
WHAT WE CAN LEARN FROM THE HIV/AIDS EPIDEMIC?¹

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“In every possible way the essential public health trusts between authorities, science, medicine and the global populace were violated during the 1994 plague outbreak in India”.

(Laurie Garret, 2000, p 48).

“Even the most natural action of all – the inhaling of clean air – ultimately presupposes a revolution in the industrial world order.”

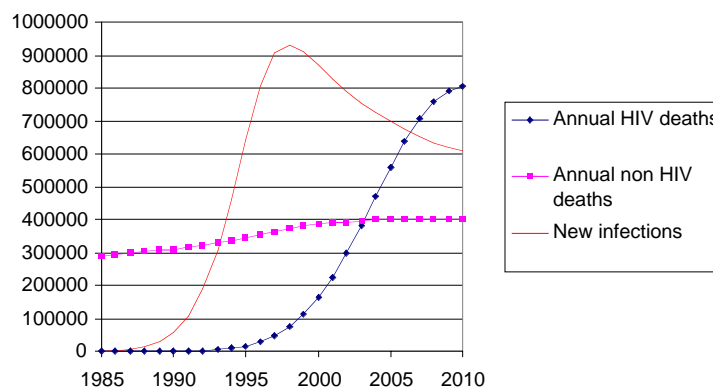
(Ulrich Beck, 2000, 168)

Introduction: Micro-organism, macro-impacts, mega-denial

Personal experience of disease is often constructed as a number of stages: denial, acceptance, living with the disease. This is true of most life-threatening illnesses. This simple framework, drawn from a counselling model also applies to the way that social science disciplines have encountered the HIV/AIDS epidemic and its implications. In particular there has been a marked failure among academic social scientists to engage with the long term social and economic effects of the epidemic. Worse, with some notable exceptions² the international agencies, in particular the UN system and larger NGOs have not responded until very recently. Indeed, in most cases, their response was only elicited at the last moment and by the United Nations Special General Assembly on HIV/AIDS of July 2001.

HIV/AIDS is different from many other infectious diseases. It is a lentivirus (developing over a long period of time) and it is largely sexually transmitted. This combination at the micro-level means that at the macro level the amplitude of the epidemic curve is very long and the morbidity mortality pattern is concentrated in the mature adult cohorts. Thus an HIV/AIDS epidemic has marked social and economic impacts over long periods in societies where seroprevalence levels are very high ranging between 10 and 40 per cent (or even higher) of the adult population. This is illustrated in Figure 1, which shows normal deaths, HIV infections and projected AIDS deaths” in South Africa from the beginning of its epidemic in the mid-1980s.

Figure 1: HIV Infections, AIDS Deaths and "Normal" Deaths, South Africa 1985 – 2005



² The United Nations Development Programme (UNDP) and of course UNAIDS.

People's existential perspectives relate to their own lifetimes and those of people around them. Some specialists, for example, historians, geologists and climatologists consider long time periods: centuries or millenia, much longer than a human lifetime. Other human beings may be so tested to survive that their perspective is survival from week to week or month to month. Different actors, people but also organisations and institutions, have differing perspectives on time and the epidemic. We are aware of and inhabit differing timescapes (Adams, 1998).

The individual who is sick seeks a cure or relief of symptoms now; an epidemiologist sees the epidemic as it develops over many months or years; while an historian may consider it in the context of centuries. To understand the impact of this epidemic, we must adopt a perspective that spans several decades. And here is a paradox: the longer the required perspective, the easier it is to deny and not take responsibility. While we may all feel urgency and compassion in the face of immediately apparent need – the begging child, the dying victim of famine, the refugee fleeing from certain death – few of us have the time to respond to the long term roots of a situation and its long term implications

The social and economic impact of the epidemic operates at different ends of the range of time perspectives - the very short and the very long. Illness strikes. It weakens an individual; it weakens the household and the community. This is a timescape of maybe five years. At the other end of the continuum, there is the very long timescape of "history".

It can take years of infection before debilitating symptoms become apparent in the individual. The HIV/AIDS epidemic spans many years. By the time the wave of HIV infection makes itself felt in the form of AIDS illnesses in individuals, the torrent of the epidemic is about to overwhelm medical services, households, and communities. It is these impacts that academic social scientists, most of the UN system and the most international NGOs have been denying for at least a decade. We must now see whether we can collectively learn what the experience of this epidemic has to teach us about public health. This paper is a reflection on some of these issues.

The Roots of the Epidemic

The HIV/AIDS epidemic has deep historical roots. Its impacts indicate a long, history-changing trajectory. The epidemic must be seen against this broad background. Unlike previous generations, and from the vantage point of the 21st century, we can think about the epidemic in its full waveform. We can discern some of its deepest origins and reflect on its distant effects. There are lessons to be learned, not just about this disease, but about health, wellbeing and development. It is the first global epidemic of which we have been commonly conscious. It *may* be the epidemic that enables us to respond to the need for a common global public health. The epidemic makes us think how to bend global forces to provide more "goods" for more human beings – and in areas beyond what is usually thought of as "health".

