

The Vicious Cycle of AIDS, Poverty, and Neoliberalism

By Bernardo Useche and Amalia Cabezas | December 1, 2005

World maps illustrating areas of high poverty largely overlap those of high HIV/AIDS prevalence. It's no coincidence that both poverty and the HIV/AIDS pandemic have run rampant in these last two decades of neoliberalism, since the root causes of both can be found in the economic model.

The most recent United Nations figures show the true magnitude of the tragedy: approximately 40 million people are currently living with the Human Immunodeficiency Virus (HIV) or are suffering from illnesses associated with Acquired Immunodeficiency Syndrome (AIDS). In 2003 alone, five million people joined the list of those who tested HIV-positive and nearly three million others died from complications associated with AIDS.

Faced with a tragedy of epic proportions, the UN's World Health Organization (WHO) and UNAIDS launched a plan to provide antiretroviral medications to three million AIDS patients in the next two years—approximately half the patients currently estimated to need this kind of treatment. The WHO strategy incorporates plans recently proposed by the World Bank and the U.S. government.

At first glance, this global strategy appears to be a humanitarian gesture and a decisive intervention by the international health organizations and the White House to control this devastating disease. However, to thoroughly understand the true dimension of the AIDS pandemic and the possible scope of the WHO-World Bank-Bush government plans, it is essential to consider the socioeconomic world context in which the disease has been gestating over the last two decades.

This context continues to be defined by the prevalence of multinational pharmaceutical companies' interests above those of the patients who are supposed to benefit from their medicines. Neoliberal economic policies in recent decades have created conditions in which it has proven impossible to detain or reduce the number of infections, despite the efforts of scientists, the investment of billions of dollars, and the work of innumerable organizations in prevention programs.

Epidemics and Economics

Social epidemiology, defined initially as “the study of the role of social factors in the etiology of an illness,” grew out of Friedrich Engels' study of the living conditions of English workers in the 19th century. Today this area of public health looks at how historical, political, and economic tendencies influence the dissemination of an illness among different populations and how social forces and factors affect individuals' bodies and generate pathologies.

In the case of HIV/AIDS, Nancy Krieger has pointed out that “neoliberal economic policies such as the North American Free Trade Agreement (NAFTA), which result in economic austerity plans, environmental degradation, and growing intra- and inter-regional social disparities in health, are of particular concern.” The study of the effect of health service organization and coverage, and of drug production and marketing systems on a specific society's most vulnerable population is also important to epidemiology and social medicine.

All studies agree that the AIDS pandemic is concentrated in the poorest countries and among the poorest sectors of wealthy countries. But very few works analyze the close relationship between the causes of the affected nations' socioeconomic reality and the so-far uncontrollable advance of the epidemic during the last two decades. With a few very valuable exceptions, most research simply describes the situation without clearly defining the fundamental responsibility of the economic globalization model imposed on nations in these times of AIDS.

British epidemiologist Thomas McKeown demonstrated that progress in controlling a population's illnesses cannot be attributed to vaccines, antibiotics, and improved medical treatments alone, given that socioeconomic conditions and their effects on nutrition constitute an essential health factor. Without denying the importance of



advances in biomedicine, epidemiological studies currently confirm that health expectations are directly associated with quality of life, which in turn is determined by environmental health, nutritional status, water quality, housing, education, working conditions, and emotional and psychological factors that benefit human development throughout the life cycle.

Health in a given country depends not only on inhabitants' income, but also on the degree of equality within the society. Health expectations are greater in countries with relatively less income and social inequality among the population. This explains the differences in life expectancy and other health indicators among industrialized countries. Sweden, Switzerland, and other developed countries, for example, have better health rates and higher life expectancy than the United States, a country that despite having the most powerful economy on earth also has abysmal social inequalities, with 46 million citizens currently unprotected because they cannot afford health insurance.

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Blaming the Victim

The undeniable link between health problems and social inequalities presents an ideological dilemma. Are the sick to blame for their illnesses or do they result from social inequality? The social history of AIDS has largely been one of apportioning blame to the victims. At the beginning, AIDS was even defined as the disease of the four Hs: homosexuals, Haitians, hemophiliacs, and heroin addicts—to which one could more recently add “hookers.” All these categories carried implicit derogatory social connotations.

