Economic Commission for Africa

Globalised Inequalities and HIV/AIDS

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About CHGA

Under the Chairmanship of the Executive Secretary of the Economic Commission for Africa (ECA), K. Y. Amoako, the Commission on HIV/AIDS and Governance in Africa represents the first occasion on which the continent most affected by HIV/AIDS will lead an effort to examine the epidemic in all its aspects and likely future implications. The challenge for CHGA is to provide the data, clarify the nature of the choices facing African governments today, and help consolidate the design and implementation of policies and programmes that can help contain the pandemic in order to support development and foster good governance.

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Globalised Inequalities and HIV/AIDS

The challenges posed by HIV/AIDS in the modern world encompass a potent mix of sex and death, science and politics and deep-rooted divisions and inequalities between North and South, as well as between rich and poor, men and women, black and white, homosexuals and heterosexuals. In this sense, an account of the pandemic is not only a gruesome tale of desolation the scale of which humanity has yet to comprehend, but probably the furthermost illustration of the opportunities, challenges and threats posed by globalisation. Globalisation is not to be blamed for all the many social challenges that now face us, nor indeed is it the primary cause of HIV/AIDS. But equally, there is clear evidence that global restructuring has exacerbated many old problems while also introducing new ones of its own, and it is in this context that HIV/AIDS must be placed. Across the world, the dominant drivers of globalisation (multinational corporations, the multilateral institutions of global economic governance and the G8 group of powerful states) structure not only the contours of the pandemic in terms of transmission and new infections, but also the outcomes once an individual is sick with complications of HIV infection (Berwick et al., 2002, Cheru, 2000, Poku, 2002a).

The aim of this paper is to detail the complex, but real relationship between the processes, forces and agents of globalisation and the pace, intensity and destruction of HIV/AIDS. Drawing examples from Africa, I will argue that the changes in the distribution of income and poverty and the impact of neo-liberal economic strategies, which characterize globalisation, have a direct impact on human well being and thus provide the context for the rampant spread of HIV/AIDS. It is, however, with a brief global overview of challenges posed by the pandemic that I begin my analysis.

An uneven pandemic

The current epidemiological data from the United Nations Joint Programme on HIV/AIDS (UNAIDS) confirms the strikingly patterned nature of the HIV pandemic (UNAIDS, 2003). Despite nearly 76,000 new infections last year, HIV

prevalence rate in the High Income Countries of Western Europe, North America and Japan remains relatively low, with infections concentrated principally among injecting drug users and men who have sex withy men – although recent studies indicates that this is changing. Across Western Europe, data suggests that a larger proportion of new HIV diagnoses (59 per cent, overall between 1997 and 2001) are taking place among the heterosexual community (UNAIDS, 2002c). In the case of the United Kingdom, for example, there were more than 33 percent increase between 1998 and 2001 (UNFPA, 2002a). In Ireland, a similar trend is visible, with the number of heterosexual transmitted HIV infections increasing fourfold between 1998 and 2001 (UNFPA, 2002b).

The position is more diverse across the developing world where most transmission occurs through sex between men and women, but there are also very high rates of infection among men who have sex with men and injecting drug users. In much of Latin America, HIV infections are confined largely to these sub-populations. This is also the case in Eastern Europe, the Middle East and North Africa (UNAIDS, 2002e). With particular reference to Eastern Europe where the world's fastest growing epidemic is taking place, the then Director General of the World Health Organization (WHO), Dr Brundtland, puts the risk of contracting HIV associated with injecting drug use in the following way: 'Unsafe injecting drug use [in Eastern Europe] drives very rapid expansion of the epidemic, but it also does not take long before the sexual partners of the injecting drug users become part of the steadily widening epidemic' (WHO and UNAIDS, 2003). While in Africa - where over 70 per cent of the global HIV positive population resides – the virus is spread primarily through heterosexual and perinatal transmission, with heterosexual activity being the dominant mode of transmission (Hope SR, 2001).

