Encyclopedia of World Poverty

HIV/AIDS

Contributors: M. Odekon
Print Pub. Date: 2006
Online Pub. Date: September 15, 2007
Print ISBN: 9781412918077
Online ISBN: 9781412939607
DOI: 10.4135/9781412939607
Print pages: 491-494

This PDF has been generated from SAGE knowledge. Please note that the pagination of the online version will vary from the pagination of the print book.

10.4135/9781412939607.n320

THE RAPID SPREAD OF HIV through all social strata and all sexual orientations has proved that the initial risk categories and the identification of the virus with gay men make little sense. Yet with the passing of years, the true risk category linked to the virus may be that of the poor, with poverty representing a considerable risk factor.

The AIDS epidemic is not only a health issue but also a socioeconomic and security issue. AIDS has killed millions of adults, reducing the workforce, exacerbating famine, impoverishing families, and orphaning millions of children in the regions hardest hit. As Stephen Lewis, the United Nations (UN) special envoy for HIV/AIDS in Africa, has put it in his notes on one of his travels to Lesotho, Zimbabwe, Malawi, and Zambia, there is a clear link between hunger and AIDS.

Western governments are all too often hiding behind the doubt that the African developing countries may not even have the will to fight the virus. During his travels, Lewis noticed “how even in the most extreme of circumstances, such as those which prevail today in the four nations [he] visited, Africans are engaged in endless numbers of initiatives and projects and programs and models which, if taken to scale, if generalized throughout the country, would halt the pandemic, and prolong and save millions of lives.” Yet African countries lack adequate financial resources to face the pandemic effectively, and Lewis defines this shortage as “mass murder by complacency”: “This pandemic cannot be allowed to continue, and those who watch it unfold with a kind of pathological equanimity must be held to account. There may yet come a day when we have peacetime tribunals to deal with this particular version of crimes against humanity.”

Lewis's account goes on to detail the links between poverty and AIDS, which, according to the UN special envoy, were visible everywhere: “In Malawi, for example, analysis of the data shows that 50 percent of poor households are affected by chronic illness due to HIV/AIDS. You can’t till the soil, grow the crops, feed the family, when disease stalks the land.” Lewis appeals to G-8 countries to augment their contributions to the Global Fund so that African countries may be provided with the necessary resources to fight the pandemic.

Yet he also concludes that the Global Fund seems more ready to finance wars (the report was written a few months before the second Gulf War) than schemes to fight AIDS in developing countries. The account of the UN special envoy shows the grip of poverty on people living with AIDS in Third World nations and the reluctance of the more industrially developed countries to intervene. While poverty and AIDS are now firmly associated with one another, when the virus made its first appearance in the 1980s, such a link was ignored and the pandemic was considered only a Western phenomenon, limited to risk categories.

As Sharon Walker reminds us, although the virus spread rapidly through developing countries right from its discovery, no links were made between the Western victims of AIDS and those who died from it in Africa. In the late 1970s, the virus was identified as a disease of the gay community as a group of gay men from San Francisco and Los Angeles showed signs of rare opportunistic diseases. The very name initially given to the virus, GRID (Gay Related Immunodeficiency), points to the first definition of the virus as a new “gay plague.”

No one wanted to make the connection between the virus that was spreading through Western countries and that which was affecting Africa. Making this connection would have implied the recognition that poverty and heterosexuality were important factors in the diffusion of the disease. From 1982 on, however, the presence of the virus in women and children even in Western countries could no longer be ignored. So the name of the disease was changed to AIDS (Acquired Immunodeficiency Syndrome). The following year the virus that caused the disease was isolated. Yet until the late 1980s, AIDS largely remained a disease of intravenous drug users and homosexuals.

[p. 491 ↓] AIDS is caused by the human immunodeficiency virus (or HIV). The virus can show no symptoms of its presence in the body for a phase as long as 10–15 years. During this phase, however, the immune system is constantly attacked and becomes compromised. Moreover the individual is able to transmit the disease. The virus damages the immune system by destroying those cells, the so-called helper T-cells, that function to detect and eliminate infections in the body.

The absence of helper T-cells and the consequent lack of activation of the immune system cause the body to become prey to multiple infections. As the immune system

deteriorates, these infections become increasingly serious and can cause pneumonia, pulmonary tuberculosis, musculoskeletal pain, and neuropathy. HIV is transmitted between individuals through seminal or vaginal fluids, contact with infected blood (including blood transfusions), and between mother and child during pregnancy, childbirth, and breastfeeding.

