
# Global Social Issues

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## An Encyclopedia

**Christopher G. Bates and James Ciment, Editors**

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# GLOBAL SOCIAL ISSUES

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# Introduction: *Global Social Issues in Perspective*

In many ways, we live in unprecedented times. At no other time in history has the world as a whole experienced such enormous progress in so short a time. With China and India leading the way, hundreds of millions of people in dozens of developing countries have been lifted out of poverty and into the middle class in a few short decades. Thanks to the Internet and mobile telephony, virtually the entire population of the planet has access to information and to one another to a degree that even the best-informed and most powerful people in the past could not have dreamed of. Medical breakthroughs and public health initiatives are reducing the incidence of age-old scourges. Safe drinking water is becoming accessible to more and more people. Literacy rates are increasing.

Unfortunately, the uniqueness of the times also extends to the problems the world faces. While enormous wealth has been generated in recent decades, its distribution has grown increasingly unequal. Civil conflict and international terrorism—whether spurred by religious zealotry or ethnic hatred—know no borders, threatening virtually everyone, wherever they live. Population growth, combined with the material abundance produced by unprecedented economic growth, threatens the environment and climate that sustain us as a species.

To that end, this work attempts to encompass—to the degree any single work can do so—the enormous complexity of the world in which we live, with all of its hope and despair and all of its problems and progress. Each chapter essay includes a discussion of the nature of a particular problem or issue as well as the efforts being made to address it.

A few words about the title, *Global Social Issues,* are in order. The work covers a range of issues so broad that no single definition encompasses all of them. We chose the word "social" not in the traditional, academic sense—referring to the specific realm of family or community—but to highlight the work's emphasis on contemporary issues that affect societies around the world. Thus, the emphasis of coverage in each chapter is less on the technical and conceptual aspects of the issue at hand—though these are explored to the extent necessary to help uninitiated readers make sense of them—and more on its social ramifications.

The encyclopedia also attempts to balance historical and contemporary aspects of the issues under discussion, with an emphasis on the latter. Like technical terms and conceptual underpinnings, historical background is offered for context and perspective—to help readers understand how they arose as problems and how they have evolved over time. The extent of the historical discussion, naturally enough, varies from chapter to chapter, depending on the origins of the issue. The chapter on cybercrime, for example, is much less concerned with the past than the one on women's rights.

One of the hardest tasks facing the contributors and editors of this work has been striking the appropriate

geographic balance. Given the sheer limitations of space, it was impossible to discuss how each of the issues affects every country or region on Earth. Instead, we have tried to focus coverage on representative countries or regions, usually with an eye toward balancing discussions of the developed and developing worlds. In some cases, of course, the issue is largely confined to one or the other—malaria in the developing world, for example. More problematic are imbalances in the availability of information. Even with so many issues presenting dire circumstances in the developing world, the fact remains that data, documentation, and the secondary literature are much more extensive regarding issues in the developed world. Thus, the discussion of some issues may be skewed toward the latter.

Despite these limitations, the contributors and editors have strived to provide the broadest possible discussion of the challenges facing global society today. To that end, we have included topics from a wide range of issue areas—education, health, the environment, economics, war and peace, law and order, family and community, science and technology.

This work is divided into 136 chapters, arranged in alphabetical order. The naming of each chapter has followed a simple rule—what would the reader intuitively turn to first?

Each chapter has several components. First, and most important, is the essay. These range in length from 2,000 to 4,000 words, with some running longer, depending on the complexity and importance of the issue. A relatively narrow topic, such as land mines or the digital divide, does not warrant the same extent of coverage as such wide-ranging topics as climate change or human rights.

Every chapter also includes a selection of primary documents relevant to the subject at hand. In most cases, there are two—one historical in nature and the other contemporary. These are provided to give the reader a sense of how the issues have been, and are being, approached by key individuals and organizations. For background and context, all primary documents are preceded by a brief introductory text. Where the documents are short or where relevant passages could be excerpted, the actual text of the document is included. Where they are very long or cannot be meaningfully excerpted—and as a means of directing readers to still other notable documents—we have provided Internet addresses (URLs).

Also accompanying each essay are lists of Further Readings and Web sites. The former are not lists of sources the author necessarily consulted in researching the subject, but lists of recommended works for readers interested in exploring the topic further. The selection of relevant Web sites lists advocacy groups and non-governmental organizations, government and international agencies, and independent information clearinghouses. Where advocacy groups have been included—particularly regarding controversial topics—sites representing opposing sides of the issue are represented.

Other essential reference features include a master bibliography, bringing together the recommended readings from all chapters, and a topic finder, arranging the 136 issues by general area of study.

*James Ciment*

# Adoption

Adoption is the process by which a person or people assume responsibility for the rearing of a child. Usually a legal procedure is required to establish this relationship, which transfers all rights to the parent or parents who are assuming care for the child. In a few cultures, adoption can be done through a religious ceremony, but in most nations, the process is carefully governed by statute and regulation. Though adoption can be a complex proceeding, it has a long history and remains a popular means of building a family. For example, in the United States (which accounts for about half of the world's 250,000 adoptions each year), as many as six in 10 people are affected by one kind of adoption or another, whether through traditional, kinship, step-parent, or international adoption.

Adoption is not without its challenges, however. Adoptees or adoptive parents have sometimes been stigmatized, poor parents have been exploited, and adoptive children's needs frequently have been ignored. Over time these issues have faded in importance, but in their place have arisen other sources of contention, including the strictness of adoption regulations, cross-racial and cross-cultural adoption, the question of whether gays should be allowed to adopt, the degree of secrecy or openness surrounding adoption, and the appropriateness of international adoption. Despite these issues, adoption remains an important means of providing for some orphaned or abandoned children who need safe, nurturing homes.

## History

Adoption dates back several millennia. Ancient Romans engaged in the practice so that the wealthy could ensure inheritance rights and cement political alliances between families. These arrangements occurred frequently, and the sons sent for adoption maintained ties to their original families even while being considered full members of their adoptive families. Historically, variations on this custom have played a role in dozens of monarchial governments across the world.

In the centuries after the fall of the Roman Empire, adoption remained commonplace throughout the world, and it was often the province of religious institutions—most notably the Catholic Church—which took in vast numbers of orphaned and abandoned children. Similarly, the Koran dictates specific rules for an arrangement called *"kafala."* Kafala permits the upbringing, care, and education of a child by adults other than the child's biological parents, although it differs from the Western conception of adoption in that it does not establish a legal parent-child relationship. The child retains his or her original father's name, inherits from his or her biological family, and is not considered a blood relative when it comes to marriage and other legal matters.

The rapid social and economic changes that gripped the globe—particularly the West—after 1700 had a profound impact on adoption, which evolved rapidly and in dramatic ways. The example of the United States is instructive in this regard. From the colonial era, adoption was commonplace, particularly in Puritan Massachusetts and Dutch New York. Often the practice was used to provide a livelihood for children, who would be placed in apprenticeship situations akin to today's foster care so that they could learn a trade.

In the nineteenth century, the influx of immigrants to the United States and the rise of factories and large cities resulted in a dramatic increase in the extent and severity of poverty. Public almshouses and private orphanages formed to ease these conditions. These were controversial—welfare reformers criticized them as being too expensive, harsh, and rigid, while Protestants worried that the Catholic Church was using them to inculcate Catholicism. Protestant minister Reverend Charles Loring Brace was so deeply concerned that he determined to do something, and so he arranged for tens of thousands of orphaned New York children to be placed with rural families in Indiana, Iowa, Kansas, Michigan, Missouri, and Ohio.

Though it was not Brace's intention, his "orphan trains"—as they came to be called—spurred states to codify rules

for adoption, laying the foundations of modern adoption law. Early statutes—in Mississippi in 1846 and Texas in 1850, for example—eased the burdens for private adoptions, clarified inheritance issues, and emphasized mothers' roles as primary caregivers. Most significant was the establishment of the "best interests of the child" standard, which was first codified in the Massachusetts Adoption Act of 1851. Judges were empowered to determine adoptive parents' fitness, to weigh a child's needs and desires in custody matters, and to legally separate a child from his or her biological parents. The "best interest of the child" standard was quickly embraced by the other states of the Union, and it has now become a global benchmark.

## Adoption Today

The legal precedents developed in the United States during the nineteenth century—inheritance rules, the importance of mothers, the "best interest of the child" standard—are embraced throughout much of the world today. Still, there are certainly important differences among nations and critical issues to be grappled with.

To start, there is much debate worldwide on how rigorous standards for adoption should be. While the needs of children must be paramount, a system that is too rigorous can leave thousands of individuals in orphanages who would otherwise be adopted. For example, Australia has very stringent regulations that mean an average wait of five years to adopt. (In the United States, by contrast, the wait averages one year.) As a consequence, Australia has among the lowest adoption rates in the entire world.

Further, although most nations have accepted that all races and cultures should be equal, there remains controversy over the propriety of parents of one race or culture adopting children of another race or culture. British adoption agencies, for example, are very reluctant to place nonwhite children with white parents. As the nation's orphans are disproportionately nonwhite, this means that minority children tend to wait much longer to be adopted than do white children. It also means that some white parents who would welcome a nonwhite child are unable to adopt, which contributes to the United Kingdom's very low adoption rate. Similarly, many Muslim countries—most notably Iraq and Malaysia—do not allow non-Muslim parents to adopt Muslim children, while in India the Hindu Adoption and Maintenance Act of 1956 only allows adoptions by Buddhists, Hindus, Jains, and Sikhs. The United States, by contrast, has taken aggressive action in this area. The Multiethnic Placement Act of 1994 made it illegal for U.S. states to delay adoptions in order to match children and parents ethnically or racially.

Adoption by lesbian, gay, bisexual, and transgender (LGBT) parents is another contentious subject. Opponents, most of them connected to religious groups or conservative political movements, argue that children adopted by LGBT parents are at greater risk of becoming alcoholic, being sexually abused, suffering from depression, and committing suicide. Supporters of LGBT parents respond by pointing out that there are no scientific studies that confirm these risks, while there are several that indicate that children of LGBT parents are just as well adjusted as those of straight parents. Professional organizations, including the American Psychological Association, the American Medical Association, and the British Medical Association, have affirmed this position. Nonetheless, LGBT adoption remains impermissible in most of the world. Outside of Canada, Western Europe, and a dozen U.S. states, LGBT parents are only allowed to adopt in Argentina, several Australian states, Brazil, Israel, Mexico City, Slovenia, South Africa, and Uruguay.

A more recent issue is the question of "open adoption." The nations of the Middle East tend to follow the dictates of the Koran, which sustains the ties between a child and his original family. Similarly, many African cultures will send children to other families to develop kinship alliances. In both of these cases, the relationship between a child and his biological parents is well known. Throughout much of the rest of the world, however, the general tendency has been to erase the link—legally and physically—between adoptees and their biological parents. The open adoption movement, which is most thoroughly established in North America and includes activist groups such as Bastard Nation and Origins USA, stands in opposition to this practice. They argue that knowledge of, or even contact with, biological parents improves an adoptee's self-worth, allows for more informed medical decisions, and even helps to overcome the "devastation which the infant feels because of separation from its birth mother."

## International Adoption

One of the most important modern developments in adoption practices is the rise of international adoption. This effectively got its start during World War II, a conflict that resulted in a both a great many child refugees and a great many mixed-race children born to service personnel. Both groups of children engendered much sympathy in the United States, inspiring the founding of such organizations as the League for Orphan Victims in Europe (LOVE) and the American Joint Committee for Assisting Japanese-American Orphans.