Health and well-being are not individual concerns: they are a global issue. Paradoxically, there is a good to be gained, a lesson to be learned, from the HIV/AIDS epidemic. That lesson is neither straightforward nor will it be easy to understand because there is much resistance. It is the following: we need, at the

beginning of the twenty first century, to wake up to the emergency of Global Public Health. We can no longer depend on a view of disease, illness and disease control which is essentially medieval in conception and understanding. We must turn away from the excessive individualism of the final decades of the twentieth century to a *re-cognition*, literally a rethinking, of the ways in which our individuality depends upon common undertakings for the common good. Health and well-being are human rights; they are also public goods.

Rights can be protected and deepened through legal instruments and international agreements; public goods must be protected by collective action and organisation. But first of all a change of consciousness is required. It is necessary to recognise health and well-being as public goods, like the road network, clean air and clean water (Yach and Bettcher, 1998). Right now this is not the case. Individualistic attitudes to health and well-being lead naturally to a defensive stance towards public health, a view that it is a last ditch stand against disease. This is a primitive stance which has its origins in the middle ages and before, in a more parochial and local period of our history.

A Medieval Approach to Disease

Laurie Garrett's Pulitzer Prize winning documentation of emerging diseases and their implications *The Coming Plague* (Garrett, 1995), contains startling accounts of brave scientists from the US, Belgium, UK or somewhere else in the rich world, travelling to Congo, Uganda, Bolivia or wherever to identify, confront and contain local outbreaks of terrifying disease. These people **are** committed and courageous; Garrett's account sometimes reads like a thriller. But the theories underlying the need for such adventures are a hangover from and an extension to medieval thinking. Instead of quarantining the infected households into the lazar house of a medieval town or village, we now send out the viral emergency SWAT squad to quarantine and contain the threat that may emerge from some remote neighbourhood of our global village. In the process we also save lives.

This is done in the interests of the rich – they want disease contained. It also has an air of charity about it. And what is wrong with charity? What is wrong with charity is its personal, fickle nature; its air of the dependence of the weak and poor on the will and disposition of the rich and powerful. What is wrong with charity is that it is subject to the vagaries of short term funding. What is wrong with charity is that it should be a complement to, not a substitute for, concerted social, economic and political commitment and action for common welfare. What is wrong with charity is that personal moral agendas can be smuggled into action and remain unexposed to public examination and debate.

Right now, we try to contain infectious disease in the poorer neighbourhoods of the world as we have always tried to keep them in the poorer parts of our cities and whole societies. This was a sensible risk-avoiding response in a small village or town. It will not work in a global society. The flux of the globalised world of the twenty first century is too porous, too flexible, too changeable and capricious to permit us to avoid risk. We live in a world of global risks; disease is only one of them: "Distant happenings impinge on both local events as well as on ... the 'intimacies of self'" (Caplan, 2000). The very large scale – what happens a world away – has serious and often immediate implications for the workings of our bodies, our intimate selves. Epidemics are societal events: disease is individual, corporeal distress; sexually

transmitted diseases are intimate in the extreme. HIV/AIDS shows us very clearly how the construction and fulfilment of our intimate desires has implications for our common good. It presses us to reflect anew about the nature of health and well-being.

An outdated view of Medicine, Health, Well-being

“Health” appears to be a quality of our body. That is where we feel unwell, where the symptoms of disease are experienced. It appears “natural” that we should see health, or its opposite: sickness, as an individual, isolated experience for which we take individual responsibility. The underlying metaphor is of a machine that we either maintain or neglect. Such ideas link with broader notions in western thought concerning the importance of the individual and his/her responsibility for her/his actions. This is not the only way to see the issue. Consider the following two problems:

- is health really the issue or is there something broader called “well-being” which questions the purely individual and bodily nature of “health” and places more emphasis on the social and economic origins of “ill-being”?
- Do we need to understand the idea of “the individual” differently? This is not to suggest that individuals do not exist or have significance. It is to point out that the centrality of the individual as an acting and responsible entity is a product of western history and experience. Others, elsewhere, see things differently, placing the social nature of the individual centre-stage.

Amartya Sen³ is an important commentator on these issues. He is deeply steeped in both Western and Eastern philosophical traditions. His approach to problems of poverty and well being starts from the use which people get from their lives, how they are able to express and/or present themselves in the world. To understand the injustice of inequality, we need to see how economic, social, institutional and cultural structures stunt people’s abilities to gain access to the resources which enable them to function as full human beings.

