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The Political Economy of HIV in Africa: new perspectives and challenges

Matteo Rizzo, Deborah Johnston and Kevin Deane

Given all the positivity and self-congratulation over HIV in the international policy world, it might be hard to remember how many lives have been destroyed and continue to be devastated by this illness. Looking to UNAIDS headlines, we hear of plans for an 'AIDS free generation in Africa', 'ending the epidemic by 2030' and 'eliminating stigma and discrimination'. In this case, the boldness of the goals is partly driven by what Michel Sidibé, Executive Director of UNAIDS, called 'game-changers' in his World AIDS day message in 2011. Biomedical revolutions seem to have radically altered the environment for HIV transmission: anti-retrovirals (ARVs) and drugs to reduce mother-to-child transmission promise to cut HIV transmission rates, as does male medical circumcision.

Of course, the hopeful messages of UNAIDS are tempered with warning about expenditure shortfalls and calls for funding. With austerity as the watch word in the world's wealthy countries, the problem of gaining sufficient pledges, and then turning those pledges into money, is harder than ever. In this special issue, the debate piece by *Whiteside*, throws the question of funding into sharp relief. To what extent is the end to HIV insight, when the costs of providing ARVs under the present approach are potentially 'crippling' for high prevalence countries? *Whiteside* questions the HIV-free narrative, highlighting the 'treatment tension' that exists as the absolute number of those living with HIV rises and ARVs continue to be costly.

Both the debate pieces by *Whiteside* and by *Harman* remind us that, along with the external money that has been central to the HIV response, there have been new fractures in state power and in the organisation of health systems. *Harman* argues that the positive progress narrative on HIV overlooks several limitations to the global response. Funding is a major issue given the cost of treatment, HIV continues to be transmitted and stigma persists. At the same time, the governance of HIV/AIDS has seen competition among international institutions, an expansion of the market into health care and the co-option of many civil society organisation. More specifically *Harman* argues that health systems have been fragmented, distorted and an extra layer of bureaucracy added.

More than this, the contributions to this special issue fundamentally call into question the bio-medical approach. The problem is even more serious than one of a crisis of funding and a fracture of the state and the health service. While biomedical interventions promise to change HIV transmission, there are doubts about whether they will be able to affect 'the social roots of this disease' (Hunter 2010: 225). A clear reading of international public health history, from malaria to measles, shows us that technical fixes to health problems tend to leave the social and economic determinants of health, and the relationships that

underpin them, untouched. For this reason, technical fixes can be far less successful than public health policy makers predict – even disastrous for the population they intend to help.

Alternative Approaches

From the very beginning, social scientists fought to get attention for an alternative to the narrow narrative of HIV transmission arising from the public health literature. One reason for this is that the bio-medical response to HIV has at times been inaccurate, divisive and stigmatising. So, for example, the initial view that HIV in African countries was driven by an aberrant sexual behaviour has disappeared. How could it survive when sexual behaviour surveys, anthropological accounts and activists have challenged it so comprehensively? Among this maelstrom, brave and committed academics, such as Stillwaggon (Stillwaggon 2002; Stillwaggon 2006; Stillwaggon 2006), named the origin of such views as a combination of racism and the dregs of a colonial view of African 'otherness'. Public health officials consequently can no longer argue that the origins of HIV lie in a substantially different pattern of sexual partnership - even though they may argue that it's transmission is heightened by sexual behaviour inappropriate to high prevalence environments. As *Whiteside* argues, the origins of HIV in Africa remain an unanswered public health question, even though critical social scientists have raised a range of issues pertinent to the creation of a high risk environment.

However, whilst early responses were overwhelmingly framed within a biomedical/behavioural paradigm (Campbell and Williams 1999), *Parkhurst & Hunsmann* discuss the (re)emergence of the focus on structural drivers and the acknowledgement of their importance by key global institutions, and remind us of the context and long history of the social science battle against over-medicalisation of HIV analysis. Whilst this is encouraging and has opened up new spaces for the social sciences (and humanities), this also raises a further set of questions and challenges that will influence the degree to which social scientists are able to impact the response in a meaningful way. *Parkhurst and Hunsmann* locate these challenges in the potential mis-alignment of the needs and priorities of donors and NGO's and what they term HIV-prevention realities, such as the need for structural interventions (which are, by their nature, aimed at addressing complex social issues) to demonstrate quantifiable short term impacts on transmission rates or related behaviours to justify initial funding, which in turn influences the nature of interventions implemented in the first place. Further, they emphasise the silo-based response to the epidemic, in which disciplinary boundaries limit the potential for the design of responses that are truly holistic, though it is emphasised these boundaries work both ways, and that social scientists are also required to engage constructively with their biomedical colleagues.