Beyond the differential impact of the pandemic globally, it is possible to make at least three general observations about the unique challenges posed by it. First, HIV/AIDS is at one and the same time both an emergency and chronic condition. It is an emergency because the speed of its spread has proved to be quite overwhelming. In many countries, infection rates have increased from 7 to 25 per cent in adult populations in less than a decade. In South Africa, for example, the level of infections has risen roughly ten-fold in just the last six years. Thus, before people are even aware that infected families and friends surround them, their communities have been deeply penetrated. That the pandemic is a chronic condition is demonstrated by the fact that HIV infection moves through a population giving little sign of its presence. It is only later – when substantial numbers are infected – that AIDS deaths begin to rise. Whiteside puts the position this way; 'people do not leave the infected pool by getting better as there is no cure….

the effect of life-prolonging ARVs is, ironically, to increase the pool of infected people'(Whiteside, 2002).

Second, the pandemic manifests itself both as a precise problem but also as an all-encompassing one. Its precision is revealed in its associated morbidity and mortality in increasing numbers of people - mostly otherwise healthy, productive, young people - getting sick and dying (Cohen, 2002, Collins and Rau, 2000, UNAIDS, 2002a). The response of the first two decades of the epidemic addressed this quality of the crisis. It focused on the epidemic as a health crisis and on its ramifications for health service delivery. However, the repercussions of these deaths are beginning to permeate and affect every facet of human life and national development in the regions most affected (Stillwagon, 2000, Poku, 2001). Take the case of the agricultural sector. Recent studies suggests that for all types of households in farming communities, AIDS death also brings with it loss of productive resources through the sale of livestock to pay for sickness, mourning and funeral expenses, as well as a sharp decline in crop production (Donahue, 1998, Mutangadura, 2000). Sickness also contributes to the scarcity of labour because of both the incapacity of infected workers and the time others have to devote to looking after them. In addition, the scale of the number of people dying from the agricultural communities is threatening to undermine the transmission of vital intergenerational farming knowledge in some communities. On this, a study in Kenya showed that 7 percent of farming households headed by orphans have inadequate knowledge of agricultural production (UNAIDS, 2002d).

Third, across the world HIV infectivity shows a great gender variance - with women being particularly vulnerable to contracting the virus (UNFPA, 2002b). Recent figures from UNAIDS suggests that more women then men are dying of HIV/AIDS, and also that the age pattern are significantly different for the two sexes (UNAIDS, 2002a). In the western Kenyan city of Kismusu, for example, 23 per cent of girls aged between 15 and 19 are infected with HIV, as compared with only 8 per cent of boys (Buvé, 1999). This difference persists among men and women in their 20s also, although it narrows somewhat with age. Some 38 per cent of women aged 20-25 tested positive for HIV in Kismusu, against 12 per cent of men of the same age (Williams et al., 2000). In explaining the vulnerability of women to the pandemic, a combination of factors are clearly involved, reflecting differences in biology (Seidel, 1993), sexual behaviour (Orubuloye et al., 1997, Orubuloye et al., 1993, Baylies and Bujra, 2000), social attitudes and pressures (Poku, 2001a), economic power and vulnerability (Schoepf, 1993, Smith and Cohen, 2000).

An unequal world

It is largely within the context of globalisation that one can make sense of the pandemic's differential patterns of manifestation north/south and the overt vulnerability of the countries in the latter category. Over the past decade, the utility of globalisation as a concept has been the subject of intense debate and a veritable avalanche of writings (Albrow, 1996, Allen and Hammett, 1998, Falk, 1995, Giddens, 1990). Without wishing to traverse the corpus of this literature, it is possible to see the concept as denoting a fundamental process in global politics that exhibits at least three core manifestation: first, the multiplication and intensification of economic, political, and cultural linkages among people, organisation and countries at the global level (Dicken, 1992); second, the real or perceived tendency towards universalisation of some economic, institutional, legal, and cultural practices (Falk, 1990); third, the compression of both time and space (Albrow, 1996). For many observers, even if the eventual picture remains in doubt, the principal agents of these processes are evident enough, such as globalising corporations emerging from a rapid development of super-mergers, technoscientific networks and the aesthetic architects of mass culture. At the same time, there is also a shrinking of the world brought about by the third technological revolution that has enabled us to travel both vicariously and instantaneously to almost all regions of the world (Allen and Hammett, 1998).