John Cameron has summarised Sen’s account of these stunting and limiting processes as follows:

- “...from sets of commodities available to an individual, to the individual’s potential absolute capabilities, there will be limitations arising from particular advantage or disadvantages which they encounter in comparison with others consequent upon their historical, economic, cultural and social environment;
- the actual capabilities that an individual achieves in their life means that they have a particular set of abilities to function;
- the next step is to note that these abilities to function - “functionings” in Sen’s language - are the direct source of a particular individual’s particular level of well-being.” (Cameron 2000)

Sen's ‘capability’ approach focuses on the opportunities for choice open to people, rather than on the final outcomes they achieve. Potentially, this approach offers a way

³ These ideas have been developed in a variety of publications over the past twenty five years – see for example: Sen, 1985; Sen, 1997; Sen and Sengupta, 1983; Drèze and Sen, 1989. Many of the arguments and ideas are usefully reviewed in Cameron, 2000.

of limiting the need for contestable judgements about the nature of well-being as it notes that there can be a variety of limits to opportunity, different from one society to another. These ideas are important because they move away from the currently hegemonic western account of health and poverty as aspects of the individual. They involve a much broader perspective that spans cultures.

Sen's is a cross-cultural perspective. It allows a variety of interpretations of what it means to be a person and to have an identity. It engages with issues beyond the western cultural tradition and conflicts with the currently dominant emphasis on "the market" and "the private" in considering the provision of public goods and services.

These ideas were foreshadowed in the work of Karl Polanyi (Polanyi, 1945). Polanyi's view was that in past societies the market mechanism was closely integrated with other aspects of social relations. But in "the west" it became separated, "disembedded", and thus uncontrolled and unmoderated by considerations of values other than price. In its most extreme manifestation, "the market" is today held up by many politicians and philosophers as the best and only "rational" way to decide on the allocation of goods and services, including health and welfare.

Polanyi's perspective engages with a question that takes us beyond the conventional perspective of the "individual". While the western medical tradition deals with "individuals" and even dissects individual's complaints into "specialisms", this question locates individuals in their social field. It asks whether social relations can be considered as ends as well as means. In other words, whether social relations should themselves be considered as part of well being. If this were to be the case, then the social relations of making a living, living with other people, and rearing children, would have to be taken seriously as components of "well-being" in ways which are not currently the case in the "health" industry.

We live our lives in our minds but also through and in our bodies. We guard and worry about our health. *Our* health, *our* individual body, *our* well being or *our* ill-being. Medical doctors deal with our individual health. We pay them or make public provision for them to be paid. But is this really what health, well-being and ill-being are about? These questions confront us with the necessity to consider how we relate to each other in this new world which we all share.

These social relations are all important aspects of public health inasmuch as the perspective which identifies "health" with "medicine" implies a much more individualistic version of a "person" than does that which identifies "health" with "public health". In the process, of course, the issue of whether or not social relations can be considered ends as well as means links once again to the notions of social cohesion, solidarity and public goods and their location and guardianship in a globalised world.

Social relations contribute to wellbeing⁴. They may be considered as :

- 'relational goods' (Gui, 2000),

⁴ We are grateful to Richard Palmer-Jones, Cecile Jackson and Robert Sugden for their helpful discussion of these ideas in an unpublished document circulated in the School of Development Studies.

- goods which have characteristics of being “public” or “common” like, for example, transport infrastructure.

It may not be possible to supply the former category of good through markets, depending on whether a relationship, which is the good, is provided through a market. For example a foster parent provides care and support, a parent provides love as well. Can money buy love, can you cost a cuddle? The latter is not supplied or is under-supplied by markets because individuals and corporations have little incentive to supply those goods. Relational goods can be final consumption goods (i.e. valued for themselves) and/or intermediate goods (e.g. certain social relations may facilitate co-operation and trust). Social relations can be a source of value in themselves (Sugden, 2000, Bruni and Sugden, 2000). Social capital, social cohesion or community connectedness, make a huge difference to many facets of human life. Putnam (2000, 290) argues that “social capital makes us smarter, healthier, safer, richer and better able to govern a just and stable democracy.”, and Wilkinson (1996) has tried to demonstrate the “healthier” part by means of some empirical studies.

Such ideas are rich in their implications for thinking about public health. Public health should be seen as a communal process that has elements of both a public good and a *relational good*: the good is consumed and enjoyed but the relationships through which it is provided are in themselves a “good”. This “good” is one that demonstrates care for others, an aspect of living with others. The problem is to develop an institutional locus for provision of such goods. These ideas about public health, health, medicine and the individual confront us with both challenges and opportunities in an era of “globalisation”.

What is globalisation?

