

IMPACTS OF POVERTY, RACISM, AND GLOBALIZATION ON GLOBAL AIDS

Brook K. Baker¹ (Draft 9/18/02 © 2002)

CONTEXTUALIZING THE PANDEMIC – HOW POVERTY CONTRIBUTES TO HIV/AIDS

The impact of poverty in Africa, made worse by the cruel machinations of globalization, is certainly a factor in the African HIV/AIDS crisis. Although there is no credible doubt that HIV causes AIDS, there is considerable confusion about how poverty exacerbates or contributes to the HIV/AIDS pandemic.² Public awareness in the U.S. tends to focus on the racist specter of Africans having promiscuous, unsafe sex³ and on Africans' alleged resistance to prevention campaigns and a culture of denial. Similarly, the political culture of prevention tends to focus on the ABC's of sexual behavior, "abstain, be faithful, condomize," thereby individualizing the pandemic. Thus, increased understanding about the structural impacts of poverty on the incidence of HIV/AIDS is important both to counteract the typical, and racist, blame-the-victim response and to assess the importance of local and global poverty alleviation strategies as additional tools in fighting the pandemic. Tracing the sources of African poverty, in both colonial and neo-colonial practices, is also crucial in catalyzing public opinion and policy responses to a crisis the U.S. government, international organizations, and the pharmaceutical industry have helped to create.

To understand the multiple and complex impacts of poverty, it is helpful to separate poor health and poor health care effects from a number of other poverty-related social and economic effects arising from histories of colonialism, racism, and patriarchy and from effects of poor information and poor education. Likewise, in the section that follows, it is useful to contextualize the stark reality of poverty/AIDS in Africa within the actions and inaction of the major powers, including the U.S., which have failed to address, and in fact have complicated, poverty and AIDS crises in Africa through callous trade and debt policies, policies made morally possible only when rich countries discount the dignity and worth of poor people, particularly black people.

Poor Health and Poor Health Care Effects

¹ Professor, Northeastern University School of Law; member Boston Global Action Network Africa AIDS Project and Health GAP.

² One difficulty of talking about how poverty "interacts with," is a "key determinant of," or even "causes" HIV/AIDS is how such formulations resonate with President Thabo Mbeki's torturous courtship of HIV dissidents and his corresponding attempt to label poverty as a "cause" (not just a co-factor) of HIV. For example, in a recent TIME Magazine interview, Mbeki has suggested that poverty and tuberculosis can be "causes" of AIDS even in the absence of HIV infection or even more erroneously that TB can cause one to test positive for HIV. Given Mbeki's "new science" and the confusion he has created on the ground in South Africa (and perhaps even in the U.S.), any discussion of the "connection" between AIDS and poverty must attempt to clarify the role of poverty in "exacerbating" the AIDS pandemic but not "causing" it in the absence of the HIV virus.

³ Eileen Stillwaggon, *AIDS and Poverty in Africa*, The Nation 22, 23 (May 21, 2001); Eileen Stillwaggon, *Racial Meaphors: Interpreting Sex and AIDS in Africa* (draft 2000). The 2001 Durex Global Sex Survey carried out 28 countries worldwide found that South Africans have sex fewer times per year than Americans, that they keep their virginity until a later age (17.2 vs. 16) and that they have fewer sexual partners, averaging 8.2 versus 14.3 in the U.S. *South Africans Still Take Risks Despite AIDS Fears*. ZANOW Daily Mail & Guardian, November 27, 2001.

The chain of argument about the direct impacts of poverty- and inequality-related *poor-health* and *poor health care* on the incidence of HIV infection is as follows: (1) poverty⁴ reduces resistance to infectious disease in general because of poor nutrition and harsh living conditions, including poor access to clean water and sanitation;⁵ (2) because of poorly resourced and inaccessible health care systems and because of the cumulative effect of untreated pre-natal and post-natal diseases, poverty results in a generally poor state of health;⁶ (3) conditions of poverty increase exposure to particularly debilitating diseases, e.g., tuberculosis, malaria, hepatitis, respiratory, and parasitic and diarrheal disease, which in turn (in conjunction with generally poor health) impact susceptibility to HIV transmission/infection;⁷ and (4) even if the general degradation of health does not increase susceptibility to HIV transmission/infection, the prevalence of untreated STDs and other genital infections/lesions substantially increases the risk of sexual transmission of HIV.⁸ In sum, poverty creates poor health and untreated poor health, particularly reproductive health, increases vulnerability to HIV infection.