Manifestly, the benefits are enormous, as a result of the increased sharing of ideas, cultures, life-saving technologies, and efficient production processes. Yet, the euphoria these developments generate can often serve to disguise the very real social and economic inequalities that are not merely leftovers from the past, but are the results of the globalising process. Most obviously, global welfare inequalities have mushroomed alongside the noted advancements in technological developments and the rapid expansion of trade and investment. Take, for example, the gap in income and investment patterns over the past decade. According to the United Nations Development Programme (UNDP) the gap between the richest and the poorest 20 per cent of the world has increased to 86:1 and widens every day (UNDP, 2004). Similarly, at the beginning of this decade, the Organisation for Economic Cooperation and Development (OECD) countries held over three-quarters of the accumulated stock of Foreign Direct Investment (FDI) and attracted over 60 per cent of new FDI flows. Insofar as FDI went to the developing countries (South), it was concentrated in ten countries, with China alone accounting for more than one third. Thus foreign-investment resources are being concentrated on those countries – such as Thailand, Indonesia, Colombia, Malaysia, Taiwan – which are performing most strongly in global trade (Sachs,

2001). Eight countries that accounted for 30 per cent of developing country GDP absorbed around two-thirds of total FDI (World-Bank, 2000b). At the other extreme, the 48 Less Developed Countries (LDCs) received around $800 million in FDI in 1999 – roughly the same size as flows into Brazil, and less than 1 per cent of the total transfer to developing countries (UNCTAD 2000).

This uneven distribution of global investment patterns with its associated selectivity and polarisation of societies has given rise to: a growing gap between the rich and poor within and between nations – in particular between North and South (UNDP, 2002); the destruction of quality jobs and their replacement by casualisation and temporary jobs brought by a process of sub-contracting of so called non-core business activities (ADB, 2002); growing unemployment in particular in the developing countries, which goes hand in hand with poverty, that itself leads to more social problems (Wallace, 1999); and mass migration in pursuit of adequate standards of living (Allen and Hammett, 1998). As a result, a true process of immiseration is now observable in many parts of the world, particularly within developing countries.

The living standards of Sierra Leone – ranked bottom of the United Nations Human Development Index – are roughly equivalent to those in the west 600 years ago. The average income per head stands at only $130 a year, less than $1-a-day level that the World Bank regards as subsistence level (World-Bank, 2000a). Not surprisingly, the resulting inequalities in life outcomes are stark. The average Sierra Leonian can expect to live until age 37, a life expectancy level not witnessed in Western Europe since the industrial revolution (UNDP, 2001). Indeed, across the developing world, those living in absolute poverty are five times more likely to die before reaching five years of age than those in higher income groups (Whitehead et al., 2001). Moreover, poverty has a woman's face. Of the 1.3 billion people defined by the World Health Organisation (WHO) as the poorest - that is those surviving on less then $1 per day - only 30 per cent are male. Poor women are often caught in a damaging cycle of cultural bias and gender discrimination that further exposes them to exploitation and disease (Baylies and Bujra, 2000). Take the following passage from one woman's experience in South Africa:

'My husband lost his job about five months ago. It was a big shock but we thought we could cope. I was earning a reasonably good wage. We had to cut a few corners though. We had to eat less meat. We had to save on all kinds of things…. Then two months ago I lost my job. We were desperate. There was no money coming in now…. Now they've cut off the electricity and we're two months in arrears with rent. They're going to evict us, I'm sure, we just can't pay though. My husband decided to go to Jo'burg… I don't know where he is…. Sometimes (the children)

lie awake at night crying. I know they are crying because they are hungry. I feel like feeding them Rattex. When your children cry hunger crying, your heart wants to break. It will be better if they were dead. When I think things like that I feel worse… I'm sick. I'm sick because of the cold. I can't take my children to the doctor when they are sick because there is no money… What can one do? You must start looking. You can also pray to God that he will keep you from killing your children'(Poku, forthcoming)