Globalisation means many things: the unleashing of market forces; the triumph of capitalism; the dominance of the “truth” of neo-liberal economic theory; the market as the arbiter of welfare; the death of Keynesian intervention; minimisation of the role of the state; concern with economic growth at the expense of growing inequality; the assumption of individualism as the well-spring of human endeavour. In practice it means greater integration of the world’s economies and formation of large trading blocs such as the European Union and the North American Free Trade Area. These organisations are remote from democratic control. The multinational companies that do most of the business are by definition not democratic. They answer to their shareholders. In these circumstances, many of our most important relationships are remote from democratic control or popular participation other than through the clumsy operation of markets and Byzantine bureaucracies whose operation remains opaque to ordinary people.

Globalisation: upsides and downsides

There are profound disagreements about globalisation. Some argue that it must lead to greater inequality, more poverty, more exploitation on a global scale (Went, 2000). Others believe that such dramatic developments offer opportunities for greater assistance to the world’s poor; innovative and creative use of the new interdependence and interconnectedness of the modern world. In this view, globalisation means better communication, more sharing of ideas and information, decreased cost of international transactions, more perfect markets and thus better distribution of goods and services, the spread of norms and values and the proliferation of global

agreements on things such as human rights. The new wealth so created could be managed wisely to provide opportunities and better levels of life for more people (Her Majesty's Government, 2000).

But globalisation is not about markets and economics alone. It is about cultural and political change. There was a time when locality was of the greatest importance and reputation mattered. That has been less the case since the growth of industrial society. Our relationships are mediated through an often-distant market. Those processes have moved even further ahead in the past twenty years with the development of electronic communications, of branding (Klein, 1999), marketing and a global culture. Some of us can move beyond the local and maintain quite complex and close relationships across time-zones and cultures.

What does globalisation do for the distribution of “goods” and “bads” in the world? This question must be considered as we think about the impact of HIV/AIDS and its implications. Globalisation is not a neutral process of closer and faster linkages between diverse areas of the world. It is an asymmetrical process. It does not affect all areas of the world equally or in the same way. Certain relationships, for example capital transactions, are highly integrated while others, movements of people and access to technology, are governed by restrictive regulations – as for example with regard to anti-retrovirals and other pharmaceuticals. The result is that certain regions of the world – notably Sub-Saharan Africa – “remain on the periphery of these trends towards progress and economic dynamism.” (Alonso, 2001, 87), except where skilled labour is imported or the poor world provides a dumping ground for toxic waste and a location for hazardous and arduous work. This global process has local effects. One locality bears the cost, another reaps the return.

Investment, cost, productivity and realisation of profit are spread across a whole world of space through complex networks of finance and organisation, and through decades of time. Cause and effect are often so widely separated in space and time that it is often difficult or impossible to locate responsibility. The same is true of losses and costs associated with the impact of HIV/AIDS. With an epidemic affecting the whole world we must think about how much it is costing whom and when and over what period. This question is not simple and it has social, economic and ethical dimensions.

There is another argument. This recognises that the globalised world is replete with risk and hazard. The risks arise from the complex interactions which occur when, for example, uncontrolled industrial production results in pollution and environmental damage, when inadequately controlled animal feed processing resulting in prions jumping species and the “mad cow”/nCJD epidemic saga erupts in Europe. Or when new processes, genetically modified organisms for example, are introduced and the only real “test” of their safety is their mass marketing and use. At this stage, “risk” becomes an *inappropriate* word, with its implications of calculability and scientifically based knowledge (Beck, 2000, 50-1). It has to be replaced by another word: “hazard”. Hazards are uninsurable because the risk is incalculable and the “experiment” to ascertain the degree of risk is in effect carried out on the world at large. However, these new risks and previously unperceived hazards may, paradoxically, offer opportunities. They are no longer controllable by the nation state

and thus they require an alternative form of organisation if they are to be brought under control and contained.

For the past two hundred years human beings have found it useful – even “natural” - to live in nation states and for nationality to be their primary identity along with sexuality, gender, language and belief. This process has gone further in some parts of the world than in others. In Europe there are now strong but contested moves away from nationality towards “super-nationality”, the European Union. In other parts of the world, ethnicity competes with and contests nationality as in multi-ethnic states like Indonesia where the construction of nationality remains incomplete and maybe unachievable (Leith, 2001). Nationality is one of the great “imagined communities” within which we live our lives– but it is imagined and therefore changeable.

Few politicians seriously argue that national governments can control and manage the economies of individual nation states. Many large international companies have turnover and reserves far larger than many nation states⁵. Indeed, there are several individuals whose total wealth far exceeds that of a swathe of the world’s states. The power of large multinational corporations suggests that nation states may no longer be the right, appropriate or effective mechanism for dealing with the risks and hazards created by such powerful entities. There is a disjuncture between personal identity as a member of a nation and this realisation.

The limitations of the nation state should be obvious to us all. Indeed, one of the key functions of the idea of the nation state – in the hands of contemporary politicians at least - now seems to be to explain why it is not possible to do things that citizens may wish to have done on their behalf. There is some justifiable concern about the potential and future of nation states. There is a real issue: nation states may in fact be fossils from an earlier period of political evolution, inappropriate mechanisms for the challenges that we now face. The difficulty is that those who govern and administer them have an interest in their maintenance. For the rest of us it is hard to see viable alternatives.