In the last few decades, international adoption has become commonplace, with the number of children adopted rising from approximately 19,000 in 1988 to more than 40,000 by 2004. The United States is the primary "receiving" country, accounting for approximately 60 percent of all international adoptions. Among the most important "sending" countries are China (2,587 children in 2011), Ethiopia (1,732), Russia (962), South Korea (736), Ukraine (640), the Philippines (229), India (226), and Colombia (216).

Today, international adoption is governed primarily by two major pieces of international law: the United Nations Convention on the Rights of the Child (UNCRC, 1989) and the Hague Adoption Convention (HAC, 1993). These two documents came about after concerns arose over whether international adoption was the best choice for children. Some critics suggested that international adoptions merely exploited the sending country, permitting a form of Western imperialism over countries deemed "unable" to care for their youth. Further, there were and are fears that children placed for international adoption may be sold into slavery, that women from sending countries may be compelled to surrender their children unwillingly, and that the institutions arranging the adoptions are corrupt. These issues are part of the reason why the number of international adoptions peaked in 2004 and has been in decline since then, down to about 20,000 children in 2011. Many experts go so far as to say that international adoption is currently in crisis.

Proponents of international adoption dismiss these concerns. They observe that more than 16 million orphans exist globally (more than half of them in Africa), and that international adoption provides some of these children with families. Further, the international community—with the United States taking the lead—has done much to ensure the safety and protect the best interests of the children. The UNCRC, HAC, and the United States Final Rules regarding the Hague Convention (2006) all decree that international adoption should be a last resort in the absence of other alternatives, and all strictly prohibit various forms of child abuse.

*Haitian orphans await transport to their adoptive families in France after the catastrophic earthquake of 2010. International adoption, which dates to World War II, now enables tens of thousands of orphans and needy children each year to find new homes.* (Thony Belizaire/AFP/Getty Images)

## The Future

For the great majority of the 250,000 children adopted worldwide each year, adoption provides a family and leads to a dramatic improvement in quality of life. Regrettably, the vast majority of the world's orphans remain unadopted.

Activist groups are hard at work on this issue. Some, like the ONE Campaign, the Bill & Melinda Gates Foundation, UNICEF, and the United Nations Development Programme are trying to reduce the number of orphans worldwide by ameliorating poverty and disease, both of which can lead to the premature deaths of parents and the breakup of families. At the same time, organizations—including Adopt Us Kids, Adoption Advocates International, the Child Welfare League, and the Family Pride Coalition—strive to maximize the number of children placed with stable, loving families. The number of orphans worldwide has remained relatively stable since the 1990s; it remains to be seen if current efforts will be able to change that.

*Tracy Lassiter*

See also: Children's Rights; Marriage and Divorce; Reproductive Issues.

## Documents

### UN Convention on the Rights of the Child (excerpts), 1989

*Before 1989 there was no universal set of standards that protected the rights of children specifically. UNICEF's Convention on the Rights of the Child is the first legally binding document to grant children worldwide all basic human rights—civil, cultural, economic, political, and social. These include the right to survival, to develop fully, to be protected from harm and exploitation, and to participate in their family, culture, and society. Following are the articles of the convention that deal specifically with adoption.*

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;

(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

*Source:* UNICEF.

## Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption (excerpts), 1993

*The purpose of this international convention was to establish safeguards and protocols for international adoption. It establishes standards to ensure that children are not abducted or trafficked, and it makes clear that such adoptions should be made only in the child's best interest and with regard to his or her basic rights as established under other international law. As of January 2011, 85 nations had ratified the convention. The following excerpts address some of the core issues.*

Article 29

There shall be no contact between the prospective adoptive parents and the child's parents or any other person who has care of the child until the requirements of Article 4, sub-paragraphs a) to c), and Article 5 [not included herein], sub-paragraph a), have been met, unless the adoption takes place within a family or unless the contact is in compliance with the conditions established by the competent authority of the State of origin.

Article 30

(1) The competent authorities of a Contracting State shall ensure that information held by them concerning the child's origin, in particular information concerning the identity of his or her parents, as well as the medical history, is preserved.

(2) They shall ensure that the child or his or her representative has access to such information, under appropriate guidance, in so far as is permitted by the law of that State.

Article 31

Without prejudice to Article 30, personal data gathered or transmitted under the Convention, especially data referred to in Articles 15 and 16 [not included herein], shall be used only for the purposes for which they were gathered or transmitted.

Article 32

(1) No one shall derive improper financial or other gain from an activity related to an intercountry adoption.

(2) Only costs and expenses, including reasonable professional fees of persons involved in the adoption, may be charged or paid.

(3) The directors, administrators and employees of bodies involved in an adoption shall not receive remuneration which is unreasonably high in relation to services rendered.

Article 33

A competent authority which finds that any provision of the Convention has not been respected or that there is a serious risk that it may not be respected, shall immediately inform the Central Authority of its State. This Central Authority shall be responsible for ensuring that appropriate measures are taken.

Article 34

If the competent authority of the State of destination of a document so requests, a translation certified as being in conformity with the original must be furnished. Unless otherwise provided, the costs of such translation are to be borne by the prospective adoptive parents.

Article 35

The competent authorities of the Contracting States shall act expeditiously in the process of adoption.

*Source:* Hague Conference on Private International Law.

## Further Reading


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Simon, Rita J., and Howard Altstein. *Adoption, Race and Identity from Infancy to Young Adulthood.* 2d ed. New Brunswick, NJ: Transaction, 2002.

Wegar, Katarina. *Adoptive Families in a Diverse Society.* New Brunswick, NJ: Rutgers University Press, 2006.

## Web Sites

Adopt Us Kids: www.adoption.org

Child Welfare League of America: www.cwla.org

National Adoption Center: www.adopt.org

National Adoption Information Clearinghouse: www.childwelfare.gov

UNICEF: www.unicef.org

United Nations: www.un.org

U.S. Office of Civil Rights: www.hhs.gov/ocr/civilrights/resources/specialtopics/adoption

U.S. State Department, Office of Children's Issues: http://adoption.state.gov

# Affirmative Action

"Affirmative action" is the common term for a variety of efforts aimed at improving the conditions of people from underprivileged groups and increasing those groups' representation in areas of society in which they have

traditionally been underrepresented. The intention behind affirmative action is to offset historical patterns of discrimination and to provide greater equality, frequently described as creating a “more level playing field.” Affirmative action is employed in many countries around the world and has, in most of those places, proved controversial; responses have included debate, protest, and legal challenges.

The two central questions shaping affirmative action policies are: (1) which groups will receive affirmative action assistance and (2) what form that assistance will take. In answering the first question, countries around the world have defined “underprivileged groups” quite differently; veterans and the disabled are frequently included, as are groups defined by color, race, sex, religion, ethnicity, caste, tribal identity, and even linguistic ability. As to the second question, affirmative action, by definition, goes beyond laws that ban discrimination to include positive steps to increase the opportunities available to qualified groups. Specific policies range from outreach programs to special training or tutoring, preferential hiring or admission policies, and quotas or set-asides (reserving a certain set percentage of government contracts, seats in schools, or jobs for underprivileged groups).

## Affirmative Action Globally

Many countries have adopted some form of affirmative action, though specific policies vary dramatically from place to place. For example, South Africa has a variety of affirmative action programs to offset the results of decades of apartheid. Israel, to offset the education gap between the Arab and Jewish populations, devotes proportionately more educational funding to Arab schools. Finland provides set-asides in education and jobs for those who speak Swedish. China has given some of the country’s 55 ethnic minorities extensive educational and governmental support and quotas.

In some countries, laws requiring equal treatment make affirmative action illegal. France, Japan, and the United Kingdom, for example, all severely limit affirmative action policies. France’s constitution bars distinctions based on race, religion, or sex; Japan bars preferences based on sex, ethnicity, or other social background; the UK’s “equality laws” specifically prohibit any sort of affirmative action.

The cases of India (the first country to adopt affirmative action) and Brazil (the most recent to adopt it) offer some sense of the broad range of policies around the world.

***India***

In India, affirmative action (known as Reservation) began with independence from Britain in 1947. Reservation is a product of the ancient caste system, which by the 1800s had created one of the most restrictive and discriminatory societies in the world. The caste system divided society into thousands of hereditary groups called jatis that sharply defined social status, the types of jobs one might hold, and even whom one might marry. There are four hierarchical groupings of jatis, from the Brahmins—including priests and educators—at the top, to Sudras—many of whom were laborers—at the bottom. Even more unfortunate were people who were considered outside the jatis system. These individuals, known as untouchables (now called Dalit), formed the lowest rank in India, a class whose mere presence was seen as polluting by higher castes. Sudras and untouchables (together called Scheduled Castes) have a long history of being victimized by discrimination, exclusion, and violence.

Discussions about the inequality of the caste system began in the late 1800s, while India was still part of the British Empire. Reservation was first proposed in the early 1900s, was incorporated into some British policies in the 1930s, and was codified into law after independence in 1949. The Indian constitution specifically mandates set-asides in education and government positions for “Scheduled Castes” (SC), “Scheduled Tribes” (ST), and “Other Backward Classes” (OBC). These three groups make up about 25 percent of the Indian population.

Like analogous policies in other countries, Reservation policy has recently become a subject of debate in India, with detractors urging a merit-based system rather than quotas. However, support for Reservation remains so strong that India currently reserves 49.5 percent of all government positions, only 0.5 percent less than the maximum allowed by Indian law. A bill to reserve one-third of the seats in the lower house of India’s Parliament

for women, the Lok Sabha, was being considered in 2012.

***Brazil***

Brazil, which passed its first affirmative action law in 2010, reflects more modern trends in affirmative action policy. Brazil has more black citizens than any other non-African country, and many Brazilians of all colors proudly believed that Brazil was unique in having little or no racial discrimination. This was, Brazilians thought, a product of their distinctive history—though Brazil was the last country in the Western Hemisphere to abolish slavery, interracial marriage had always been common there—even while slavery had been practiced. This situation resulted in extensive racial mixing, with skin tones of all hues present in the population. Brazil, therefore, avoided the strict categorization common in many other countries and never experienced anything like the racial violence seen in Haiti, the United States, or Venezuela. In fact, Brazilians of all hues tended to avoid racial distinctions, defining themselves only as Brazilians.

In the 1990s, a black movement arose that challenged these idyllic notions of racial equality and charged that discrimination was, in fact, common in Brazil. Studies were conducted that revealed significant gaps between white Brazilians and black and mixed-race Brazilians in income, employment, and education. Brazil began to rethink its racial past, and its 2010 affirmative action law formally defined illegal discrimination, offered tax breaks to firms that employ more black Brazilians, and required teaching black and African history in public schools. Although the new law remained silent on university admission policies, 70 percent of Brazil's universities were practicing some form of affirmative action by that time.

The new law prompted a broad national discussion on racial equality and legal challenges to the new system. Brazil today resembles the United States: struggling with the legacy of a racist past and engaged in a heated debate over the fairness and efficacy of affirmative action. Indeed, a careful examination of the history of affirmative action in the United States illustrates both the impulses that gave rise to the policy in most countries and some of the issues that make it controversial.

