AIDS, capitalism and oppression

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Infectious diseases have long inflicted suffering and misery on the human race. Today in semi-colonial countries infectious diseases are all too familiar, estimated to be the cause of death for 17 million people (45% of all deaths in such countries) each year. Deprived of the resources necessary for the provision of elementary sanitation the masses of the semi-colonies have all too often become the helpless victims of infectious diseases.

At the same time they have been blamed for the spread of such diseases because they are ‘dirty’, incapable of looking after themselves and careless in infecting others. The victims are turned into scapegoats. Reality is turned on its head. They are blamed for the appalling conditions under which they are obliged to live, conditions that do allow epidemics to spread, thus absolving the system of capitalist and imperialist super exploitation and oppression of any blame. Yet it is precisely these social and economic factors that are the root cause of the poverty and filth that facilitate the spread of disease.

For many people in the imperialist west the prospect of killer epidemics haunting their daily lives appeared to have receded in the post-war period. Welfare capitalism, created in the context of the long post-war boom, seemed to have relegated epidemics of infectious diseases, like tuberculosis, to the realm of memory. Ten years ago the recognition of a new condition, first described in the USA, significantly altered this situation. Within five years of first being described, the acquired immune deficiency syndrome (AIDS) had become the single biggest cause of death in young men in major urban centres such as New York and San Francisco. This rapid increase in the number of cases, with the early years of the epidemic seeing a doubling in number of cases every eight to ten months, brought home to many in the west the lethal potential of communicable diseases.

The impact of this new disease has been dramatic. AIDS, unlike the other major infectious diseases, preferentially attacks young adults, a vital and numerous section the economically active population. With an estimated five to ten million people in Africa already infected, and few resources to prevent further spread, AIDS will have a major impact on the economy and the demography of the continent.

This article looks at the developments over the last decade, and in particular the increasing evidence that AIDS, like other infectious diseases, is associated primarily with poverty, deprivation and oppression.

Ten years of the ‘gay plague’?

On the 5 June 1981, the Morbidity and Mortality Weekly Report from the Centre for Disease Control in Atlanta, USA, reported the first cases of a disease which was to kill over 100,000 in the USA alone over the next ten years. Two young men in Los Angeles had been treated for pneumocystis carinii pneumonia, a rare infection. All five had evidence of a defective immune system. At about the same time 26 cases of Kaposi’s sarcoma, a rare tumour also indicating immune suppression, were reported. Initial investigation of these two separate reports revealed all those affected were gay men. Further investigation and
identification of other related conditions led to the definition of the new syndrome, AIDS.

Early speculation about the cause of the disease focused on the sexuality of those affected. Gay related immune deficiency (GRID), as it was initially dubbed, was thought to be the result of some aspect of the lifestyle of gay men in the USA. Those doing the speculation knew little about gay culture, but leapt to conclusions about the possible causes, such as immune suppression due to repeated infection with sexually transmitted diseases, or due to frequent partner changes, too much taking of recreational drugs and too much anal sex.

In general these theories revealed not only a lack of knowledge about the disease, but also a prejudice against gay sexuality. If it wasn’t anal sex itself then it was blamed on too much high living and too many late nights. Revelations about the large numbers of reported partners that some of the men with AIDS had fuelled bigotry against homosexuality and its associated ?unnatural? and ?perverted? practices. The press ran sensationalist articles on the ?gay plague? and rabid Christians voiced the views of many when they cried ?this is God?s retribution?, and felt themselves immune as a result.

When the same syndrome was described in other groups it became apparent that such speculation was erroneous, and that the most likely cause was an infectious agent, transmitted through sex or via blood products. By 1983 the virus which causes AIDS, the human immunodeficiency virus (HIV) had been identified. Even then, the official and media sponsored belief that the disease was in some way the fault of those affected continued to play a large role in shaping the general attitudes towards people with AIDS and acted as an obstruction to efforts to tackle the epidemic. Even now the term ?innocent victims? (children, or those infected through blood transfusions) remains in common usage and perpetuates an idea that there must continue to be a ?guilty? party for whom sympathy is correspondingly reduced.

