ENGL 114: Acting Globally
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The Limits of Moral Ideology in Foreign HIV/AIDS Intervention
by Akielly Hu

From the first cases reported in the early 1980s up until today, the HIV/AIDS pandemic has emerged as one of the world's foremost public health crises. In 2014, there were 36.9 million people living with HIV – an increase of 6.9 million from the 29.8 million infected in 2001 ("The Global HIV/AIDS Epidemic"). Such a drastic global issue has understandably garnered a large amount of foreign intervention. While international bodies such as the World Health Organization, the Global Fund, and UNAIDS have made many global efforts to combat HIV/AIDS, the United States has been and is still by far the largest single national donor for global HIV/AIDS intervention, committing over $4 billion in approved funding in 2010 alone (Allman and Ditmore 7). This funding comes primarily through the President's Emergency Plan for AIDS Relief (PEPFAR), created in 2003 under George W. Bush's administration. Over the past five years, PEPFAR authorized funding of up to $15 billion against the HIV epidemic ("The Global HIV/AIDS Epidemic"). Ample evidence has shown the positive effects of such mass funding; through these efforts, PEPFAR funding has provided anti-retroviral treatment for over 3.9 million people diagnosed with HIV/AIDS. In 2011, it provided testing and counseling for over 40 million people (Allman and Ditmore 1).

While PEPFAR has contributed significantly to the reduction of new HIV infections and HIV-related mortality, its policies and funding have also resulted in harmful consequences due to the inclusion of an anti-prostitution clause in the law creating the program. As stated in the

Global AIDS Act of 2003, the anti-prostitution clause requires: "no [PEPFAR] funds … may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution" (Allman and Ditmore 7). This pledge to actively oppose prostitution was introduced and ratified by conservative policy-makers, many of whom were motivated by the traditional Christian view that prostitution is immoral. According to Allman and Ditmore, "the pledge has received strong support from activists and politicians in the United States who take a philosophical or religious stance against prostitution" (7). While the Supreme Court ruled this clause unconstitutional in 2013 due to its violation of the First Amendment, the PEPFAR anti-prostitution pledge clearly illustrates the persistent focus on HIV/AIDS in moral terms: in this case, PEPFAR reflected the idea that prostitutes transmit and contract HIV because they make immoral choices. Rather than effectively reducing HIV transmission, however, the dominant approach of focusing on individual moral actions stigmatizes the very people who need the most help. Instead, policymakers must shift to a more accurate view of the HIV pandemic as a collective, systemic issue that can be addressed through a community-based, holistic approach.

The ideological stance against prostitution views the HIV pandemic, especially among prostitutes, as an accumulation of individual moral choices: individuals make the immoral decision to enter the sex trade or pay for sex, effectively choosing to put themselves at risk. With this mindset, PEPFAR and other ideological HIV intervention schemes actively oppose and work to eradicate prostitution as a means of reducing HIV transmission. Viewing the issue of HIV/AIDS through this moral lens, however, fails to recognize the factors outside of individual control – including widespread poverty and lack of employment opportunities – that lead to prostitution. A study by the World Health Organization on commercial sex in Asia emphasizes these outside pressures through its findings that "Most of the people who sell sex in Asia do so

because they are compelled by economic and social inequality and by terribly restricted life chances. Especially in the poorer countries of the region, they have no other realistic option" ("STI/HIV: Sex Work in Asia" 6). In other words, most people don't simply choose to place themselves at risk of HIV transmission: rather, they are forced into prostitution due to poverty, inequality, and lack of employment options. Contrary to the PEPFAR and traditional HIV/AIDS policy perspective, these collective issues – and *not* the immoral decisions of individuals – result in the extensive sex trade that drives HIV transmission. Geetha Das, a sex worker in Sonagachi, a red-light district in India, echoes the significant role of systemic factors such as poverty in driving the sex trade: "Would I have been able to pay for [my children's] studies if I had stayed at home? Society should first look at itself before condemning us… Did anyone give us a good job? Society has failed people like me" ("Inside Sonagachi"). The experiences of Das and other sex workers like her illustrate the responsibility of the entire society in driving the issue of commercial sex trade and HIV transmission, rather than just the individual sex worker. Elizabeth Pisani, an HIV/AIDS epidemiologist working in Indonesia, reiterates this need to remove moral judgment from sex workers in relation to HIV/AIDS. She argues that in many instances, the lucrative nature of the sex trade makes prostitution the financially best option for poor women: "In the factory, you earn 19 cents an hour. In the brothel, your take-home pay averages about US $3.15 an hour. Two horrid jobs; one pays sixteen times more than the other" (Pisani 217). This huge disparity between the wages of the limited employment opportunities (namely, factory work or prostitution) for women in impoverished communities further demonstrates that most people enter the sex trade out of economic necessity, rather than their own lack of morality. The above statistics and examples therefore show that viewing HIV transmission and prostitution as the result of individual moral actions clearly disregards the complex web of systematic factors in

impoverished communities (such as poverty and inequality) that lead many women to enter the commercial sex trade.