## Affirmative Action in the United States

Affirmative action in the United States began during the civil rights movement of the 1960s. President John F. Kennedy became the first president to speak about affirmative action, in his 1961 Executive Order (EO) 10925. However, while EO 10925 did use the term "affirmative action," it only addressed discrimination in hiring and promotions, requiring that job applicants be considered "without regard to race, creed, color, or national origin."

President Lyndon B. Johnson followed EO 10925 with Executive Order 11246, a much more sweeping attempt at implementing affirmative action policies. EO 11246 gave the secretary of labor the power to require that government agencies and large government contractors develop plans to increase the participation of minorities in the workplace wherever they were underrepresented. Two years later, Johnson added women to the list of groups eligible for affirmative action. These efforts met with considerable opposition inside and outside the government and ultimately accomplished little.

***Expansion***

The first substantive implementation of affirmative action policies came under Johnson's successor, Richard M. Nixon, who implemented far-reaching programs in jobs and education. Nixon's "Philadelphia Order" was addressed to contractors and unions—initially in Philadelphia and eventually nationwide—that were engaged in federally funded construction projects. It provided clear goals and timetables for greater diversity, mandating 20 percent minority union membership within five years. Nixon also established goals for the use of minority-owned businesses in federal contracting and instituted the country's first use of set-asides in awarding government contracts.

At the same time, the Nixon administration began to pursue affirmative action in higher education. Although lawsuits aimed at achieving equal access to education, like *Brown v. Board of Education* (1954), had been among

the civil rights movement's first successes, meaningful change had proved slow and difficult. Most universities ignored affirmative action requirements until 1972, when the president began to set goals and timetables—similar to those in the Philadelphia Order—that required universities to consider race and gender in admission procedures and financial aid awards. To redress the lack of female educators in higher education, the Equal Employment Opportunity Commission began to bring sex discrimination lawsuits targeting universities; hundreds were eventually filed. By 1975, minority and female enrollment and employment in higher education were growing rapidly.

### *The* Bakke *Decision and Public Debate*

For its first 15 years, affirmative action attracted relatively little public attention. That changed in 1978, when the Supreme Court agreed to hear the case of *Regents of the University of California v. Bakke.* The suit was brought by Allan Bakke, a white man who had twice applied to, and been denied, entrance to the University of California, Davis, medical school. The school had adopted an affirmative action program that set aside a certain number of spots for minority candidates, and when Bakke found that less-qualified minority applicants had won admission over him, he sued on the basis of discrimination. With *Bakke,* affirmative action exploded into public consciousness and became a national controversy for the first time.

President Johnson presented the original reasoning for affirmative action in a June 1965 speech at Howard University. Recognizing the victories of the civil rights movement, Johnson told his audience that the "beginning is freedom.… But freedom is not enough.… Equal opportunity is essential, but not enough." The long history of discrimination and oppression that African Americans had faced, Johnson argued, made it impossible for them to compete as equals unless positive steps were taken to offset the corrosive influences of the past. Poverty, racism, and lack of educational opportunities all combined to leave blacks in a painfully disadvantaged position, even after the removal of legal means of discrimination. America, he charged, had a duty to adopt policies designed to raise blacks to a position from which they could begin to compete on a basis of true equality. Johnson later expanded his argument to include other minorities and women.

With *Bakke,* critics of affirmative action arose and challenged Johnson's arguments along ethical lines, asking what appears to be a simple question: Is preferential treatment for certain groups morally right? Critics argued that it creates "reverse discrimination," a system that simply replaces discrimination against some groups with discrimination against other groups. They asserted that to fight discrimination with yet more discrimination is simply wrong. This objection carried the greatest weight in the case of college admissions, as there are a limited number of positions available—for every position given to a woman or minority, someone else does not gain a place. The argument resonated with many Americans, for whom such preferential treatment seemed the opposite of the aims of the civil rights movement.

Defenders of affirmative action have made several arguments in response to such criticisms. Some deny that there is any significant disadvantage for nonpreferred groups—that, in particular, the advantages of being a white male in the United States are still so great that they cancel out affirmative action. Others point out that schools have always discriminated in a variety of ways generally accepted by society—preferential admissions for gifted athletes or children of alumni, for example—and that racial preferences are therefore not corrupting an unbiased process but, rather, are adding one more factor to the mix. Some claim that affirmative action serves a higher justice because it redresses past wrongs: slavery and institutional racism.

As the debate continued, a deeply divided Court ruled on *Bakke:* strict quotas and set-asides were illegal because they violate the Fourteenth Amendment. At the same time, the justices held that promoting a diverse student body was essential to good education. Therefore, policies that give preferences to minorities and women but stop short of rigid quotas, were legal and encouraged.

Rather than ending the controversy, *Bakke* created a new line of debate over diversity. In accordance with the Court's decision, proponents argue that diversity, in both the workplace and schools, is beneficial to all and is sufficient reason for preferential treatment. They suggest that diversity produces a better education by exposing

students to a greater variety of ideas, and that in business a diverse company will be more competitive in the rapidly changing modern economy. Critics dismiss these claims and charge that the emphasis on the benefits of diversity—something not typically included in the conversation before *Bakke*—is simply a smokescreen that allows schools to continue to pursue affirmative action in the face of Court-ordered restrictions.

***Confusion and Retrenchment***

Affirmative action clearly was and is a complicated issue, and *Bakke* was followed by Court decisions that reflected American confusion over, and ambivalence toward, affirmative action. *Bakke* seemed to ban the use of quotas, but the ruling in *Fullilove v. Klutznick* (1980) said that quotas might be acceptable if they avoided "inflexible percentages based on race or ethnicity." Then, in *United States v. Paradise* (1987), the Court upheld strict racial quotas, saying that they were justified in cases of persistent discrimination. Further confusing the matter, *Wygant v. Jackson Board of Education* (1986) established that, although preferential hiring policies were acceptable, preferential termination policies were not.

In the late 1980s, there was a growing reaction against affirmative action. In *City of Richmond v. Croson* (1989), the Court expressed serious concerns over affirmative action in university admissions. Labeling racial preferences "a highly suspect tool," the court urged that they be subject to "strict scrutiny" to prevent abuses. A few years later, the ruling in *Adarand Constructors, Inc. v. Pena* (1995) echoed those concerns, asserting that affirmative action was legal only where "compelling government interest" existed and even then had to be "narrowly tailored" to fit the situation. The following year, the Court all but eliminated race-based preferences in higher education when it let stand a lower court's decision in *Hopwood v. Texas. Hopwood* invalidated the earlier *Bakke* decision by ruling that diversity did not amount to a "compelling state interest."

Mirroring the trend in the courts was a series of legal setbacks for affirmative action across the country. In 1995, the governing body of the University of California, one of the largest and most prestigious public university systems, voted to ban any use of racial or gender preferences in admissions or employment and contracting. Two years later, California voters passed Proposition 209, which barred the state from giving preferential treatment "on the basis of race, sex, color, ethnicity, or national origin" in public employment, contracting, or education. Within three years, Florida and Washington State had adopted similar laws.

## The Future

Affirmative action remains extremely controversial in most countries that have it. In addition to the long-standing arguments over reverse discrimination and diversity, new attacks have arisen on pragmatic grounds, claiming that affirmative action is ineffective or counterproductive. One line of argument claims that, by benefiting some groups and disadvantaging others, affirmative action creates resentment, hinders the goal of a color-blind society, and actually increases racial tensions. Another line of argument holds that affirmative action ultimately hurts minorities. Some claim that it undermines respect for members of the underrepresented groups, causing others to view them as less qualified or less capable. Others point to "mismatching," a term used to describe the placement of preferred students in schools or jobs that are too difficult for them. The result, the argument holds, is that minority students and employees struggle and fail with workloads that they are unable to handle. Finally, critics point out that affirmative action tends to benefit most the more privileged members of underrepresented groups, while harming the poor of all races. Many of the minorities and women admitted to elite schools under affirmative action come from middle-and upper-class families, while poor minorities—and poor whites—see few benefits.

As the debate continues, hard evidence on the impact of affirmative action remains limited. Some of the effects in question—the benefits of diversity in education, for example—resist empirical testing. Conclusions are also made more difficult by the fact that affirmative action policies often coincide with the passage of civil rights laws banning discrimination and with a broad public shift in sentiment against discriminatory practices. What, then, to make of the gains seen in the subsequent decades? Proponents of affirmative action see evidence of its beneficial effects, while opponents see the results of a broad rejection of discrimination and therefore find less need for affirmative action.

Nevertheless, some conclusions may be drawn. Affirmative action's most significant impact seems to have been in education, with women the primary beneficiaries. In fact, in many countries that utilize affirmative action in decisions regarding education, women today are more likely than men to graduate from college and to obtain advanced degrees. This is true among all racial and ethnic groups. For minorities, it is also clear that many have gained college entrance with help from affirmative action. Large gaps remain between minorities and whites in both college attendance and graduation, however.

In employment, results are less clear. In the United States, for example, affirmative action policies have been required only for government agencies and government contractors. Among government contractors, the proportion of minority employees has increased, although not to levels matching their proportion of the population. In government jobs, there has been a profound change since the 1960s: underrepresented minorities as a whole form 34 percent of the workforce, exactly their proportion of the population. Still, even there, inequities persist: blacks, Asians, and Native Americans are represented in numbers greater than their share of the population, while Hispanics are underrepresented.

The difficulty in judging the efficacy of affirmative action programs, coupled with the attendant controversy that they provoke, does not bode well for their continued existence. At the same time, the historical inequities in Brazil, India, the United States, and other countries that prompted the development of affirmative action programs still exist and, in some ways, have grown more pronounced in recent decades. Therefore, one can only say that the future of affirmative action in most countries remains highly uncertain.

*D'Art Phares*

See also: Children's Rights; Ethnic and Religious Conflict; Indigenous Peoples' Rights; Women's Rights.

## Documents

### "To Fulfill These Rights," Speech by President Lyndon B. Johnson, June 4, 1965

*After signing the seminal Civil Rights Act of 1964 and the Voting Rights Act of 1965, President Lyndon B. Johnson spoke at Howard University, a historically black institution of higher learning. In that address, he laid out the rationale for a policy maneuver he was working on at the time—his first attempt to implement affirmative action, which would happen four months later, with Executive Order 11246, dated September 28, 1965. In the speech, Johnson concedes the victories won to that point in the civil rights struggle, but argues that they are not enough. As a "consequence of ancient brutality, past injustice, and present prejudice" directed at African Americans, he maintains, they will need more than just an end to discriminatory practices in order to compete on a level playing field.*

I am delighted at the chance to speak at this important and this historic institution. Howard has long been an outstanding center for the education of Negro Americans. Its students are of every race and color and they come from many countries of the world. It is truly a working example of democratic excellence.

Our earth is the home of revolution. In every corner of every continent men charged with hope contend with ancient ways in the pursuit of justice. They reach for the newest of weapons to realize the oldest of dreams, that each may walk in freedom and pride, stretching his talents, enjoying the fruits of the earth.

Our enemies may occasionally seize the day of change, but it is the banner of our revolution they take. And our own future is linked to this process of swift and turbulent change in many lands in the world. But nothing in any country touches us more profoundly, and nothing is more freighted with meaning for our own destiny, than the revolution of the Negro American.

In far too many ways American Negroes have been another nation: deprived of freedom, crippled by hatred, the doors of opportunity closed to hope.

In our time change has come to this Nation, too. The American Negro, acting with impressive restraint, has peacefully protested and marched, entered the courtrooms and the seats of government, demanding a justice that has long been denied. The voice of the Negro was the call to action. But it is a tribute to America that, once aroused, the courts and the Congress, the President and most of the people, have been the allies of progress.