The early concentration of the disease amongst gay men and injecting drug users in North America and Western Europe led to a particular type of response. Firstly, it was to assume that only they were at risk, and to direct all interventions towards them. In response to the inadequacies of these programmes governments flipped over and launched prevention campaigns which argued that everyone was at risk, and that each individual was responsible for changing their behaviour. If they did this, so it was claimed, the epidemic would be controlled. The Tories? ?Don?t Die of Ignorance? poster and television campaign in Britain was a clear example of this second stage response.

Neither approach is valid. HIV and AIDS continue to disproportionately affect gay men and drug users, and it is essential to direct resources towards providing care and promoting risk reduction through health education, condom distribution, and drug treatment and needle exchange programmes. But if this was the only possible intervention to prevent the further spread of the epidemic then the way in which HIV is increasing most rapidly at the moment?through heterosexual transmission, particularly to women?would not be affected. However, it is false to then suggest that all heterosexuals are at equal risk and that the epidemic will only be contained if everyone starts to use condoms or stick to one partner for the rest of their lives. Such an approach is not sustainable, and the reality is that some people, and groups of people, are more at risk of contracting HIV than others. This is not simply because they are failing to do what the safer sex campaigners tell them, but is related to their social situation, the single most important factor in the spread of the disease.

Gay men were one such group at increased risk of HIV, and as a result of a big change in the norms of sexual behaviour amongst many gay men the risks of catching HIV have decreased considerably over the past five years. More recently the disease has begun to increasingly affect other sections of the population. The figures for HIV infection in the USA reveal that cases are concentrated in urban areas, with highest levels in the poorest most deprived parts. People with HIV are likely to be poor, with blacks and Latinos
more at risk than whites. AIDS is therefore developing a pattern similar to that of other infectious diseases in the industrialised countries, such as tuberculosis and other sexually transmitted diseases (STD) like syphilis and gonorrhoea, which are also concentrated amongst the urban poor.

The reasons for this concentration of disease amongst the poor are many, and do not only relate to AIDS or other infectious diseases. The association between poverty and ill health is well established, and the major improvements in the general health of populations are known to occur when the overall standard of living improves. For example, better housing and improved nutrition are cited as the reasons for the massive decline in mortality from tuberculosis since the 1850s in Britain, with the development of specific treatments and a vaccine making a much smaller, albeit important, contribution after 1950.3

Social conditions which facilitate the spread of HIV are likely to be very complex, relating not to housing and sanitation, the key to many infectious diseases, but to patterns of sexual behaviour. Many medical and behavioural scientists are addressing the question of why certain people are more at risk than others. A recent account of the epidemiology of STD stated:

"In most industrialised countries the incidence of classical STDs such as gonorrhoea and syphilis has been declining rapidly during the AIDS era among educated middle and upper classes, while in North America, the incidence of the same STDs has been stable or actually increasing within selected population groups of lower socio-economic status, perhaps among those least likely to modify behaviour. Thus in the United States both a relative and absolute increase of STD rates has occurred among urban, poor and minority populations, particularly among adolescents, with highest rates among adolescent females. Prostitution has re-emerged as a multiplier of STD, and the relatively new phenomenon of sex in exchange for drugs is contributing to the epidemic spread of gonorrhoea, syphilis and chancroid in North America." 4

These authors describe the associations well, but continue to look at the problem in relation to individual risk behaviour. There are likely to be many reasons why AIDS and other STDs are more common amongst the inner city poor, but behavioural scientists have tended to concentrate on individual behaviour as the key, and interventions are directed towards finding better ways of persuading people to comply with the general advice. One result of this approach is that those who fail to change their behaviour are labelled as somehow deviant and then blamed for their acquisition of disease.

