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*Neoliberal Plague: The Political Economy of HIV Transmission in Swaziland**

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Swaziland has the highest HIV prevalence rate in the world, despite the billions of dollars' worth of prevention efforts mobilised to curtail the epidemic. In this article I will argue that Swaziland's HIV prevention campaign fundamentally misperceives the causes of the epidemic by focusing on individual behaviour change to the exclusion of the wider socio-economic context of disease transmission. This model derives from a western biomedical paradigm that fetishizes the individual as the locus of responsibility and obscures the structural violence that constrains people's agency. Over the past few decades, Swaziland has been subject to a regimen of neoliberal economic policies that have created an environment of unprecedented HIV risk. Structural adjustment programmes and export-oriented investment strategies have led to declining rates of economic growth, formal employment and agricultural productivity, exacerbating pressures for labour migration and transactional sex among poor households. At the same time, free trade agreements have hobbled the public health system and prevented the rollout of antiretroviral therapy. This article concludes that high HIV prevalence in Swaziland is less a biomedical condition than a symptom of neoliberal market policy and that the burden of behaviour change should lie not with HIV patients but with the architects and beneficiaries of the prevailing economic order.

Introduction

Swaziland has the highest HIV prevalence rate in the world: the latest statistics indicate that 25.9 per cent of the adult population (ages 15–49) is infected with HIV.[1] These numbers are striking in and of themselves but dumbfounding given the massive scale of the prevention effort since the late 1980s, which has made remarkably little headway toward stemming the epidemic. Sentinel surveillance data show that, in spite of vigorous mitigation efforts, the prevalence rate among women attending antenatal clinics has risen steadily from 4 per cent in 1992 to 42 per cent today.[2] Swaziland is a tiny country, with a population of just over one million and an area small enough to traverse by car in less than three hours. In a nation of this size, where red ribbons are a ubiquitous public symbol and AIDS has been high in the national consciousness for more than 20 years, it seems odd that hundreds of local and international NGOs, billions of dollars of foreign aid and a declared state of national disaster

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1 NERCHA, 'Monitoring the Declaration of Commitment on HIV/AIDS', available at http://www.unaids.org, retrieved on 10 April 2011.

2 NERCHA, 'Monitoring the Declaration of Commitment'.

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have made no apparent impact against the epidemic. Why, despite such a mammoth effort, has Swaziland's fight against AIDS failed so dismally? Why does the prevalence rate continue to soar in the face of such widespread prevention measures?

I propose that Swaziland's HIV prevention campaign – for which I worked from 2004 to 2005 – has been built around a set of assumptions about the causes of the epidemic that misperceive and *depoliticise* the problems at hand. By focusing almost exclusively on individual behaviour change, education, promotion of awareness and testing services, the campaign obscures the wider structural context in which transmission occurs and allows crucial causes to go unaddressed. Issues such as rising unemployment rates, the collapse of subsistence agriculture, entrenched labour migration, deteriorating healthcare infrastructure, pressures for transactional sex, the effects of international trade agreements and the inaccessibility of generic antiretrovirals, though at times lamented in connection with the spread of HIV, never feature prominently in the strategies of the major actors in the prevention campaign. Instead, operating within the constraints of the western biomedical paradigm, public health practitioners fetishize individual patients as the locus of both biological and behavioural pathology and develop 'solutions' that miss the ultimate causes of the epidemic. If the policymakers and medical professionals who shape Swaziland's prevention campaign are serious about rolling back the country's AIDS burden, they must critically examine the structural violence of neoliberal economic policy in the region, which has eroded the health security of much of the population.

My concern is to problematise public health discourse about AIDS in Swaziland, to challenge its underlying assumptions and explore the broader context of the epidemic through an analysis of global and regional political economy. I argue for a complete reorientation of the national AIDS mitigation strategy in order to focus efforts where they will have the greatest impact on the epidemic. The state and NGOs must be willing to step outside the limited parameters of their mission statements and summon their resources to grapple with broader structural issues – in addition to raising awareness – even if this means becoming embroiled in local and international policy battles. Any restructuring of prevention strategies must be preceded, however, by a rephrasing of the discourse about AIDS, shifting the blame for HIV transmission from its vulnerable victims to a specific set of local and international pathologies of power.

Challenging the Biomedical and Environmental Paradigms

Swaziland's HIV prevention strategy assumes that pathological sexual behaviour is the root cause of the epidemic, coupled with widespread ignorance about how HIV transmission occurs. Given this assumption – and in line with classic studies such as those by Fisher[3] and Aggleton[4] – awareness creation and behaviour change top the list of strategic interventions, accompanied by the distribution of condoms and the provision of testing services. For example, the National Emergency Response Council on HIV/AIDS (NERCHA) – the government-funded co-ordinating agency for AIDS-related organisations nationwide – has long listed 'behaviour change' as its chief priority and explicitly focuses the bulk of its resources on education and the dissemination of information in order to achieve this goal.[5] After more than 20 years of exposure

3 J. Fisher and W. Fisher, 'Changing AIDS-risk Behavior', *Psychological Bulletin*, 111, 3 (1992), pp. 455–74.
4 P. Aggleton, K. O'Reilly, G. Slutkin and P. Davies, 'Risk Behavior, Behavior Change and AIDS', *Science*, 265, 5170 (1994), pp. 341–5.
5 NERCHA, 'National HIV/AIDS Response', available at http://www.nercha.org.sz, retrieved on 10 April 2011. Also see Government of Swaziland, 'The Second National Multisectoral HIV and AIDS Strategic Plan 2006–2008', available at http://worldbank.org, retrieved on 17 December 2011.

to awareness campaigns, however, Swazis are no longer ignorant about AIDS. A 2003 study concluded that '[t]he Swazi people are *highly knowledgeable* about HIV/AIDS' but then went on to lament that 'this knowledge has not translated into desirable behaviour change'.[6] This observation is in keeping with data that show that, in southern Africa, 'providing information about health risks changes the behaviour of, at most, one in four people – generally those who are more affluent'.[7] In other words, prevention programmes built around behaviour change are failing at a rate of three to one. Yet this fact rarely informs public health policy in Swaziland.

These data reveal something crucial about the nature of the epidemic: that the sexual practices of a significant group of people are not altered by exposure to HIV awareness campaigns and that this group is largely coterminous with the poorest and most marginalised strata of society. Something about the context in which they live renders them unable to translate knowledge into behaviour change. In the words of long-time AIDS scholar Sanjay Basu: 'The issue is not so much "behaviour" as the conditions under which such behaviour occurs'.[8] These conditions become obscured in the usual discourse about disease, however. The blinkered preoccupation with behaviour change derives from a western biomedical paradigm that fetishizes the individual as the locus of agency and responsibility and assumes rigid distinctions between individual bodies and the broader social world.[9] This dichotomy is not at all natural – it does not exist in the world 'out there' – rather, it is the product of conceptual categories that are particular to the culture of western capitalism.[10] This framework depoliticises disease and defines the clinic as a place where people go to have their bodies – abstracted from their social contexts – treated by physicians whose professional gaze rarely extends beyond the individual.[11]

In recent decades a critical literature has sought to correct this 'biomedical individualism'[12] by highlighting the social and political determinants of health and disease. Noting strong correlations between health and socio-economic status, Link and Phelan argue for 'contextualising' individually-based risk factors in order to understand what puts certain groups of people 'at risk for risk'.[13] They seek the 'fundamental causes' of illness in social conditions that determine individuals' access to the resources that they need to avoid disease. Taking this approach, Wilkinson has demonstrated that life expectancy in developed countries corresponds closely to the degree of economic inequality within the population: nations marked by severe inequality have greater public health risks and lower life expectancies than more egalitarian societies, regardless of overall wealth.[14] The World Health Organisation recently supported these claims in a report illustrating health differentials between rich and poor countries and between rich people and poor people *within* countries, concluding that 'social inequalities kill'.[15]

