

An anthropological examination of the HIV/Aids epidemic

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Introduction

Examination of the HIV/AIDS epidemic from a critical medical anthropological point of view affords insights that may be of utility in containing its spread. As noted by Farmer, the spread of HIV follows the "fault lines" of society^{1,2}. Large scale social forces—political, economic, and cultural—determine who will be at increased risk of contracting HIV. These forces join together to ensure that it is women in poverty who are most at risk³⁻⁵. They are thus subject to "structural violence," the consequence of social policies that benefit the elites³. This necessitates analysis in terms of gender, class, and the world economic order. In this paper I will examine some social scientific contributions toward an understanding of its spread within a number of populations in which HIV is now endemic: Southern Africa, Haiti, and the inner-city U.S. The current situation in the Pacific region is examined for parallel developments, and lessons for abating the epidemic here are drawn.

Political economy

The standard anthropological mode of inquiry is ethnography or participant-observation, the naturalistic observation of people's lives. One consequence of strict reliance on ethnography is the tendency to "stay close to the ground," *i.e.* to view social groups as independent totalities, when they are, rather, subunits of larger groups, subject to larger

fields of power^{6,7}. As a consequence, structures of oppression and political economy are deemphasized⁸. Thus, anthropology has been criticized for its "ahistorical, apolitical, and cultural relativistic stance"⁹.

Political economy is historically the discipline that examined "'the wealth of nations,' the production and distribution of wealth within and between political entities and the classes composing them"⁹. Concerned with "how wealth was generated in production, with the role of classes in the genesis of wealth, and with the role of the state in relation to the different classes"¹⁰, political economy preceded the disciplines of sociology, anthropology, and economics. These more focused disciplines were founded in the mid-1800s in contradistinction to political economy, the concerns of which had been shared by both conservatives and socialists alike.

Marcus and Fischer identify three meanings for "political economy" in contemporary usage: a literature on public choice and the dilemma of collective action in democratic societies; the work of latter-day Marxists, especially on dependency and underdevelopment in the third world; and a more generically defined interest in the mutual determination of political processes and economic activity in a historically viewed world system of nation states⁸.

Following Keesing, Morsy characterizes political economy as emphasizing the "structural relationship among economic systems, political power, and ideologies."¹¹ Dialectical political economy is not simply an eclectic holism but an explicitly materialist stance. The relevant variables are power... the mode of production, ... class interest, exploitation, social control, subordination, hegemony, and the world capitalist system. Indeed, to mention capitalism may seem subversive to some anthropologists who thus disguise it as modernization, industrialization, civilization, urbanization, and development in sentences that talk of 'diseases of...'¹².

Thus, much of the recent work within politically-influenced anthropology utilizes a Marxist conceptual framework.

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Critical medical anthropology

The framework for critical medical anthropology^{7,13,14} is political economy. Critical medical anthropology is defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the *interaction* between the macrolevel of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the microlevel of illness experience, behavior, and meaning, human physiology, and environmental factors. This effort is peculiarly anthropological in the sense that it is holistic, historical, and concerned with on-the-ground features of social life, social relationships, and social knowledge, as well as with culturally constituted systems of meaning⁷.

Importantly, critical medical anthropology does not deny the utility of ethnography; rather, it seeks to make the ethnographic method one informed by political economy.

Hegemonic cultural constructions

One major concern of critical medical anthropology is countering the hegemonic cultural constructions that dominate discourse about health. Ideology plays a major role in the maintenance and reproduction of the existing social order. This is the function of the ideological component of biomedicine, the hegemonic construction in the discourse about health and disease. A concept originating in the writings of Italian communist Antonio Gramsci, hegemony is defined by Glick Schiller as "the means by which subordinated populations participate in cultural constructions that contribute their continuing subordination"¹⁴. As HIV/AIDS is a relatively newly described disease, its cultural construction¹⁵, including its metaphors¹⁶, is actively being defined and redefined. While the HIV/AIDS is ostensibly scientifically described, dominant cultural values impinge on the use of the terms "HIV" and "AIDS" in actual discourse.

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Thus, critical medical anthropology examines the social production of disease in the context of the environment, "the labor process, and Third World underdevelopment"¹⁷. Consequently, the critical view attempts to define the social conditions that encourage the spread of the HIV/AIDS pandemic. It has been shown that social instability contributes to the spread of sexually transmitted diseases in general and AIDS in particular¹⁸. Delineating the manner in which this occurs is our present concern.