Blaming the victims hides the fundamental role socioeconomics plays in generating and propagating illnesses, instead placing the “cause” on the victims and saddling them with the responsibility for prevention and

treatment. The state's obligation to care for its population's health is obscured.

Yet the causes are closely interlinked to social factors beyond the victims' control. Poverty often creates the alienating conditions that lead to a culture of intravenous drug use. And in the concrete case of Haiti, Paul Farmer established that, contrary to the widely disseminated stigma that blames Haitian immigrants for introducing the AIDS epidemic to the United States, it was the sexual tourism of U.S. citizens to Haiti—fueled by the poverty that left Haitians with no other means of livelihood—that started the AIDS epidemic on the island.

As a result of viewing AIDS transmission as essentially a problem concerning the individuals involved, prevention efforts focused on trying to modify individual risk behaviors and attitudes for the first 20 years of the pandemic. This unilateral approach, which ignored the socioeconomic factors behind AIDS, predictably failed in stopping the epidemic. But it succeeded in blocking in-depth debate on the responsibility of the neoliberal economic model implemented throughout the world during this period, and the social consequences provided a breeding ground for the epidemic's progress.

Neoliberal Famines and the Spread of AIDS

Neoliberalism is the set of economic theories and policies developed by contemporary monopoly capital to consolidate its global expansion and achieve control of the world markets it needs to survive. The distribution of the HIV/AIDS infection matches the current world socioeconomic order. In this era, health problems have been polarized along with distribution of wealth, as born out by Paul Farmer's theory that the health of the world's poor is affected primarily by infections and violence, while the rich suffer from chronic illnesses associated with aging. The 21 nations with the highest AIDS prevalence in the world are found in Sub-Saharan Africa, where dramatic poverty largely resulted from the neoliberal measures imposed by the structural adjustment programs of the International Monetary Fund (IMF) and the World Bank.

Famine and AIDS go hand in hand on the African continent. As UN Special Envoy for HIV/AIDS in Africa Steven Lewis explained, when the body has no food to consume, the virus consumes the body. When the body's immune system is weakened by lack of food, the illness progresses much quicker and people die faster. The main cause of the recent famines, with their inevitable malnutrition

and death, are not the droughts and other natural disasters that frequently afflict Africa, but rather the elimination of agricultural subsidies, privatization of public services, and complete opening up of the economy, measures that are an integral part of the structural adjustment programs demanded of the African nations by the international agencies since 1986.

Zimbabwe: A Tragic Case

Zimbabwe sadly illustrates the point. According to a study by the Joint Center for Political and Economic Studies in Washington, the average real economic growth in Zimbabwe during the 80s was 4% a year. During those years, food security developed somewhat and the manufacturing sector was strengthened, which contributed to a diversification of exports. At the same time, health services increased and life expectancy rose from 56 to 64, while child mortality fell from 100 to 50 live births.

In 1991, Zimbabwe received a US\$484 million loan conditional on the structural adjustment of its economy. The demands of the adjustment included reducing public spending, deregulating the financial market, eliminating manufacturing protections, liberalizing the labor market, reducing the minimum salary, and eliminating labor stability, all to guarantee reduction of the fiscal deficit. Zimbabwe's economy entered into recession a year later and between 1991 and 1996 per capita private consumption fell 37%, salaries fell 26%, and unemployment rose, while food prices skyrocketed.

The IMF's recipe, which required the Zimbabwean government to slash spending by 46%, above all by cutting health workers' salaries, had disastrous effects on public health. The vast majority of the population was left without access to health services or medicine. Malnutrition and the incidence of illnesses such as tuberculosis rose dramatically. Life expectancy is currently down to 38, between five and eight million people—around 70% of the population—depend on international food aid to survive, and 2,500 people die of AIDS every week. Even so, the IMF has initiated procedures to expel Zimbabwe for not having consistently accepted all of the economic reforms it "recommended."

Social Catastrophes Feed the AIDS Epidemic

The situation is similar in the other African nations. Zambia, where AIDS left some 600,000 children

orphaned in 2001, liberalized its economy, including agriculture, in 1991 under World Bank-imposed conditions. It is currently in its fourth consecutive year of food crisis and over three million inhabitants have nothing to eat. Malawi and Mozambique are also suffering from chronic food insecurity.