6 Government of Swaziland, *National Behavioural Surveillance Survey* (Mbabane, Government of Swaziland, 2003). Emphasis added.
7 C. Campbell and Y. Mazidume, 'How Can HIV Be Prevented in South Africa?', *British Medical Journal*, 324, 7331 (2002), pp. 229–32.
8 S. Basu, 'US AIDS Czar Undermines WHO Initiative', Z *Magazine* (March 2004), available at http://www.zmag.org, retrieved on 10 May 2005. See also B. Link and J. Phelan, 'Social Conditions as Fundamental Causes of Disease', *Journal of Health and Social Behavior*, Special Issue (1995), pp. 80–94.
9 See E. Martin, 'Toward an Anthropology of Immunology', *Medical Anthropology Quarterly*, 4, 4 (1990), pp. 410–26.
10 See S. Barnett and M. Silverman, *Ideology and Everyday Life* (Ann Arbor, University of Michigan Press, 1979).
11 See E. Martin, *Flexible Bodies* (Boston, Beacon Press, 2001).
12 E. Fee and N. Krieger, 'Understanding AIDS', *American Journal of Public Health*, 83, 10 (1993), pp. 1,477–86.
13 Link and Phelan, 'Social Conditions'. See also G. Pappas, S. Queen, W. Hadden and G. Fisher, 'The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States', *The New England Journal of Medicine*, 329 (1993), pp. 103–09.
14 R. Wilkinson, *Unhealthy Societies* (New York, Routledge, 1996).
15 CSDH, *Closing the Gap in a Generation* (Geneva, World Health Organisation, 2008).

These studies are important inasmuch as they demonstrate the role that environments play in determining health outcomes. But – as Krieger and Bassett have pointed out – this approach tends to view negative social conditions (like poverty) as neutral phenomena, rather than as the product of active capital accumulation and exploitation.[16] The disparities that characterise global public health today are far from natural; indeed, they can be linked directly to specific economic policies aligned with the ideology of neoliberalism, which David Harvey has identified as a project consciously designed to restore class power.[17] During the late 1970s and early 1980s, Ronald Reagan and Margaret Thatcher, among others, spearheaded a number of reforms designed to 'free' the economy from state regulation and the democratic controls of society. Their agenda included tight monetarist policy, cutting government spending on social services (such as public healthcare), reducing taxes on corporations and the wealthiest individuals while raising them for working-class families, curtailing trade unions and collective bargaining rights, deregulating labour and financial markets and reducing tariffs on international trade and capital flows.

This policy package (commonly known as the Washington Consensus) has been exported around the world by international financial institutions through 'structural adjustment programmes' that leverage debt to force developing countries to liberalise their markets. Instead of facilitating 'development', however, structural adjustment has caused widespread economic destruction. Developing countries enjoyed an average per capita growth rate of more than 3 per cent during the immediate post-independence era. After structural adjustment, however, these growth rates fell to 1.7 per cent.[18] Sub-Saharan Africa illustrates this downward trend well: during the 1960s and '70s, per capita income grew at a rate of 1.6 per cent, but when neoliberal therapy was forcibly applied to the continent – beginning with Senegal in 1979 – per capita income began to *fall* at a rate of 0.7 per cent per year. In total, the GNP of the average African country *shrank* during the neoliberal period by around 10 per cent.[19] Economists estimate that poor countries have lost $480-billion per year in GDP as a result of having been forced to abandon the much-needed protectionist policies (such as subsidies, tariffs and import substitution) that they used in the first decades following decolonisation.[20] The upshot of this has been deepening poverty and worsening health, mortality and literacy rates in much of the global South; in Africa, for example, the number of people living in basic poverty has nearly doubled since 1980.[21]

This project has allowed corporations and élite families to accumulate wealth at a dizzying rate while generating historically unprecedented levels of social inequality.[22] According to the 1996 United Nations Human Development Report, during the period between 1960 and 1991, the richest 20 per cent of the world's population increased their share of global income from 70 per cent to 85 per cent while the poorest 20 per cent saw their share shrink from 2.3 per cent to 1.4 per cent. Today, the wealthiest 1 per cent controls 40 per cent of the world's wealth while the bottom 50 per cent controls a mere one per cent.[23] This transfer of wealth has been justified in the language of individual freedom, which grants economic liberalisation a certain unassailable moral appeal. Crucially, this same logic says that individuals should be

16 N. Krieger and M. Bassett, 'The Health of Black Folk', in S. Harding (ed.), *The Racial Economy of Science* (Bloomington, Indiana University Press, 1993).
17 V. Navarro, 'What We Mean by Social Determinants of Health', *International Journal of Health Services*, 39, 3 (2009), pp. 423–41; D. Harvey, *A Brief History of Neoliberalism* (Oxford, Oxford University Press, 2005).
18 H. Chang, *Bad Samaritans: The Guilty Secrets of Rich Nations and the Threat to Global Prosperity* (London, Random House, 2007), p. 27.
19 Chang, *Bad Samaritans*, p. 28.
20 R. Pollin, *Contours of Descent* (New York, Verso, 2005).
21 World Bank, 'World Development Indicators' (Washington, DC, World Bank, 2007).
22 Harvey, *A Brief History of Neoliberalism*.
23 United Nations University, *2008 Annual Report* (Tokyo, United Nations University, 2009).

responsible not only for their own financial successes and failures, but for their own individual health outcomes as well, thus reinforcing the narrow gaze of biomedical individualism. In other words, neoliberal ideology not only generates negative health outcomes, it also diminishes the ability of public health institutions to respond to this crisis by obscuring the structural determinants of disease.

It is one thing to recognise that neoliberal policies – and the widening social inequalities that they create – have caused health indicators to plummet, but we still must do the analytical work of parsing this relationship and determining how specific policies have increased people's risk of specific diseases. As Sanjay Basu has argued, 'We need to examine the basic processes of power, not merely its end pathologies'.[24] When it comes to HIV/AIDS in southern Africa, Alison Katz has done important work toward this end: she looks beyond what she calls the 'reductionist obsession with individual behaviour' and points to the macro-economic and political factors that underlie the 'fantastically exploitative relationship between the North and South' and that produce levels of poverty and deprivation that fuel HIV risk.[25]

The relationship between wealth and HIV risk is complex, however. A recent study by Parkhurst shows that in many African countries – including Swaziland – HIV prevalence is not definitively correlated with socio-economic status; indeed, in some cases wealthier people appear to be more likely to contract HIV.[26] The crucial point to make here is that high transmission rates among wealthy people have to do with their *voluntary* ability to participate in broader sexual networks.[27] These are the risk behaviours that awareness programmes would be likely to change. By contrast, high transmission rates among the poor are due to risk behaviours that are compelled by structural factors, and therefore not likely to be affected by awareness. In Swaziland, economic decline and increasing rates of unemployment force men to resort to labour migration and women to resort to transactional and commercial sex, two trends that significantly increase HIV risk. In addition, deteriorating healthcare services, inadequate labour protection measures and the inaccessibility of affordable antiretroviral drugs converge to exacerbate HIV risk for the poor. These conditions are neither natural nor inevitable; rather, they are the product of processes of class power[28] and of policies that govern resource distribution and constrain people's agency and opportunities. High HIV prevalence in Swaziland is less a biomedical phenomenon than a symptom of socio-economic dislocations associated in large part with neoliberal policy.