All of the poverty-related poor health and poor health care factors that go into increased susceptibility to HIV also affect the speed with which it progresses to full-blown AIDS and to

⁴ A recent Statistics SA report entitled *Measuring Poverty in South Africa* (2000) reports that a majority of residents live below the poverty line, that nearly a third of the population lives in shacks or huts, that more than half of the population does not have a tap inside their dwellings and that twelve percent of households do not have any toilet facilities. Being black, being a woman, and living in a rural community are highly predictive of being poor. Similarly, estimates of unemployment in South Africa range as high as 40%, though some number of these formally unemployed do work in the informal economy. Despite these alarming statistics from South Africa, it is important to remember that South Africa and Botswana are the two most affluent countries in sub-Saharan Africa.

⁵ Paul Farmer, *Infections and Inequality: The Modern Plague* (1999); Jim Yong Kim et al., *Dying for Growth: Global Inequality and the Health of the Poor* (2001). “In my work on African AIDS, statistical analysis shows that HIV prevalence is highly correlated with falling calorie consumption, falling protein consumption, unequal distribution of income, and other variables conventionally associated with susceptibility to infectious diseases, however transmitted.” Eileen Stillwaggon, *Determinants of HIV Transmission in Africa and Latin America*, 5 S.A. J. of Economics 68 (Dec. 2000). According to Stillwaggon, “malnutrition and parasitosis ... endemic in poor countries ... have long been recognized as depressing immune function,” undermining epithelial integrity and the production of B and T killer cells. *Id.* Micronutrient deficiencies are also important, particularly Vitamin A, which is essential to epithelial integrity in the genital tract, the major route of HIV infection. *Id.* For an extended discussion of the role of malnutrition in HIV prevalence, see Eileen Stillwaggon, *HIV/AIDS in Africa: Fertile Terrain*, 13-18 (draft 2000).

⁶ Farmer, *supra* note *, at 266.

⁷ Parasite infection is particularly debilitating because it robs the host of nutrients and chronically triggers an immune response, impairing capacity to resist other infections. Eileen Stillwaggon, *HIV/AIDS in Africa: Fertile Terrain*, 10-11 (draft 2000). The effect of reduced general health on the actual transmission of HIV is primarily based on conditions that facilitate the transmission of bodily fluids from an infected person to an uninfected person. For example, because poor nutrition and poor health are associated with reduced mucous production and more break down in epithelia tissues, and thus “drier” sex, it seems probable to some researchers that there is a causal relationship of poor nutrition with heterosexual transmission. Likewise, open skin exposure to weeping wounds and disuse of global precautions can facilitate accidental transmission in non-sexual encounters as can needle-sharing in IV drug use. Finally, evidence exists that some vertical transmission of the disease occurs mother-to-child during the traumas of childbirth and in some circumstances from breast-feeding. Transmission from breast-feeding is exacerbated when the infants diet includes formula, water, or any other non-breast milk food that can degrade the mucosal integrity of the infant’s digestive system.

⁸ Clearly STD’s that produce genital lesions are a major co-factor in sexual transmission of HIV, Stillwaggon, *supra* note *, at 11-13, as are sexual practices that create micro-tears in mucosa, i.e., so-called “dry sex” (produced by use of herbal astringents or other chemicals) and anal sex.

death by opportunistic infection.⁹ In particular, poverty-related lack of access to medical treatment, either to reduce viral load or to prevent and treat opportunistic infections, results in a lower quality of life, more rapid development of AIDS, and more rapid demise for poor people living with HIV/AIDS. For example, people infected with HIV, who also have latent tuberculosis are 30-50 times more likely to develop active TB. Similarly, ten percent of HIV infected persons develop cryptococcal meningitis, a fungal infection which leads inexorably to an extremely painful death within 30 days unless treated with powerful fungicides.