Viewing HIV transmission as an individual moral choice not only is inaccurate, but can also lead to disastrous consequences in policy implementation. We see these negative consequences in many foreign HIV/AIDS intervention projects affected by the PEPFAR anti-prostitution pledge. Because of this clause, many HIV/AIDS intervention projects previously funded by PEPFAR were forced to discontinue their efforts due to "lack of compliance" with the anti-prostitution pledge. Such was the case with the Lotus Project, a non-governmental HIV/AIDS program in Svay Pak, a brothel district close to Phnom Penh, Cambodia. Located above and serving in conjunction with a Médecins Sans Frontières clinic, the Lotus Club offered workshops on health, social, and economic issues as well as other topics suggested by the sex workers themselves. These included teaching workers how to use the female condom, individual counseling, English lessons, and basic computing. The Lotus Club also provided a safe space to meet and eat snacks (Busza 12). Facilitation of community participation and empowerment provided numerous qualitative benefits, such as strengthened relationships with fellow sex workers, increased knowledge on female condom usage, and increased support through workshops and discussions (Boesten 110). Rather than stigmatizing the Svay Pak prostitutes as immoral transmitters of HIV, the Lotus Club validated the sex workers' struggles by addressing the collective, systemic issues that led to HIV transmission. They then actively provided services to alleviate these societal issues, such as the lack of support, education, and contraception. This collective approach to combatting HIV, as seen in the numerous qualitative effects above, proved extremely successful in increasing measures to prevent HIV transmission.

Yet despite its effectiveness, the Lotus Club was brought before the House Committee on International Relations in 2002 as a 'Foreign Government Complicit in Human Trafficking' due to failure to "comply" with the anti-prostitution pledge (Busza 18). The denunciation and eventual discontinuation of the Lotus Club is a clear example of the failure of the current approach to HIV/AIDS intervention: when lawmakers actively condemn prostitution and focus on the idea that prostitution is immoral, they fail to recognize sex workers' struggles with systemic factors outside of their control that lead to prostitution and HIV transmission. The most telling example of this ignorance of systemic factors occurred when ideological U.S. policymakers condemned the Lotus Club staff for never having called the police. They viewed this inaction as support of prostitution, when in reality, corrupt Cambodian police often cracked down on brothels and demanded bribes in order to supplement their incomes (Busza 5). This lack of understanding of the corrupt police shows how focusing singularly on the moral ideology of prostitution fails to address the actual systemic factors such as corruption that perpetuate prostitution.

Furthermore, viewing prostitution and HIV transmission through a moral lens stigmatizes sex workers – the people who need the most support in combatting HIV – leading to ineffective HIV reduction. If sex workers are condemned and therefore unable to receive support from NGOs, they lose access to tools such as counseling and condoms that can actually reduce HIV transmission. After the implementation of the anti-prostitution pledge, the Lotus Club struggled to maintain an effective relationship with the Svay Pak community that "they are encouraged to 'oppose' and as a result… [found] they were unable to deliver services without stigmatizing their intended beneficiaries" (Allman and Ditmore 7). Out of fear of losing further funding, the Lotus Club was unable to provide their previous services that benefitted the sex workers and prevented

HIV transmission, including counseling, education, and female condoms: these difficulties eventually dismantled the entire project. By forcing The Lotus Club to discontinue support for sex workers and maintain a policy opposing prostitution, the US government prevented effective HIV reduction by rejecting the people who needed the most help and eliminating effective services. The Lotus Club case study shows how imposing a moral ideology on the NGO stifled its clearly effective prior efforts to address the realities of the local systemic issues, such as the need for peer support and discussion and occupational safety. By condemning the Lotus Club's "support" of prostitutes, ideological policymakers focused purely on the abstract moral stance against prostitution and ignored the complex on-the-ground realities of HIV transmission that must be addressed.