People usually become infected a few weeks after the primary contact with the virus and suffer with fever for several days with or without muscle and joint aches, fatigue, headache, sore throat, swollen glands, and sometimes rash. These symptoms are very similar to those of other common illnesses, thus AIDS is difficult to diagnose at this early stage. Several treatments against HIV exist; however, there is no known cure or vaccine.

> *Fidelity to a partner who has contracted the virus is as dangerous as promiscuity.*

The progression of the disease varies greatly among individuals and is influenced by many factors, such as host susceptibility, immune function, healthcare, the presence of co-infections, and peculiarities of the viral strain. The most effective prevention against AIDS is condom use. Yet while the adoption of condoms and of screenings in blood transfusion has proved effective in Europe and North America, in other regions of the world these have proved controversial.

Conservatives, led by the George W. Bush administration, and some church members both oppose the use of condoms and argue that the best way to prevent AIDS is through abstinence from sexual intercourse and faithfulness to one's partner. Abstinence promotion is criticized for denying young people, especially in poorer countries, information about HIV prevention. In addition, fidelity to a partner who has already contracted the virus is as dangerous as promiscuity.

As *New York Times* journalist Nicholas D. Kristof wrote: “President Bush is focusing his program against AIDS in Africa on sexual abstinence and marital fidelity, relegating condoms to a distant third. It's the kind of well-meaning policy that bubbles up out of a White House prayer meeting but that will mean a lot of unnecessary deaths on the ground in Africa. The stark reality is that what kills young women here is often not

promiscuity, but marriage. Indeed, just about the deadliest thing a woman in southern Africa can do is get married."

Global Reach

Figures on AIDS make it impossible to deny its global reach. The Joint United Nations Program on HIV and AIDS (UNAIDS) and the World Health Organization (WHO) reported that between 36 and 44 million people around the world were living with HIV in December 2004. During 2004, between 4.3 and 6.4 million people were newly infected with HIV and between 2.8 and 3.5 million people with AIDS died. The region of sub-Sa-haran Africa, initially ignored in reports on AIDS, remains by far the worst-affected region, with 23.4 million to 28.4 million people living with HIV at the end of 2004. Just under two-thirds (64 percent) of all people living with HIV are in sub-Saharan Africa, as are more than three-quarters (76 percent) of all women living with HIV. South and southeast Asia are the second most affected areas, with 15 percent. AIDS caused the deaths of 500,000 children. After more than 20 years of AIDS, there is still no vaccine for the disease or a cure for those who have been infected.

Yet the so-called cocktails of drugs that combine at least three medicines based on two different classes of antiretroviral agents have proved to be extremely effective in inhibiting the development of AIDS. During the 1990s, the life spans and the living conditions of people living with HIV considerably improved in spite of the many side effects of the cocktails.

The combinations of different drugs and antiretroviral agents, however, are extremely costly and this has reduced access to the treatment for patients in developing countries. Testing is expensive too and the most common test, ELISA, can produce false-positive results in individuals who have been exposed to parasitic diseases such as malaria.

This is a serious problem in developing countries where both AIDS and malaria are common. Thus the majority of people living with HIV/AIDS cannot receive adequate medical testing and therapy. The virus **[p. 492 ↓]** prevalence is stable throughout sub-Saharan Africa, although in countries such as Madagascar and Swaziland it is still rising.

On the contrary, Uganda has provided the best response to the pandemic in the entire region with a consistent prevalence decline since the mid-1990s, although recent research has challenged the official statistics. The diffusion of HIV has considerably reduced life expectancy in African countries from an average of six to 11 years. HIV has also had a serious impact on African agriculture, although many scholars have underestimated this. As Joel Negin has pointed out, “rural agriculture is a source of livelihood for millions on the African continent” and is a crucial contributor to economic growth.

Because of the invalidating effects of AIDS, the disease “has a vicious, circular, rippling effect through an economy as it initially feeds off poverty and weak health systems and then perpetuates that poverty and continues to overburden health care schemes.” The impacts on African economies and health services have also been worsened by the late response of governments to the diffusion of the virus. For years, several African countries denied that AIDS was a problem for the continent.

