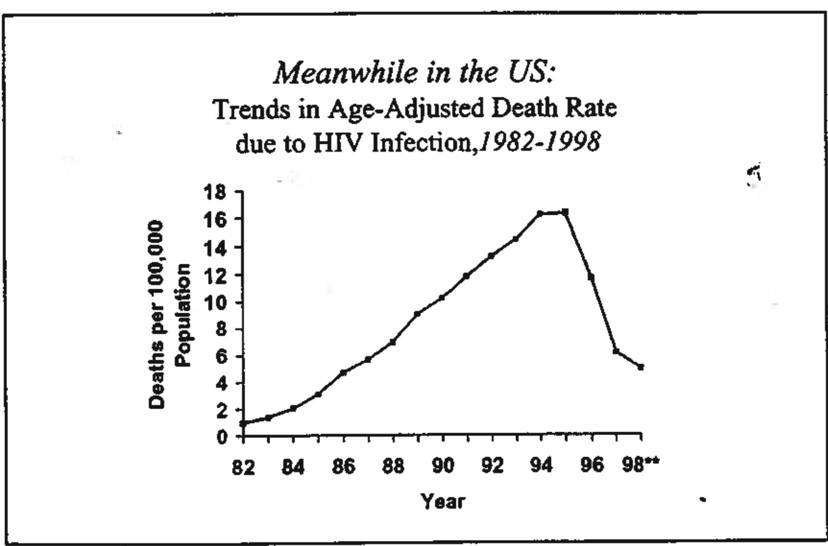
Elsewhere in Latin America, an estimated 1.5 million people are living with HIV/AIDS. Mexico's epidemic has been concentrated mainly among MSM; in some studies, just over 14 percent have tested positive for HIV.[40] Prevalence is lower among commercial sex workers and those being treated for sexually transmitted infections. Among countries in Central America, Nicaragua and Costa Rica have observed infection patterns similar to that of Mexico. However, Honduras, Guatemala, and Belize (significantly poorer countries than Mexico and Costa Rica) are experiencing

rapid increases in heterosexual transmission.[41]

Brazil, Latin America's most populous country, is also home to the largest number of people living with HIV/AIDS in the region.[42] Yet the number of Brazilians infected would be far higher if political leaders, health officials, and civil society groups had not joined forces to respond energetically to the epidemic. Brazil's policy of providing free antiretroviral medicines has propelled the country to the forefront of international debates on AIDS treatment equity.[43] Cooperation between health officials and grassroots groups has also strengthened prevention. For example, prevention programs among injection drug users have led to a substantial decline in HIV prevalence among drug users in Brazil's large urban centers.[44]

Resurgence of HIV/AIDS in High-Income Countries

Often entwined with the perception of AIDS as an African problem is the belief that AIDS is no longer a significant threat in the US. In part, this assumption reflects the real gains made in the



Meanwhile in the US:
Trends in Age-Adjusted Death Rate due to HIV Infection, ***1982-1998***

fight during the 1990s. In that period, aggressive HIV education and prevention campaigns significantly cut infection rates in the US and other high-income countries. Then, beginning in 1996, combination antiretroviral therapies turned AIDS from a death sentence into a manageable chronic disease for many North Americans and Europeans. In 1994, an estimated 48,000 Americans died of AIDS. Four years later, US AIDS mortality had been reduced to 16,000, a two-thirds drop, largely as a result of the wide availability of ARVs.[45]

Unfortunately, rapid gains proved short-lived. According to recent analyses from the Centers for Disease Control and Prevention (CDC), both AIDS mortality and rates of new HIV infections in the US have not decreased since mid-1998.[46] In fact, the US and other rich countries have since seen disturbing upward trends in risk behaviors and infection levels in certain key subgroups, suggesting the danger of what Dr. Helene Gayle terms a "newly expanding epidemic."[47]

Some of the most alarming patterns have been reported among gay men. The CDC reports that, in a 12-city study, "19 percent of HIV-positive MSM engaged in unprotected anal sex between 1996 and 1998, compared to 13 percent between 1995 and 1996."[48] A study in Seattle echoed this result, finding a "sharp increase in the number of HIV-positive gay men reporting unprotected anal sex, from 10 percent in 1998 to 20 percent in 2000."[49] While younger gay men may never have developed rigorous safer sex habits, some older men who once did so are now experiencing an "AIDS burnout" effect that leads them to give up safer behaviors.[50] The result has been a dramatic surge in HIV infections among MSM. The CDC's recent Young Men's Survey found a 4.4 percent infection rate among 23- to 29-year-old MSM. This rate is significantly higher than in any other recent US incidence study and is comparable to levels seen among