In the absence of effective nation states and in a world of multi-national corporations, who are the agents and actors in the drama and how are they to exercise and make manifest their agency and action? The answer is just discernible. The agents are networks and movements of actors in different nation states, focused on issues, pursuing common and sometimes conflicting strategies. At times these strategic alliances may consist of combinations of nation states, international agencies, national non-governmental organisations, international non-governmental organisations, UN agencies &c. This is a complex game. While the world of nation states may be akin to chess, this new world is akin to multi-dimensional chess played across cyberspace without a board. The nature of that game cannot be more poignantly evident than in the terrible events of 11 September 2001 in the USA and their equally terrible aftermath, as nation states try to engage with a threat which does not originate from within a nation state. Nowhere more than in these events and in the HIV/AIDS

⁵ “Of the 100 largest economies in the world, 51 are corporations; only 49 are countries (based on a comparison of corporate sales and country GDPs).”, and “The Top 200 corporations’ combined sales are bigger than the combined economies of all countries minus the biggest 10.” (Anderson and Cavanagh, 2000, 1).

epidemic can we see the need to begin creating a “global civil society”⁶ and the inadequacies of our existing arrangements.

In fact, though, this is not only a hope for the future: it is the way that the fight against HIV/AIDS has been and is being pursued. It is paradoxical and part of the contradictions of globalisation that the mechanisms for intervention are often so remote from the lives of those, particularly the very poor, who are acutely affected. Indeed, the mechanisms of the internet and the email which permit effective strategic co-ordination are distant from these lives. International email and internet discussion and information groups are far from the sick person in a Nairobi slum or an orphaned child on the streets of Calcutta. But they can and do influence those lives.

It is significant that UNAIDS was established in a way which was and remains different from other United Nations agencies. It contrasts with the feudal fiefs of the UN’s older and bigger agencies. These - the Food and Agriculture Organisation, based in Rome, or the International Labour Office and the World Health Organisation, both in Geneva, or the United Nations Development Programme and the United Nations Children’s Fund, both based in New York - are quite autonomous bodies with a high degree of independence from the central UN organisation. In contrast, UNAIDS struggles to be a coalition-building, inter-agency co-ordinating body. In addition to its work with the NGO and corporate sectors, UNAIDS works with some of the major actors on the AIDS scene, a veritable spaghetti soup of acronyms: the World Bank, the European Union, The United Nations Development Programme, The United Nations Children's Fund, The United Nations Population Fund, The United Nations International Drug Control Programmes, The United Nations Educational, Scientific and Cultural Organization, The World Health Organization.

HIV/AIDS is a problem that is not handled easily by the mechanisms and methods of the nation state. It has drawn out from the world community a response that depends on fluidity rather than extreme bureaucracy – although UNAIDS is inevitably affected by these features of the international administrative culture.

It is in this fluid coalition of agencies, old traditions, new technologies, new links and alliances between private, public and “third sector” (NGO) funding and action, “client” and “activist” groups, that early forms of an effective engagement with this first globally perceived epidemic are visible. This could go far beyond HIV/AIDS towards an engagement with global public health.

There are opportunities for innovation and for more “goods” but there is only a glimmer of hope. We must think about areas of immediate and medium term action that may make for the wider availability of the “goods” which the global systems could and ought to provide. These are:

1. global inter-sectoral action through trans-national co-operation and partnerships between public health and trade and finance sectors;
2. an enhanced role for international legal instruments, standard setting and global norms with regard to entitlements to health and well-being;

⁶ This idea has wide resonances, see Kaldor, 2001.

3. comprehensive global vigilance, research, monitoring and assessment to provide information about comparative health status and global determinants of health and wellbeing;
4. research programmes that concentrate on developing cost-effective technologies to improve the status of the poor;
5. development of international agreements regulating prices of medications in different markets;
6. recognition that management of health and well-being is a common human project and that the for profit sector can only have limited incentives to meet those needs (Alonso 2001).

But while they are desirable, pursuit of these goals is difficult. There are many obstacles. First of all we have to persuade people of the true cost of HIV/AIDS. Secondly business has a role to play but the business of business is profit not welfare. Perhaps that is also an assumption that must be challenged. In the same way that HIV/AIDS is about more than health, so business has responsibilities beyond profit.

In every society processes of distribution and social coordination combine three complementary mechanisms:

- The market – distribution through competitive pricing
- Hierarchy – distribution through organisation processes
- Values – distribution as a response to accepted ethical principles (Alonso 2001, 91).