## Legal Protection for Human Rights

Thus we have seen the high court of the country declare that discrimination based on race was repugnant to the Constitution, and therefore void. We have seen in 1957, and 1960, and again in 1964, the first civil rights legislation in this Nation in almost an entire century.

As majority leader of the United States Senate, I helped to guide two of these bills through the Senate. And, as your President, I was proud to sign the third. And now very soon we will have the fourth—a new law guaranteeing every American the right to vote.

No act of my entire administration will give me greater satisfaction than the day when my signature makes this bill, too, the law of this land.

The voting rights bill will be the latest, and among the most important, in a long series of victories. But this victory —as Winston Churchill said of another triumph for freedom—"is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

That beginning is freedom; and the barriers to that freedom are tumbling down. Freedom is the right to share, share fully and equally, in American society—to vote, to hold a job, to enter a public place, to go to school. It is the right to be treated in every part of our national life as a person equal in dignity and promise to all others.

## Freedom Is Not Enough

But freedom is not enough. You do not wipe away the scars of centuries by saying: Now you are free to go where you want, and do as you desire, and choose the leaders you please.

You do not take a person who, for years, has been hobbled by chains and liberate him, bring him up to the starting line of a race and then say, "you are free to compete with all the others," and still justly believe that you have been completely fair.

Thus it is not enough just to open the gates of opportunity. All our citizens must have the ability to walk through those gates.

This is the next and the more profound stage of the battle for civil rights. We seek not just freedom but opportunity. We seek not just legal equity but human ability, not just equality as a right and a theory but equality as a fact and equality as a result.

For the task is to give 20 million Negroes the same chance as every other American to learn and grow, to work and share in society, to develop their abilities—physical, mental and spiritual, and to pursue their individual happiness.

To this end equal opportunity is essential, but not enough, not enough. Men and women of all races are born with the same range of abilities. But ability is not just the product of birth. Ability is stretched or stunted by the family that you live with, and the neighborhood you live in—by the school you go to and the poverty or the richness of your surroundings. It is the product of a hundred unseen forces playing upon the little infant, the child, and finally the man.

## Progress for Some

This graduating class at Howard University is witness to the indomitable determination of the Negro American to win his way in American life.

The number of Negroes in schools of higher learning has almost doubled in 15 years. The number of nonwhite professional workers has more than doubled in 10 years. The median income of Negro college women tonight exceeds that of white college women. And there are also the enormous accomplishments of distinguished individual Negroes—many of them graduates of this institution, and one of them the first lady ambassador in the history of the United States.

These are proud and impressive achievements. But they tell only the story of a growing middle class minority, steadily narrowing the gap between them and their white counterparts.

## A Widening Gulf

But for the great majority of Negro Americans—the poor, the unemployed, the uprooted, and the dispossessed—there is a much grimmer story. They still, as we meet here tonight, are another nation. Despite the court orders and the laws, despite the legislative victories and the speeches, for them the walls are rising and the gulf is widening.

Here are some of the facts of this American failure.

Thirty-five years ago the rate of unemployment for Negroes and whites was about the same. Tonight the Negro rate is twice as high.

In 1948 the 8 percent unemployment rate for Negro teenage boys was actually less than that of whites. By last year that rate had grown to 23 percent, as against 13 percent for whites unemployed.

Between 1949 and 1959, the income of Negro men relative to white men declined in every section of this country. From 1952 to 1963 the median income of Negro families compared to white [families] actually dropped from 57 percent to 53 percent.

In the years 1955 through 1957, 22 percent of experienced Negro workers were out of work at some time during the year. In 1961 through 1963 that proportion had soared to 29 percent.

Since 1947, the number of white families living in poverty has decreased 27 percent while the number of poorer nonwhite families decreased only 3 percent.

The infant mortality of nonwhites in 1940 was 70 percent greater than whites. Twenty-two years later it was 90 percent greater.

Moreover, the isolation of Negro from white communities is increasing, rather than decreasing as Negroes crowd into the central cities and become a city within a city.

Of course Negro Americans as well as white Americans have shared in our rising national abundance. But the harsh fact of the matter is that in the battle for true equality too many—far too many—are losing ground every day.

## The Causes of Inequality

We are not completely sure why this is. We know the causes are complex and subtle. But we do know the two broad basic reasons. And we do know that we have to act.

First, Negroes are trapped—as many whites are trapped—in inherited, gateless poverty. They lack training and skills. They are shut in, in slums, without decent medical care. Private and public poverty combine to cripple their capacities.

We are trying to attack these evils through our poverty program, through our education program, through our medical care and our other health programs, and a dozen more of the Great Society programs that are aimed at the root causes of this poverty.

We will increase, and we will accelerate, and we will broaden this attack in years to come until this most enduring of foes finally yields to our unyielding will.

But there is a second cause—much more difficult to explain, more deeply grounded, more desperate in its force. It is the devastating heritage of long years of slavery; and a century of oppression, hatred, and injustice.

## Special Nature of Negro Poverty

For Negro poverty is not white poverty. Many of its causes and many of its cures are the same. But there are differences—deep, corrosive, obstinate differences—radiating painful roots into the community, and into the family, and the nature of the individual.

These differences are not racial differences. They are solely and simply the consequence of ancient brutality, past injustice, and present prejudice. They are anguishing to observe. For the Negro they are a constant reminder of oppression. For the white they are a constant reminder of guilt. But they must be faced and they must be dealt with and they must be overcome, if we are ever to reach the time when the only difference between Negroes and whites is the color of their skin.

Nor can we find a complete answer in the experience of other American minorities. They made a valiant and a largely successful effort to emerge from poverty and prejudice.

The Negro, like these others, will have to rely mostly upon his own efforts. But he just can not do it alone. For they did not have the heritage of centuries to overcome, and they did not have a cultural tradition which had been twisted and battered by endless years of hatred and hopelessness, nor were they excluded—these others—because of race or color—a feeling whose dark intensity is matched by no other prejudice in our society.

Nor can these differences be understood as isolated infirmities. They are a seamless web. They cause each other. They result from each other. They reinforce each other.

Much of the Negro community is buried under a blanket of history and circumstance. It is not a lasting solution to lift just one corner of that blanket. We must stand on all sides and we must raise the entire cover if we are to liberate our fellow citizens.

## The Roots of Injustice

One of the differences is the increased concentration of Negroes in our cities. More than 73 percent of all Negroes live in urban areas, compared with less than 70 percent of the whites. Most of these Negroes live in slums. Most of these Negroes live together—a separated people.

Men are shaped by their world. When it is a world of decay, ringed by an invisible wall, when escape is arduous and uncertain, and the saving pressures of a more hopeful society are unknown, it can cripple the youth and it can desolate the men.

There is also the burden that a dark skin can add to the search for a productive place in our society. Unemployment strikes most swiftly and broadly at the Negro, and this burden erodes hope. Blighted hope breeds despair. Despair brings indifferences to the learning which offers a way out. And despair, coupled with indifferences, is often the source of destructive rebellion against the fabric of society.

There is also the lacerating hurt of early collision with white hatred or prejudice, distaste or condescension. Other groups have felt similar intolerance. But success and achievement could wipe it away. They do not change the color of a man’s skin. I have seen this uncomprehending pain in the eyes of the little, young Mexican-American

schoolchildren that I taught many years ago. But it can be overcome. But, for many, the wounds are always open.

### Family Breakdown

Perhaps most important—its influence radiating to every part of life—is the breakdown of the Negro family structure. For this, most of all, white America must accept responsibility. It flows from centuries of oppression and persecution of the Negro man. It flows from the long years of degradation and discrimination, which have attacked his dignity and assaulted his ability to produce for his family.

This, too, is not pleasant to look upon. But it must be faced by those whose serious intent is to improve the life of all Americans.

Only a minority—less than half—of all Negro children reach the age of 18 having lived all their lives with both of their parents. At this moment, tonight, little less than two-thirds are at home with both of their parents. Probably a majority of all Negro children receive federally aided public assistance sometime during their childhood.

The family is the cornerstone of our society. More than any other force it shapes the attitude, the hopes, the ambitions, and the values of the child. And when the family collapses it is the children that are usually damaged. When it happens on a massive scale the community itself is crippled.

So, unless we work to strengthen the family, to create conditions under which most parents will stay together—all the rest: schools, and playgrounds, and public assistance, and private concern, will never be enough to cut completely the circle of despair and deprivation.

### To Fulfill These Rights

There is no single easy answer to all of these problems.

Jobs are part of the answer. They bring the income which permits a man to provide for his family.

Decent homes in decent surroundings and a chance to learn—an equal chance to learn—are part of the answer.

Welfare and social programs better designed to hold families together are part of the answer.

Care for the sick is part of the answer.

An understanding heart by all Americans is another big part of the answer.

And to all of these fronts—and a dozen more—I will dedicate the expanding efforts of the Johnson administration.

But there are other answers that are still to be found. Nor do we fully understand even all of the problems. Therefore, I want to announce tonight that this fall I intend to call a White House conference of scholars, and experts, and outstanding Negro leaders—men of both races—and officials of Government at every level.

This White House conference's theme and title will be "To Fulfill These Rights."

Its object will be to help the American Negro fulfill the rights which, after the long time of injustice, he is finally about to secure.

To move beyond opportunity to achievement.

To shatter forever not only the barriers of law and public practice, but the walls which bound the condition of many by the color of his skin.

To dissolve, as best we can, the antique enmities of the heart which diminish the holder, divide the great democracy, and do wrong—great wrong—to the children of God.

And I pledge you tonight that this will be a chief goal of my administration, and of my program next year, and in

the years to come. And I hope, and I pray, and I believe, it will be a part of the program of all America.

### What is Justice?

For what is justice?

It is to fulfill the fair expectations of man.

Thus, American justice is a very special thing. For, from the first, this has been a land of towering expectations. It was to be a nation where each man could be ruled by the common consent of all—enshrined in law, given life by institutions, guided by men themselves subject to its rule. And all—all of every station and origin—would be touched equally in obligation and in liberty.

Beyond the law lay the land. It was a rich land, glowing with more abundant promise than man had ever seen. Here, unlike any place yet known, all were to share the harvest.

And beyond this was the dignity of man. Each could become whatever his qualities of mind and spirit would permit—to strive, to seek, and, if he could, to find his happiness.

This is American justice. We have pursued it faithfully to the edge of our imperfections, and we have failed to find it for the American Negro.

So, it is the glorious opportunity of this generation to end the one huge wrong of the American Nation and, in so doing, to find America for ourselves, with the same immense thrill of discovery which gripped those who first began to realize that here, at last, was a home for freedom.

All it will take is for all of us to understand what this country is and what this country must become.

The Scripture promises: “I shall light a candle of understanding in thine heart, which shall not be put out.”

Together, and with millions more, we can light that candle of understanding in the heart of all America.

And, once lit, it will never again go out.

*Source: Public Papers of the Presidents of the United States: Lyndon B. Johnson, 1965,* Volume 2, entry 301, pp. 635–640.

## Proposition 209, California Ballot Initiative, 1996

*In November 1996, California became the first state to ban the use of racial preference in government employment and public education, as voters in the state passed Proposition 209 by a vote of 54.5 percent to 45.5 percent. Since then, California has been joined by five other states in rejecting racial preference laws, which demonstrates growing opposition to such measures.*

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8, of the Constitution.