Social/Economic/Racial/Gender Effects

Poverty affects HIV/AIDS not simply through *poor health* and *poor health care effects*, it also impacts the incidence of HIV through *social/economic/racial/gender effects*. These effects are myriad, particularly given the historical effects of colonialism/neo-colonialism, slavery/apartheid, misogyny/patriarchy. For example, the "logic" of slave, colonial, and apartheid economies was to disrupt family structures, to displace and concentrate agricultural, mining, and industrial workers into squalid, single-sex living conditions, and to foster migration between regions and unplanned urbanization of heretofore predominately rural societies. These conditions were forced on African communities and justified through racism, a racism that rationalized the even greater disruptions and dislocations of slavery and apartheid.¹⁰

These colonial/economic/racial effects combine with "imperial" and "traditional" gender inequalities to expose rural women and women-at-home to the dangers of AIDS.¹¹ In particular, there has been increased sexual exploitation of women through formal and informal prostitution,¹² fueled in part by the increasingly impoverishment of women in rural and township communities.¹³ Moreover, the disruption of traditional family structures, traditional cultural mores, and communal forms of regulating sexual relations may also have resulted in an increase

⁹ Estimates vary in developing countries on the latency period of HIV, ranging generally from 7-9 years depending on other health factors. See UNAIDS 2000 Report, *supra* note 2, at *. This is several years faster than in the developed world. However, the development and progress of fatal opportunistic infections is much faster, currently estimated to be one year only. *Id.*

¹⁰ Ronal Bayer and Mervyn Susser, *In South Africa, AIDS and a Dangerous Denial*, The Washington Post (April 20, 2000).

¹¹ Men returning home from work sites and urban areas where they became infected spread HIV to their spouses and other sexual partners. Since the concentration of poverty is even worse in the countryside and because health and living conditions are worse as well, rural women are particularly prone to infection. After a certain period of time, some of the rural infection rates become even higher than the urban/township rates.

¹² Too much emphasis on female prostitution is problematic when it is offered as the major explanation for the transmission of HIV. Clearly, poor women are driven to prostitution and to performing unsafe sex for a premium price. Clearly, as well, prostitution concentrates the infection and thereby facilitates the spread of the virus to uninfected sexual partners, both to the men who frequent prostitutes and to those men's future sexual partners. There are few good studies that estimate the relative effect of prostitution on the spread of HIV. No matter how big a role sex work plays in the epidemiology of the disease, prostitution in Africa should be contextualized within the legacy of apartheid, gender oppression, and colonialism, particularly their disruptions of family structures, sexual dynamics, and places of residence.

¹³ Like poverty everywhere, poverty is becoming more feminized in southern Africa as well. For example, in South Africa, approximately 74% of women live in poverty. The causes of this feminization are complex, but they include the legacies of apartheid that relegated women to barren homelands with little arable land and no other means of production except subsistence farming and home care of children and elders. Women in the countryside are highly dependent on meager remittances from men and other relatives working at low wages in the formal economy.

in the number of sexual partners for both sexes as well as increased incidence of sexual violence¹⁴ and sexual exploitation of younger women and girls.¹⁵ In addition, because of gender inequality and traditions of patriarchy, women have limited power to negotiate safer sex with their sexual partners inside or outside of marriage.

These combined social factors have been highlighted in various studies that emphasize the role of migration in HIV transmission,¹⁶ as well as the role of the transportation industry,¹⁷ the mining industry,¹⁸ the hostel system, and the military¹⁹. As previously discussed, these social factors have led to the disproportionate concentration of HIV infection in the Black African community and to the greater vulnerability of women to HIV infection.

Poverty also produces *educational/informational* effects that exacerbate the spread of HIV. Poor children in southern Africa often receive little or no science/health education and what education they do receive is post-Bantu²⁰ at best. Likewise, basic adult education is virtually non-existent.²¹ What limited educational opportunities that exist are being undermined by the pandemic itself, both because of losses of teachers²² and because of the unaffordability of even minimal school fees for a new and growing generation of AIDS orphans.²³ Thus, in less developed sub-Saharan African countries, many people do not have a medical/scientific world-view that prepares them to understand the causes and epidemiology of HIV. Moreover, because

¹⁴ South Africa is regrettably reported to be the rape and sexual violence capital of the world. HIV Insite, *supra* note 8, at 3-4.