Conditional rationality

In terms of HIV/AIDS, it is often noted that the spread of HIV should be completely preventable because it depends on certain behaviors for its transmission. In order to understand the processes, by which people decide upon courses of action, why they behave the way that they do, we must become aware of the basic constraints on their lives. Only then is it possible to see that what are often termed "life style" choices are not really freely chosen by many people. Engels noted that social groups often adopt "health-related behavioral patterns that reflect compensatory responses to onerous social conditions"¹⁹. Levins and Lewontin note,

The constraints on the lives of oppressed peoples present the limited choices available; within those constraints they often make conditionally rational choices. For instance, a man's decision to smoke may increase his risk of heart disease and cancer in the long run, but as one of the few ways he has of coping with stress, it may save the lives of his wife and children. Our assumption of conditional rationality means that we cannot expect to change behavior by education alone: rather, we must alter those circumstances that make such harmful choices seem optimal².

The concept of conditional rationality is useful in understanding the spread of HIV/AIDS. It allows for an understanding of why prevention programs based solely on education about the modes of transmission of HIV have not been successful.

The social production of illness

Another concern of critical medical anthropology is the social production of illness. Waitzkin notes that disease is not the straightforward outcome of an infectious agent or pathophysiologic disturbance. Instead, a variety of problems—including malnutrition, economic insecurity, occupational risks, bad housing and lack of political power—create an underlying predisposition to disease and death⁸.

The New World Order

A common factor in much of the transmission of HIV/AIDS throughout the world is poverty, particularly the feminization of poverty^{3,5}. This necessitates analysis in terms of gender, class and the world economic order. The work of Wallerstein^{9,10,20} in world-system theory has provided a framework for much recent work in politically informed interdisciplinary research. Addressing the shortcomings of development theory, in the early 1970s Wallerstein proposed viewing local situations in terms of the

economic history of capitalism since the sixteenth century. In brief, the world is ordered into the core countries and the periphery, broadly, the First and Third Worlds^{21, 22}, the consequence of imperialism, the worldwide spread of capitalism,^{23,24}. The countries of the periphery are integrated to a greater or lesser extent into the world economy.

The international economic order, as imposed upon the Third World by the First through the structural adjustment programs of the World Bank and the International Monetary Fund has meant the following (1) privatization of state corporations, (2) cutbacks in public sector employment and social spending, (3) opening of markets to expatriate corporations, (4) ease of repatriation of their profits, (5) currency devaluation, (6) cuts in minimum wage, (7) emphasis on exports rather than local needs.

The predictable results have been as follows: (1) diminishing world commodity prices, (2) depletion of natural resources, (3) degradation of environments, (4) more debt (from 1982 to 1990, debtor countries paid \$1.3 trillion and were in 61% more debt at the end of this period), (5) more poverty (according to the U.N. 1.2 billion people in the Third World live in absolute poverty, almost double the numbers of a decade ago)^{25,26}.

HIV/AIDS in Southern Africa

We will now examine critical approaches to the HIV/AIDS epidemic in other areas of the world, starting with Southern Africa, with the intent of learning lessons for the Pacific. As noted above, we will incorporate contributions from historic, political, and economic approaches. In the colonial era, Belgian enterprises operating in the Congo earned twice the profit on their investments

than were possible in Belgium²⁶. Zaire, inheriting the mineral export industry that had dominated the economy of the Belgian Congo since the 1920s, received foreign loans for this sector. Dependency on copper production and a lack of investments in the peasant economy led to increased migration to the cities. Around the same time that the price of copper in the international market declined in 1974, the foreign debts fell due. Over the next decade, the national economy shrunk by 18% while prices rose 6580%²⁶. In 1983, the International Monetary Fund instituted a structural adjustment program, leading to cuts in education and health programs and unemployment for 80,000 teachers and health care workers²⁵. The long-standing economic crisis has led to widespread poverty, especially among women. In turn, this has led many women to depend on multiple partner sexual relationships in order to receive economic support— a conditionally rational strategy for survival. The majority of women at risk, however, are not

engaged in prostitution. In addition, many women who are monogamous with their partners are at risk from their partner's polygynous behavior⁶. Schoepf utilizes life history vignettes to illustrate these points. While women's groups visited by Schoepf stress the need for income-generating activities, she is not optimistic about the prospects of local communities being able to mitigate the effects of worldwide economic crisis.