Take the example of a young woman who takes up prostitution in conditions where she has little alternative form of income. If she becomes infected with HIV through drug use but continues to work as a prostitute she will be regarded as immoral by many people. If she agrees to have sex with clients without condoms she is then considered even more deviant and blamed for spreading HIV to the "general population." In this situation it is not necessarily lack of knowledge about how to avoid catching or transmitting HIV which is the problem, but the lack of alternative options for an income. This is combined with the effect of a social norm in which the prostitute is regarded as deviant, and is consequently criminalised, more likely to be associated with drug use and drug users, whereas the client is regarded as a normal family man who should be protected from disease by the good behaviour of the prostitute.

This example is given to illustrate just some of the factors which influence the risk of HIV being spread. In the end it is individual behaviour that determines whether the virus is transmitted, but this behaviour is itself the result of social factors which are not directly amenable to change simply through well meaning safer sex campaigns.

Understanding the exact nature and role of these social factors is decisive for developing a coherent and effective response to the AIDS epidemic, yet they are continually ignored in capitalist society. If AIDS was simply comprehensible in terms of a direct association between its spread and the poverty of people who
have it then the social dimension might have been more readily recognised. But for gay men with AIDS poverty isn’t the decisive factor. Their social oppression, capitalism’s oppression of them as homosexuals, plays a central part in the pattern of AIDS.

Homosexuality has been legalised, within limits, in a number of capitalist countries. But nowhere is it accepted as a valid form of sexuality. Gay men and lesbians are denied a whole range of legal rights because of their sexuality. Their relationships are stigmatised as unnatural. Their ability to form relationships, express affection and engage in sexual activities, are all restricted, both legally and by the promulgation of officially sponsored prejudices. In Western Europe and North America these restrictions kept millions in the closet for decades. And today, despite the relative liberalisation of attitudes that occurred in the 1970s, fear continues to keep untold numbers in the closet. The climate of sexual reaction that has developed over the last few years is reinforcing this fear.

The sexual behaviour of gay men is shaped by this oppression. Casual sex, often with large numbers of partners, was for many gay men the only possible form of sexual outlet. John Shiers expresses this well:

> Casual sex has been a constant in the life experience of, I would guess, the majority of men who have desired other men and done anything about it down the ages. It takes place whether the participants define themselves as homosexuals or not. It is a direct consequence of living in societies which deny men the right to openly love other men. 5

For many men, especially if they were in the closet, their inability to openly express their desires means that their sexual encounters can be nothing other than casual, and secret.

In addition to these reasons for the high incidence of casual sex amongst some gay men we should recognise the gay community’s conscious attempt to challenge the stifling morality of bourgeois society, one aspect of which was to deny their sexuality any validity whatsoever. In reaction to this many gay men fought back by breaking with the morality of monogamy, which they correctly identified as oppressive, and asserted their right to a flourishing and liberated sexuality. These aspects of gay lifestyle that developed, in particular in Britain and North America in the 1970s, did not cause AIDS or HIV in the way that the bigots claim. They did, however, lead to a particular pattern of sexual activity which facilitated the rapid spread of STD, including HIV. But oppression also meant that the social cohesion of the group was sufficient for behaviour changes, through promoting alternative and safer forms of sex, to be very effective through the strong networks which had developed in response to oppression.

Any understanding of the pattern of disease in a society therefore has to look at the interrelationship of oppression, poverty and social norms. In short, it has to appreciate the role of the structure of society, fundamentally the existence of class and social oppression.

The global pattern of AIDS

The vast majority of cases of AIDS reported to the World Health Organisation (WHO) are from the Americas, with almost 200,000 of the world total of 334,215 cases. But these figures hide the real burden of AIDS and HIV which falls on the oppressed semi-colonial countries which already suffer the ravages of other infectious diseases. The official figures are those which get reported to the WHO. Reporting is best from the wealthiest countries, worst from those which neither have the resources to diagnose the disease, nor the infrastructure to collect the information and produce regular accurate reports.

WHO estimates suggest that as many as six million people may be infected with HIV in Africa alone.6 Such estimates should be treated with caution, but whatever the true figure, it is clear that the burden of
AIDS is massive in Africa, and rapidly increasing in Latin America and Asia.