This initiative measure expressly amends the Constitution by adding a section thereto; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

### Proposed Amendment to Article I

Section 31 is added to Article I of the California Constitution as follows:

*SEC. 31. (a) The state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting.*

*(b) This section shall apply only to action taken after the section's effective date.*

*(c) Nothing in this section shall be interpreted as prohibiting bona fide qualifications based on sex which are reasonably necessary to the normal operation of public employment, public education, or public contracting.*

*(d) Nothing in this section shall be interpreted as invalidating any court order or consent decree which is in force as of the effective date of this section.*

*(e) Nothing in this section shall be interpreted as prohibiting action which must be taken to establish or maintain eligibility for any federal program, where ineligibility would result in a loss of federal funds to the state.*

*(f) For the purposes of this section, ''state" shall include, but not necessarily be limited to, the state itself, any city, county, city and county, public university system, including the University of California, community college district, school district, special district, or any other political subdivision or governmental instrumentality of or within the state.*

*(g) The remedies available for violations of this section shall be the same, regardless of the injured party's race, sex, color, ethnicity, or national origin, as are otherwise available for violations of then-existing California antidiscrimination law.*

*(h) This section shall be self-executing. If any part or parts of this section are found to be in conflict with federal law or the United States Constitution, the section shall be implemented to the maximum extent that federal law and the United States Constitution permit. Any provision held invalid shall be severable from the remaining portions of this section.*

*Source:* Office of the Secretary of State of California.

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## Web Sites

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Minority Rights Group International: www.minorityrights.org

National Leadership Network of Black Conservatives Affirmative Action Information Center: www.nationalcenter.org/AA.html

U.S. Department of Labor, Affirmative Action page: www.dol.gov/dol/topic/hiring/affirmativeact.htm

U.S. Equal Employment Opportunity Commission: www.eeoc.gov

University of California at Irvine's Office of Equal Opportunity and Diversity, A Brief History of Affirmative Action: www.oeod.uci.edu/aa.html

University of Missouri-Kansas City Law School's Exploring Constitutional Issues, Affirmative Action page: http://law2.umkc.edu/faculty/projects/ftrials/conlaw/affirmativeaction.htm

# AIDS/HIV

AIDS (Acquired Immune Deficiency Syndrome) is a condition in which the capacity of a person's immune system to fight disease becomes so depleted that he or she is susceptible to opportunistic infections (infections caused by organisms that do not generally cause disease in a healthy host). People with AIDS are also at greater risk of developing some types of cancers, because the damaged immune system cannot control the growth of malignant cells.

Among the worst pandemics to afflict humanity, HIV/AIDS has infected more than 60 million people and killed nearly 30 million since it was first described in 1981. It has been estimated that more than 16.6 million children worldwide have been orphaned by AIDS.

AIDS is caused by the human immunodeficiency virus (HIV), though not everyone who is infected with HIV has

AIDS. A person is considered to have AIDS if he or she is HIV-positive with a CD4+ T cell count of fewer than 200 cells/?L blood and/or certain types of infections, such as *Pneumocystis jiroveci* (formerly *carinii*) pneumonia, or certain cancers, such as Kaposi sarcoma. CD4+ T is a type of cell central to the immune system and a major target of HIV.

HIV is found in blood, semen, vaginal secretions, and breast milk of infected people. Therefore, the primary modes of transmission are through unprotected sexual activity, infected needles or blood products, breastfeeding, or perinatal transmission (passage of infection from mother-to-child in utero or at time of birth).

## Historical Background

The HIV/AIDS epidemic is thought to have originated in the transmission to humans of a simian precursor virus to HIV known to have existed among a species of chimpanzees native to western sub-Saharan Africa. The first simian-to-human virus transmission event probably occurred around the turn of the twentieth century. Over time, the virus adapted to replication in human cells and transmission from human to human.

### *Uncovering a Pandemic*

The condition that would later be recognized as AIDS was first described in June 1981 in the U.S. Centers for Disease Control's *Morbidity and Mortality Weekly Report.* The article described the illnesses of five homosexual men in Los Angeles, who suffered from pneumocystis pneumonia and other opportunistic infections. Additional reports of disease clusters in the homosexual male populations of New York and California led to the initial name given to this condition, Gay-related immune deficiency, or GRID. Only after the same disease was noted among heterosexual Haitians, injection drug users, and hemophiliacs was the name changed to AIDS.

Early on, before the cause of AIDS was identified, it was determined that transmission through blood transfusions, needle sharing, and sexual contact, as well as from mother-to-child could occur. Despite clear public health reports of the determined modes of transmission, public fear of contagion grew, and people with AIDS or in the identified risk groups were discriminated against.

Ryan White, for example, was a hemophiliac teenager who, in 1984, was diagnosed with AIDS, having contracted it from Factor VIII (a blood product) transfusions. He fought a long legal battle to attend school after school officials with misconceptions about AIDS transmission prohibited him from doing so. White became an advocate for people living with AIDS until he died of complications of his disease in 1990. His story changed the public perception of AIDS in the United States as a disease of gay men and drug users. Shortly after White's death, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was passed, which still provides federal support for medical care for low-income people living with HIV, benefiting an estimated 500,000 people in 2011.

Public perception of AIDS was also influenced by affected celebrities. American actor Rock Hudson was among the first famous people to die of AIDS, in 1985. His death and the attention it garnered spurred an increase in charitable giving, activism (particularly among other celebrities), and government support to combat AIDS. In 1991 Earvin "Magic" Johnson, a professional basketball player and star of the Los Angeles Lakers, announced that he had been diagnosed with HIV. As a successful athlete and advocate for people living with HIV, he has been an inspiration for those affected by the disease, particularly African Americans, who have borne a disproportionate HIV burden in recent years.

As the epidemic took a devastating toll, community groups were organized to raise awareness of AIDS, educate those at risk, support those who were affected, and advocate for societal action. AIDS Coalition to Unleash Power (ACT UP) is an AIDS-activist organization founded in 1987 by American author and LGBT activist Larry Kramer. This protest organization shone a spotlight on the devastation of AIDS and the need for treatment and prevention efforts. The confrontational methods of ACT UP and its successes in demanding a say in how new treatments are investigated, approved, and funded revolutionized how disease advocates operate.

### *Identifying the Cause*

The virus that would later be named HIV was discovered by Luc Montagnier and Françoise Barré-Sinoussi at the Institut Pasteur in 1983. For this discovery they shared the Nobel Prize in Physiology or Medicine in 2008 with Harald zur Hausen, a German virologist who discovered the role of papilloma viruses in cervical cancer. The virus Montagnier and Barré-Sinoussi identified, which they called lymphadenopathy-associated virus (LAV), was isolated from a lymph node taken from an AIDS patient.

Robert Gallo and his laboratory at the U.S. National Institutes of Health developed an efficient method to propagate other isolates of the virus in cell culture and developed a blood test to detect HIV infection. Gallo initially called the newly isolated virus "human T-cell leukemia virus III" (HTLV-III), believing it to be related to the human retroviruses HTLV-I and HTLV-II. As a result of this research, in 1985, the first HIV test became available. The blood test detected the antibodies (which are proteins the body makes in response to a pathogen) to HIV. This test enabled countries with the necessary resources to screen and ensure the safety of their blood supply.

In the years that followed, researchers determined that HIV is a type of virus from the lentivirus subfamily of retroviruses. Retroviruses are distinguished by the presence of an RNA genome (the message that encodes the viral genes), reverse transcriptase (a viral enzyme that copies the viral genome into DNA), and integrase (an enzyme that inserts the DNA copy of the viral genome into the host cell's DNA). Both reverse transcriptase and integrase are targets of anti-HIV (antiretroviral) medications. The relatively high error rate of its reverse transcriptase and its ability to undergo recombination (the swapping of segments between different copies of the viral genome) allow HIV to mutate and adapt to its host. Lentiviruses like HIV are notable among retroviruses for their ability to infect nondividing cells, which is, in part, why they are able to persist in the host indefinitely. The primary target cells of HIV are CD4+ T lymphocytes ("helper T cells") and macrophages, which play essential roles in the human immune response.

HIV has been found to exist in two types, HIV-1 and HIV-2, each with several groups. HIV-1, group M (for "major"), is responsible for the AIDS pandemic. Other HIV-1 groups (N, O, and P) have caused rare infections in central Africa. HIV-2, regarded as less virulent, has caused a smaller epidemic, mostly in western Africa. Sequence analysis of HIV-1 group M isolates has determined that their closest relative is a simian immunodeficiency virus, SIVcpz, from the chimpanzee species *Pan troglodytes troglodytes,* found in southeastern Cameroon. This chimpanzee virus was thought to have crossed species to humans through the bushmeat trade when the killing of chimpanzees and preparation of chimpanzee meat exposed humans to SIVcpz.

Testing of preserved tissue biopsies from Kinshasa, Democratic Republic of the Congo (then Léopoldville, Belgian Congo) found evidence of HIV-1 infection from 1959, and comparison of its sequence to the SIVcpz sequences suggested that the virus had been evolving in humans for several decades by that time. Kinshasa sits along the Congo River, downstream of the infected chimpanzees' habitat. HIV-2 is most closely related to a simian immunodeficiency virus found in sooty mangabeys (SIVsm) with the different HIV-2 groups representing separate mangabey-to-human transmission events.

Several sociopolitical factors likely contributed to the diffusion of HIV from isolated transmission events to bushmeat traders to the global pandemic that it is today. At the time when HIV-1 group M is thought to have entered the human population, the traditional social structure of African society was disrupted by colonization, and the migration of people and development of cities all presented opportunities for the virus to spread. The stresses of tropical infections and malnutrition contributed to the immune suppression that allowed the virus to take hold. Further, the use of inadequately sterilized syringes and needles to treat infections and administer vaccines likely contributed to the rapid expansion of infection in the population of central Africa. With advances in transportation throughout the twentieth century, the ease of international travel permitted HIV to make its way to distant continents.

## HIV/AIDS Today

In the initial years of the AIDS epidemic, the diagnosis was a death sentence. There was no effective treatment,

and affected people would invariably succumb to opportunistic infections or cancer. Public health entities had great interest in identifying infected people to obtain accurate estimates of the epidemic in order to control its spread. But because a diagnosis of HIV infection often resulted in loss of personal relationships, health insurance, employment, or opportunities for education, among other things, testing without consent was unethical. The sociolegal history of AIDS has been one of balancing the interests of the public in controlling the epidemic with the individual's right to liberty and privacy. As new treatments altered the course of the disease and public attitudes about people living with HIV began to change, reconciling these interests became more feasible.

***Antiretroviral Treatment and the Changing Face of the Pandemic***

The first antiretroviral drug to be approved was AZT (zidovudine), in 1987. Other antiretroviral drugs followed. In 1993 there was documented transmission of AZT-resistant HIV, presenting another challenge to HIV treatment. As more drugs were approved, the use of combination antiretroviral therapy (so-called highly active antiretroviral therapy, or HAART) became the standard of care. While HAART is very effective at suppressing HIV and can do so for decades if taken consistently, it cannot cure HIV. Once the medications are stopped, the virus returns to wreak havoc on the immune system.

Initial treatments were limited by toxicities, including nerve damage, kidney damage, fat redistribution, and the increased risk of heart disease and diabetes. More recent therapies are generally well tolerated. Yet the cost of newly developed drugs is often prohibitive, especially for developing nations. Generic drugs and price reductions on new medications have eased this burden on middle-and low-income nations, but challenges remain. Now countries must determine how to pay for decades of expensive therapy for a growing number of patients who are living longer.