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In 1991, the Malawi government had grain deposits in even the most remote parts of the country and could sell cheap food, saving a large part of the population from famine. The IMF "recommended" selling part of these food reserves to guarantee payments on the country's foreign debt, at the same time enriching private traders. Ten years later food costs ten times more and with the elimination of agricultural subsidies, the price of maize rose by 400% between October 2001 and March 2002. Peasants started eating unripe maize, resorting once again to the diet responsible for the disease pellagra, and there was generalized famine. In 2002, seven million of Malawi's total population of ten million suffered from pellagra. Between 2001 and 2005, an estimated 125,000 children under the age of five died of AIDS in Malawi.

Even in the United States, where neoliberal measures also increase social inequalities, new HIV infections are concentrated among Afro-Americans and Latinos. In neoliberal Russia an estimated three million people are intravenous drug users—one of the most important AIDS risk factors—and half that number are infected with HIV. In Latin America and the Caribbean, the lack of social and economic equity provides a favorable context for the AIDS epidemic to reach disastrous proportions in the coming decades, according to the UN's adviser for Colombia, Ricardo García. The worst cases so far correspond to the region's most economically depressed countries or regions. In Colombia, it is predicted that 1.6% of the population will be infected with HIV by 2010.

The Current Anti-AIDS “Crusades” of the IMF, World Bank, WHO, and Bush Administration

Ninety-five percent of AIDS cases occur in the pauperized Third World. In response, the U.S. government and the World Bank, which are the main bodies responsible for the neoliberal reforms that have destroyed national economies and starved vast sectors of the world population, have launched a worldwide campaign to combat the pandemic.

In January 2003, President Bush announced a US\$15 billion program to provide antiretroviral drugs to two million people infected with HIV in 12 African countries, Haiti, and Guyana. For its part, the World Bank began financing projects and developing an AIDS policy in 1986. In 2000, the World Bank and the IMF jointly decided to incorporate their anti-AIDS plans into their development assistance programs, arguing that AIDS is increasingly delaying economic growth by reducing productivity and the work force. At that time, the Bank illustrated its point using the case of Zimbabwe, a country whose 1% drop in economic growth was attributed to the fact that 25% of its adults were HIV positive.

The champions of “free trade” seek to blame economic and social problems on a biological agent—the virus—rather than on their imposed structural adjustments, privatization programs, and other reforms.

In December 2003, the WHO urged that these projects be coordinated with the UN Global Fund to Fight AIDS, Tuberculosis, and Malaria, established in 2001, and launched an initiative known as “Treating three million by 2005.” As its name suggests, the WHO campaign proposed providing antiretroviral medicines to three million AIDS patients in the next two years.

It is worth analyzing the origin, philosophy, and political and economic content of these anti-AIDS crusades to assess if they will indeed translate into relief for those people and regions in the grip of the epidemic.

Is AIDS the cause of poverty?

World Bank Director General Mamphele Ramphele categorically stated on June 1, 2003, that “our dream is a world free of poverty. But we now know that that mission will remain only a dream until the world is free of AIDS.” Paraphrasing the title of Doctor Ramphele’s speech that day—“HIV/AIDS: Turning Adversity into an Opportunity”—it could be said that the adversity of the AIDS tragedy has represented an opportunity for the agencies of international capital to blame the epidemic for the poverty caused by their own policies. Worse still, they attempt to postpone any hope of economic recovery in impoverished nations until AIDS has disappeared from the planet.

Such words are not isolated. World Bank documents have been insisting on this idea for some time now. One stated that while it is still not clear if poverty increases the probability of HIV infection, there is strong evidence that HIV/AIDS causes and increases poverty. The U.S. government also defends the idea the AIDS is a cause of poverty. As U.S. Secretary of Health, Tommy Thompson, recently stated, “Poverty, unfortunately, is a common symptom of AIDS.”