Secondly, the spread of HIV in much of Southern Africa is a consequence of the low-intensity wars of destabilization conducted by the former apartheid state of South Africa against its neighbors. The wars ruined rural economies and force populations into flight from marauding armies. This has swelled the population of street children and led many to prostitution as a means of survival¹⁷. Similarly, the civil war in Uganda has played a role in the spread of HIV²⁷.

AIDS in Haiti

The modern history of Haiti can be characterized as one of colonial subjugation leading to chronic underdevelopment. The first colony to free itself from a colonial power, the Republic of Haiti, declared in 1804 was the first free nation of free people. From 1849 to 1913 the U.S. violated Haiti's waters twenty-one times. By 1913, the U.S. controlled 60% of Haiti's market. The U.S. occupied Haiti from 1915 to 1934. During the reigns of Francois "Papa Doc" Duvalier and Jean-Claude "Baby Doc" Duvalier, Haiti was further integrated into the U.S. economy, especially in assembly, becoming the world's largest producer of baseballs^{1, 28}.

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As Haiti took its place as "the poorest country in the hemisphere," a sex industry catering to North American gays flourished in the '70s and early '80s, particularly in the Port-au-Prince

suburb of Carrefour. This was probably a major route for the introduction of HIV into Haiti¹. In a study published in 1984, 17% of Haitians with AIDS reported sexual contact with North American tourists¹. Thus, contrary to assertions in the medical and popular literature early in the epidemic that HIV/AIDS had been introduced into the U.S. from Haiti¹, HIV was probably introduced into Haiti via North American tourists or Haitians returning from North America. Farmer notes that if the epidemic had occurred some decades earlier, the former "tropical playground of the Americas," Havana, would surely have become a major epicenter. Having escaped the U.S. sphere of influence, however, Cuba has had very low prevalence rates of HIV¹.

According to WHO terminology, HIV transmission in the Caribbean basin follows "Pattern II," *i.e.* predominantly heterosexual transmission from the start. Early reports of AIDS among Haitian-Americans in the U.S. stressed the lack

of the accepted risk factors. (Only 6% were bisexual, and only 1% used intravenous drugs.) Consequently, Haitians overall were designated a risk group, and intensified discrimination against Haitians in the U.S. predictably followed. However, studies conducted in Haiti early in the epidemic showed that half the men had a history of homosexual relations. Pape *et al* note, "The disparity in the data from the United States and Haiti may be attributable, in part, to a greater willingness of Haitians to provide reliable responses to personal questions in their native country and language". In Haiti, while, heterosexual transmission is, indeed, predominant at present, homosexual transmission was significant in the early stages of the epidemic in Haiti.

Currently, there is a close association between HIV infection in women and poverty. The main risk factor for HIV seropositivity for women from the Haitian countryside is the occupation of their partners. Eight of ten women with HIV had had sexual contact with soldiers or truckdrivers. Poor women in Haiti often enter into liaisons with men from the city, as such men are more likely to be able to support them economically. The women often thus contract HIV from their first sexual partner²⁹. The choice that such women make is conditionally rational in the context of their poverty. That it leads to HIV and AIDS is an unforeseen consequence of their decisions.

The Third World within the First World

Within the imperial centers, oppressed peoples are subject to economic exploitation, political repression, and racism. Within the U.S., the oppressed people are African Americans and Latinos, and in some areas of the country, Native Americans and Asians. Cities such as New York City and Washington DC has seen "desertification,"⁶ the collapse of minority community physical and social structures, a result of political and economic abandonment as manifested by planned shrinkage during the 1970s. With the lack of viable economic alternatives, many turn to selling drugs and sex, and the young are socialized into such activities⁶. Singer suggests the use of the term "syndemic" to describe the "set of synergistic or intertwined and mutual[ly] enhancing health and social problems facing the urban poor"⁶. The syndemic is characterized by high rates of infant and child mortality, cardiovascular disease, alcohol and drug abuse, HIV, and STDs. While African Americans and Latinos together comprise 28% of the U.S. population, they account for 47% of the AIDS cases (30% African American, 17% Latino)⁶. The elements of the syndemic are closely interrelated: Poverty contributes to poor nutrition and susceptibility to infectious diseases; social conditions con-

tribute to alcohol and drug abuse, which make one susceptible to HIV and STDs²⁹.