At the end of 2010, approximately 34 million people were living with HIV worldwide. There were an estimated 2.7 million new infections and 1.8 million AIDS-related deaths in that year. Fortunately, these numbers are declining due to aggressive testing, education, and treatment programs in many nations. Unfortunately, for most people infected in sub-Saharan Africa, initiation of therapy comes too late to significantly impact the course of the disease. By the end of 2010, 6.65 million people living with HIV worldwide were receiving antiretroviral treatment, although this is less than 50 percent of those who should receive treatment by World Health Organization guidelines. Much of this deficiency is a result of insufficient funding. Recent data show that early antiretroviral therapy also reduces transmission; therefore, these missed opportunities lead to a vicious cycle of new infections and disease progression.

***Vulnerable Populations***

While the HIV/AIDS epidemic in the United States, Western and Central Europe, and much of Oceania continues to be driven by male-to-male sexual transmission, the epidemic in Africa is overwhelmingly female, with 15-to 24-year-old women being nearly eight times more likely than men to be HIV-positive. In Africa the primary mode of transmission is heterosexual sex. Male-to-female transmission is about eight times more efficient than female-to-male transmission, due to the greater vulnerability of the female genital tract. In addition, because of gender inequality in much of the developing world, women are often the victims of intimate partner violence, dependent upon their partners for economic support, and without the power to demand safe sexual practices. Further, the HIV epidemic intersects with armed conflict in some areas, and sexual violence against women is a weapon of war, with a resultant spread of infection. The Caribbean is the only region besides Africa where women with HIV outnumber HIV-positive men.

Mother-to-child transmission of HIV, perinatally or through breastfeeding, occurred in an estimated 390,000 cases in 2010. While still high, this is 21 percent below the rate of new mother-to-child infections in 1997, at the epidemic's peak. Antiretroviral therapy, improved maternal and perinatal health care, and education are responsible for these gains.

The nation that bears the greatest burden of HIV disease is South Africa, where in 2010 an estimated 5.6 million

people were living with HIV. This is true despite HIV-1 having originated in central Africa, the habitat of the chimpanzees infected with the viral precursor to pandemic HIV-1. Factors contributing to the South African epidemic include the ravages of apartheid; the resultant poverty and social upheaval destabilized families, leading to an increase in sexual partnerships and transactional sex. In addition, the discriminatory health-care system in place during apartheid engendered a mistrust of the medical establishment that has kept many from receiving necessary treatment for their HIV or other sexually transmitted diseases that facilitate the transmission of HIV.

In 2000, partly because of this mistrust of the apartheid medical establishment, and, by extension, Western medicine, then–South African president Thabo Mbeki publicly questioned the safety and efficacy of antiretroviral medications and expressed doubt about whether HIV was truly the cause of AIDS. He argued that poverty and other diseases were responsible for AIDS. Mbeki and his government subsequently restricted the use of donated antiretroviral medications and blocked international grants aimed at combating the AIDS epidemic in South Africa. A Harvard study published in 2008 estimated that more than 330,000 lives were lost between 2000 and 2005 as a result of these misguided policies. A study from the University of Cape Town that same year estimated that in excess of 171,000 HIV infections occurred between 1999 and 2007 due to Mbeki's actions.

In North America, Western and Central Europe, and parts of Oceania, the majority of new infections are in men who have sex with men. In the United States, African Americans are disproportionately affected. Although African Americans represent less than 14 percent of the U.S. population, they accounted for half of new HIV infections from 2005 to 2008. HIV incidence actually increased among U.S. men who have sex with men aged 13 to 29, particularly African Americans, from 2006 to 2009. Several factors are likely to have contributed to this increase, including increasing risky sex practices fueled by complacency about HIV, substance abuse, lack of testing and treatment opportunities, and insufficient education about prevention.

The features and trajectory of the epidemic in South and Southeast Asia vary by country. Some nations, such as Thailand and Cambodia, have witnessed significant declines in prevalence, while others, such as Bangladesh and Pakistan, have seen increases. Asia's epidemic was initially concentrated in high-risk populations, particularly sex workers and their clients, injection drug users, and men who have sex with men. More and more, heterosexual transmission to partners of those from high-risk groups accounts for a greater proportion of new infections. Countries that have turned the tide against HIV have found success with concerted national efforts aimed at testing, prevention, and treatment. National failures have been the result of denial, criminalization of risk groups, and inadequate investment in health infrastructure. Although the Asian epidemic, with an estimated 4.8 million people living with HIV in 2010, is smaller than the epidemic in Africa, Asia is home to 60 percent of the world's population, so the stakes are high.

The AIDS epidemic in Eastern Europe and Central Asia is fueled by injection drug use, and there is no end in sight. From 2001 to 2010, these regions saw an increase of 250 percent in the number of people living with HIV, fueled by new infections. This public-health failure has been driven in part by ineffective government health programs, which in many cases block access to antiretroviral therapies for active injection drug users, considering them to be untrustworthy and noncompliant. Further, many of these governments are reluctant to support opiate substitution and needle-exchange programs, which have been proved to increase adherence to antiretroviral therapy and decrease HIV transmission among injection drug users. Nevertheless, imprudent approaches to controlling the epidemic among injection drug users are not limited to this region of the world. In the United States, federal funds could not be used for needle-exchange programs from 1988 until the ban was overturned in 2009, only to be reinstated in 2011. Public perception of drug users has translated into a lack of political will to fund these programs, despite their demonstrated effectiveness.


*An anti-AIDS poster in Niger advocates abstinence, one of the pillars of prevention campaigns across Africa. The continent continues to account for more than 70 percent of the world's AIDS fatalities and new HIV infections.* (Pascal Parrot/Getty Images)

## Impact of the Pandemic

People living with HIV have been stigmatized and discriminated against since the disease was first recognized. This is in part due to the stigma already associated with the initially identified high-risk groups: homosexual and bisexual men, injection drug users, and prostitutes. Especially early in the epidemic, there was significant fear of HIV contagion among the general public and health-care workers. In addition to fear, many hold the moralistic view that those with HIV deserve their infection as some sort of divine punishment for risk behaviors seen as "wrong."

The stigma associated with groups at high risk of contracting HIV has been a barrier to the development of effective prevention strategies, since many governments do not commit the necessary resources to aiding these groups. Moreover, since injection drug use, prostitution, and, in some countries, homosexual sex are criminalized, people who engage in these behaviors are often reluctant to seek testing and treatment out of fear that they might be arrested.

The AIDS pandemic has uncovered the need for social change and greater legal protections for vulnerable groups. Much of the fear and misinformation that contributed to the spread of HIV resulted from antiquated and uninformed notions of human sexuality. Open dialogue about safer sexual practices and greater acceptance of sexual minorities have allowed for successful prevention and treatment interventions.

Particularly in parts of the developing world, gender inequality has made women and children disproportionately vulnerable to the ravages of AIDS. Not only do intimate partner violence and low relationship power prevent women from employing safe sexual practices, but sparse economic opportunities for women often push them to transactional sex in order to feed their children. As the status of women improves, so do the prospects for controlling the pandemic in the developing world.

In parts of Africa, AIDS has devastated economies and created a generation of orphans. These nations, ravaged by colonialism and wars in the last century, now face the seemingly insurmountable challenge of treating the ill and providing for the next generation while struggling with a workforce decimated by HIV.

Not all news is dire, however. The worldwide response to AIDS has resulted in the building of important health infrastructure and international partnerships in the developing world. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is an international organization established by the UN in 2002 to supply financial support for programs to combat these diseases. It is funded by developed nations and private contributions. The largest contributor is the United States, but at the fund's inception, it was the $100 million pledge by Microsoft founder

and philanthropist Bill Gates that inspired a series of substantial contributions. The Bill & Melinda Gates Foundation remains the largest contributing foundation to AIDS relief and research. In 2006, activists U2 frontman Bono and attorney Bobby Shriver founded Product Red (RED), a brand licensed to partner companies whose profits benefit the Global Fund, contributing over $180 million to date. Efforts funded by these and other organizations have been instrumental in the fight against AIDS and other diseases. The challenge for contributing nations and nongovernmental organizations in a time of recession is to avoid negating the progress that has been made with short-sighted cuts to treatment, prevention, and research programs.

## The Future

The HIV/AIDS pandemic is believed to have peaked in 1997. The achievements in HIV treatment and prevention are a credit to the organizations, governments, activists, scientists, health-care workers, and people living with HIV who have prioritized bringing an end to this disease.

Nearly every year, new drug therapies are approved, many of which are more effective and better tolerated than those that came before. Promising data indicate that uninfected people at risk for HIV who take a daily combination of antiretroviral medications (so-called pre-exposure prophylaxis, or PrEP) might prevent infection. Initial testing of a daily vaginal microbicidal gel suggested that this gel might prevent male-to-female transmission of HIV, giving women the ability to protect themselves when they are unable to refuse sex or demand condom use. Unfortunately, a subsequent study has found this gel to be ineffective. Further efforts to develop effective microbicides are ongoing. Adult male circumcision in regions with high levels of HIV infection has been found to reduce female-to-male sexual transmission, and programs are in place to promote this procedure and provide it to those who desire it.

The development of a preventative vaccine is essential for the eradication of HIV. Unlike other vaccines, which need only induce enough of an immune response to help the body control the target infection, an effective vaccine against HIV must entirely prevent infection. Up to this time, no HIV vaccine trial has been successful. In 2010 a vaccine trial in Thailand showed modest but not complete protection against HIV infection, but it is unclear if this approach can be modified to be more effective. Despite 30 years of research, the prospect of a preventative HIV vaccine remains distant.

The search for a cure has been equally challenging. One reason why HIV is so difficult to eradicate from the body is its propensity to infect and persist undetected in long-lived memory CD4+ T cells. These cells live for decades, and once infected they can be prompted to produce a new HIV virus at any time. An approach for eradication of this “latent reservoir” of HIV is to treat with drugs that activate this hidden virus. As the virus is drawn out of the infected cells, the body is able to eliminate them. Some such medications are in the early stages of investigation.

A cure for HIV is not impossible, however, and thus far there has been one documented case. A man living in Germany (known in the press as the “Berlin patient”) with HIV and acute myeloid leukemia (a cancer of the bone marrow) underwent a stem-cell transplant in 2007 to treat his leukemia. During the course of a stem-cell transplant, chemotherapy is given to eradicate the leukemic cells as well as the patient’s own immune system, allowing the donor stem cells to regenerate the bone marrow. It is known that people with the “delta 32” mutation in both copies of a gene called CCR5 are resistant to infection by certain types of HIV that use CCR5 as a co-receptor to gain entry into cells. So the Berlin patient’s doctor identified a stem-cell donor who had the delta 32 mutation in CCR5 that made him resistant to infection. Four years after his successful stem-cell transplant with these HIV-resistant cells, the Berlin patient has no signs of HIV infection, despite being off antiretroviral therapy. Unfortunately, this approach is only practical for those HIV patients who have both leukemia requiring a stem-cell transplant and a compatible donor harboring the CCR5 mutation.

The history of the HIV/AIDS pandemic has been one of triumph and setbacks—scientific, social, and political. The challenge for the future is to avoid complacency that would undermine the progress that has been made.