When AIDS was recognised in sub-Saharan Africa in the early 1980s it was apparent that the pattern was very different to that observed in North America and Western Europe. There were approximately as many women as men affected, and transmission appeared to be primarily heterosexual. The commentators leapt to their conclusions, using the same logic that blamed 'unnatural?' practices for AIDS amongst gay men in the west, to blame 'primitive?' practices for AIDS amongst Africans. Racism and prejudice led to assumptions about the causes for heterosexual transmission being so common. Firstly, there was the idea that all Africans practiced anal sex as a form of contraception, making them guilty of the same 'unnatural?' act as gay men in the west. No-one ever produced any evidence for this claim, which is now totally discredited. But this is the kind of racist theory which gets widely reported in the press and never repudiated. Next came the idea that all Africans are promiscuous, based on the hoary old racist belief that 'civilised?' society was a product of the west (read Christianity), and that these people were savages from whom primitive behaviour was to be expected.

All of these suggestions were found to be false, all were based on prejudice rather than on any knowledge of the cultures involved. Black people in general, and Africans in particular were the subject of considerable abuse in the west as a result of these claims.

The rapid spread of HIV in some populations in urban centres of Africa was certainly remarkable. In the early 1980s the proportion of prostitutes with HIV, in one area of Nairobi, rose from 4% in 1981 to 61% by 1985.7 But this was not limited to examples in Africa?similar rapid increases amongst selected groups occurred amongst young injecting drug users in Edinburgh in the mid-1980s and in Thailand in the late 1980s.

HIV and AIDS in Africa are concentrated in urban areas, associated with high levels of other STDs. Spread is through heterosexual contact, and significantly also from infected mothers to their children, where the virus can be passed on around the time of birth, and through infected blood transfusions.

Why is AIDS spreading so widely and rapidly in Africa? As in the imperialist countries, HIV and AIDS are not only related to absolute poverty, they are also closely associated with social oppression and indeed with exploitation and work. Again we are faced with the complex relationship between disease, poverty and, in this case, the particular impact of imperialism.

The spread of HIV seems to be assisted by conditions of urban deprivation in both the imperialist countries and the semi-colonies. Spread does not occur so rapidly in rural areas. In Zaire, for example, the level of HIV in the rural Equateur region remained stable at 0.8% from 1976 to 1986, whereas in the town of Kinshasa the level rose from 1% to about 6% in the same time period.8 Many towns in Africa are experiencing rapid growth as a result of migration from the countryside. Rural communities are being disrupted and people driven off their land as a result either of the land being taken over for agri-capitalist ventures or because the land is no longer capable of sustaining them, itself a result of over exploitation of the land for years. In addition the development of urban industry in parts of South and East Africa has led to the migration of men producing a large male to female ratio in the population.

The differences in social structure of the rural and urban populations are considerable. Relatively stable family groups in rural settings are disrupted by migration to towns, just as they were in nineteenth century Britain. Prostitution increases with women migrating to towns and unable to find alternative work, and with men separated from families. The pattern of sexually transmitted diseases in these urban areas is similar to that seen in the past where large military settlements occur near cities. In this situation much sexual activity occurs in temporary relationships, whether with prostitutes or others, and the potential for
transmitting infections is consequently increased.

The conditions for a rapid spread of any sexually transmitted disease therefore exist in many cities. The pattern of spread in Africa is being repeated in South America and in Asia where, although there are far fewer people currently infected, the conditions exist for a similar spread. In India cities such as Bombay have massive populations of prostitutes, often very young and many are literally bonded labour?slaves kept in brothels, again providing the conditions for a rapid spread of HIV. Here the relationship with work and exploitation is obvious. People kept in conditions of slavery have no ability to influence their work practices to make them safer. But even prostitutes who are ?free?, either working independently or working for a brothel or some other manager, are not necessarily able to insist on safe working practices which would protect themselves and their clients from infection. The managers of the business may determine the rules, or they may be the result of the norms of the business. If all the prostitutes do not follow the same rules (insistence on condom use for example), then one who wishes to is likely to be out of a job if she continues to insist.