¹⁵ There is some evidence that some South Africans are having sex at younger and younger ages, but in particular there is evidence that younger women and girls are being forced/enticed into sex with older males, including teachers. Human Rights Watch, *supra* note *. Thus, the demographics of infection among young people in South Africa is that women become infected at a significantly younger age than their male peers by an average of 5-10 years.

¹⁶ Joseph Collins & Bill Rau, *Aids in the Context of Development*, 8-13 and sources cited (UNRISD Programme on Social Policy and Development, Paper No. 4 Dec. 2000). Rates of infect among men and women who migrate in and out of country are two to three times higher than their non-migrating peers.

¹⁷ Truckers use of prostitutes and the substantially higher rates of HIV infection rates in transportation corridors has been offered as a major factor in the inter-regional spread of AIDS in Africa and in the spread from truckers to the sexual partners back home in rural communities.

¹⁸ The mining sector is a particularly poignant example of an industries where men are lured from the countryside, housed in large numbers in hostels, denied access to their families for as many as 50 weeks out of the year, and thus especially likely to have multiple sexual partners and sex with prostitutes.

¹⁹ The military HIV infection rates in the northern provinces of South Africa have been reported astoundingly high, with estimate ranging from 50-90%.

²⁰ Bantu education, as a term of art, is an education “fit for water carriers and for wood-carvers” – in other words, fit only for a subordinated community denied the benefit of literacy, numeracy, and scientific knowledge. Coincidentally, Bantu education was imported to South Africa from the Jim Crow South early in the 20th century. One consequence of Bantu education is that many African teachers have received very little education themselves. In rural schools, many of the teachers did not complete high school let alone attend college. While in school, they received no training themselves in health or science.

²¹ Less than 50% of South Africans have received more than a primary education.

²² Teachers in southern Africa are paradoxically experiencing above average infection rates and are beginning to die faster than they are being trained. Because of younger and younger initiation in sexual activity, typically between age 13 and 15, life lessons about HIV/AIDS will need to be taught effectively to very young children. *Lessons in Dying*, The Teacher – Daily Mail & Guardian, Sept. 11, 2000.

²³ The number of AIDS orphans is truly frightening with estimates of over 13 million in Africa by 2001 and an estimate of 40 million by 2010. Although South African families show an incredible willingness to take in AIDS orphans (in one survey 74% are willing with no government report and 86% with some government support), there is still an alarming increase in homeless children and children headed households. These children often lack the economic means and secure social structures to attend school.

of low literacy rates, multiple home languages,²⁴ and poor access to telecommunications and print media, many people in developing countries do not have access to the official AIDS prevention message. Because of customary belief systems, social taboos against talking about sex, disinformation from some traditional healers,²⁵ and bizarre myths about HIV/AIDS,²⁶ people in poor communities frequently do not understand the most basic means to protect their own health and the health of others.

FURTHER CONTEXTUALIZING THE PANDEMIC – HOW RACISM AND GLOBALIZATION EXACERBATE POVERTY AND AIDS

Because of its *ideologies of racial and class/regional supremacy*, the First World, particularly the U.S. government and corporate elites, make the above effects of poverty worse first by callous and knowing neglect of the HIV/AIDS crisis in Africa and second by imposing neo-liberal policies that exacerbate rather than relieve poverty. With respect to neglecting the AIDS crisis, the U.S. and European community have had important information about HIV/AIDS since the mid-1980's and plausible means of treatment since the early 1990's and yet both have done little or nothing to address the growing pandemic in Africa. Instead the U.S., and its World Bank, International Monetary Fund, and World Trade Organization allies, have used debt policy, trade policy, international currency market policy, structural adjustment policy, and intellectual property regimes to guarantee profits to the pharmaceutical industry and stability for U.S. financial and export/import industries at the expense of hundreds of millions of Africans.