Notwithstanding decades of domestic economic mismanagement with its associated corruption and violence, the culpability of global forces in shaping this disheartening reality cannot be overlooked. Take the role of Structural Adjustment Programmes (SAPs). Today, there are scant signs that the policies are achieving their desired objectives: macroeconomic stability and growth. Amid the bitter recriminations between the concerned parties - developing countries, non-governmental organisation (NGOs) and the institutions of global economic governance - it is not clear whether the lack of effective results steams from the unwillingness to undertake effect reforms from the part of the developing countries; or from the objective conditions of the economies not permitting the kind of adjustment policies being recommended. Yet, SAPs have led to a radical rationalization of recipient governments' expenditure commitments in mainly –but not exclusively – areas concerned with the provisions of welfare (i.e. the heath, education and basic sustenance such as food subsidies). Cuts in government expenditure have forced up the costs of primary education and health care beyond the reach of many ordinary people. Rushed privatisation has resulted in the laying off of tens-of-thousands of workers in many adjusting countries. The removal of price controls and the devaluation of the national currency have led to the cost of living spiralling.

In this sense the combined effects of SAP policies on the developing world has been to push millions of people already on the margins of vulnerability to adopt coping mechanisms which exposes them to greater risk of disease. In Africa, for example, Lipumba observes that the dominant 'opinion among African intellectuals is that structural adjustment programs are part of the continent's problems rather than the solution' (Lipumba, 1994). It is not difficult to see why: the promotion of exports for debt repayment and the cutting of public expenditure on welfare in a region where 200 million people are undernourished; where there is 1 doctor for nearly 40,000 people, compared with 1 for 400 people in industrial countries; and where nine out of the ten HIV infected people worldwide reside, is an embarrassment to say the least.

Perhaps the most perverse aspect of this embarrassment is unfolding in relation to the availability of international funds to bolster the resource needs to confront HIV/AIDS across the developing world. In 2003, Governments, international organizations, foundations and nongovernmental organizations spent an estimated $4.7 billion to address the AIDS epidemic in low- and middle-income countries. This represents a nine-fold increase from 1996 to 2003; from just under $ 300 million to the current level. The $4.7 billion estimate includes $1.6 billion in international bilateral assistance; $1 billion in spending through multilateral programs and the Global Fund to Fight AIDS, Tuberculosis and Malaria; $1 billion in projected spending by governments in affected countries; and more than $1 billion in spending by individuals in affected countries.

With these global resources at hand, and available resources expected to increase over the coming years (Bush Initiative, Gates Foundation, Clinton Foundation etc.), issues related to absorptive capacity has become a central political subject. The ensuing discourse emanating out of the donor organizations – particularly the Global Fund, is that people, programmes and states have a clear 'choice' to make: they can choose to take advantage of the additional funds coming on stream to upscale their treatment, care and mitigation strategies, or continue to struggle with the demands of the various epidemics they face in limited resource settings. In Africa, an increasing corollary to this 'choice' is a struggle between fiscal prudence on the part of Ministers of Finance under intense pressure from multilateral organizations (as part of SAPs), and a clear urgency on the part of Health Ministers to respond to the insatiable demands of health systems buckling under pressure from the increasing disease burden.

Uganda provides a clear example of these unpalatable alternatives. To date, Uganda's Minister of Finance has made it virtually impossible for the Minister of Health to accept additional funds from the Global Fund on the grounds that 'any new donor monies absorbed into a government sector must be accompanied by a similar reduction within the sector in order to keep the expenditure limits.' In other words, for Uganda to accept the $52 million it has been granted by the Global Fund, it will need to reduce its own contribution to the health budget. The budget will therefore remain the same, with or without Global Fund monies. Since the Global Fund is mandated only to give money for additional activities, not to replace government contribution to fixed budgets, Uganda has not gained access to the available funds. The solution proposed by Uganda's Minister of Finance – to cut into other parts of the health budget to 'make way' for the intervention approved by the Global Fund – is clearly not acceptable.

Underlying this tension between the Health Minister, on the one hand, and the Minister of Finance on the other, is a context of harsh realities. Like most African countries, Uganda, under varies SAP arrangements, has committed itself to a public health budget that cannot exceed $9 per person per year, no matter how much donors are willing to provide. This is predicated on the assumption that real development and economic growth can only take place when governments limit public spending to a percentage of their gross domestic product. However, in the context of an AIDS epidemic showing no signs of abating and demanding huge sums of public expenditure for prevention, care and mitigation strategies, the public expenditure ceilings are increasingly becoming very difficult to justify.