Wallace and Wallace point out that the disintegration of urban minority communities has led to outmigration to suburban minority enclaves. The resultant extended social networks between the city and the suburbs serve as routes of spread of HIV infection. Wallace and Wallace maintain that "policies of marginalization may create social dislocations resulting in both increased rates of serious infectious disease and increased coupling between communities"³⁰.

HIV/AIDS and drug use

Despite education programs regarding the transmission of HIV that reach their intended audience, injection drug users continue high risk practices: sharing needles and unprotected sexual contact. This has led to increasing rates of seroprevalence. Connors proposes that among injection drug users, "AIDS is not so much denied as are its meanings contested"³⁰. She maintains that dissent is the salient characteristic of the injection drug users attitude toward public health messages.

Drug users face the multiple stigmas of race, class, and deviance as illicit drug users. Their experience with authority often includes being fired from jobs, being imprisoned, or having their children taken away. Public health messages, embedded in discourse that serves to legitimate the prevailing power structure, are thus interpreted by drug users in light of their distrust of medical and governmental authority. Dissent is directed outward, toward "the system" as well as inward, toward one's own body⁷.

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While the recognition of social scientific contributions to health research is welcome, Glick Schiller is critical of the manner in which the concept of cul-

ture has been utilized in AIDS epidemiology. While anthropologists work to view the at-risk behaviors of people within the context of the social problems that they face, Glick Schiller sees health researchers as identifying culture as an explanatory variable.

For the health researcher, drug users and minority populations are at high risk for HIV because they belong to subcultures that deviate in practices and life-style from the behavior and values of the general population. By incorporating racial and ethnic categories within their conception of cultures at risk, the health researchers were implicitly suggesting that the risky behavior of intravenous drug use was a product of African American or Hispanic culture³¹.

Glick Schiller thus identifies the seemingly neutral HIV risk categorizations as hegemonic constructions.

Sexual decision-making and conditional rationality

In inner-city communities where a high proportion of the population uses drugs, there is a relative dearth of young men secondary to high mortality rates and high rates of incarceration. In such areas, poor, minority women have difficulty protecting themselves from HIV infection³². A woman's insistence that her partner use a condom could imply that she does not trust him, that she has been promiscuous herself, or a lack of commitment^{6,31,32,37}. If he is prone to violence, she could be placing herself at risk of violence. If she is economically dependent on him, she could be placing herself at economic risk. In these ways, social conditions constrain the choices available, and women are forced to make conditionally rational decisions—in many cases not insisting upon the use of condoms.

My impression from clinical work in the Filipino and Samoan communities in Hawaii is that many women in immigrant communities in Hawaii are at risk for contracting HIV from (a) multiple sexual partners and (b) male partners who have had multiple partners previously.

Lessons for Hawaii and the Pacific

Although the number of AIDS cases reported from the Pacific jurisdictions is relatively low, cases are increasing rapidly³³. Let us consider what the implications of a critical approach might be for the local situation. Firstly, we need to better understand the commercial sex industry as it is presently constituted in the Pacific. The commercial sex industry thrives on Oahu and other Pacific districts such as Guam, Saipan, Papua New Guinea³³ and Fiji³⁴. Incumbent on the public health system is the prevention of HIV infection in the sex industry workers. Secondly, while it is important not to view prostitutes as simply "vectors" of infection^{7,35}, the example of the introduction of HIV into the island nation of Haiti via the commercial sex industry points out the possibility of similar scenarios being repeated in the various island districts of the Pacific.

Ethnographic research in other areas of the world has examined the nature of commercial sexual work, including the frequency and nature of the use of condoms^{36,39}. The WHO has investigated prostitution in Saipan³⁰, and condom use has been shown to be very low among sex workers in Papua New Guinea³³ and Fiji³⁴.

Further research should examine whence these workers come, the life circumstances that led them to engage in such work. The majority of sexual workers in Saipan, for exam-

ple, are from the Philippines, part of the *Gastarbeiter* work force that performs much of the labor in the Commonwealth of the Northern Marianas Islands (CNMI)³⁰. The Filipino community on Saipan took umbrage at discussion of the report in the CNMI media, with criticism largely directed at the government HIV/AIDS educator for the "slander" of Filipino women. More properly, protest should have been directed at those who run and those who frequent the brothels, and, more generally, the social and economic system that profits from the work of these women.