Perpetuating a Culture of Neglect

The Central Intelligence Agency had notice of the impending African AIDS pandemic as early as 1987 and began studying it in earnest in 1990. In an Interagency Intelligence Memorandum 91-10005 entitled “The Global AIDS Disaster,” the authors projected 45 million HIV infections by 2000 – inexorably fatal, the great majority in Southern Africa.²⁷ This prediction, though surprisingly close, was actually an underestimate – 53 million people had contracted HIV by the year 2000, 19 million of whom have died. When the CIA Report was first released, it was either ignored or trivialized. One militarist is reported to have quipped, “Oh, it will be good because Africa is overpopulated anyway.”²⁸ The World Bank apparently agreed, releasing a June 1992 Report that stated, “If the only effect of the AIDS epidemic were to reduce

²⁴ South Africa has eleven official languages and many other unofficial languages as well. Most media and public billboard AIDS prevention messages are in English, a language which many South Africans cannot read.

²⁵ Rural and tribal South African rely substantially on traditional healers (Sangomas) both for spiritual and indigenous medical cures for their illnesses. Many of these healers are highly skilled in the use of medicinal plants and are very concerned with the medical and spiritual well-being of their patients. Moreover, some traditional healers are connecting with mainstream medical providers for the first time to better understand HIV/AIDS and to provide more appropriate medical support and advice about transmission, diet, and healthy living. However, there are clearly Sangomas who have promised and charged for charlatan cures of HIV and there are reported incidents of unnamed Sangomas recommending that men sleep with virgins as a cure for AIDS. Nonetheless, whatever hope there is for an effective AIDS prevention and treatment campaign in South Africa depends in substantial part on involvement and collaboration with traditional healers and with other leaders in traditional communities.

²⁶ In addition to myths about sleeping with virgins, there are reports of myths about sleeping with “fat” women instead of “skinny” women as well as many myths about the danger posed by close association with people living with HIV/AIDS, not dissimilar from the early fear myths in the U.S.

²⁷ Barton Gellman, *The Belated Global Response to AIDS in Africa*, Washington Post A1 (July 5, 2000).

²⁸ *Id.*

the population growth rate, it would increase the growth rate of per capita income in any plausible economic model.”²⁹

Similarly, the World Health Organization, ineffectual by most standards in stemming the pandemic, but highly effective in predicting it, foretold tens of millions of deaths by 2000.³⁰ Despite this prediction, most of the 1990’s was characterized by indifference, petty infighting, and procrastination at the WHO and in other UN structures; it wasn’t until 1996 that the UN even succeeded establishing its UNAIDS program. The moment UNAIDS was established, however, its partners, the World Bank, WHO, and UNICEF, dropped their funding to AIDS from \$225 million to \$40 million.³¹

The most telling measure of the First World neglect is financial. The first U.S. budget submitted after the 1991 CIA report appropriated only \$124.5 million for all overseas AIDS control, only a portion of which went to Africa.³² In a recent study, Amir Attaran and Jeffrey Sachs of Harvard’s Center for International Development found that between 1996 and 1998, financial aid from all rich countries to sub-Saharan Africa for AIDS control projects was between \$69-140 million annually. Since the late 1980’s, absolute aid levels dropped relative to HIV prevalence and recently stood at only \$3 per HIV-positive person.³³

The Impacts of Globalization

It would, of course, have been bad enough if southern Africa were to merely have suffered the insult of First World neglect. However, at the same time that world powers were ignoring the impending AIDS catastrophe through their political structures, their economic structures, through neo-liberal policies that have come to be called globalization, have caused disastrous injury to the general health of African economies and to the well-being of public health systems in particular. Although this is not the place to document the entire story of failed neo-colonial “development” and globalization in Africa, it is appropriate to trace some of the key aspects of neo-liberal policy that have intensified the AIDS crisis. These include: (1) maintaining colonial patterns of ownership; (2) creating crushing debt through aid and loan policies; (3) deforming economies towards exploitation of natural resources and production of low-cost exports and importation of high-cost finished goods; (4) liberalizing currency exchanges and financial markets resulting in currency devaluations, market volatility, and net outflow of capital; (5) enforcing structural adjustment policies, including (a) fiscal austerity and reduced government spending particularly in health care and (b) privatization and commodification of public resources, goods, and services; and (6) increasing income inequality and feminizing poverty.