Globalisation is an ideology that suggests distribution through the market is the best and only way, to the exclusion of the other two. The challenge is to find arrangements whereby the production and distribution of international public goods such as primary health care and public health provision may be managed within a multilateral system. UNAIDS is a precursor of how this might be achieved. And it is perhaps also a signifier of the forces against such change and the conservatism of the institutional fossils of the UN system that- at the time of writing - efforts are apparently afoot to reabsorb UNAIDS back into the World Health Organisation!⁷

Responsibility in a Global Economy

The impact of the HIV/AIDS epidemic affects the poor, local and already risk-burdened more than it does the rich and the cosmopolitan. Of course it affects individuals and that pain is never to be discounted just because they are rich. But the impact of the epidemic causes more than individual pain among the poor. Indeed the epidemic has very far-reaching consequences.

There is an issue of remoteness: how far do you track the process of cost-bearing? Anybody who has had an inconsiderate neighbour hold a noisy party knows the cost of the neighbour's enjoyment is paid through others' loss of sleep and bad mood the

⁷ Personal communications from several senior UNAIDS officials.

following day. With a long wave epidemic of infectious disease, the question of downstream costs - impacts - is very complex. So also is the question of upstream responsibilities - the roots of the epidemic in social and economic events. And with those questions arise also the possibility of demands for compensation from those who are paying today and tomorrow for events which happened long ago. Of course such responsibilities cannot be clearly identified, causal chains will be debated, and arguments as to legal liability and compensation would enrich many lawyers. But the idea that such things could be possible should make us more careful about current neglect of those who do not live in the Triad countries. The decidedly minority interests in saving threatened species and environments of fifty years ago are becoming mainstream global political issues, demands for apology and compensation for the abuses of the north Atlantic slave trade are seriously – if unproductively - debated in international fora.

We think of costs as associated with identifiable units, individuals, households, communities, companies, and nations. These entities have legal statuses and can be held responsible because they are subject to legislation and due legal process. At least in principle. The problem is that it is just this perspective of legally responsible entities, bounded by identifiable spatial spheres of assumed influence and effect of their actions that may limit consideration of *responsibility*. It is quite possible for an irresponsible group of producers in the same industry to cause general hazard to the environment and yet escape individual responsibility. This is because in a world of legal entities, individual contributions to the hazard cannot be precisely identified through any legal process. Many activities undertaken in the pursuit of “wealth”, “economic growth”, “development”, involve transferring the costs to another place which is geographically remote, or to another time (as with disposal of highly radioactive waste). Economists describe the idea of a project’s cost being paid elsewhere as an “externality”. Take an example from the late 19th and early 20th centuries which has resonances today. The exploitations and brutality of the colonised Belgian Congo in that period laid some of the foundations for the conditions which have contributed towards that country’s contemporary epidemic of HIV/AIDS. It is ironic that availability of impermeable rainwear and motor tyres in the rich world were rooted in the brutalities associated with wild rubber supplies in King Leopold’s Congo. Ironically, this was true also of the rubber condoms that facilitated the birth control revolution in Western Europe and North America (Banks and Banks, 1954), the mechanism for the famous western “demographic transition”. It is even more ironic to think that donor campaigns to popularise “Prudence” condoms as a protection against HIV infection in modern Congo are in part necessary because of the conditions under which latex was collected for manufacture of European condoms in the early twentieth century. The connection is worthy of a book by W.G. Sebald!

While the world’s wealthy and comparatively wealthy create problems for the poor, the poor create problems for themselves as they endeavour to survive. The poor are very likely to inhabit or move within a series of overlapping risk environments. On most measures, chances of encountering a hazard are high. If you are very poor, a recent migrant to a city, with accommodation hard to find, then a river bank shanty settlement may be the only option despite the flies, the slant of the floor and the density of people. More people, more sanitation problems, more marginal areas of the river bank are colonised. The river bank is undermined and then, in addition to the

costs in illness and death associated with poor sanitation and drinking water, the next flood brings death destruction and environmental change as the river bank is swept away. Michael Zurn puts the problem as follows:

“Whereas many wealth-driven ecological threats stem from the *externalisation of production costs*, in the case of poverty-driven ecological destruction it is *the poor who destroy themselves* with side effects for the rich. In other words, wealth-driven environmental destruction is distributed evenly around the globe, whereas poverty-driven environmental destruction strikes at particular spots and becomes international only in the form of side-effects appearing over the medium term.” (Beck, 2000, 35 quoting: Michael Zurn, 1995, 51).

The conditions whereby the poor destroy themselves are another aspect of the local risk environment. This is just one aspect of the way that large scale events and processes associated with economic growth in some parts of the world have resulted in impoverishment and local damage – of which the HIV/AIDS epidemic is but one manifestation.