The relationship of risk of infection to social oppression is also considerable. The use of condoms to stop the transmission of HIV is being promoted across the globe, and many of the messages are directed specifically towards women. In all cultures sex is related to economic ties, whether through marriage and the family with the mutual dependence of its members, or through prostitution where the commercial nature is more overt. But in the majority of situations women are economically dependent upon men, and this power relationship influences sex. Women are often not able to set conditions upon sex, such as insisting that condoms are used, without risking the economic relationship. Again, the emphasis of interventions on persuading people to change their behaviour is utopian and can be harmful in situations where that behaviour is an integral part of a wider relationship or organisation of society.

In developing countries the average family size is much higher than in the imperialist countries, and the links between marriage, sex and reproduction is much stronger. The continuing influence of family structures based on the norms of peasant society underlies, and continually reinforces, these links. In an interview in New Scientist, Rahma Tozin, a doctor from Kinshasa, relates low levels of condom use to the pressure on women to have children:

?The woman is very afraid that if she is not having a baby, the husband is going to have the baby outside. The baby is a very important element in married life in Africa.? 9

This is clearly a problem when one or other of the couple has HIV, but even when the woman wants to use a condom Tozin suggests that she has little option:

?We are talking about women who are not economically independent . . . there is no way, culturally, that a married woman can ask her husband to use a condom.? 10

This is not just a cultural problem for women in Africa as Tozin implies, but is the norm for women around the world. Lack of control over decisions about childbirth, contraception and particularly abortion, is integral to the socialisation of women. The extent to which women are denied control over their fertility and the particular form this denial takes vary widely, but the general nature of women?s oppression ensures that in all cultures it exists. It is completely utopian to expect women to suddenly throw off this oppression and take the lead in making decisions about the use of condoms, whilst they are at the same time denied the right to decide whether or not to have a child. As with gay men in North America and Western Europe, therefore, the central issue is social oppression.

**Imperialism and the continued spread of HIV**
The decade since AIDS was first described has seen an unprecedented speed of advance in scientific knowledge about HIV and AIDS. Large amounts are known about the clinical progress of people with AIDS and HIV, and already treatments exist to slow down the reproduction of the virus in infected people. The average survival time for people with AIDS in the west has doubled with improved treatment. Trials are underway for vaccines which may control the spread of HIV.

This progress is remarkable, and testimony to the capacity of human application of science to a new and challenging problem. But whilst these scientific advances continue, the application of the most simple control programmes to reduce transmission of HIV are not being implemented in the developing countries.

One method of transmitting HIV is through blood transfusions. Whilst in the UK we read of litigation against the government to get compensation for people infected through blood transfusions in the early 1980s, before the virus could be detected in blood, many countries in Africa are still not able to screen all blood. In Kinshasa, for example, the level of HIV in the population as reported above is about 6%, but less than 30% of blood is screened for HIV before being given.11 This means that thousands of people are continuing to be infected with HIV in a way which is easily preventable. The obstacle to this is lack of resources.

At an even more basic level, hospitals and health centres in many developing countries do not have sufficient resources to buy sterile disposable equipment for injections and transfusions, thereby increasing the possibility of people being infected as a result of receiving treatment for some other condition. Health workers are also at risk because there are inadequate supplies of gloves and other protective equipment for use when caring for people with HIV.

Again it is due to lack of resources. Some of the countries in Africa which are worst affected by AIDS are the poorest in the world. This is reflected in the amount spent each year by governments on health care. In Zaire, for example, the annual per capita expenditure is $0.90, in Burkina Faso it is $1.20, India $0.95, Argentina $7.90. This compares with $425 in Italy and $498 in the USA (excluding private health care).

The decisions about where to direct such meagre resources in these countries pose impossible contradictions. The cost of treating people with AIDS competes with the cost of preventing transmission through screening blood or promoting condom use.