First, no story about the impact of globalization can start without first recognizing that most of the productive capacity in many African countries, South Africa in particular, resides in the portfolios of former colonial masters. Although local elites have been given managerial and window-dressing positions and occasional junior partner status so as to create a narrow strata of local elites who help to manage the status quo, the vast majority of productive capacity in Africa is owned by multinational corporations and Africa’s colonial heirs. Thus, wealth continues to be extracted from Africa literally and figuratively, from the mines, from the farms, and from the sweat of Black labor.

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ Amir Attaran & Jeffrey Sachs, *Defining a Refining International Donor Support for Combating the AIDS Pandemic*, 357 *The Lancet* 57 (2001).

Second, Africa has been buried in debt starting in the late 1960's, culminating with \$227 billion in debt by 2000. Although much of that debt was at one point private debt, frequently debt of private industry to private banks used in the capitalization of productive capacity, the debt increasingly became multilateral and bilateral, debt owed by African governments to individual governments and/or to the World Bank and International Monetary Fund. As the value of export products plummeted in the 1980's and as the costs of luxury and capital imports increased, African countries needed to borrow more and more money to refinance their foreign currency reserves. Similarly, as the World Bank lent money to governments to build physical infrastructure appropriate to an import/export economy and as First World governments bilaterally lent money to finance purchase of excess goods, military and non-military, from same-nation producers, the African debt burden became more and more bloated. Fundamentally, Africa is now permanently indebted as a result of an inherently imbalanced pattern of trade between the under-priced agricultural and pre-industrial economies of the South and the overpriced industrial economies of the North.³⁴

Paying this old debt off is particularly problematic since so little of it resulted in increased productive capacity, job creation, or wealth redistribution.³⁵ Not only was loan money used to buy expensive Western consultants, questionable showcase infrastructure projects, e.g., hydro-electric dams, and Western luxury imports, a great deal of it was given to undemocratic, racist, and corrupt governments that were proxies to foreign business interests and lackeys to the great powers during the Cold War. Since these debts incurred by old elites did not result in economic benefit to the poverty-stricken masses, it is doubly burdensome to make the current poor pay them off.

As stated, sub-Saharan African countries owe the IMF, World Bank, and rich countries more than \$227 billion dollars, with an annual debt servicing charge of nearly \$14.5 billion, equaling 5% of GDP and 15% of export earnings. As a consequence of this enormous debt burden and usurious repayment schedule, many southern African countries spend more on debt repayment than on public health. For example, Uganda spends 1.6 percent of GDP on health and 2.4 percent on debt service; Zimbabwe 3.4 percent and 10.3 percent; and Zambia 3.2 percent and 9.8 percent. In South Africa, the debt load is not just loans from international lenders, it is also internal debt owed by the current government to internal financial institutions and public pensions plans, a burdensome and odious debt that capitalizes the legacy of apartheid.

The Jubilee 2000 Campaign and many other activist groups have campaigned for cancellation of this debt.³⁶ Despite limited promises of debt relief from the World Bank (Highly Indebted Poor Country Initiative) and the G-8, only minimal debt has been forgiven and to date in only a handful of countries.³⁷ Jubilee 2000 South Africa and South Africa's Alternative Information and Development center are simultaneously launching more aggressive Apartheid Caused Debt and Odious Debt campaigns, calling not only for debt forgiveness but for reparations.³⁸

Third, the general effect of international trade policy, all too readily accepted in South African and other African countries, has been to dismantle rural subsistence economies and multi-sectorial economies in favor of predominantly import/export-oriented economies.³⁹ Thus, it has

³⁴ See Francisco G. Pascual, Jr., *The Development and Historical Context of the Debt Crisis* (1999) (http://jubileesouth.net/summit/19991119/address_pascual.html) (1/05/01).

³⁵ Sean Flynn, *A Program for Democratic Development: A Savings and Investment Policy for South Africa* (draft 2000).