So what does it cost for a Filipino woman with a college degree to leave her home and work as a maid in Los Angeles? What does it cost for a trained teacher to leave rural Uganda to seek work in a town in Europe? What does it cost if a woman teacher dies of AIDS in Tanzania, Thailand or South Africa? The movement of a migrant, the loss of a person to illness, both of these impact upon the individual concerned of course. But they also affect and change the lives of those who are left behind and on the lives of people beyond the immediately identifiable domestic unit where the obvious burden of cost is concentrated. However, the optic of globalisation should ensure that we no longer fall into the trap of thinking that anything is any longer “local”.

What has HIV/AIDS to do with corporations?

Large corporations operating in a global economy can plan their way out of the AIDS epidemic just as they avoid most other local constraints on their activities. By the 1990s some large corporations operating in Africa had completed AIDS related risk analyses. For reasons of commercial and political sensitivity, these studies remained confidential. These actions have to be understood against a background of how business is done in a world of intimate global links and increasingly centralised and concentrated corporate structures and finance.

In the last forty years, business has changed fundamentally. The first industrial revolution of the 18th and 19th centuries depended on large, underpaid and initially non-unionised work forces and involved cheap labour, mass production methods and the satisfaction of home markets followed by expansion overseas. Such highly integrated factory-based organisations were profitable and expanded against a background of regular fluctuations in the trade and production cycles. These corporations were a clear target for workers’ organisations. During the twentieth century, workers gained better wages and working conditions. They made *political* bargains assuring additional social wages in the form of health care provision, pensions and education, and government intervention to create better lives and reduce individual risk.

By the mid-1960s this was changing. The limits of mass production with its inflexibility, fixed capacity and inability to respond to trade and production cycles had been reached. Some economists and politicians saw the social wage as unsustainable. This was the beginning of the “New International Division of Labour”, a period of peripheral industrialisation when production capacity and plant was relocated to low wage regions of the globe. These countries offered cheap labour and weak workers’ organisations, often associated with “strong”, undemocratic governments which did not respect human rights. This was an important point in the process that has come to be called globalisation. A recurring theme throughout has been the search for co-ordination and control. The electronic and communications revolution of the past fifty years has made this easy and instantaneous.

In the past three decades, many companies have endeavoured to free themselves from fixed plant and large workforces with complex needs through becoming increasingly virtual organisations. In principle, a modern corporation might be located in a small suite of offices in an anonymous city block anywhere in the world. From there it would make contracts with sub-contractors and other suppliers, with assembly plants and packaging and logistic specialists. E-commerce is the end-state of the globalised multinational corporation. In such systems of production and distribution, a company is immune to many risks, including those of the AIDS epidemic. It has insignificant numbers of employees, holds little in the way of stock, and has no long-term commitment to a workforce. Therefore it can and will move its production requirements to wherever they can be fulfilled at the cheapest price available. Or it can move its capital assets to the market with the best yield. Only if the epidemic hits sales do modern corporations have to take HIV/AIDS on board. Even then they have little incentive to deal directly with the immediate or long term effects of the epidemic. They could simply withdraw from that market.

Few corporations have achieved quite this degree of elevated virtuality – a kind of corporate other-worldliness. “By shifting more and more of their production to contractors, companies can distance themselves from potential charges of labour rights abuses and other illegal behaviour and keep labour costs low by forcing contractors to compete for business with an ever smaller number of giant purchasers. The giant firms also have more freedom to hire and fire contractors to meet shifting demand.” (Anderson and Cavanagh, 2000, 5). Firms can avoid cost-incurring risks associated with employing a labour force. They can at the same time avoid any involvement with or concern about what, viewed from within the Triad, looks like a “local” HIV/AIDS epidemics.

Some companies do consider HIV/AIDS and are prepared to bear the costs. These are mainly companies that are tied to particular geographical regions and are thus compelled to take the potential costs and liabilities on board. Large companies which are not tied to localities do not have to bear the risk. But smaller companies which are tightly tied into local or regional economies cannot avoid risk. Indeed, the further down the chain of value, the more likely a company is to be a sub-contractor to a contractor to one of the virtual corporations at the top of the chain. In effect, it is these third or fourth order local companies which will be bearing the burden of HIV/AIDS risk locally while the larger international corporations will be able to avoid those direct costs which attack the bottom line. The statistics for the degree to which major multinationals avoid employing people directly are arresting. The sales of the

top 200 corporations world wide are the equivalent of 27.5 percent of world economic activity, yet they employ only 0.78 percent of the world's workforce. At the same time, between 1983 and 1999, the profits of the Top 200 firms grew 362.4 percent, while the numbers of people they employed grew by only 14.4 percent (Anderson and Cavanagh, 2000, 1).