Globalisation and AIDS: the context of vulnerability

It is largely in this framework of uneven globalisation with its associated defencelessness that the HIV/AIDS pandemic can be situated, in terms of the social changes that transnational neo-liberalism precipitates, and relates to peoples vulnerability to, and capacity to live with the disease. In the case of Africa, for example, Sisonke Msimang provides this compelling dramatisation of the complexly interrelated relationship between history (colonial legacies) and the forces of globalisation to outline the intense vulnerability of the continent's people to HIV/AIDS:

Take some men from rural areas and put them in hostels far away from home in different countries if need be. Build excellent roads. Ensure that the communities surrounding the men are impoverished so that a ring of sex workers develops around each mining town. Add HIV. Now take some miners and send them home for holidays to their rural - uninfected wives. Add a few girlfriends in communities along the road home. Add liberal amounts of patriarchy both home grown and the colonial variety. Ensure that women have no right to determine the conditions under which sex, will take place. Make sure that they have no access to credit, education or of any of the measures that would give them options to leave unhappy unions or dream of lives in which men are not the centre of their activities. Shake well and watch an epidemic explode (Poku, forthcoming).

Three key themes from Sisonke Msimang's dramatisation becomes particularly worthy of further attention: (i) spatial changes relating to the migration of people resulting from global inequalities affecting poverty, (ii) the role of poverty in both providing the context for the pandemic to spread and retarding the possibility of effective response to it on the part of developing countries, and (iii) the gendered nature of global inequalities and its implications for the spread of HIV amongst women.

Spatial changes

The spread of HIV/AIDS is facilitated by the resultant changes in the spatial dimensions of human relations. Due to globalisation, a number of major developments in global migration patterns have placed the phenomenon at the heart of the spread of HIV/AIDS (Poku and Graham, 2000). First, the scale of movements has increased exponentially (Cohen, 1997). In the 1960s only a handful of countries, mainly the traditional immigration nations of North America and Oceania, were significantly affected by international mig ration, but by the late 1990s more than 22 per cent of the world's population was living outside of their country of birth, and virtually every nation was influenced in some way by immigration or emigration of various kinds (UNHCR, 1998). Secondly, there has been an enormous increase in the diversity of international population movement (Hugo, 1997). Whereas in the past the bulk of such movement involved permanent, or at least long term, settlement at the destination, world migration is now characterised by not only increased levels of permanent settlement in foreign countries but also by a myriad of temporary, circular migrations of varying duration with a range of largely economic purposes from mainly rural to urban areas.

The dislocation of so many millions of people from their traditional places of residence stems - in large part - from the gross inequities in global distribution of wealth identified earlier (Chirwa, 1998). Across the developing world, the development paradigm imposed through SAP has focused on exporting agricultural products and minerals (Poku, 2002b). The plantations, mines and industries, though development enclaves from one point of view, have required and attracted massive quantities of labour not only from the traditional rural areas, but also from neighbouring and regional states. Decosas and Adrien note that migrants have higher infection rates than those who do not migrate, independent of the HIV prevalence at the site of departure or the site of destination (Decosas and Adrien, 1997).

The mining community in Carletonville, South Africa, is a tragic but powerful reminder of how mobility provides an environment of extraordinary risk for HIV infection. With a mine-working population of 85,000 people, of whom 95 per cent are migrant workers, Carletonville is the biggest gold-mining complex in the world. These migrant workers leave their families behind in rural villages, live in squalid all-male labour hostels and return home maybe once a year. Lacking formal education and recreation, these hardworking men rely on little else but home-brewed alcohol and sex for leisure. For these men, there is a 1 in 40 chance of being crushed by falling rock, so the delayed risk of HIV seems comparatively

remote. Astonishingly, some 65 per cent of adults in Carletonville were HIV-positive in 1999, a rate higher than any region in the world (Williams et al., 2000). When these men return back to their families, they often carry the virus into their rural communities. A study in a rural area in the South African province of KwaZulu-Natal, for example, showed that 13 per cent of women whose husbands worked away from home two-thirds of the time were infected with HIV (Morar et al., 1998). Among women who spent two-thirds of their time or more with their husbands, no HIV infection was recorded (Lurie et al., 2000).