*Mary Lewinski*

See also: Drug Abuse; Gay, Lesbian, Bisexual, and Transgender Issues; Sexually Transmitted Infections.

## Documents

### "Pneumocystis Pneumonia—Los Angeles," ***Morbidity and Mortality Weekly Report,*** 1981

*This report from the U.S. Centers for Disease Control's Morbidity and Mortality Weekly Report of June 5, 1981, presented the first published cases of what would become known as AIDS. The short case study included here describes the illnesses (and two deaths) of five homosexual men in Los Angeles who were found to be very sick with pneumocystis pneumonia and cytomegalovirus (CMV) disease, among other opportunistic infections. The contributors of the case study note that the men all had severely depressed cellular immune function*

In the period October 1980–May 1981, 5 young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at 3 different hospitals in Los Angeles, California. Two of the patients died. All 5 patients had laboratory-confirmed previous or current cytomegalovirus (CMV) infection and candidal mucosal infection. Case reports of these patients follow.

Patient 1: A previously healthy 33-year-old man developed *P. carinii* pneumonia and oral mucosal candidiasis in March 1981 after a 2-month history of fever associated with elevated liver enzymes, leukopenia, and CMV viruria. The serum complement-fixation CMV titer in October 1980 was 256; in May 1981 it was 32.* The patient's condition deteriorated despite courses of treatment with trimethoprim-sulfamethoxazole (TMP/SMX), pentamidine, and acyclovir. He died May 3, and postmortem examination showed residual *P. carinii* and CMV pneumonia, but no evidence of neoplasia.

Patient 2: A previously healthy 30-year-old man developed *p. carinii* pneumonia in April 1981 after a 5-month history of fever each day and of elevated liver-function tests, CMV viruria, and documented seroconversion to CMV, i.e., an acute-phase titer of 16 and a convalescent-phase titer of 28* in anticomplement immunofluorescence tests. Other features of his illness included leukopenia and mucosal candidiasis. His pneumonia responded to a course of intravenous TMP/.SMX, but, as of the latest reports, he continues to have a fever each day.

Patient 3: A 30-year-old man was well until January 1981 when he developed esophageal and oral candidiasis that responded to Amphotericin B treatment. He was hospitalized in February 1981 for *P. carinii* pneumonia that responded to TMP/SMX. His esophageal candidiasis recurred after the pneumonia was diagnosed, and he was again given Amphotericin B. The CMV complement-fixation titer in March 1981 was 8. Material from an esophageal biopsy was positive for CMV.

Patient 4: A 29-year-old man developed *P. carinii* pneumonia in February 1981. He had had Hodgkins disease 3 years earlier, but had been successfully treated with radiation therapy alone. He did not improve after being given intravenous TMP/SMX and corticosteroids and died in March. Postmortem examination showed no evidence of Hodgkins disease, but *P. carinii* and CMV were found in lung tissue.

Patient 5: A previously healthy 36-year-old man with clinically diagnosed CMV infection in September 1980 was seen in April 1981 because of a 4-month history of fever, dyspnea, and cough. On admission he was found to have *P. carinii* pneumonia, oral candidiasis, and CMV retinitis. A complement-fixation CMV titer in April 1981 was 128. The patient has been treated with 2 short courses of TMP/SMX that have been limited because of a sulfa-induced neutropenia. He is being treated for candidiasis with topical nystatin.

The diagnosis of *Pneumocystis* pneumonia was confirmed for all 5 patients antemortem by closed or open lung biopsy. The patients did not know each other and had no known common contacts or knowledge of sexual partners who had had similar illnesses. Two of the 5 reported having frequent homosexual contacts with various

partners. All 5 reported using inhalant drugs, and 1 reported parenteral drug abuse. Three patients had profoundly depressed *in vitro* proliferative responses to mitogens and antigens. Lymphocyte studies were not performed on the other 2 patients.

*Source:* Centers for Disease Control.

### UNAIDS World AIDS Day Report, 2011

*This report from the Joint United Nations Programme on HIV/AIDS (UNAIDS) examines the progress made and the challenges still faced in the international response to AIDS. It also includes recent statistics on HIV incidence and prevalence and presents a broad outline of UNAIDS priorities for the coming years. The excerpt below is the preface to the report.*

#### Transforming the Responses

We are on the verge of a significant breakthrough in the AIDS response. The vision of a world with zero new HIV infections, zero discrimination, and zero AIDS-related deaths has captured the imagination of diverse partners, stakeholders and people living with and affected by HIV. New HIV infections continue to fall and more people than ever are starting treatment. With research giving us solid evidence that antiretroviral therapy can prevent new HIV infections, it is encouraging that 6.6 million people are now receiving treatment in low-and middle-income countries: nearly half those eligible.

Just a few years ago, talking about ending the AIDS epidemic in the near term seemed impossible, but science, political support and community responses are starting to deliver clear and tangible results.

Yet, to be effective, the AIDS response must be transformed. We need to move from a short-term, piecemeal approach to a long-term strategic response with matching investment. The road map for this vision is clear. The United Nations General Assembly set bold new targets in its historic 2011 *Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS,* with a focus on clear, time-bound goals designed to bring about the end of HIV and also improve human health across diverse communities.

To reach these targets and bring the end of AIDS in sight we must step on the accelerator. Joining with partners, UNAIDS has mapped a new framework for AIDS investments, focused on high-impact, high-value strategies.

The world cannot live up to the targets and spirit of the Political Declaration unless countries and donors commit to using the tools available, focusing them on the most effective programmes and investing accordingly.

Michel Sidibé

UNAIDS Executive Director

Under Secretary-General of the United Nations

*Source:* United Nations.

## Further Reading


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## Web Sites

AIDS.gov, the U.S. Government’s HIV/AIDS portal: http://aids.gov

amfAR, The Foundation for AIDS Research: www.amfar.org

AVERT International AIDS charity: www.avert.org

The Body, The Complete HIV/AIDS Resource: www.thebody.com

Centers for Disease Control and Prevention Web site on HIV/AIDS: www.cdc.gov/hiv/default.htm

Joint United Nations Programme on HIV/AIDS: www.unaids.org/en

# Alcohol Use and Abuse

Among the threats to public health around the world, alcohol is one of the most destructive. It is the primary cause of more than 60 health problems and a contributing cause of 200 more. It is the third-leading risk factor for disease worldwide and is the highest risk factor in the regions where the most alcohol is consumed—Europe, the Americas, and the Western Pacific. In addition to health complications, problem drinking often plays a role in automobile accidents that result in fatalities, child abuse, crime, domestic abuse, and high-risk sexual behavior. Consequently, alcohol is directly responsible for about 4 percent of deaths worldwide each year—about 2.5 million people—as well as billions of dollars in government and health-care expenditures (as much as 6 percent of the gross domestic product in some countries).

Nobody is immune to the costs exacted by alcohol use; even those who abstain can lose a relative to alcohol abuse, be involved in a car crash, or have their tax dollars spent on incarcerating an alcohol-addicted felon.

However, the burden of alcohol falls most heavily on the estimated 140 million people worldwide who regularly consume alcohol to excess. In popular parlance, such individuals are called “alcoholics,” though today’s medical professionals tend to prefer more precise clinical descriptors. Currently, the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV) and other medical references divide problem use into two categories: “alcohol abuse” refers to repeated consumption of alcohol despite adverse consequences, while “alcohol dependence” refers to alcohol abuse coupled with a physical tolerance or a biochemical need for alcohol. The line between the two is often blurry, though in most places where alcohol is consumed, between 15 and 20 percent of adults will meet the criteria for either abuse or dependency at some point in their lives.

Many organizations are working to fight the pernicious effects of alcohol use, and they do battle on many fronts: detoxification centers, government policy, informational campaigns, medications, support groups, and so forth. However, given the complex physiological nature of alcohol addiction, as well as the economic and cultural importance of alcohol in many societies, activists often find themselves fighting an uphill battle.

## History

It is impossible to say exactly when humans began to make and consume alcohol. Archaeologists’ discovery of Stone Age beer jugs puts the innovation at least 12,000 years ago, though many scholars believe that fermented beverages date back thousands of years more. Indeed, alcohol may even have preceded bread as a food staple, because humans have long understood that fermentation makes diseased water safe to drink (even though they did not understand exactly why until the nineteenth century).

Certainly, alcoholic beverages were well established in human society by the time the Bronze Age started 5,000 years ago, and most ancient civilizations have left ample evidence of their alcohol usage. Egyptians, for example, had a god of spirits (Osiris) to whom they offered at least 17 varieties of beer and 24 varieties of wine, which were used for celebrations, medical purposes, nutrition, rituals, and as currency. The Chinese used alcohol for many of the same purposes; in ancient China, spirits were drunk daily, and the emperor derived a large portion of his income from taxes on fermented beverages. The ancient Hebrews were imbibers; in fact, one of the first passages in the Old Testament (Genesis 9:20) speaks of Noah’s cultivation of a vineyard on Mt. Ararat. The Babylonians, Greeks, Hittites, Macedonians, Persians, Romans, and Sumerians all enjoyed alcohol as well.

It is fair to assume that problem use of alcohol started at the same time as alcohol production, and the legal codes and other documents left by ancient civilizations tend to affirm that assumption. The Egyptians warned against overconsumption of spirits, as did the Persians. Around 650 B.C.E., a Chinese writer remarked that “[the people] will not do without beer. To prohibit it and secure total abstinence from it is beyond the power even of sages. Hence, we have warnings on the abuse of it.” Two centuries later, the Greek writers Xenophon and Plato expressed similar sentiments.

The rise of Christianity in the centuries after the ministry and execution of Jesus of Nazareth laid the groundwork for significant debate over the propriety of alcohol use. Jesus and St. Paul, the two men whose ideas form the bulk of the New Testament, embraced moderate alcohol use (Matthew 15:11; 1 Timothy 4:4, 5:23) while condemning drunkenness. Ephesians 5:18, for example, commands: “And do not get drunk with wine, for that is debauchery,” and other passages (Galatians 5:19–21; Luke 21:34; Matthew 24:45–51) have similar language. For millennia, the Catholic Church has taken this point of view, insisting that alcoholic spirits are a gift from God so long as they are not abused. Consistent with this, for many centuries the finest distilleries and vineyards in Europe were owned and operated by the Catholic Church.

Around 400 C.E., however, some Christian sects began to adopt a different perspective. Distressed and disgusted by the wanton abuse of alcohol that was common in the late Roman Empire, they argued that when Jesus and Paul spoke of “wine” in a positive way, they were referring to grape juice, and when they condemned drunkenness they were referring to fermented drinks. Therefore, they concluded that the use of spirits was neither appropriate nor consistent with the teachings of the New Testament. This view of scripture has waxed and waned in popularity among Christians in the 1,500 years since, but still has currency among most Jehovah’s Witnesses, Mormons, and

Seventh-Day Adventists, as well as many Baptists, Methodists, and Pentecostals. Similarly, Muhammad condemned alcohol consumption when he founded Islam in the seventh century C.E., and this attitude is emphasized in the Koran. To this day, the vast majority of the world's Muslims do not imbibe.