Labour Migration and HIV Risk

Capitalism in southern Africa has long depended on an entrenched system of rotating labour migration. After the 'mineral revolution' in the 1860s, European capitalists needed a steady flow of cheap black labour to work in the gold and diamond mines in South Africa. They pressured colonial administrations across the region to restrict Africans' access to arable land and to impose taxes on African households in order to undermine subsistence agriculture and force people into

24 S. Basu, 'Institutionalised AIDS and the Quest for Social Responsibility', *Z Magazine* (November 2003), available at http://www.zmag.org, retrieved on 19 May 2005.

25 A. Katz, 'AIDS, Individual Behaviour and the Unexplained Remaining Variation', *African Journal of AIDS Research*, 1 (2002), pp. 125–42.

26 J. Parkhurst, 'Understanding the Correlations between Wealth, Poverty and HIV Infection in African Countries', *Bulletin of the World Health Organization*, 88 (2010), pp. 519–26. Note that Parkhurst measures wealth by looking at the status objects that people possess; this might not be the most accurate way to measure wealth in Swaziland, where inalienable status objects acquired through marriage exchange, for example, do not reflect the ability of a household or individual to withstand the pressures of poverty.

27 Parkhurst, 'Understanding the Correlations between Wealth', p. 523.

28 J. Bujra, 'AIDS and Socio-Economic Privilege in Africa', *Review of African Political Economy*, 33, 107 (2006), pp. 113–29.

the labour market.[29] At the same time, systems of racial segregation – such as South Africa's 'pass laws' – prevented migrant workers from settling permanently in urban centres, forcing them to travel back and forth between the urban workplace and their rural homes. This allowed companies to pay workers a 'bachelor wage' substantially less than that which settled urban workers required to support their families, relying on African women and children to subsidise social reproduction through subsistence activities in rural areas.[30] To this day, unskilled workers in South African mines, plantations and factories come from as far afield as Malawi and return home as infrequently as once a year. As Shula Marks has put it, these longstanding migration patterns created a context in which HIV/AIDS was an 'epidemic waiting to happen'.[31]

The public health literature is inconclusive about the relationship between mobility and HIV risk, as it appears to vary across contexts,[32] but data from southern Africa seems to suggest a strong link between the two. For example, HIV prevalence appears to be closely correlated with occupational skill level: in South Africa, it stands at only 12 per cent among highly skilled workers, 20 per cent among skilled workers and as high as 27.2 per cent among unskilled workers.[33] This skewed distribution can be explained in part by the vulnerability of unskilled workers to the pressure for labour migration, which, according to Lurie and his co-researchers is an 'independent risk factor for HIV infection among men'.[34] In a 2003 study, Lurie and his co-researchers found that 25.9 per cent of migrant men in South Africa were infected with HIV, compared to 12.7 per cent of non-migrant men. Another study by the same authors found that, among sending communities in KwaZulu-Natal (Swaziland's southern neighbour), 35 per cent of migrant couples had one or both partners infected, compared to 19 per cent of non-migrant couples.[35] Also using data from KwaZulu-Natal, Coffee, Lurie and Garnett have demonstrated that migration increases high-risk sexual behaviour among males away from their partners for protracted periods and that this increase in risky behaviour among males in turn increases HIV prevalence among their female partners by a factor of ten.[36]

Part of the blame for these high transmission rates lies in the living and working conditions that characterise migrant destinations. Workers in South African mines, for example, live in all-male barracks, work six days a week with a 42 per cent injury rate and are often supplied with alcohol and prostitutes to prevent worker militancy and to alleviate the depression caused by loneliness, the daily threat of death and squalid working and living conditions. This kind of environment is hardly conducive to either abstinence or protected sex.[37] In addition, migrants are often forced to select low-income housing in

29 J. Crush, A. Jeeves and D. Yudelman, *South Africa's Labour Empire: A History of Black Migrancy to the Gold Mines* (Boulder, Westview Press, 1991).

30 H. Wolpe, 'Capitalism and Cheap Labour Power in South Africa', *Economy and Society*, 1, 4 (1972); C. Meillassoux, *Maidens, Meal and Money: Capitalism and the Domestic Community* (Cambridge, Cambridge University Press, 1981).

31 S. Marks, 'An Epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective', *African Studies*, 61 (2002), pp. 13–26.

32 See K. Deane, J. Parkhurst and D. Johnston, 'Linking Migration, Mobility and HIV', *Tropical Medicine and International Health*, 15, 12 (2010), pp. 1,458–63, for an excellent discussion.

33 L. Gilbert and L. Walker, 'Treading the Path of Least Resistance', *Social Science and Medicine*, 54, 7 (2002), pp. 1,093–110.

34 M. Lurie, B. Williams, K. Zuma, D. Mkaya-Mwamburi, G. Garnett, A. Sturm, M. Sweat, J. Gittelsohn & S. Abdool Karim, 'The Impact of Migration on HIV-1 Transmission in South Africa', *Sexually Transmitted Diseases*, 30, 2 (2003).

35 M. Lurie, B. Williams, K. Zuma, D. Mkaya-Mwamburi, G. Garnett, A. Sturm, M. Sweat, J. Gittelsohn & S. Abdool Karim, 'Who Infects Whom? HIV-1 Concordance and Discordance Among Migrant and Non-Migrant Couples in South Africa', *AIDS*, 17, 15 (2003), pp. 2,245–52.

36 M. Coffee, M. Lurie & G. Garnett, 'Modelling the Impact of Migration on the HIV Epidemic in South Africa', *AIDS*, 21, 3 (2007), pp. 343–50.

37 Campbell and Mzaidume, 'How Can HIV Be Prevented?'. The use of alcohol may partially explain the low rates of condom use among men at migrant destinations; see J. Crush (ed.), *Migration-Induced HIV and AIDS in Rural Mozambique and Swaziland* (Cape Town, Southern Africa Migration Project & IDASA, 2010), p. 19.

either illegal peri-urban settlements or all-male hostels that are only marginally served by public healthcare arrangements. In this context even easily curable sexually transmitted infections (STIs) – endemic in mining communities[38] – go untreated, which elevates the likelihood of HIV transmission by up to 400 per cent. Furthermore, workers often have little or no access to antiretroviral therapy. These conditions make it unlikely that workers will plan for their (all too precarious) futures with safe behavioural choices. Some of the highest rates of HIV infection documented in all of southern Africa are found at migrant destinations: mines in South Africa exhibit rates of up to 50 per cent, while the prevalence on sugar plantations in Zimbabwe can be as high as 70.7 per cent.[39]

Labour migration into South Africa has long been a major feature of Swaziland's economy. In 1990, nearly 18,000 people from Swaziland were employed in the South African mining industry alone,[40] accounting for more than 16 per cent of formal employment nationwide.[41] That same year, according to Andre Leliveld, 36 per cent of Swazi households had members living and working in South Africa – with the vast majority of them in the mining industry.[42] By 2001, David Wilson confirmed that more Swazis worked in the mining, sugar and timber industries of South Africa than did in Swaziland, noting that the highest HIV risk categories corresponded with labourers involved in trade, mining and agro-industrial migration.[43] Widespread dependence on labour migration has emerged as a consequence of limited economic opportunity in Swaziland. Remittances sent home by migrant labourers have become absolutely critical to household survival, accounting for up to 72 per cent of disposable income for poorer households;[44] 80 per cent of migrant-sending households have no source of income aside from remittances.[45] Surveys show that families are not likely to forfeit such staple earnings in favour of maintaining geographical cohesiveness.[46] In this context, 'monogamy', 'abstinence' and 'fidelity' – the values promoted by Swaziland's prevention campaign – become impractical ideals for both men and women.