The success of the social/structural drivers literature in forcing this issue onto the global agenda (Sumartojo et al. 2000; Gupta et al. 2008; Auerbach et al. 2010) has both created opportunities for radical rethinking of the responses to the epidemic, as well as a space in which biomedical and behavioural methods and ways of thinking attempt to reassert

themselves. This is seen particularly in relation to methodology, with randomised control trials increasingly being used to address 'social' issues, and hence a danger that the structural drivers agenda is subjected, through the application of inappropriate technical frameworks, to a reductionism and individualisation that is paradoxically at the heart of the critical rejection of biomedical and behavioural approaches. This is best illustrated by the uncritical borrowing of currently fashionable strategies, such as microfinance and cash transfers, from the international development sphere (where these strategies are themselves hotly contested), as they provide interventions that can be viewed as addressing 'structural issues', but are also easily assimilated into standard biomedical and behavioural methodological frameworks.

This reductionism of the structural emphasises the need for alternative approaches that go beyond these narrow conceptualisations, a challenge that political economy approaches are well placed to take up. What have the alternative views been? All the authors in this issue show that the pattern of HIV prevalence in African countries reflects complex social and economic inequalities, enable a reflection on both how structural drivers can be better conceptualised, and also the limitations of microfinance and cash transfers as 'structural' interventions.

O'Laughlin discusses the way in which structural drivers have been conceptualised by those emanating from the public health silo, and presents an alternative political economy perspective in which, rather than a focus on how structures and contexts influence individual disease outcomes and behaviours, structural drivers are viewed as the factors that determine how infection and risk are distributed across the population. This provides a more nuanced notion of the term 'structural', directing attention to broader socio-economic processes, structures, and social relations, and the need for a radical political economy approach that is able to address them.

However, political economy has to compete in its explanations for HIV with mainstream economics. Mainstream economics presents a picture of rational individuals who 'optimise' their risk to HIV. Increasingly, this framework is used to justify microfinance and cash transfer strategies as it directs attention to the incentives that individuals face, and the trade-offs that they have to make when weighing up whether to engage in risky (and potentially harmful) sexual behaviour. However, as the articles by both *Johnston* and by *Deane & Wamoyi*, mainstream economics offers a highly stylised view of individual behaviour. In relation to transactional sex, *Deane and Wamoyi* note that mainstream economics fail to address with central concerns related to transactional sexual practises, such as gendered power, that are reflected in the progressive public health literature, which consistently emphasises the role of unequal gender relations. In the Tanzanian context, and it is likely elsewhere in sub-Saharan Africa, the focus on individual incentives is limited due to the lack of engagement with local sexual norms around sex and exchange, the historical socio-economic roots of this practice, and how the ongoing dynamics of this practice are influenced by developmental processes and the penetration of capitalist relations.

Hunter also addresses the role of economic and social relations in creating sexual norms around concurrency that are related to the growing materiality of sex, and how concurrency is shaped by the giving of gifts in this context. Further, *Hunter* reflects, in a more nuanced way, on differences in the forms of concurrency between rich and poor countries. These differences, and the recognition of transactional sex in Northern countries, are important to tease out in a sensitive manner to enhance our understandings of these practices, but also to ensure that this analysis is divorced from the derogatory and racist framing noted above. As with other papers here, the role of a range of structural factors, such as high unemployment in the context of expanding informal settlements and reduced marriage rates shape concurrent relationships, offering alternative sites for intervention.

Long and Deane show how simple stories about poverty and HIV are confounded by the data on the relationship between HIV prevalence and HIV infection, which for Tanzania shows that the poorest do not have the highest rates of prevalence. Whilst there are a range of biases within the data, such as the longer life expectancies and better access by the wealthy to ARVs, the data present a challenge to the notion that the poorest are most impacted, and suggests that more comprehensive understandings of the dynamics of the epidemic must account for the role of both poverty and wealth. This also enables a reflection on responses such as microfinance targeted at poor women, who typically do not have the highest prevalence rates, that are presented as 'structural', but that do not engage with broader socio-economic structures that shape economic dependence and unequal access to economic opportunities that are experienced by women of all income groups.