Poverty and HIV/AIDS

Poverty affects the course of HIV/AIDS in three fundamental ways: The first of these is the existence of undiagnosed and untreated sexually transmitted diseases among many of the poor. Take the case of Africa. Data for 2003 indicate that the continent has the highest incidence of curable STDs at 284 cases per 1,000 people aged 15–49 years, compared to the second highest of 160 cases per 1,000 people in South and South-East Asia (WHO, 2003). There is now growing recognition of the public health implications of curable STDs (especially those causing genital ulcers) by virtue of their frequency of occurrence as well as their ability, when present, to facilitate the transmission of HIV (World-Bank, 2000c). One study suggests that the presence of an untreated STD can enhance both the acquisition and transmission of HIV by a factor of up to ten (Mutangadura, 2000). Such painful bacterial STDs are relatively uncommon in rich countries because of the availability of antibiotics. Yet, in the developing world, even when the poor have access to health care, the clinics may have no antibiotics to treat those bacterial STDs that act as cofactors for the transmission of HIV.

Second, the nature of poverty leads to outcomes which expose the poor to a higher probability of contracting HIV. Poverty, especially rural poverty, and the absence of access to sustainable livelihoods, are factors in labour mobility – a key function of globalisation (Whiteside and Sunter, 2000). The dynamics through which labour migration and HIV reinforce each other have been laid out above.

Third, poverty structures not only the contours of the pandemic but also the outcome once an individual is sick with complications of HIV infection. A feature of HIV infection is that it clusters within families, often resulting in both parents being HIV-positive, in time falling sick and dying. Poor families have a reduced capacity to deal with the effects of morbidity and mortality than do richer ones, for very obvious reasons. These include the absence of savings and other assets that can cushion the impact of illness and death. The poor are already on the margins of survival, and are unable to deal with the costs associated with HIV/

AIDS. These include the cost of drugs—when available—to treat opportunistic infections, the cost of transport to health centres, reduced household productivity through illness and diversion of labour to caring roles, loss of employment through illness and job discrimination, funeral and related costs, and so on. In the longer term such poor households may never recover even their initial level of living, since their capacity is reduced through the loss of productive family members through death and migration, and through the sales of any productive assets they once possessed. As a result, a true process of immiseration is now observable in many parts of the developing world, particularly southern Africa.

Feminisation of HIV/AIDS

The gendered dimension of deprivation noted earlier becomes particular significant in considering women's vulnerability to HIV/AIDS. Today, more women than men are dying of HIV/AIDS and the age patterns of infection are significantly different for the two sexes (Gupta, 2000). Current trends indicate that existing gendered disparities in access to and control over resources are being exacerbated by AIDS. Resources are defined broadly to include information, decision-making, power, educational opportunities, time, income and other economic resources (such as land, the capacity to inherit, or credit), as well as internal resources (such as self-esteem and confidence). Access is having a resource at hand, while control is the ability to define and make binding decisions about the use of a resource (WHO 2002).

There are, however, profound differences in the underlying causes and consequences of HIV/AIDS infections in men and women, reflecting many of the uneven facets of globalisation noted earlier. Of particular importance here, is the fact that, worldwide, there are increasingly more poor women than poor men, a phenomenon commonly referred to as the 'feminisation of poverty' (Doyal, 1995, Doyal, 2002). As a result, we are seeing differential vulnerability to HIV – with young women showing the highest incidence. This is the direct result of women's lack of autonomy in sexual decision-making and violence against women both of which intersect with women's poor economic situation which makes negotiation of sexual relations difficult. That society condones such violence; that women's subordinate position is normative both attest to women's status as second-class citizens in society.