Migrants from Swaziland differ from migrants from other southern African countries in that – because of their geographical proximity to labour destinations in South Africa – they tend to return home more frequently. Nearly half of Swazi migrants return home once a month and another 37 per cent at least once every three months (by contrast, 87 per cent of migrants from Mozambique return home twice a year or less).[47] This pattern increases the risk of HIV transmission between partners (82 per cent of Swazi migrants are married or cohabiting[48]) because the probability of HIV infection among HIV-discordant couples tends to correspond

38 B. Williams, D. Taljaard, C. Campbell, E. Gouws, L. Ndhlovu, J. van Dame, M. Caraël and B. Auverl, 'Changing Patterns of Knowledge, Reported Behavior and Sexually Transmitted Infections in a South African Gold Mining Community', *AIDS*, 17, 14 (2003), pp. 2,099–107.

39 Cited in A. Whiteside, A. Hickey, J. Tomlinson & N. Ngcobo, 'What is Driving the HIV/AIDS Epidemic in Swaziland? And What More Can We Do About It?' (Report prepared for the National Emergency Response Committee on HIV/AIDS and UNAIDS, Mbabane, 2003).

40 H. Simelane and J. Crush, *Swaziland Moves: Perceptions and Patterns of Modern Migration* (Cape Town, Southern Africa Migration Project, 2004).

41 A. Leliveld, 'The Effects of Restrictive South African Migrant Labour Policy on the Survival of Rural Households in Southern Africa', *World Development*, 25, 11 (1997), pp. 1,839–48.

42 Leliveld, 'The Effects of Restrictive South African Migrant Labour Policy'.

43 D. Wilson, 'Lesotho and Swaziland: HIV/AIDS Risk Assessment at Cross-Border and Migrant Sites', Family Health International (2001).

44 Leliveld, 'The Effects of Restrictive South African Migrant Labour Policy', p. 1,842.

45 Crush (ed.), *Migration-Induced HIV*, p. 15.

46 Simelane and Crush, *Swaziland Moves*, p. 13, shows that Swazi families prefer not to rely on labour migration as a survival strategy but are forced to do so by financial need.

47 Crush (ed.), *Migration-Induced HIV*, p. 8.

48 *Ibid*.

with the frequency of sexual intercourse.[49] Furthermore, this migration pattern encourages concurrent sexual partnerships, which have been found to significantly increase HIV risk.[50]

Gender Inequalities, Women's Incomes and HIV Risk

The migrant labour system renders Swazi women vulnerable to heightened HIV risk in a number of ways. A recent study by the Southern African Migration Project found that male Swazi migrants exhibit 'a strong inclination for multiple sexual partnerships' while away at South African mines: 30 per cent claimed to have had sex with between two and five women, 33 per cent with between six and ten women and 22 per cent with more than ten women.[51] Whiteside attributes risky sexual behaviour among migrants to loneliness, boredom, anonymity, the macho culture of the mines and the availability of cheap commercial sex at migrant destinations.[52] By contrast, multiple partnerships are not as common in rural areas: 35 per cent of female partners in sending communities reported that they had only one lifetime sexual partner and 32 per cent reported only two. Aware of the sexual habits of their migrant partners, these women regard themselves as being at high risk of infection and almost all of them desire to use condoms for prevention. Despite this, 79 per cent of women reported that they *did not* use condoms during their last sexual encounter, in most cases because their partners refused.[53] This illustrates the degree of coercive power that men continue to wield over women in domestic partnerships in Swaziland. Note, however, that this gender inequality is less a product of 'traditional culture' than of the fact that women are so highly dependent on male incomes – a legacy of the migrant labour system.

The migrant labour system also appears to promote increased levels of commercial sex in Swaziland, which in turn entails higher incidence of concurrence. David Wilson identified over 170 sex workers regularly plying three of Swaziland's border towns, catering to the migrant traffic passing through.[54] According to the interviews he conducted, many of these women reported having moved to border sites to escape the even higher competition in Manzini/Matsapha, which has the densest concentration of internal migrant workers in the country (and the highest HIV prevalence).[55] The supply of sex workers does not correlate only with clients' demand, however, but also with women's access to income. Many women who work as domestic servants and street vendors must supplement their meagre incomes with sex work, which can furnish them with an average of about E1,000 per month (about twice what they can earn in the textile industry or as domestic servants). In addition, women who cannot access paid employment and women widowed by migrant partners who have succumbed to AIDS often resort to transactional sex to secure the income they need.[56] Again, part of the reason that women cannot negotiate the terms of sex (such as condom use) is their dependency on male wealth.[57]

49 T. Quinn, M. Wawer, N. Sewankambo, D. Serwadda, C. Li, F. Wabwire-Mangen, M. Meehan, T. Lutalo & R. Gray, for the Rakai Project Study Group, 'Viral Load and Heterosexual Transmission of HIV Type 1', *New England Journal of Medicine*, 342 (2000), pp. 921–29.

50 See H. Epstein and M. Morris, 'Concurrent Partnerships and HIV: An Inconvenient Truth', *Journal of the International AIDS Society*, 14, 13 (2011).

51 Bear in mind that the overall number of total sexual partners is less important than the incidence of concurrence when determining HIV risk; indeed, men and women in Africa report fewer lifetime partners than do heterosexuals in many western countries. See D. Halperin and H. Epstein, 'Why is HIV Prevalence So Severe in Southern Africa? The Role of Concurrent Partnerships and Lack of Male Circumcision', *Southern African Journal of Medicine* (2007), p. 19.

52 Whiteside, Hickey, Tomlinson & Ngcobo, 'What is Driving the HIV/AIDS Epidemic in Swaziland?'.

53 Crush (ed.), *Migration-Induced HIV*.

54 Wilson, 'Lesotho and Swaziland', pp. 35–41.

55 *Ibid*., p. 35.

56 See M. Hunter, *Love in the Time of AIDS* (Bloomington, Indiana University Press, 2010).

57 See S. Zierler and N. Krieger, 'Reframing Women's Risk', *Annual Review of Public Health*, 18 (1997).

Women's income insecurity is related in part to the decline of Swaziland's rural agricultural sector – a trend that I will discuss in the following section. Women have been central to small-scale farming in Swaziland since the introduction of the male migrant labour system more than a century ago, but their ability to make farming profitable has been hampered by the fact that Swazi law confers upon married men absolute control over the disposal of land and denies women the freedom to acquire plots or access credit without the consent of their husbands. Lack of access to land and credit renders most women incapable of engaging in any but the most menial income-generating activities, which often makes the option of transactional sex an economic necessity.[58] A recent study found that food insufficiency is an important factor in increased sexual risk-taking among women in Swaziland: food insufficiency is associated with inconsistent condom use with a non-primary partner, intergenerational sexual relationships and lack of control over the terms of sexual intercourse.[59]

Campaigns that focus on awareness promotion among women have little effect in light of these conditions. A NERCHA report concluded that 'although basic information on HIV/AIDS is available to women, this knowledge does not assist them in making decisions to avoid risky sexual behaviour'.[60] In a national survey, 56 per cent of female respondents reported that awareness about HIV would not translate into behaviour change, which indicates that the financial desperation that so many women face is grave enough to outweigh concerns about their own health; they are willing to risk one health threat (HIV infection) in order to stave off another, more immediate, one (hunger).[61] The confluence of family poverty, the limitations that gender inequalities impose upon women and the resultant relative poverty of women as compared to men makes the probability that women will pursue transactional sex for survival dangerously high. Recognising this, cash-transfer programmes tested in Malawi have successfully reduced HIV (and STI) infection rates among women.[62] Similarly, studies have found that when women can secure sufficient livelihoods through formal employment they feel less pressure to engage in transactional sex.[63] For instance, Oshoek, the border town with the highest proportion of formally employed women, has the lowest rates of commercial sex.[64] These data demonstrate that the issue of risky sexual behaviour among women must be reframed to account for socio-economic pressures.