³⁶ See Jubilee South, *South-South Summit Declaration: Toward a Debt-Free Millennium* (Nov. 21, 1999).

³⁷ Drop the Debt, Draft – Debt Cancellation to Combat the Global HIV/AIDS Pandemic (Dec. 10, 2000).

³⁸ Alternative Information & Development Center, *Apartheid Caused Debt Campaign - Challenging Apartheid's Foreign Debt* (<http://www.aidc.org.za/adc-summary.html>) (1/5/01).

³⁹ Patrick Bond, *Can Thabo Mbeki Change the World? Strategies, Tactics and Alliances Towards Global Governance* (The Frantz Fanon Inaugural Memorial Lecture, University of Durban-Westville School of

become increasingly impossible for persons in the countryside, with minimal access even to marginal land, to make a living.⁴⁰ Instead, agricultural economies have been restructured towards a narrow range of export farm products, many of which, like timber in South Africa, are destructive of fertile land and heavy users of scarce water resources. People, particularly young men, dislodged from the countryside, have migrated in mass to the cities, where rumors of jobs far outweigh their actuality. Even here, in urban contexts, the new industries are export oriented and increasingly capital intensive. It is an environment with few jobs, but one with decreased social and familial stability. It turns out to be a perfect breeding ground for AIDS.

Fourth, as if external ownership, crippling debt, and liberalized trade policy were not disruptive enough, globalization has also liberalized currency exchanges – causing capital flight – and forced currency devaluation – typically 50% as an initial adjustment – both with horrendous economic effects. One of the most significant aspects of the current neo-liberal regime is the greatly expanded international currency exchange market and the proliferation of national and regional liquid asset markets. The sale and movement of import/export goods in the world's markets is considerably less important to finance capital now that it used to be. In contrast, the volume of international currency exchange/speculation and financial market investment has increased thirty-fold in the last 30 years. Thus, international finance capital has become more interested in making money off of currency markets and capital markets, especially stock exchanges, than it is in investing in productive capacity.⁴¹ This new focus on financial rather than productive investment has led to speculative bubbles in currencies and financial exchanges, with a temporary influx of external capital, followed, almost inevitably, by currency and market crashes such as those in Asia's Tiger economies.

Because of international (external) and national (internal) currency flight to more stable and profitable currencies, the money available for productive capacity investment in Africa is greatly decreased, down 50% in South Africa in 2000. Similarly, as a result of devaluation systematically engineered by the IMF, such as the 300% devaluation of the South African rand in the last seven years, African exports are worth even less (though more price competitive) and First World imports, including pharmaceuticals, cost even more. At the same time that import costs increase and basic-goods export income falls, the foreign debt, calculated in local currencies, multiplies. Thus, the vibrant U.S. economy and stock market boom of the 1990's, to a large extent, was "purchased" as a result of marketplace misery in the Third World.⁴² Low-cost imports into the U.S. keep rates of inflation low, which eased Federal Reserve Board anti-inflation policy. These policies resulted in significant wealth effects in the U.S., at least for the top tier of the economy. Conversely, prices African countries have risen dramatically, and life-saving imports, including HIV/AIDS medications, have become even more expensive.

Fifth, the debt and balance-of-payment crises in Africa, which consolidated debt within multilateral institutions, set the stage for infamous structural adjustment policies that have further deflated and destabilized African economies. These structural adjustments, imposed by the IMF and the World Bank as a condition of extending and refinancing African debt, invariably included

Governance 17 Aug. 2000); Patrick Bond, *Elite Transitions: From Apartheid to Neoliberalism in South Africa* (2000); Patrick Bond, *Cities of Gold, Townships of Coal: Essays on South Africa's New Urban Crisis* (2000).

⁴⁰ Collins & Rau, *supra* note 30, at 18.

⁴¹ Noam Chomsky, Speech on Globalization, MIT (Sept. 26, 2000).