Imagining for a moment society's response to the full citizen, that is to men, it is hard to envision social acceptance of generalised rape of men; of men having to carry a pregnancy to term which resulted from coerced sex; of men being thrown

out of the homes they have created and the relationships they have nurtured simply because they get sick. Yet this is the conditions of women. As a result, we are seeing differential impacts of HIV, with women more likely to be stigmatised and left without care; more likely to face financial difficulties in accessing treatment or care; more likely to be engaged in a form of income-generation which offers no legal protection and no medical aid. At the community level, women are least likely to be influencing the priorities and budgets of local public institutions, whether local government, health care or schools or local religious institutions or civic groups which shape the 'community' response to HIV/AIDS. Yet, women are most likely to be putting in more time and more strategic thinking on how to create a spiritual, domestic and reproductive environment within which those who are sick and dying, and those who have lost parents, guardians or children have to cope and create futures for themselves. So it is women who are the vast majority of care-givers, both informally and through programmes of care in Africa.

Take Zuki's example in South Africa:

She works as a security guard at a shopping centre in Johannesburg. Everyday she spends two hours getting to work because of the distances apartheid's architects put between city centres and townships that serviced them. Zuki is grateful to have a job. Her two little ones are in KwaZulu-Natal with their grandmother until Zuki can get stable work. She is on a month-to-month contract with the security company. She watches expensive cars all day, protecting their owner's investments while they work. The company doesn't want to take her on as staff so each month she faces the uncertainty of not having a job the next month. Joining a union is not an option- she's not technically a staff member and anyway, she can't afford to make trouble. Zuki's boyfriend Thabo drives a taxi. Their relationship saves her cash because he drives her to and from work every day - a savings of almost one third of her salary each month. She has another boyfriend at work who often buys her lunch. She has to be careful that Thabo doesn't find out. But last month Zuki discovered that she was HIV positive (Poku, 2004).

Zuki's story details the vulnerability of millions of women across the developing world who are so-economically marginalised that they are reduced to exchanging sex for money, food, shelter and other necessities – with its associated risk of

HIV infectivity. In a study of low-income women in long-term relationships in Mumbai –India, the women believed that the economic consequences of leaving a relationship that they perceived as risky were far worse than the risk of contracting HIV/AIDS (Gupta, 2000).

Where do we go from here?

It is clear from the above review that significant changes have been taking place in the world economy that have major social, environmental and public health implications. The globalisation of capital is a central feature underpinning these changes. The momentum of globalisation is linked to accelerated technological change and consumerism; and to the policies of national governments and global corporations. In its negative aspects, globalisation generates strong pressure on nation-states to remove regulations concerned with national protection and the development of local industry. Globalisation creates downward pressures on wage rates and tax levels, increases socio-economic inequalities, and can contribute to poor health outcomes and increased mortality. The pursuit of a 'level playing field' for global corporations accentuates other imbalances: between capital and labour, between economy and environment, and between the private power of corporations and the democratic institutions within nation-states. These contradictions make the process of globalisation intensely political. Not surprisingly, therefore, responses occur at various levels—global, national and local—and this opens up the possibility of a truly progressive globalisation: of human rights, of environmental consciousness, and of a global redress of the causes of health inequalities.

In the face of a pandemic that, in a short time has already killed more people than all the wars of the twentieth century combined, we cannot remain silent about the factors that either directly or indirectly contributes to its devastation. To be clear, globalisation is not to blame for global AIDS. Blame, if there is one, must reside with humanity's apparent inability to modify sexual behaviour sufficiently to halt the unremitting march of a sexually transmitted disease. But, the underlining societal causes are much broader and familiar and all related to either the process of globalisation or the actions of the dominant agents driving the process. Take the case of poverty, as we have noted, poverty structures not only the contours of the pandemic but also the outcome once an individual is infected with HIV. Thus, until poverty is reduced there will be little progress with either reducing transmission of the virus or creating an enhanced capacity to cope with its socio-economic consequences.

It follows that sustained human development is an essential precondition for any effective response to the HIV/AIDS pandemic. Herein lies the predicament: how to achieve sustainable development in a polarised world. A world, underscored by a tectonic struggle between two competing ideological projects: on the one hand, there is the neoliberal project, concerned with firstly disembedding the market from political influence, and secondly expanding its reach across social institutions. On the other hand, there is a social-democratic project concerned with the delivery of welfare provisions on a more egalitarian basis rooted in conceptions of social justice. In the context of global marginalisation, however, the disconnect between these two ideological projects appears incredibly perverse, even more so, given the fact that both project purports to advance a universal notion of right to basic services.

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