As pressure for cost reduction is passed down the chain, so the final squeeze is applied to labour which must either be substituted for by capital or persuaded to accept lower wages and/or less favourable working conditions. The local effects of this downward pressure are in low wages, poor conditions, occasionally coerced working conditions and ultimately the creation of urban and rural risk environments in which infectious diseases, among them HIV, are more easily transmitted. This applies as much to the rural producers of high value horticultural products and cut flowers in Kenya, Nicaragua or Malawi as it does to the factory workers in Thailand, Côte d'Ivoire or China. Only through a sustained campaign to get businesses and governments to sign up to ethical policies and legal provisions in relation to the rights of their workers, will we be able to intervene to stop businesses from burden shifting and thus creating the risk environments which facilitate an epidemic such as HIV/AIDS. In the absence of this the costs will devolve to government and ultimately households.

Inequality, Susceptibility and Outcomes

Whether a person contracts HIV depends on their social and economic position. Social class, gender, ethnicity, market position all combine to create particular ways of making a living. Livelihood opportunities determine entitlements. Together these are the major influence on sexual networks. Farmer comments in relation to Haiti that:

“...conjugal unions with non peasants (salaried soldiers and truck drivers who are paid on a daily basis) reflect women's quest for some measure of economic security. In the setting of a worsening economic crisis, the gap between the hungry peasant class and the relatively well-off soldiers and truck drivers became the salient local inequality. In this manner, truck drivers and soldiers have served as a “bridge” from the city to the rural population, just as North American tourists seemed to have served as a bridge to the urban Haitian population.” (Farmer, 1999, 135).

This vignette is but a microcosm of the global situation. Some of us inhabit a world where we can be spatially – if not sexually - polygamous; others are stuck in their locality, but the world comes to them. We should not be surprised that the initial distribution of this epidemic was among the rich and more cosmopolitan in Africa and elsewhere. They could travel and become infected. They had easy sexual access to “local” people, people who were neither cosmopolitan nor wealthy. Hence the later and continuing epidemic among the poor. This is the effect of globalisation as a creator and distributor of “bads”.

Initial states of individual health, nourishment, parental and grand-parental nutritional status, degree of physical exhaustion, mental state, work conditions, residential location, these all influence susceptibility to infections (Farmer, P., 1996; 2: 259-269; Cohen, Doyle, Skoner, Rabin, Gwaltney, 1997; Cohen, Doyle, Skoner, 1999). With specific relation to HIV/AIDS, how the disease progresses, its outcome, is also an expression of social and economic inequality (Chaisson, Keruly and Moore, 1995).

Life expectancy after HIV infection is associated with diet, environment, state of mind, housing and a host of other factors that are usually associated with income. With the introduction of ARVs the difference in outcome between the rich and the poor has become even more stark.

Risk

But treatment is not really the starting point of the problem; it is the end state. To always think about treatment is to remain distanced from the social and economic origins of illness and ill-being. Illness and ill-being are not only or most importantly about individual risk. Rather they are “systematic events, which are accordingly in need of general political regulation. Through the statistical description of risks ... the blinkers of individualisation drop off.” (Beck, 2000, 51). This is important. Risks appear as systematic events, common events, when they are described and measured. Otherwise they appear as local or even individual events. We only see aggregates through measurement and abstraction. When we are aware of these aggregate events we can then respond. But response requires that we can enable “the blinkers of individualisation” to drop off and see what is common. For the moment, we tend to see “risk” in very local terms, either geographically or the individual. These blinkered perceptions are no longer appropriate, but they are part of a process of denial.

All human groups know how to insure by spreading and thus sharing risk. This is not because they are motivated by altruism or are natural socialists. Rather it has to do with the need to survive. Risk spreading and sharing may range from very simple and humane interactions – the care that we give each other in the domestic group, the intergenerational bargains which extend that care over time, the immediate care found in the domestic bonds of child-rearing. In a globalised world, risks are amplified and the opportunities for risk differentiation are greatly augmented as the number of risk niches increases. Advances in data collection and analysis enable those with power to identify and avoid these risks. However, the possibilities and mechanisms for risk sharing among the poor barely exist. There are few structures and little willingness beyond the ideologies of charity and self-interest. Public health is a way of pooling risk. And in the contemporary world we have to put risk in a perspective that is wider than the individual.

A broader implication of the HIV/AIDS epidemic is that we must examine and reflect upon the ideas of “health” and “well-being” critically and anew. We cannot act as though we were inhabitants of a medieval city-state and exclude those who are sick and/or poor. There is no longer any quarantine, we cannot avoid contagion. This is a vital task for the first decade of the 21st century. Debates about and understandings of poverty have moved from ‘absolute’ poverty to relative deprivation, inequality and the multi-dimensional nature of deprivation. So too must our understanding of well-being.

But we must go further. Human beings must and will continue to interact. Will we build just and cohesive societies both within and beyond national borders? Or will we continue to isolate and defend ourselves in islands of prosperity, in Europe, North America and then in city blocks and rural refuges within those regions? Or within elite enclaves in the capital cities of the poor world, while remaining surrounded by an increasingly hostile, desperate and suspicious world?

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