The Social Impact of Market Liberalisation

The number of Swazi men employed in South African mines rose from 8,090 in 1980 to 17,757 in 1990.[65] This increase in out-migration was not caused by greater demand for labour in the mines; the *proportion* of Swazis employed in the mines (as a ratio of total foreign workers) also increased during this period, from 4.4 per cent to 9.2 per cent,[66] suggesting that Swazis

58 See B. O'Laughlin, 'Widows' Weeds: Gender, AIDS and the Agrarian Question in Southern Africa', Instituto de Estudos Sociais e Economicos (2007) for a discussion of land tenure and women's risk. Transactional sex is significantly less dangerous than sex work, but it does enhance the risk of HIV transmission; see Epstein and Morris, 'Concurrent Partnerships'.

59 S. Weiser, K. Leiter, D. Bangsberg & L. Butler, 'Food Insufficiency is Associated with High-Risk Sexual Behaviour Among Women in Botswana and Swaziland', *PLoS Medicine* (2007), available at www.plosmedicine.org/article/info:doi/10 . . . /journal.pmed.0040260

60 Whiteside, Hickey, Tomlinson & Ngcobo, 'What is Driving the HIV/AIDS Epidemic in Swaziland?', p. 28.

61 *Ibid*.

62 This is according to the results of a new but as yet unpublished study titled 'Schooling, Income and HIV Risk (SIHR) Malawi', available at http://go.worldbank.org/VWB5TOK8M0, retrieved on 15 December 2011.

63 These income rates are based on data that I gathered in 2005.

64 Wilson, 'Lesotho and Swaziland', p. 36.

65 Simelane and Crush, *Swaziland Moves*, p. 4. Whiteside, Hickey, Tomlinson & Ngcobo, in 'What is Driving the HIV/AIDS Epidemic in Swaziland?' indicate a lower number (5,050) for 1980.

66 Simelane and Crush, *Swaziland Moves*, p. 4.

were driven to migrate because of the scarcity of local employment.[67] During the 1990s the mining industry in South Africa shed some 150,000 jobs and Swazi migration to the mines decreased gradually to its present rate of about 9,000, but Swaziland's general migration rates into South Africa continued to increase during this period, from 182,792 outward crossings in 1991 to 429,195 in 1992. By 2000, this number reached 742,621 – a staggering four-fold increase over the course of a single decade.[68]

This increase in out-migration was driven in large part by the rapid decline of Swaziland's formal economy during this period. While per capita growth rates were high during the immediate post-independence period, they fell from an average of 4.5 per cent in the 1980s to an average of 1.2 per cent in the 1990s and then plummeted to 0 per cent during the last decade. Unemployment rates have responded accordingly, rocketing from 22 per cent in 1995 to 40 per cent in 2005. This crisis has exactly paralleled the general trend of slower growth and rising unemployment in the developing world – and particularly in Sub-Saharan Africa – during the late 1980s and 1990s, which economists Ha-Joon Chang, William Easterly and Robert Pollin attribute directly to neoliberal structural adjustment.[69] In Swaziland, this has resulted from a number of policy changes. The International Monetary Fund (IMF) imposed a structural adjustment programme on Swaziland in 1983, which included gradually cutting subsidies and tariffs (which exposed infant industries to crushing competition) and raising interest rates to lower inflation (which reduced investment in local production).[70] Another likely factor is that Swaziland became a signatory in 1989 to the free trade agreement with the European Community, known as Lomé IV, which – in contrast to previous versions of the Lomé Convention – included forced structural adjustment as a method of debt reduction. In addition, Swaziland took more than US$30 million in loans from the World Bank in the 1980s, which came with structural adjustment conditions attached;[71] crucially, payments on IMF and World Bank loans (and interest) have cost Swaziland a significant proportion of its national budget.[72] These neoliberal policies were further reinforced when Swaziland joined the World Trade Organisation (WTO) in 1995, after which the country's economy stagnated.

This decline has had a particularly pernicious effect on Swaziland's agricultural sector. Food production per capita plunged by 25 per cent between 1991 and 1995 and then by another 12 per cent before 2000.[73] The drought that hit Swaziland in the early 1990s is generally blamed for this decline,[74] but drought alone cannot explain the steady downward trend; the abolition of price controls, subsidies and import tariffs during this period made it difficult for small farmers to sustain profitable production.[75] This has been exacerbated by the fact that economic policy has focused on enhancing corporate agribusiness (much of which is foreign-owned) on highly-productive 'Title Deed Land,' while unproductive 'Swazi Nation

67 A number of other factors may have influenced this trend. For example, South African immigration policies, hiring practices in South African mines and the relative availability of labour from other countries (for instance, the labour supply from Malawi was cut off for a while in 1974) may have made Swazi workers more desirable.

68 Simelane and Crush, *Swaziland Moves*.

69 H. Chang, 'Free Market Policies Rarely Make Poor Countries Rich', in *23 Things They Don't Tell You About Capitalism* (Penguin, 2010);W. Easterly, *The White Man's Burden* (London, Penguin, 2006); Pollin, *Contours of Descent*.

70 B. Riddell, 'Things Fall Apart Again: Structural Adjustment Programmes in Sub-Saharan Africa', *Journal of Modern African Studies*, 30, 1 (1992), pp. 53–68.

71 Data available at https://finances.worldbank.org, retrieved on March 8 2011. Swaziland took a total of between US$73 million and US$116 million (World Bank records are inconsistent) in loans from the World Bank between 1962 and 1995.

72 Another factor contributing to economic decline during this period was that sanction-busting companies left Swaziland and relocated to South Africa after the collapse of apartheid in the early 1990s.

73 Whiteside, Hickey, Tomlinson & Ngcobo, 'What is Driving the HIV/AIDS Epidemic in Swaziland?'.

74 *Ibid*., p. 31.

75 Even if drought *was* the chief cause of this decline, the state should have been able to protect small farmers using subsidies – but structural adjustment restricted its ability to do so.