⁴² The effect of currency devaluation and cheap imports on inflation rates in the U.S. is much more important vis a vis our major trading partners, Asia, than Africa. Since African imports play such a minor role in the U.S. economy, it would be misleading to suggest that the U.S. stock market boom is strongly tied to devaluation in Africa. What is more true generally is that low prices on raw materials and low technology goods, combined with devaluation, do help subsidize U.S. prosperity. It is also fair to note that the reverse effect of import/export prices on GDP and price stability may be proportionately much worse in African countries than in the U.S. Email from Kieran Honderick, economist, September 14, 2000.

two phases. The first phase required macro-economic stabilization via currency control deregulation/devaluation, price stabilization through reduced real wages and consumption, and budgetary austerity including a mandatory 3% cap on deficit spending. Phase two required trade liberalization, tax reform transferring tax burdens from businesses to workers and consumers, privatization/commodification of government services and assets, including user fee policies, and liberalization of labor laws including non-indexing of wages.⁴³ Thus, at the same time that the global powers were using structural adjustment policies to force reductions in social spending, including social spending on public health, on education, and on HIV/AIDS prevention and treatment, they were imposing user fees on medical visits, charging for condoms, and retailing medicines. World Bank and IMF “un”healthy SAPs, such as cost-recovery or fee-for-services, have resulted in dramatic lower attendance in STD clinics in Kenya and in reduced condom use in Zimbabwe.⁴⁴

Sixth, the net effect of structural adjustment, debt, and trade policies mandated by the North has been greater income/wealth inequality and the feminization of poverty in the South.⁴⁵ These policies have to some extent helped to create a thin layer of black African elites, but good times have clearly not trickled down to the poor in general and women in particular.⁴⁶ In the new South Africa, there are fewer rather than more new jobs than there were at the end of apartheid. Similarly, income inequality too has grown so that South Africa⁴⁷ is now the most income inequitable country in the world. As economic inequality increases and as women are increasingly forced into poverty, studies show that HIV infection rates *invariably* increase.⁴⁸ Thus, it is no exaggeration to argue that globalization is a leading cause in the African AIDS pandemic, contributing not only to its severity but confounding its cure.

Globalization & aids.doc

⁴³ See Pascual, *supra* note *; Eric Toussaint, *From North to South: The Debt Crisis and Structural Adjustment Policies* (trans. Vicki Biault, 2000) (http://jubileesouth.net/documents/discussions/debt_crisis_saps.html) (12/12/00). As a matter of institutional competence, the IMF and the World Bank play two different roles. The IMF is typically involved in policy negotiations regarding the exchange rate, currency exchange, financial market deregulation, and the overall budget deficit. The World Bank micro-manages government spending and infrastructure investment.

⁴⁴ See Collins & Rau, *supra* note 30, at 18 and sources cited; Sanjay Basu, Kedar Mate & Noor Jehan Johnson, *Poverty's Pathologies: Global Inequalities and the Lives of the Destitute Sick 3* (Draft 9/5/00).

⁴⁵ Female poverty is intensified as a result of structural adjustment policies of the World Bank, International Monetary Fund, and World Trade Organization, all of whom favor the creation of low-wage export industries at the expense of broad-based and sustainable economic development and local micro-enterprise, policies which would produce more equitable employment opportunities for women. As a result, not only are women poorer, they live in disrupted family structures, and are often forced into high risk, survival sex work. Collins & Rau, *supra* note 30, at 13-15, 19-21.

⁴⁶ South Africa's infamous GEAR policy has been an abysmal failure at job creation, having resulted in the loss of nearly a half a million jobs in the formal sector, with few new jobs taking their place. In addition, so-called labor flexibility policies have resulted in reduced job protections, wage stagnation, and attacks on organized labor.

⁴⁷ Income inequality in South Africa has actually increased as a result of its neo-liberal economic policies, many of which were mandated by the forces of globalization. Roy Cokayne, *Inequality Increasing, Says Poverty Report*, S.A. Business Report (Sept. 8, 2000).

⁴⁸ See Farmer, *supra* note *, at 265; A World Bank Policy Research Report, *Confronting AIDS: Public Priorities in a Global Epidemic*, Chapter 1, subsection 3, p. 1 (Oxford University Press, Revised edition 1999) (<http://www.worldbank.org/aids-econ/confront/confrontfull/chapter1/chp1sub3.html>) (11/01/2000).