By critiquing the current approach of moralizing the issue of prostitution and HIV transmission, one begins to understand the HIV pandemic as not a result of individual moral actions, but a collective issue resulting from of a web of systematic factors including poverty, lack of employment opportunities, and corruption. This collective, systematic nature of the HIV pandemic therefore requires a community-level, holistic intervention. One successful example of this approach is the Sonagachi Project, an empowerment HIV/AIDS intervention project in the red-light district of Calcutta, India. Along with promotion of condom usage and the establishment of free STD and healthcare clinics, sex workers were trained as Peer Outreach Workers to give free medication, care for an assigned caseload of sex workers, and provide social and physical support. As the project continued, the Sonagachi workers and Peer Outreach workers provided literacy classes, HIV awareness education, child-care, a micro-loan service, and even the creation of a condom-selling business (Smarajit, et. al 411). All evidence points towards the effectiveness of this systematic, community-based approach to combatting

HIV/AIDS. While other cities in India such as Bombay, Delhi and Chennai had HIV rates of 50% to 90%, in Calcutta, the rate dropped to about 11%, despite the tens of thousands of sex workers in the red-light district (Arora, Cyriac, and Jha 1337). Condom use also rose as a result of Sonagachi, from 3% in 1992 to 90% in 1999 (Arora, Cyriac, and Jha 1337). The Sonagachi Project focused on the facts of the issue of HIV in Calcutta: namely, the lack of STD treatment and testing services, the lack of education and child-care, the need for economic support, the need for measures for occupational safety and support in the form of Peer Outreach Workers, and the health benefits and business potential in condom promotion and distribution. This approach recognized that a complex web of collective issues, including various economic and social factors, contributed to the HIV epidemic. By addressing these systemic changes needed in the Calcutta community rather than focusing on attacking the "immoral" choices of individual sex workers, the Sonagachi Project achieved significant, quantifiable outcomes in reducing HIV transmission.

Another systemic change the Sonagachi Project addressed was the need to engage and mobilize sex workers to combat HIV transmission. Though sex workers are at the highest risk of contracting HIV, they are often stigmatized and therefore too disempowered to take action against this shared issue of HIV transmission. Therefore, effectively reducing HIV rates also requires addressing this collective issue of disempowerment. The extreme success of the Sonagachi Project was due in part to its recognition of this collective disempowerment and its policies to instead empower and engage sex workers in the fight against HIV. The leaders of the Sonagachi Project began doing so by reframing sex work as means of survival and not as an immoral state of being in their official policies. They affirmed that "rather than 'fallen' women seeking personal gain, these women were surviving only because of their employment but

largely aspired to the same goals as mainstream society—marriage and family" (Smarajit, et. al 407). This policy empowered sex workers by recognizing that the stigma that prostitutes are immoral and "seeking personal gain" is false: in fact, prostitutes enter this "employment" as a desperate means of "surviving". The Sonagachi workers asserted that like most other people who desire "marriage and family", sex workers are humans who require income to survive and deserve to be protected against HIV. By legitimizing sex workers and their need for employment and safety, the aid workers of the Sonagachi Project empowered sex workers to recognize their need for safety and begin actively combatting HIV infection. This empowerment was not only achieved by reframing prostitutes as sex "workers" rather than "fallen women", but also by employing sex workers in leadership roles as Peer Outreach Workers. These Peer Outreach Workers worked in conjunction with Sonagachi leaders to distribute condoms and increase negotiation of condom use with clients (Smarajit, et. al 408). When sex workers realized the legitimacy of their needs and their ability to take action such as promoting negotiation of condom use, they were able to overcome the issue of collective disempowerment and instead enact systemic change in order to reduce HIV transmission.

Solving the global HIV/AIDS pandemic requires not only continued funding into research and policy implementation, but also a concerted effort to shift our attention from the morality of the pandemic to the fact-based community-level approaches that can be taken to most effectively address these issues. The HIV/AIDS pandemic in particular can often be a morally contentious issue, as high-risk groups include men who have sex with men (MSM), those who engage in unprotected sex, and commercial sex workers, the main subjects of this paper. However, as the Lotus Club Project and other case studies have shown, focusing too narrowly on the inherent morality of individual actions ignores the more relevant and pressing systemic

factors that cause these issues, such as the inevitability of people entering the sex trade and the subsequent need for occupational safety such as increased condom usage. Effective reduction of HIV/AIDS therefore requires the recognition of the pandemic as a collective issue and a community-based, holistic approach to intervention.

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