Land' – to which most small-scale farmers have been relegated – suffers from chronic underinvestment.[76] These pro-rich investment patterns articulate with the interests of the monarchy, which holds substantial shares in foreign agribusiness companies and thus tends to support agricultural policy that directs capital into its own coffers, even at the expense of the well-being of the majority of the population.[77]

The key point is that diminishing returns on small-scale farming enterprises (mostly maize, but also sugar cane and cotton) have had a major effect on migration rates. Rural Swazis' need for both internal and cross-border labour migration is sharpened by their growing inability to wrest sufficient livelihoods from agriculture, on which more than 70 per cent of the population relies. Leliveld demonstrates a close relationship 'between the relatively low production… of small scale agriculture and the high incidence of migrant labour among rural homesteads'.[78] The regions with the lowest maize production rates – such as Shiselweni – also have the highest rates of out-migration and AIDS-related deaths.[79]

The connection between market liberalisation and increased HIV transmission became acutely clear during the first few months of 2005, when the textile industry abruptly shed some 25,000 jobs. Almost all of these jobs had been held by women. In an economy already saddled with huge unemployment, women desperate to keep afloat had few other options aside from sex work and other forms of transactional sex. A survey of sex workers in Manzini during the period of layoffs found that most of the women were newcomers to the industry, driven there after the sudden closure of textile factories. 'We are not happy with the work we are doing but we have to make a living', one said; 'the number of people working here is increasing at a high rate, which is evidence that people are desperate for money and there are no jobs'.[80]

The retrenchments in the textile sector resulted from international trade agreements geared toward market liberalisation. Beginning in 1974, international trade in textiles was governed by the Multi Fibre Arrangement (MFA). The purpose of the MFA was to protect the textile industries of developed countries from being undercut by cheap imports from nations where labour and production costs are far lower. The MFA accomplished this by imposing quotas on big exporters such as Korea and Hong Kong to limit their access to the markets of developed countries. At the same time, the Generalized System of Preferences (GSP) and the African Growth and Opportunity Act (AGOA) allowed a certain set of poor countries to have duty-free access to Western markets as part of a development initiative designed to boost job growth. When Swaziland acquired these benefits in 2000, Asian textile manufacturers rushed in to take advantage of the country's new competitive advantage, and the textile industry quickly became the second largest formal employer in the country, employing 35,000 workers at its peak in 2004.

This improvement came to a screeching halt in 2005 as a result of the World Trade Organisation's Agreement on Textiles and Clothing (ATC). The ATC was implemented to liberalise the global textile trade by removing protectionist policies that 'distorted' competitive advantage. The elimination of quota restrictions on 1st January 2005 caused the instantaneous collapse of Swaziland's textile industry, as producers frantically relocated back

76 A. Terry, 'Extending Participation in the Swaziland Sugar Industry to Small-Scale Growers: Patterns and Prospects', *Singapore Journal of Tropical Geography*, 18, 2 (1997), pp. 196–209.

77 See R. Levin, 'Uneven Development in Swaziland: Tibiyo, Sugar Production and Rural Development Strategy', *Geoforum*, 17, 2 (1986), pp. 239–50.

78 Leliveld, 'The Effects of Restrictive South African Migrant Labour Policy', p. 1,845. Note that the correlation between migration and agricultural productivity runs both ways.

79 Crush (ed.), *Migration-Induced HIV*, p. 10.

80 'Don't Arrest Us, Plea Prostitutes', *Times of Swaziland* (30 March 2005).

to Asia to take advantage of cheaper labour and raw materials – a classic instance of the so-called 'race to the bottom' that characterises global trade liberalisation.

When companies laid off textile workers in 2005, they gave no prior notice, no severance pay, and refused to give workers their wages due for previous weeks. This reflects what has become one of the central tenets of neoliberal policy, namely, the 'flexibilisation' of the labour force, which allows multinational corporations to boost profits by cutting labour costs.[81] In Swaziland, a growing proportion of private sector workers are employed as 'casuals' – contracted labourers with no job security, limited access to benefits and no union representation. Subject to the constant threat of unemployment, workers must accept conditions in which they could lose their incomes at a moment's notice, leaving them without the means to acquire healthcare and compelled to migrate in search of re-employment or, in the case of women, to resort to transactional sex. As Pierre Bourdieu succinctly states, neoliberal policy enforces 'precarious arrangements that produce insecurity and the existence of a reserve army of employees rendered docile by... the permanent threat of unemployment. The ultimate foundation of this entire economic order... is in effect the *structural violence* of unemployment'.[82]

Future Structural Adjustments

Despite the fact that neoliberal economic policy has failed to generate equitable prosperity, Swaziland seems set to continue on this trajectory. In 1996 the United States won a case against the Lomé Convention by claiming that its system of preferences for African, Caribbean, and Pacific (ACP) countries contravened the free trade principles of the World Trade Organisation. As a result, the Cotonou Agreement replaced Lomé in 2000, requiring that, beginning in 2008, ACP countries such as Swaziland would have to sign Economic Partnership Agreements (EPAs) with the EU in order to retain access to European markets. The Southern African Development Community (SADC) is torn with disagreement about whether or not to sign an EPA, since it requires eliminating tariff barriers. South Africa, Namibia and Angola have refused, primarily out of fear that European goods would undermine local producers and that the South African Customs Union (SACU) – of which Swaziland is a member – would suffer serious revenue shortfalls. Swaziland, however, chose to sign an interim EPA nonetheless, agreeing to remove tariffs on 86 per cent of EU imports. Sugar was the primary issue of concern in this decision. The Swazi monarchy controls an investment firm called Tibiyo Taka Ngwane that has large financial interests in the sugar industry, including a 40 per cent share in Ubombo Sugar. Tibiyo drove the decision to sign the EPA with these interests in mind,[83] despite the likelihood that the agreement will cause further economic decline and shortfalls in SACU revenue (which provides 60 to 70 per cent of Swaziland's total income). The monarchy has effectively bartered away Swaziland's economy for the sake of a narrow set of corporate interests.

To make matters worse, the global financial crisis of 2008 has brought a new wave of neoliberal policy to Swaziland. The crisis caused SACU revenues to drop by 40 per cent, which translated into a revenue deficit for Swaziland equal to 16 per cent of GDP. South Africa is considering a plan to bail out the Swaziland government with R2.4 billion ($354 million), in exchange for Swaziland's agreement to adhere to new structural adjustment recommendations made by the IMF to reduce the country's fiscal deficit. The IMF plan includes increasing VAT

81 See G. Standing, *Global Labour Flexibility* (London, Macmillan Press, 1999).
82 P. Bourdieu, 'Utopia of Endless Exploitation: The Essence of Neoliberalism', *Le Monde Diplomatique* (1998).
83 'SD to Liberalise 86% of EU Imports', *Swazi Observer*, 25 August 2011.

and making deep cuts to transfers and wages, including a 30 per cent cut to salaries in the government sector, Swaziland's largest employer. This plan places the bulk of the austerity burden onto working citizens, and, given that a large proportion of the Swazi population relies on salaries from the public sector (the only stable employment sector left in Swaziland), it will create household budget deficits that will exacerbate the many factors that lead to HIV risk, such as the need to resort to labour migration and transactional sex. In addition, the IMF-mandated budget cuts may hamper the government's ability to provide the public health services required to curb the epidemic. The new loans that Swaziland took from the World Bank in 2011 – totalling US$47 million – may further exacerbate these problems, depending on the interest rates and conditions attached.

These Draconian measures will be furthered by the new Free Trade Agreement (FTA) that SACU is presently negotiating with the United States. Because the negotiations are conducted in secret, it is impossible to predict what the agreement will include; but its provisions will likely mirror those of other recent US FTAs, such as those that have been signed with Chile and the Central American countries. With concerns about HIV transmission in mind, some of most damaging impacts of the US–SACU FTA could be the following: foreign investors would have the right to sue the government if they perceive that public-interest laws (such as minimum wage laws) impede their profits; farmers could lose their rights to save indigenously developed seeds and could be forced to buy genetically modified varieties; the United States would be allowed to continue to export subsidised agricultural products into the country; foreign firms would have the right to compete for government contracts; and tariffs on imports from the United States would be drastically reduced.