Given these tendencies, it’s no surprise that the introduction to the document in which the WHO set out its strategy establishes that “HIV/AIDS is destroying families and communities and sapping the economic vitality from countries. The loss of teachers through AIDS, for example, contributes to illiteracy and lack of skills. The decimation of civil servants weakens core government functions, threatening security. The burden of HIV/AIDS, including the death toll among health workers, is pushing health systems to the brink of collapse. In the most severely affected regions, the impact of disease and death is undermining the economic, social, and political gains of the past half-century and crushing hopes for a better future.”

The champions of “free trade” seek to blame economic ruin, loss of political conquests, illiteracy, destruction of health systems, and social problems on a biological agent—the virus—rather than on their imposed structural adjustments, privatization programs, and other reforms.

A World of Clients, Not Patients

Hundreds of millions of poor people in the world suffer and die from infectious diseases for which there are almost no cheap and effective medicines, despite the existence of the scientific and technological knowledge to develop them. Likewise, while North America, Europe, and Japan consume 82.4% of the medicines produced in the world, Asia and Africa consume just 10.6% of those available on the market, despite accounting for two-thirds of the world's population.

Patrice Trouiller and colleagues have documented the reason for this criminal inequity: in the neoliberal economy it is not the population's health needs but rather the financial interests of the large-scale pharmaceutical industry that influence both the research to develop new drugs and the production and marketing of available medicines. In a world with no patients, just clients, and in which the state is abandoning its public health responsibility, the drug transnationals don't invest in medicines to treat illnesses affecting poor people with no money to pay for them; their production and sales strategies focus on the market sector from which they can obtain greater profit margins.

Although there is currently no cure for AIDS, anti-HIV medicines can delay the disease's progress and reduce mortality by up to 80%. The "free trade" policies that have allowed the drug-producing corporations to make record profits off these medicines have also intensified the misery of people who need them. In the case of the AIDS pandemic, neoliberalism has been responsible for exacerbating to the extreme one of the basic contradictions of the capitalist economy: It created an immense potential market for the new antiretrovirals—42 million people with HIV/AIDS—among a population without the capacity to buy them.

Only 8% of the six million AIDS patients who currently require medicines to improve their health have access to antiretrovirals, a figure that in countries such as South Africa is as low as 1%. It is estimated that the current cost of treating a person with HIV/AIDS in the United States is about \$20,000 a year, including the value of antiretroviral therapy, lab tests, medical visits, and medicines to prevent or treat opportunistic illnesses.

WHO believes this situation can now be resolved: "The prices of antiretroviral drugs, which until recently put them far beyond the reach of low-income countries, have dropped sharply. A growing worldwide political mobilization, led by people living with HIV/AIDS, has educated

communities and governments, affirming treatment as a human right. The World Bank has channeled increased funding into HIV/AIDS. New institutions such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and ambitious bilateral programs, including the United States Presidential Emergency Plan for AIDS Relief, have been launched, reflecting an exceptional level of political will and unprecedented resources for the HIV/AIDS battle. This unique combination of opportunity and political will must now be seized with urgent action."

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But despite all the "political will" a fundamental obstacle remains—the pharmaceutical patent monopolies. Since 1995, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement established by the World Trade Organization (WTO) has backed up the patents of the transnational pharmaceutical corporations, guaranteeing them a market monopoly and exorbitant profit margins. As is the norm in neoliberal strategies aimed at eliminating competition by national products to benefit big capital, mainly from the United States, the WTO initially allowed its member countries to produce generic medicines during the first years after intellectual property rights came into force. A few countries, including South Africa, India, and Brazil, used this regulation to start producing generic versions of medicines used to treat AIDS and demonstrated that companies run by the state or national capital could substantially reduce prices and generate profits while at the same time attending to the health needs created by the epidemic in their own countries.

The U.S. government and representatives of the pharmaceutical companies soon started pressuring for “respect” for the patent monopolies. In 2000, 39 companies sued the South African government. During the 14th International AIDS Conference in Barcelona in 2002, there were mass protests rejecting transnational corporations that deal in these medicines while millions of poor people throughout the world are dying without access to them. On August 30, 2003, in a measure to forestall a repeat protest at the WTO meeting in Cancún, México, the Bush administration and the large-scale pharmaceutical industry agreed that poor countries could temporarily continue buying generic medicines, while adding a clause stipulating that all member countries would soon only be able to buy medicines patented by the transnational companies.