The lack of money for health care is seen even more starkly for other diseases. Of the 10.5 million infants and children under five who die each year from infectious and parasitic diseases, four million are from diseases for which safe and effective vaccines already exist. Measles, whooping cough and tetanus can be prevented by vaccinating children, but the vaccines are not distributed where they are most needed. Measles vaccine is now being given to all children in Britain in an attempt to eradicate the disease. In fact it is usually a mild disease here, but the decision to spend money on vaccinating everyone was taken to try and prevent the relatively small number of cases in which measles leads to serious long term health problems. In the semi-colonies the pattern is completely different with measles killing an estimated two million children in 1985, because of inadequate money being provided for vaccination programmes.12

Hepatitis B infection is another serious disease for which a vaccine exists. The vaccine was licensed ten years ago and is targetted in Britain towards those thought to be at highest risk?health workers, patients on renal dialysis, drug injectors, gay men, prostitutes. The places where the vaccine is most needed, countries such as Africa and Asia where hepatitis B is common in the whole population, have been unable to use the vaccine. It is produced and distributed by a drug company which charges high prices which the countries most at need can little afford.

These inequalities are now being replicated in relation to AIDS. The desperate search for a vaccine or a
cure? is the hope of everyone in the imperialist heartlands where we can all anticipate that once developed a vaccine will be available to those of us who need it. But for the majority of the world’s population, including those who are at most risk of AIDS, the development of a vaccine will just further highlight their exploited position.

Many of the groups that are working on vaccines are financed by drug companies who are racing to get the first licence, and with it no doubt the biggest profits, just as Wellcome did with the development of AZT. The needs of these companies have a big influence on the type of vaccine research that they will fund, and for a vaccine against HIV this may mean that once developed it will not be useful in Africa. HIV has many different strains. One vaccine type is unlikely to be suitable for all areas, and to date almost no-one has focused vaccine work on African strains of the virus. Professor Peter Piot from the Institute of Tropical Medicine in Antwerp suggests that, ‘the groups that are working on [a vaccine] are not interested in developing one for the third world’.13

Where vaccines are developed they will need big field trials, and, notwithstanding the problem of their usefulness in Africa, it is very likely that many researchers will suggest using African cities for this experimentation. Whilst this could well be scientifically valid for some trials, the fact that they will be carried out by western researchers, essentially testing a product for marketing in the west means that the African countries and the people experimented on will get little benefit and may get all the side effects. Drug companies prefer trials in third world countries because the chances of them being caught up in litigation as a result of side effects are far less than in the west, and the cost of trials can be reduced by employing cheap local labour to work on the project. In such trials the supplies of the vaccine are free for the period of the study, but once the produce is licensed the costs become so high that these same countries would be unable to implement an effective vaccination programme for the population.

The health workers in these countries are well aware of such dangers and have put up strong arguments against the misuse of trials in Africa, but of course they do not want to obstruct research which could lead to a real breakthrough in vaccine development. The contradictions are real and cannot be solved by simply urging the drug companies to act in a more responsible way. They are, after all, in business to make money, and whilst that situation remains, and they have such widespread control over the direction of research and development spending, resources will not be distributed according to human need and rationally determined priorities. The training of local researchers with adequate funds to develop drugs and vaccines in the third world is the understandable demand of those who work in these countries, but the fundamental obstacle to this is not just the policies of drug companies or international research agencies, but imperialism itself.

The lack of resources for health care and research in Africa and Latin America is not because these countries are naturally ?poor?. Most have massive natural resources which is why the colonialists, followed by the imperialist magnates and financiers have systematically conquered, plundered and subordinated them. These countries provide cheap labour and cheap natural resources which can be exploited by the big businesses of the west. But in setting up mines, or processing plants, or big agri-capitalist enterprises, the imperialists do not then plough back the profits into developing the infrastructure of these countries, to provide basic housing, schooling and health care. The result is the creation of massive urban shanty towns, of rural wastelands and a huge army of semi-employed or unemployed workers who have been driven off their land. The investment required for basic infrastructural development, such as that spent in England in the nineteenth and twentieth centuries to provide a reasonable standard of living for the bulk of the working class, is sucked out of these exploited countries.