Without protection for the interests of small-scale farmers and industrial workers, the FTA will mean more prosperity for large corporations but deepening desperation for Swaziland's poor, with devastating implications for the country's AIDS predicament. It is critical that the anti-AIDS campaign collaborate with advocacy groups to demand that the FTA negotiations be subject to democratic scrutiny and that the interests of workers and the market share of local, small-scale producers be protected. In conditions of high HIV prevalence, neoliberal policies such as these can result in apocalyptic human losses. Programmes focused on HIV/AIDS should concern themselves with issues beyond the narrow purview of public health and narrowly conceived ideas of health need. They must expand to include attention to global economic and trade policy.

The Politics of Antiretroviral Therapy

A central strategy of Swaziland's AIDS mitigation campaign seeks to reduce the stigma attached to AIDS patients, as stigma creates denial around the disease and fosters resistance to testing. According to the dominant public health discourse in Swaziland, stigma is rooted in ignorance, but my fieldwork in Swaziland suggests that stigma there is less a matter of ignorance than an understandable aversion to the physical deterioration of patients.[84] Indeed, the most effective strategy for reducing stigma is providing access to antiretroviral (ARV) therapy and treating opportunistic infections, which allows patients to regain bodily wholeness and thus alleviates some of the stigma.[85] Furthermore, the availability of effective treatment options, along with evidence of their success, actually encourages people to seek testing. Paul Farmer's ARV programme in Haiti confirms this: women's willingness to accept

84 I. Niehaus, 'Death before Dying: Understanding AIDS Stigma in the South African Lowveld', *Journal of Southern African Studies*, 33, 4 (2007), pp. 845–60.

85 Note, however, that even people on ARVs may attract some forms of stigma, albeit for different reasons. *Ibid*.

free voluntary counselling and testing rose from 15 per cent to over 90 per cent when ARV treatment options were introduced into prenatal clinic procedures.[86] As Farmer has noted, '[T]he transformation of AIDS from an inevitably fatal disease to a chronic and manageable one has decreased stigma dramatically'.[87] As long as ARVs remain widely unavailable in Swaziland and as long as hospitals cannot treat auxiliary diseases, stigma and denial will continue to inhibit prevention efforts.

Swaziland has slowly increased its provision of ARVs over the past decade, largely as a result of the WHO initiative to provide three million AIDS patients in the world's poorest countries with antiretroviral treatment by the year 2005, but the accessibility of affordable ARVs is not a given. For most of the lifespan of the epidemic, lifesaving drugs were unavailable to all except the wealthiest patients because of the patents held by western pharmaceutical companies. In 2000, patented ARVs cost more than US$10,000 per yearly regimen. Generic producers were able to manufacture the same drugs for one tenth of the price, but the World Trade Organisation (WTO) prevented them from doing so through the TRIPS (Trade Related Aspects of Intellectual Property Rights) agreement of 1995, which was developed to protect patents. Fortunately, in response to popular outrage, the Doha Declaration on the TRIPS Agreement and Public Health was signed in November 2001 in order to allow Least Developed Countries (LDCs) to produce generic drugs for internal consumption in the case of emergency public health crises. Nevertheless, the Doha Declaration failed to benefit countries that lacked the capacity for pharmaceutical production, including Swaziland, for TRIPS still prevented the *importation* of generic drugs. It was not until the WTO succumbed to pressure and signed the General Decision of August 2003 that poor nations were allowed to import generics. By this point, however, the HIV prevalence rate in Swaziland had already reached devastating proportions. The bulk of Swaziland's present AIDS burden can be directly attributed to constraints imposed by the TRIPS agreement and the resistance of the WTO and pharmaceutical companies to changing it.

The Doha Declaration and the General Decision marked a tremendous victory in the battle for public access to ARVs in Swaziland, but this victory is by no means secure. A central component of the TRIPS agreement stated that 'developing' countries would have to observe patent protections for pharmaceuticals after 2005, stripping countries like India and South Africa of the ability to export generics and leaving countries like Swaziland with diminished options for generic imports. Furthermore, beginning in 2016, LDCs will no longer be exempted from patent restrictions on public health goods and will be forced to uphold the original TRIPS agreement. To make matters worse, the proposed bilateral free trade agreement between SACU and the US will implement intellectual property restrictions that may further hinder ARV access for the poor, as happened with the US-Morocco Free Trade Agreement. In a 2002 letter, Robert Zoellick, the former United States Trade Representative (USTR), revealed some of the provisions that an agreement with SACU might include:

> We plan to use our negotiations with the SACU countries to . . . address barriers in these countries to US exports – including high tariffs on certain goods, overly restrictive licensing measures, inadequate protection of intellectual property rights and restrictions the SACU governments impose that make it difficult for our services firms to do business in these markets. [We] seek to . . . build on the foundations established in [TRIPS] and other intellectual property agreements . . .[88]

86 P. Farmer, 'Introducing ARVs in Resource-Poor Settings', paper presented at the 2002 International AIDS Conference, Barcelona (2002).

87 Farmer, 'Introducing ARVs in Resource-Poor Settings'.

88 Cited in T. Avafia, 'The Potential Impact of US–SACU FTA Negotiations on Public Health in Southern Africa', Trade Law Center for Southern Africa (2004), p. 18, available at http://www.bilaterals.org/spip.php?article1357, retrieved 8 March 2011.

Analysts have warned that the primary objective of the United States in this agreement will be to abolish the exceptions provided by the Doha Declaration and the General Decision.[89] Indeed, during the 2006 negotiations the USTR sought agreement on provisions that would prevent the manufacture of generic drugs.[90] These concessions may very well be granted by SACU negotiators in exchange for access to US markets, which could spell disaster for attempts to increase ARV access for the poor in Swaziland. The point here is that these measures are part of the same package of neoliberal policies that has created the conditions for HIV risk; the agents of global capital will continue to be responsible for the deaths of people in Swaziland from AIDS.

Conclusion

The paradigm of individual responsibility has become widely accepted not only in Swaziland's public health community, but also among AIDS patients, who have been forced to accept the language of the powerful and blame themselves for so-called personal pathologies and moral deficiencies.[91] In this article I have argued that it is not the behaviour of Swazi AIDS patients that is pathological, but the behaviour of powerful entities such as the IMF, the WTO, the USTR and the EU, as well as the policies of a dominant global class bent on maximising corporate profits regardless of the human cost. In Swaziland, these class interests have articulated with a monarchical system that has become infamous for its lavish spending, flagrant misappropriation of state funds and violent repression of social movements that agitate for democratic transformation. The rhetoric of 'responsibility', 'behaviour change' and 'moral depravity' should be directed toward the individuals and institutions that have created the socio-economic conditions that condemn the poor to AIDS. After nearly 30 years of failed prevention efforts, it is clear that the epidemic will continue to ravage southern Africa as long as these conditions go unchallenged.

In their analysis of AIDS in South Africa, Gilbert and Walker assert that '[h]ealth education programs which primarily argue that individual behavior needs to be challenged and altered before transmission rates will decline are naïve, misplaced and misleading'.[92] Epidemiological interventions that target proximate, biological pathologies direct attention away from the ultimate, distal conditions that give rise to those pathologies in the first place. As Wende Marshall puts it, 'the biological discourse works to efface the social production of health and shroud the relationships between poverty, [class] and disease'.[93] Anti-AIDS strategies have typically focused on *behavioural/cultural* explanations for HIV prevalence to the exclusion of *materialist/structural* considerations. As I have demonstrated, however, economic and normative realities are interdependent; behavioural choices cannot be abstracted from the material environment in which they are made.