Financial Resources

Financial resources given to healthcare have traditionally been limited in African countries, leaving national health services totally unable to face the AIDS pandemic. After independence, African regimes privileged military spending and developed countries were only too eager to satisfy their requests. In addition, the legacy of colonial rule of health services left them geared toward cures rather than toward research and prevention.

Yet prevention is the core for an effective response to the virus and this rethinking of the entire structure of health services has proved an enormous task. Education is an important part of prevention policies and is instrumental in fighting stereotypes and dangerous practices related to AIDS, such as the belief held in some regions of Africa that sexually violating young girls can cure men of the disease.

Other harmful stereotypes that can be defeated through education regard condom use and are well summarized by the African saying, “Who wants a sweet with the wrapper still on?” Inadequate healthcare, lack of the expensive antiretroviral medicines, and

insufficient nutrition will cause the development of full-blown AIDS in large sectors of the population of African and other developing countries. Antiretroviral agents can be afforded only by 7 percent of all the six million AIDS patients in developing countries. Access to these drugs is essential to AIDS treatment.

Although the virus cannot be completely eliminated, antiretroviral treatments can slow the progression of the virus, thus allowing patients to continue to work and support their families. With adequate treatment, people who have contracted the virus can still participate in the social and economic lives of their countries. Yet to be effective, antiretroviral medication must be continuous once it is started. Otherwise patients develop strains of the virus resistant to drugs, and these can spread dangerously.

The cost of antiretroviral cocktails depends on patents that allow pharmaceutical companies to have a monopoly on them, banning the development of generic versions of brand-name drugs. Pharmaceutical companies argue that the patent status makes possible further research, but international aid organizations have repeatedly challenged this claim. Several countries such as Thailand, India, and Brazil have breached international drug patent laws, arguing that the societal need for advanced treatments is more important than the rights of pharmaceutical companies.

Because fees are not paid to patent holders, these generic versions can be distributed at prices that governments and patients in developing countries can afford. In turn, competition from generic products has led patent holders to reduce the prices of their brand-name drugs. The production of generic drugs has helped reduce the annual cost of treatment from $15,000 a patient to a little more than $200 in less than 10 years.

Yet the World Trade Organization (WTO) has supported the right to intellectual property put forward by pharmaceutical companies. This has put pressure on those countries that had developed copies of patented drugs. India, for example, has already passed a bill that restricts the reproduction of patented drugs and these consequences for developing countries may be devastating.

The issue of intellectual property rights (IPR) links once again AIDS, poverty, and the dangers of globalization for those who are excluded from its benefits. With such a strict definition of IPR as that enforced by the WTO, a clear imbalance is created between

the public interest and the monopolistic privileges of patent holders. The WTO ban on generic AIDS drugs will make it impossible for developing countries to effectively contain **[p. 493 ↓]** the diffusion of the disease, which will continue to impact on the economies of developing countries through its vicious cycle of poverty and death.

Luca Prono, Independent Scholar

10.4135/9781412939607.n320

See Also:

Bibliography

T. Barnett and Alan Whiteside, AIDS in the Twenty-First Century (Palgrave Macmillan, 2003)

R. Devraj, “Goodbye to Cheap Indian AIDS Drugs?” Inter Press Service (November 26, 2004)

E. Guest, Children of AIDS: Africa's Orphan Crisis (Pluto Press, 2003)

S. Hunter, Who Cares: AIDS in Africa (Palgrave Macmillan, 2003)

E. Kalipeni et al., HIV and AIDS in Africa: Beyond Epidemiology (Blackwell, 2004)

K.D. Kauffman and David L. Lindauer, eds., AIDS and South Africa: The Social Expression of a Pandemic (Palgrave Macmillan, 2003) http://dx.doi.org/10.1057/9780230523517

N.D. Kristof, “When Marriage Kills,” New York Times (March 30, 2005)

S. Lewis, “The Lack of Funding for HIV/AIDS Is Mass Murder by Complacency,” http://www.globalpolicy.org (cited October 2005)

J. Negin, “Assessing the Impact of HIV/AIDS on Economic Growth and Rural Agriculture in Africa,” Journal of International Affairs (v.58 / no. 2, 2005)

R. Ramesh, “Cheap AIDS Drugs Under Threat?” Guardian (March 23, 2005)

S. Walker, Women with AIDS and Their Children (Garland Science, 1998).