In Latin America the recent outbreak of cholera shows the results of such exploitation in human terms.
Hundreds of thousands of people living in squalid conditions around the cities of Latin America, with little or no sanitation, are bound to be at risk from infectious diseases. There will be no fast cure for this?no magic drug to solve the problem of disease but leave the economic and political situation of the masses unchanged.

In Britain such social problems existed for the working class in the nineteenth century when cholera, smallpox and syphilis were rife in London. In such situations disease can also threaten the wealthy, although not in such large numbers, but it also undermines the basis for capitalist development by weakening the working class, the essential source of profit. The British capitalists were forced through the pressure of the organised working class, but also through the need to develop their own industries, to improve the conditions for their workers. Better housing, sanitation, health care, education, improved working conditions and the shorter working day all developed and gradually reduced (though never eliminated even to this day) the threat and burden of disease.

But capitalism has shown time and again that it is not able to carry through such progressive changes consistently and globally. Indeed the investment which made possible the improvements of the lives of the working class in the imperialist countries was funded by the very exploitation of the workers in the colonies and semi-colonies, and the super-profits which the capitalists are able to make there.

Now countries in Africa and Latin America are facing enormous economic problems. They are crippled by debts to the imperialist banks, and told to introduce austerity programmes in order to pay. The cholera epidemic in Peru comes at a time when public spending has been savaged repeatedly in economic packages designed to meet the demands of the world banks and the IMF. In Africa health care is so underfunded that the demands placed upon services by thousands of people with AIDS is undermining their ability to treat other diseases. In some hospitals, in Zaire for example, up to 50% of all beds are now taken up by people with AIDS. There has been no increase in the number of hospital beds which means that they can treat only half as many people with other diseases as they did ten years ago.

As AIDS selectively kills young adults the impact of the disease on the economies of these countries will be dramatic, and worsen an already desperate situation. Millions of children are likely to be orphaned over the next years as one or both parents die of AIDS. Older relatives will have to care for these children who may themselves also be ill with AIDS. The economic impact of this on communities is already enormous. Those who have HIV and are still healthy also face problems with companies beginning to institute pre-employment screening programmes and not allowing those with HIV to work.

Conclusion

AIDS has to be seen in context. In the west it appears as a major threat, the biggest public health problem witnessed for years, as it strikes down young adults who we have come to expect to be safe from the horrors of plague. AIDS has been used to reassert a sexual morality which stresses monogamy and heterosexuality. Homosexuality, drug use and prostitution have been further stigmatised. As the epidemic develops it is becoming focused on those sections of society who suffer most, those in the inner cities who have missed out on the fruits of imperialist prosperity.

In the imperialised and exploited world, the conditions have proved ripe for a massive epidemic, which adds further to their health care and wider economic problems. The epidemic puts into sharp focus the widening inequalities created by imperialism.

Medical science has made great advances in the understanding of AIDS and HIV. But at the level of developing interventions to tackle the spread fundamental problems exist which are not being addressed.
The focus of prevention is currently on behaviour modification?if we all adopted the safer practices explained on the leaflets then HIV would be stopped in its tracks. Behavioural scientists are studying the best ways to achieve such change, experimenting with different messages and media for the intervention. But the major weakness of such approaches has been their inability to deal with the social relations in society which ultimately shape most people?s behaviour. Persuading people to use condoms for all vaginal, anal or oral sex will certainly cut down on the spread of infection. But far more influential on the spread of disease is the structure of the society; the fact that, for example, there are 50% more men than women in many cities of Southern Africa, that families are not able to live together, that the men live in factory dormitories and that the women who migrate to the same cities have little alternative to prostitution as a way of earning money. Likewise for gay men, behavioural solutions can have only limited value so long as social oppression continues.

Interventions which stress the screening of all blood before transfusion and the use of disposable needles are very sensible, as are those which urge health workers to take special precautions when dealing with people who have HIV. But as the WHO tries to develop such basic interventions on the one hand, its own funders, primarily the USA, are clawing money out of these countries to pay back debts, leaving them unable to carry out the programmes.