MSM in the mid-1980s, when AIDS exploded to epidemic proportions in gay communities.[51]

While the abandonment of safer sex practices and the increased spread of sexually transmitted infections have been particularly notable among MSM, these patterns are not limited to any single group. Estimated incidence of HIV/AIDS transmitted through heterosexual sex has also risen in recent years.[52] In 2001, for every AIDS case diagnosed among gay or bisexual men in the US, two were diagnosed among heterosexual men or women.[53]

The demographics of HIV/AIDS are changing in the US. AIDS is now a disease patterned by race and income level. African-Americans, for example, make up only 12 percent of the US population but in 2000 accounted for 50 percent of new AIDS cases and 57 percent of new HIV diagnoses.[54] The CDC's Young Men's Survey found that 15 percent of Latino MSM are HIV-positive before age 30. Among African-American MSM, the rates are even more devastating, with nearly one in three African-American MSM infected before reaching the age of 30.[55] Women of color also suffer disproportionate rates of HIV infection. In the northeastern US in 1999, HIV incidence among women stood at three cases per 100,000 for whites, 57 cases per 100,000 for Hispanics, and 104 cases per 100,000 for African-American women.[56]

Similar differentials are seen in treatment outcomes. From 1987 to 1995, before the advent of effective ARV therapy, African-American women saw the greatest increase in age-adjusted HIV death (425 percent), while the increase was smallest among white males (133 percent).[57] Today, effective treatment options exist, but HIV-positive Americans do not enjoy equal access to their benefits. African-Americans, Latinos, and the rural and urban poor have low rates of health insurance coverage and limited access to medical care. As a result, they are more likely to go undiagnosed and

untreated during the early stages of HIV infection and to develop full-blown AIDS more rapidly.[58]

The Need for Global Mobilization

The AIDS crisis has struck sub-Saharan Africa with exceptional force. Yet Africa's struggle with AIDS, like many of the continent's battles, shows not Africa's uniqueness and isolation but rather the extent to which Africa's history and destiny are intertwined with those of other regions, above all the wealthy former colonial powers of Europe and the US. There is nothing intrinsically African about the key factors driving the spread of HIV/AIDS—above all poverty, socioeconomic inequality, instability and armed conflict, and the disempowerment of marginalized groups. These phenomena are widespread in the contemporary world. Thus, AIDS is advancing rapidly today in many regions.

The AIDS disaster unfolding in sub-Saharan Africa can happen elsewhere. Indeed, we can say with grim confidence that it *will* happen elsewhere—unless we take action. As Louise Fréchette, UN deputy secretary-general, observes, "Globalization, travel, and migration add to the risk of increased spread to what we might think of as 'safe' countries. The reality is that in our globalized world, there are no 'safe' countries."[59] It is said that, compared to countries in sub-Saharan Africa, other countries and regions are "low prevalence" when it comes to HIV. But low-prevalence statistics may mask great suffering for large numbers of people. And with the history of the epidemic in mind, low prevalence is not a timeless condition. All countries, including South Africa, Zimbabwe, and Botswana, were once low-prevalence countries.[60] If energetic action is not taken to combat the spread of HIV, low-prevalence areas—in particular those characterized by poverty and deep socioeconomic inequalities—will inexorably turn into high-prevalence areas.

For over 20 years, Africans have borne the greatest burden of the AIDS pandemic—not only because the disease has so far claimed the majority of its victims on African soil, but also because people in other parts of the world have stigmatized and blamed Africans for the origin and spread of AIDS. But AIDS is not and never was an African problem. No group, whether Africans or Americans, singlehandedly created the conditions which allow this disease to flourish. And no group will singlehandedly end the pandemic. This crisis crosses geographical and political boundaries, while highlighting the polarization between "haves" and "have-nots" worldwide. Defeating the pandemic will demand an unprecedented international effort, offering people in affluent countries, like the US, an opportunity to recognize our interdependence with people in low-income countries, and to work cooperatively for global health equity.