Kim and Moody have argued that interventions that address socio-economic pathologies have a greater impact on overall health outcomes than interventions that address individual biological pathologies directly.[94] HIV prevention campaigns will have to address these social issues – and the power interests that produce them – if they are to succeed. Brazil presents an example of how this can be done. In 1990, the World Bank estimated that Brazil would have

89 Avafia, 'The Potential Impact of US–SACU FTA Negotiations', p. 19.
90 K. McNeely, 'Is the US Trade Agenda Coming Apart at the Seams?' (2006), available at http://www.commondreams.org, retrieved on 10 April 2011.
91 See Basu, 'Institutionalised AIDS'.
92 Gilbert and Walker, 'Treading the Path'.
93 W. Marshall, 'AIDS, Race and the Limits of Science', *Social Science and Medicine*, 60 (2005), pp. 2,515–25.
94 K. Kim and P. Moody, 'More Resources Better Health?', *Social Science and Medicine*, 34 (1992), pp. 837–42.

1.2 million HIV infections by 2000, but the actual number amounted to fewer than 600,000, less than half the prediction.[95] Abadia-Barrero attributes the success of Brazil's mitigation efforts to the influence of progressive social movements that contested free-market policies related to healthcare, antiretrovirals and citizens' rights, while directly confronting social inequalities and corporate class power.[96]

The most obvious counterexample to this claim is the case of Uganda. Uganda is frequently cited as a successful case in the public health literature for bringing its HIV prevalence rate down from a peak of 15 per cent among all adults in 1991 to around 5 per cent in 2001 with a campaign based almost solely on awareness and condom distribution.[97] At first glance, this seems to provide evidence for the behavioural approach; but the social context of transmission in Uganda differs from that of southern African countries in important respects – a fact that the literature almost universally ignores. Since independence in 1962, Uganda has implemented economic reforms designed to guarantee strong production, distribution and export conditions for small-scale farmers, directly flouting IMF recommendations.[98] This has allowed people to maintain their livelihoods in rural areas, thus eliminating the pressure for labour migration. Uganda's HIV prevention efforts have succeeded because the country has a much greater degree of local social cohesion and less rotating migration than most of its southern counterparts.

Following these models, Swaziland could harness its aid resources and the impressive capacity of AIDS NGOs to take meaningful strides toward remediating the structural violence of neoliberal policy. NGOs in Swaziland, however, remain averse to this kind of intervention. When I raised some of these concerns with World Vision Swaziland – the largest and most influential among them – I was told that, while the local staff wanted to pursue this direction, the international offices refused to back interventions of a 'political' nature, since many of their top donors supported (and derived their profits from) free-market policy. This is unfortunate indeed, given that HIV/AIDS is a deeply political problem. One cannot hope to solve a political problem – a problem of power – with an apolitical strategy that systematically ignores power. Such is the conundrum of NGO-led intervention: most NGOs cannot question the global order of inequitable economic arrangements because they depend on it for their very existence, in the form of donations from rich people and rich countries. AIDS NGOs should also be directly involved in agitating for democratic change in Swaziland – a necessary precondition for any popular challenge to the economic status quo – but cannot do so for fear that the monarchy might expel them.

Assuming that Swazi policymakers *were* willing and able to confront the power matrix that underpins HIV transmission, what should they do? In light of the data I've presented, the highest-impact intervention would be to create employment options that would slow labour migration rates. To do this, one strategy would be to invest in making small-scale agriculture profitable: tariff barriers should be erected to protect the domestic market from subsidised foreign imports; the US Farm Bill should be tweaked so that US food aid – which has flooded the market – can be sourced from local farmers instead of American agribusiness; the sugar industry (and other agricultural industries) should be decentralised so as to incorporate small farmers into the production stream;[99] and legislation should be introduced that allows women

95 G. Levi & M. Vitória, 'Fighting against AIDS: The Brazilian Experience', *AIDS*, 16, 8 (2002), pp. 2,373–83.
96 C. Abadia-Barrero, 'The Cultural Politics of the Brazilian AIDS Social Movement', paper presented at the Latin American Studies Association Meeting (2003).
97 W. Kirungi, J. Musinguzi, E. Madraa and N. Mulumba, 'Trends in HIV Prevalence and Sexual Behavior in Uganda', International Conference on AIDS (2002).
98 J. Baffoe, 'Structural Adjustment and Agriculture in Uganda', Working paper, International Labour Office, Geneva (2000); N. Bazaara, 'Impact of Liberalisation on Agriculture and Food Security in Uganda' (unpublished paper for the Centre for Basic Research, 2001).
99 Following the recommendations of Terry, 'Extending Participation in the Swaziland Sugar Industry Growers'.

to utilise land and obtain credit within the traditional tenure system.[100] Another way to create local employment might be through state- and donor-funded infrastructure projects, open to both male and female workers. Like the cash-transfer projects in Malawi, these employment policies would reduce the likelihood of risky sexual behaviour. On a broader level, Swaziland should seek to restore the levels of GDP growth and employment that it enjoyed in the immediate post-independence era, before the imposition of neoliberal policy. It could do this by reintroducing infant industry protections and import substitution programs designed to support local enterprises[101] – the same measures that every single one of today's rich countries used during the crucial stages of their own economic consolidation.[102]

The AIDS campaign should also seek to protect Swazi workers' current incomes by supporting labour unions in their efforts to bolster workers' rights, ensure employment security, guarantee the timely disbursement of wages and provide unemployment insurance to protect workers from unforeseen layoffs. It should also introduce special minimum wage laws in industries where women predominate (such as the domestic service and textile industries) to reduce women's need to engage in transactional sex. The campaign should follow the recent policy of South Africa and push for all large employers (such as the sugar, forestry and citrus industries) to supply infected workers with ARV treatment. More broadly, the campaign should strive to decommoditise ARVs and other crucial pharmaceuticals so that public health outcomes are not contingent on the calculations of corporate profit. Finally, on a more global level, the prevention campaign should fight to re-organise international trade rules and introduce a system of targeted quotas that would channel foreign direct investment to the places it is needed most for poverty alleviation, not solely to the places where labour is cheapest and regulations are most lax.[103] This would require building alliances with the global justice movement, which has long pushed for the democratisation and de-corporatisation of the World Bank, the IMF and the WTO.

In short, battling HIV in Swaziland requires battling the neoliberal order in which Swaziland has become entangled and challenging the power of rich nations over the world's resources; it requires imagining a world in which economic policies and concepts of the social good are collectively determined and democratically ratified and where capital is harnessed to benefit humanity, rather than the other way around. The tragedy of the current public health crisis provides an extraordinary opportunity to do exactly that, even in the face of entrenched corporate interests and resistance posed by international financial institutions. With nearly 20,000 people dying of AIDS in Swaziland alone each year – 2 per cent of the country's population – never before has there been a more compelling reason or greater popular mandate to interrogate the tenets of neoliberalism.

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100 O'Laughlin, 'Widows' Weeds', argues that collective tenure systems in southern Africa are often better than individual title deeds when it comes to protecting the poor.

101 C. Collins, 'Mozambique's HIV/AIDS Pandemic' (UNRISD Programme on Social Policy and Development, Paper No. 24, 2006), p. 1 argues for economic alternatives to the migrant labour system in order to stem the HIV epidemic in Mozambique.

102 H. Chang, *Kicking Away the Ladder* (London, Anthem Press, 2003).

103 J. Stiglitz and A. Charlton, *Fair Trade for All: How Trade Can Promote Development* (Oxford, Oxford University Press, 2006).