Only the destruction of capitalism, imperialism and the social oppression integral to the capitalist system can create the conditions for a society that will direct the necessary resources to health care and disease prevention to a degree sufficient to minimise the threat of infectious diseases to the mass of the population. A socialist society is necessary for the unfettered development of the required resources, for their rational allocation on the basis of human need and for the organisation of society in a manner that facilitates the changes in the behaviour pattern of human beings in a way beneficial to their health. Only a socialist society will create the conditions in which medical science itself can climb to new heights and bear fruit for millions of people.

In a limited way the early years of the Soviet Union demonstrated this. The revolutionary Bolshevik leadership of that state consciously directed resources to the needs of the masses and enabled the self-organisation of the masses themselves to play a full role in changing the patterns of behaviour shaped by years of peasant backwardness. Education on matters of hygiene and health was carried out by the democratic Soviets in ways and with a success rate that even the most dedicated doctors, on their own, could not hope to achieve. The self-organised masses, using the gains of medical science, were able to carry the torch of civilised behaviour into the darkest and most remote villages of the country. Old cultural norms were not bludgeoned out of the way. The masses were rather drawn into a dialogue, the benefits of science were demonstrated to them in a practical way that undercut superstition, tradition and the dangerous practices associated with them.

But if this is our goal it does not mean that we are complacent in the face of the AIDS epidemic in the here and now, short of our goal being achieved. While we point to the limitations of behavioural solutions to the AIDS epidemic, we argue for health and sex education, paid for by the state and free from the restrictions of capitalist morality, so that people can learn as much as possible about their bodies, their sexual options and choices and the dangers they face. We fight every aspect of the social oppression of gay men, the social oppression of women, the national oppression and exploitation of the semi-colonies in order to create conditions in which treatment and resources for the AIDS epidemic can be fought for and won. The ?gay plague? propaganda was insidious and set back the development of treatments and interventions. It was a product of the oppression of gay men. Fighting that oppression on every front can only help defeat the remaining influence of that propaganda in the battle against AIDS. Likewise, fighting in the semi-colonies for the cancellation of the debts that the countries owe to imperialism can assist in the struggle for
the resources necessary to improve and develop health care so that it is, at the very least, able to cope with the spread of AIDS.

Everywhere the battle against AIDS requires encroachments on the capitalist structure of health care. It is underfunded. Resources are scarce. Health workers are deprived of control in their own workplaces. The drug companies amass profits by peddling their cures at exorbitant prices. Our health has a price tag on it under capitalism. And with AIDS it means that our lives do too. A fight to combat these aspects of the capitalist system of health care, to nationalise the drug companies under workers? control, to expand the health services massively in every country, to grant health service workers control over their workplace and their jobs, the better to enable them to meet the needs of people who are ill, are all necessary, are all part of the battle against AIDS.

AIDS has certainly had an enormous impact on the pattern of disease throughout the world in the last ten years. New epidemics such as this could occur at any time, in any social system; they are the results of ?natural causes? outside our control. But the devastation of whole communities and countries by a disease is not a ?natural disaster??. It is rather the product of a system of exploitation and oppression which leaves gay men, inner city youth and recently urbanised masses in the semi-colonies susceptible to a deadly disease.

Scientific advances will ensure that treatments improve and a vaccine is developed, probably within the next ten years, but capitalism will continue to obstruct the implementation of such advances, leaving millions more to die of AIDS well into the next century.

Endnotes
2 Figures for the USA, to end January 1991: 164,129 reported cases, including 102,803 deaths, reported in AIDS, 1991, 5. In Britain the respective figures are 4,454 and 2,549 deaths.
3 HMSO Statistics
6 This compares with 14,000 reported cases of HIV in Britain, although the true figure may be nearer 30,000
9 Quoted in New Scientist, 17.11.90, p41
10 Ibid
12 Alan D Lopez, op cit
13 Quoted in New Scientist, op cit
14 B N?Galy, op cit

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