In the words of South African finance minister Trevor Manuel, there is a risk that most of the budgeted \$15 billion announced by Bush to fight AIDS will end up directly in the coffers of U.S. pharmaceutical companies.

The Bush Plan: Big Business for the Transnationals

At the same time it is promoting its own commercial interests in the WTO, the United States is continuing to push bilateral agreements and regional treaties such as NEPAD in Africa, CAFTA in Central America, and the FTAA in Latin America as a whole. This ongoing attempt to impose its neoliberal policies includes increased patent protection. President Bush’s anti-AIDS initiative was launched independently of the existing Global Fund to Fight AIDS, Tuberculosis, and Malaria with the evident aim of directly controlling both the project’s philosophy and the money that Washington will invest in the campaign.

Bush named Randall Tobias to run the program in Africa. Tobias had no experience either working in that region or managing AIDS-related programs, but he is a

major Republican Party contributor and former general manager of Eli Lilly, a powerful pharmaceutical company.

In Bush’s plan, the U.S. government will subsidize capital investments in anti-AIDS medicines by buying up the medicines the companies can’t sell to the impoverished nations of Africa and the Caribbean due to their high prices. In the words of South African finance minister Trevor Manuel, there is a risk that most of the budgeted \$15 billion announced by Bush to fight AIDS will end up directly in the coffers of U.S. pharmaceutical companies. It is hence no surprise that big laboratories such as Bristol-Myers Squibb, which controls the patent of the antiretroviral drug Stavudine (Zerit®), support the initiative and are competing to obtain their share of the \$15 billion, or that the giant corporations that produce anti-HIV drugs are financing lobbying of Congress to support the White House anti-AIDS plan. Under this plan, 130 transnational companies have joined a Global Coalition against AIDS.

The Bush administration’s fight against AIDS is governed by its policy of globalizing the free trade agreements that benefit its own interests. This was made clear by former U.S. Trade Representative Robert Zoellick, when he stated that they aren’t thinking of discussing new economic development models for African countries; they are simply looking at how to apply development based on market laws in very poor regions. The aid dedicated to the fight against AIDS will be conditioned on the nations accepting the economic measures prescribed by the World Bank and the IMF.

Washington’s initiative to take antiretroviral medicines to countries in Africa and the Caribbean also contains a strong ideological component that promotes sexual abstinence as the basis for HIV-prevention. In May 2003, the U.S. Congress introduced an amendment to the Bush initiative obliging it to invest a third of the millions earmarked for prevention into projects whose only objective is chastity. This is yet another of the neoliberal paradoxes: the very promoters of economic policies that leave millions of people unemployed and force many women into prostitution are now the standard bearers of a sexual morality that the vast majority of the population finds impossible to fulfill in real life. But this does not stop them proclaiming it as the most effective way of combating the AIDS pandemic.

Any attempt to illuminate the reasons behind the promotion of sexual abstinence as a means of prevention needs first to clarify certain questions about how sexual life affects HIV transmission.

With a few exceptions, most scientists believe that the main form of HIV transmission is via sexual relations with an infected person. Since the virus was discovered, it has been insisted that the highest-risk behavior is anal intercourse between homosexuals or heterosexuals and that in vaginal intercourse the virus is most easily transmitted if the infected person is male. Researchers believe that the number and concurrence of sexual partners and the frequency of sexual activity with new partners also play an important part in increasing the probability of transmission.

In the United States, the AIDS epidemic was initially identified among male homosexual drug users. Not until 2003 was it estimated that heterosexual contact produced a third of all new infections in the United States and Canada, while intravenous drug users sharing infected needles caused 25%. In Africa, in contrast, the epidemic was associated from the start with heterosexual transmission. Lately other possible means of transmission, such as use of needles and other medical instruments and equipment that do not comply with basic biosecurity norms due to the deteriorating health services and terrible conditions in which they are provided are being examined.

The problem with the abstinence approach to AIDS control is that it doesn't work. In sex education offered to young people in the United States, current programs promote abstinence, despite the lack of any definitive demonstration of their effectiveness. A systematic evaluation of these programs by Douglas Kirby concluded that "the weight of the evidence indicates that abstinence-only programs do not delay the onset of intercourse."