As noted by Schoepf²⁶ and Hamblin and Reid³⁴, however, the majority of women at risk for contracting HIV are not commercial sex workers. Schoepf notes that many women in Zaire have multiple sexual partners as part of an economic survival strategy. Hamblin notes that the largest group of women at risk of contracting HIV are wives.

As regards the situation in Saipan, the men who frequent prostitutes (locals, expatriates, and tourists) put themselves and their wives at risk of HIV infection. My impression from clinical work in the Filipino and Samoan communities in Hawaii is that many women in immigrant communities in Hawaii are at risk for contracting HIV from (a) multiple sexual partners and (b) male partners who have had multiple partners previously. Critically informed research on the circumstances, whether they be social or economic, that lead such women into these relationships is needed. With the economy of Hawaii so highly dependent upon a single sector (tourism) and in stagnation, there has been an increase in economic difficulties among residents. The lack of viable economic opportunities will lead to more people engaging in the illegal drug and sex industries, leading to greater risks for contracting HIV.

Conclusion

In this paper I have examined the HIV/AIDS epidemic from the viewpoint of critical medical anthropology, using the examples of Southern Africa, Haiti, and the inner-city U.S. Lessons for Hawaii and the Pacific have been drawn. The utility of an approach that includes, historical, social, and political-economic modes of inquiry toward understanding the entry and spread of HIV in endemic populations has been demonstrated.

A recurring theme has been the effects of the feminization of poverty, and the economic and social conditions within which people make the decisions that place themselves at risk for contracting HIV. The manner in which people make conditionally rational choices within the constraints on their

lives has been examined. Connors urges a change in paradigms with which we approach HIV prevention.

Medical anthropology must continue its study of the personal and social processes of power appropriation, but from a new epistemological base which acknowledges the limitations of current behavior-change strategies for their implicit assumption that disenfranchised individuals possess the kind of social and political agency required to avoid HIV infection⁴⁰.

As regards the situations of women that place them at risk for contracting HIV, as noted by Katz, the only reasonable long-term strategy is "to strive for social justice and equality for women."⁴¹ This will entail empowering women economically and socially. From the above discussion, we can conclude that other long-term strategies to combat the spread of HIV should also include a more just re-making of the world economic order, elimination of economic exploitation and political repression, and continued struggle against racism.

That the prospects for such sea changes in our society do not seem to be in the immediate offing should not make us despair. Neither should we devote our energies solely to "achievable" goals. Singer described what can be achieved with community involvement.¹³ Recognizing that Haitians in the Boston area were concerned about the racial discrimination resulting from the designation of Haitians as a "risk group" for AIDS, Partners in Health (which offers technical and financial assistance to community-based organizations) initiated the Haitian Teens Confront AIDS project⁴². By addressing the racist treatment that Haitians were experiencing and countering the misinformation promulgated about Haitians and HIV, HIV prevention messages were well-received by the Haitian community.

Singer¹³, in a discussion of critical praxis in medical anthropology, discusses the work of the Hispanic Health Council, a community-based health institute in Hartford, Connecticut, founded by medical anthropologists and Puerto Rican community health activists. In response to the HIV/AIDS epidemic, the council organized research regarding attitudes toward AIDS, the extent of HIV risk behavior, and life problems of drug abusers in the community. Subsequently, the council trained community members to be AIDS activists, and organized AIDS prevention, education, and support. The council sought to counter portrayals of AIDS as caused by gay people and as divine retribution. The

council also advocated needle exchange in Connecticut, currently the only state east of the Mississippi with a sterile needle exchange program⁴¹.

Farmer and Kim identify five tasks for anthropologists confronting AIDS: (1) explaining why AIDS is becoming a disease of marginalized people, (2) demonstrating how societal responses to AIDS reflects core cultural values, (3) witnessing the experience of individuals and communities afflicted by AIDS, (4) countering misinformation in order to mitigate the cruelties inflicted on people with AIDS, (5) documenting the effects of such false information⁴¹. These are apposite tasks for all of us involved in health care.

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A recurring theme has been the effects of the feminization of poverty, and the economic and social conditions within which people make the decisions that place themselves at risk for contracting HIV.

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No sex is better than bad sex.

Germain Greer