[HIV transmission Policies: fashions and fads](#)

The response to bio-medical policies has been complex. Behaviour change policies have widely been seen as failing to change behaviour (for example, *Whiteside* and *Parkhurst and Hunsmann* this volume). This failure has not only been recognised in the social sciences, but is also widely acknowledged within biomedical circles. Whilst the reasons for this failure depend on perspective, social scientists, and political economists, are well placed to comment. Rather than simple technical solutions or simplistic approaches to behaviour change, a political economy approach has instead focused on the complexity of the analysis, not least because the patterns of capitalist development and labour flows in Africa are complex and not reducible to easy simplification (O'Laughlin 2013). The outcomes for HIV risk will be differentiated, with different patterns of nutrition, different sexual norms and different kinds of access to health facilities. This will mean that it will not be possible to chart unambiguous HIV risks, and so not possible to assert that there is an HIV 'magic bullet'. However, as *O'Laughlin*, this volume, argues, while it is difficult to describe the linkages between wider social processes and health, it is vitally important to do so if we want to explain the general population-wide incidence of disease.

Certainly, policy has to have a wider focus than individual decision-making. Indeed, Stillwaggon (2006) argues that broader structural change may be easier to accomplish than

approaches that require all individuals to change their sexual behaviour. More than this, rather than solely local solutions, radical political economy approaches argue that HIV risk reduction needs global change in several respects (Johnston 2013). First, in order to counter uneven development, the policy space for active industrial and trade policy needs to be expanded. Second, migrant health rights need to be improved and protected if we are to end the health externalities of migrant labour systems that endanger worker and abandon them when they are ill. Third, the fiscal space for health expenditure must be expanded, if we are heal fractured and inadequate public health systems. Fourth, long-term, low cost access to the latest generation of ARVs must be negotiated.

Johnston discusses the fashion for HIV-related cash transfers, which aim to reduce HIV risk by changing behaviour. Cash-transfers have offered a new and attractive policy option to international agencies trying to reduce HIV prevalence. Measurable and time-bound, they promise quick but long-lasting results. The analytical starting point for these policies is varied, but all start out with a simplified set of assumptions about the way that cash payments can change sexual behaviour. In a re-reading of the empirical record, *Johnston* argues that these policies and projects have been far less successful than the sounds-bites of international organisations would suggest. The evidence on reductions in HIV is extremely limited, while in at least one case, HIV risk was *increased* by a cash-transfer project. More than that, it is not clear how ethical or sustainable these interventions are. They are unlikely to have any effect on the underlying causes of the HIV epidemics in African countries: uneven development, inequality and inadequate health service access.

In her debate piece *Seeley* discusses the fashion for micro-finance initiatives and questions whether providing short-term loans to poor women, an intervention arising from a drastically over-simplified structural approach, could ever have the potential to reduce HIV transmission by transforming power structures within society. Seeley also discusses the broader debate on the role of microfinance in relation to other developmental issues such as poverty and gender-based violence, and emphasises the mixed and inconclusive nature of the evidence on micro-finance, suggesting that the case for microfinance as a one-size-fits all solution rests on both shaky analytical and empirical grounds.

The limitations of microfinance as a core component of women's economic empowerment and HIV prevention are laid bare in the case study of female fish traders on the shores of Lake Malawi. *MacPherson et al* provide evidence from a recent research project to show that provision of loans to female fish traders in a vulnerable socio-economic context led to situations in which they were unable to meet repayment schedules, in part due to the way that loans were disbursed, and ended up engaging in transactional sexual interactions so that they could pay the loans back. Paradoxically then, some fish traders were compelled to engage in the sorts of sexual interactions that the microfinance intervention was supposed to prevent. The unintended (and perhaps unanticipated) consequences of the programme were thus greatly at odds with the initial project aims, and this is a prime example of the potentially disastrous impact of poorly-framed HIV policy.

Conclusion

This special issue acts to reassert a long-standing political economy approach to HIV, and to adapt it to reflect new competing theoretical approaches and new policy initiatives. However there are many challenges to anyone constructing an alternative analytical approach to HIV. Knowledge about HIV/AIDS is not complete or uncontested. The debate over some of the key 'game-changers', treatment-as-prevention and male medical circumcision, illustrate this well. While UNAIDS believe that the epidemiological evidence for reductions in HIV transmissions is clear cut, others argue about the quality of the epidemiological data, the consistency of results in different settings or the potential to scale-up these interventions (Wamai et al 2011; Wilson et al 2014)

In the light of these constraints, it is no surprise that social science writing on HIV/AIDS has often been 'unsatisfactory' (Marks 2007) due to its reliance on limited information, dated evidence and poor theorisation. Of course, this special issue is on one level a snapshot of what is known in time (about biomedical responses to HIV transmission, about the impact of micro-finance or cash transfers). If this was all it was, then the special issue would quickly become a reservoir of the kind of dated evidence that Marks refers to above. However, at the same time, this special issue aims for something of longer lasting value -- to connect the debates about HIV/AIDS to larger discussions both about globalisation, class differentiation, inequity and uneven development in African countries.

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