How the AIDS Virus Incubated in Inequity

Neoliberalism expresses the interests of big capital concentrated in the giant monopolistic corporations. Based on the thinking of neoclassic economics, it proposes reduction of the state including eliminating or privatizing many public services, public sector workers, and government housing, education, food, and health programs. In recent decades, the U.S. government and its allies have promoted globalization under neoliberal principles and "free trade" economic policies and imposed them on the nations of the world mainly through the international agencies under their control—the IMF and the World Bank—as a supposed panacea for all social problems.

World Bank and IMF structural adjustment programs have devastated Latin America, Africa, Asia, and the

Caribbean over the last 20 years. Promoting privatization, fiscal austerity, deregulation, market liberation, and the cutting back of the state, these programs have increased and globalized poverty, migration, unemployment, and temporary work contracts, and produced extremely polarized income and living conditions across the world to the benefit of big capital.

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AIDS was incubated and has been propagated in this system of social inequity and it will be impossible to prevent and combat it in any effective way without going after the conditions that are generating the pandemic. The anti-AIDS initiatives implemented by the Bush administration and the World Bank are set within the U.S. government's strategy of neoliberal globalization, a strategy that also guides the projects of the United Nations and the WHO. All of these plans basically consist of creating funds for channeling money donated by the governments of developed countries and philanthropic organizations attached to the big corporations to be used mainly to purchase and distribute antiretroviral medicines and fund AIDS prevention programs that promote sexual abstinence. These anti-AIDS programs also serve to reinforce the implementation of neoliberal policies in the countries to which the "aid" is offered.

Advanced medicines must be made available to the patients who really need them, the vast majority of whom are from the poor countries. But the management of HIV is complex. As even those who defend antiretroviral therapy point out, the severe toxicity of these pharmaceutical agents must be seriously considered when prescribing their use, despite their notable effects so far.

It is important to insist that antiretroviral medicines are not a cure for AIDS and that there is not complete

unanimity on their use. There are still many questions related to the use of this kind of therapy that science has yet to solve. The problems related to these pharmaceutical agents, just over 20 of which have so far been approved in the United States, include their high toxicity, the loss of effectiveness as the organism develops resistance after a certain amount of time, and the difficulty for patients to stick to the treatment adequately.

An Alternative Proposal

An alternative proposal to confront the AIDS pandemic with any probability of success should include the following basic points:

- *Defend national employment and production to promote independent economic development, guaranteeing food security and adequate nutrition for the population. A population with severe malnutrition is easy prey for the illnesses that characterize AIDS.*
- *Stop and reverse privatizations, particularly those that have eliminated public services and health systems, so the state can fulfill its responsibility to provide services and treat those affected.*
- *Allow the production of generic medicines, eliminating patent monopolies conceded by the WTO to pharmaceutical transnationals under the guise of respecting intellectual property.*
- *Expand prevention and treatment of drug addiction as an integral part of AIDS prevention and treatment.*
- *Guarantee the necessary scientific debate on the causes, prevention, and treatment of AIDS.*
- *Research cannot be limited to the commercial interests of a handful of companies that invest more money into publicizing a few profitable products than into basic research to develop the medicines that are really needed.*
- *Resisting the discrimination and stigma attached to people and communities affected by the epidemic must be an integral part of confronting the AIDS pandemic. Stigmas fuel, reinforce, and reproduce existing inequalities related to class, race, gender, and sexuality.*

Prevention programs must be based on scientific knowledge about the AIDS epidemic, not on prejudices about sexuality or people's behavior. It is inappropriate for the United States to establish the standards governing the whole world, as it seeks to do in its abstinence programs. Each country, culture, and society has a right to maintain its own standards, rules, norms, taboos, and lifestyles.

Defeating the Neoliberal Model to Defeat AIDS

After 20 years of ignoring the relationship between poverty, economic models, and AIDS, empirical studies are finally beginning to emerge that demonstrate that the incidence of AIDS increases with economic impoverishment and that to reduce the syndrome's prevalence it is essential to expand and strengthen public health systems. Paul Farmer stated in his report to a U.S. Senate Commission that the fight against AIDS is the fight against poverty. And given that poverty in the contemporary world is of neoliberal origin, it will be impossible to defeat AIDS without defeating the neoliberal model.

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