The emergence of anti-alcohol sentiments—which would eventually be labeled "temperance" (alcohol should be used very sparingly) or "abstinence" (alcohol should not be used at all)—did little to slow global alcohol use over the course of the next thousand years. And when countries started to expand and urbanize in the sixteenth century, spirits actually grew in importance. In addition to its role in recreational activities and religious rituals, alcohol served as an important form of currency, often utilized as salary for sailors and soldiers or as payment for debts. It also had medicinal purposes—a source of warmth, a painkiller, and a "cure" for many diseases. As a consequence of these developments, global alcohol use peaked in the seventeenth and eighteenth centuries. Around the world today, adults consumes an average of 6.13 liters of pure alcohol per year. By contrast, the statistical information from four centuries ago—though admittedly imprecise—suggests that the figure then was closer to 17–18 liters per year.

Consumption of alcohol in this quantity inevitably led to an increase in problem use. Further, as noted, this went hand in hand with other major developments, among them industrialization and urbanization. Thus, alcohol abuse began to attract the blame for social problems that were partly its doing and partly the result of these other developments. This included increases in crime and poverty, more frequent outbreaks of urban riots and other violence, a rise in infant mortality rates, and the increased prevalence of prostitution. The chorus of criticism was loudest in Europe and the United States, but was also heard in some Asian countries.

By the early decades of the nineteenth century, concerns about the pernicious effects of spirits led to the rise of anti-alcohol movements in many countries—some of them preaching temperance, others abstinence. These were sometimes led by secular groups, but were more commonly the province of religious leaders. In Western countries, evangelical Christians tended to take the lead, while in Asian countries like China, Japan, and Sri Lanka (then Ceylon), it was Buddhists. In regions dominated by Catholicism (South America, much of Europe), Islam (the Middle East, Northern Africa), or Hinduism (India), alcohol use was either much less common or was much less likely to be seen as problematic, and so anti-alcohol activism was rarer.

Temperance and abstinence movements had a great deal of success in reducing the high levels of alcohol consumption that accompanied industrialization, aided by the fact that modern currencies and medicines took over some of the functions that had been filled by alcoholic spirits. By the end of the nineteenth century, the world's adults, on average, consumed about 7 liters of pure alcohol per year. Efforts to go further than this—to ban alcohol altogether, as during Prohibition in the United States (1919–1933)—have generally been ineffectual. So, the per capita alcohol consumption today is about the same as it was a century ago.

## Highest Per-Capita Alcohol Consumption, by Nation, 2005

| Country | Alcohol Consumption* |
|---|---|
| Moldova | 18.22 |
| Czech Republic | 16.45 |
| Hungary | 16.27 |
| Russia | 15.76 |
| Ukraine | 15.60 |
| Estonia | 15.57 |
| Andorra | 15.48 |
| Romania | 15.30 |
| Slovenia | 15.19 |
| Belarus | 15.13 |
| Croatia | 15.11 |
| Lithuania | 15.03 |
| Korea, Republic of | 14.80 |
| Portugal | 14.55 |
| Ireland | 14.41 |
| France | 13.66 |
| Denmark | 13.37 |
| United Kingdom | 13.37 |
| Slovakia | 13.33 |
| Poland | 13.25 |
| Austria | 13.24 |
| Luxembourg | 13.01 |
| Germany | 12.81 |
| Latvia | 12.59 |
| Bulgaria | 12.44 |
| United States | 9.44 |
| **World Average** | **6.13** |

*Liters of pure alcohol per capita, over age 15.
*Source:* World Health Organization.

## Global Impact

The use and abuse of alcohol have a wide variety of deleterious effects. To start, alcohol is associated with 5 percent of diseases and injuries worldwide, with its effects divided roughly in these proportions: neuropsychiatric disorders (37.6 percent of the burden of disease caused by alcohol), unintentional injuries (25.4 percent), intentional injuries (10.7 percent), cardiovascular disease (9.7 percent), cirrhosis of the liver (8.9 percent), and cancer (7.6 percent). Alcohol abuse also facilitates addiction to other drugs, most commonly nicotine. It contributes to many psychiatric disorders, including anxiety, dementia, depression, and panic attacks, and it sometimes encourages suicide.

Alcohol also causes a variety of social ills. Abusers and dependents often struggle to perform at or keep their jobs, to manage their money, and to maintain their interpersonal relationships. Further, drinking affects key neurotransmitters in the brain (most important of which is gamma-Aminobutyric acid), leading to increased lapses in judgment, risk taking, and aggression. This can lead to drunk driving and car accidents, violent crime, altercations, and high-risk sexual behavior.

Children are often victimized by alcohol, both before and after they are born. To begin with, pregnant mothers who drink place their fetuses at risk of fetal alcohol syndrome (FAS), which is most commonly characterized by brain damage but can also include cognitive disabilities, physical defects, and stunted growth. It is estimated that about one child in 1,000 in the Western world suffers from FAS. The offspring of alcoholics are vastly more likely to be the victims of abuse. They are also more likely to begin using alcohol themselves in a problematic fashion, sometimes at a very early age, leading to a generational cycle of problem use.

The negative impacts of alcohol use and abuse are distributed very unevenly across the world. A scant majority of the world's adults do not drink—about half of men and two-thirds of women have not consumed any alcohol in the past year. The regions of the world where abstainers make up the majority of the population—the Middle East, North Africa, and Southeast Asia, where 85 percent to 95 percent of the population does not drink—necessarily avoid most of the harm done by alcohol.

Even when looking at regions where alcohol use is common—Europe, the Americas, and Australia—the burden is felt differently depending on patterns of consumption. Scholars divide alcohol-consuming cultures into two broad types. In "wet" cultures—which are predominant in Western Europe and the Mediterranean south of the continent—drinking is integrated into daily life. The amount of alcohol consumed can be quite high—perhaps 13 to 18 liters of pure alcohol per person annually. However, it is spread out across many days, is most commonly consumed in the form of wine, and is less likely to be drunk to excess. In "dry" cultures—Australia, Canada, Eastern Europe, Scandinavia, and the United States—alcohol use is more restricted and is not generally a daily occurrence. In these areas, total annual consumption of alcohol is lower—7 to 12 liters of pure alcohol per person, in most cases. However, "hard" liquor, binge drinking, and drunkenness are more common. The "dry" pattern is far more dangerous and does far more damage to people and societies than does the "wet" pattern.

The burden of alcohol abuse is also felt differently among different segments of the population. Poor people are generally unable to afford spirits on a regular basis. They are therefore the most likely to "splurge" when they do drink—to engage in dangerous binge-drinking behavior. At the same time, they are less likely to be able to afford the medical care that their drinking might necessitate, whether treatment for injuries, rehabilitation services, or psychological care.

Young people also bear a disproportionate share of the harm done by alcohol. They are more likely to binge drink, and their bodies are less likely to have adapted to the effects of liquor. Consequently, alcohol is the leading risk factor for death among people age 15 to 29 worldwide, responsible for approximately 320,000 fatalities a year in that segment of the population. This is more than the number of deaths from AIDS, cancer, influenza, malaria, and tuberculosis combined.

There is a gender imbalance in the effects of alcohol use as well. Men are much more likely than women to imbibe and are yet another group that is more likely to binge drink. Consequently, men are more likely to be problem users, to suffer from cirrhosis or other alcohol-related health complications, to be involved in alcohol-fueled acts of crime or violence, and to be at the wheel in drunk-driving accidents. They are also, not surprisingly, more likely to be killed by alcohol use. About 6.2 percent of men worldwide die from alcohol-related causes, compared to 1.1 percent of women.

The case of Russia, among the countries most affected by alcohol use, illustrates the harm that can result from a combination of the risk factors outlined above. Russia is relatively poor, and its usage patterns are characteristic of a "dry" culture—binge drinking is common, and alcohol is likely to be consumed in the form of hard liquor (in particular, vodka). Making matters worse, Russians' consumption of pure alcohol on an annual basis is more in line with a "wet" culture—13 to 18 liters per year. Nearly all males in Russia drink, as do many young people, including more than 10 million children between the ages of 10 and 14.

A number of serious social and political issues have resulted from these patterns of use. More than 2 million Russians are alcohol dependent, and more than half a million Russians die every year from alcohol-related causes. The country's health-care system is overburdened, while at the same time the Russian government is

struggling to fully staff its military because so many young men are unfit for service. Fully 20 percent of Russian men die from alcohol abuse, at an average age of 59. Their spouses live to an average age of 74, which has given rise to a phenomenon called “widow alcoholism”—Russian men drink themselves to death, leaving behind wives who cope by drinking, in the process becoming alcohol dependent themselves.

*Russian men drink beer and hard liquor on the street in downtown Moscow. Alcohol consumption in the former Soviet republics is among the heaviest in the world, contributing to high rates of liver disease, traffic deaths, suicide, and mental disorders.* (AP Photo/Mikhail Metzel)

## Fighting Abuse

For many reasons, combating the harmful effects of alcohol is a daunting challenge. From a physiological standpoint, alcohol affects individuals broadly, with both mental and physical components. Furthermore, once an individual is alcohol dependent, the change is permanent. The condition cannot be cured or reversed, only managed.

Another complicating factor is the extent to which alcohol use is linked to many social and cultural norms. Many religious adherents, including Catholics, Jews, some Buddhists, and many Africans have rituals that include wine or other spirits. A great many civic and secular customs—the lunar new year in many Asian nations; Mardi Gras, New Year’s Eve, Oktoberfest, and St. Patrick’s Day in the West, Independence Day in many African countries—are accompanied by alcohol use.

Furthermore, many individuals and businesses have a vested interest in promoting alcohol use. Not unexpectedly, they tend to focus their efforts on markets where they are most likely to increase the number of drinkers or the amount they drink (primarily “dry” cultures). For example, the producers of alcoholic beverages have made a concerted effort since the early 1970s to lobby the government of Thailand for less-restrictive laws, while at the same time blanketing the countries with advertising. The result has been a staggering 33-fold increase in alcohol

consumption in the previously temperate country.

Finally, in many—perhaps even most—regions of the world alcohol abuse and dependency are seen as weak or unmanly. This stigma often causes sufferers to avoid seeking treatment, while encouraging family, friends, and colleagues to look the other way. In some cultures, this effect is so pronounced that health-care professionals are hypervigilant in seeking out male alcohol abusers, which leads to an unexpected consequence: female abusers are often overlooked.

***Combating Abuse in Individuals***

One of the biggest challenges in grappling with alcohol abuse at an individual level is identifying which people are abusers or dependents and then persuading those individuals to admit that they have a problem. To this end, medical professionals have a number of quickly administered screening tests at their disposal, including the Alcohol Use Disorders Identification Test (AUDIT), Michigan Alcoholism Screening Test (MAST), and Paddington Alcohol Test (PAT). Most widely used is the CAGE questionnaire, whose name is an acronym of its four questions:

1. Have you ever felt you needed to Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt Guilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (E ye-opener) to steady your nerves or to get rid of a hangover?

An answer of “yes” to two or more questions is a strong indication of alcohol dependence. This is particularly true of the fourth question, an activity in which practitioners sometimes engage alone, and for which a positive response strongly suggests withdrawal symptoms.

After an addict has been identified and has confronted his or her condition, serious challenges still remain. Withdrawal from alcohol is generally accompanied by a constellation of symptoms, some of them life threatening, including anxiety, delirium, depression, hallucinations, heart palpitations (and possible heart failure), insomnia, and seizures. Such symptoms must be managed—in a clinical setting in more severe cases, and otherwise with medications, including Disulfiram, Naltrexone, and Odansetron. Benzodiazepines are particularly useful in managing the symptoms of alcohol withdrawal, but are risky because they are also highly addictive and can lead to overdoses.

The symptoms of withdrawal from alcohol tend to last one to three weeks; thereafter, rehabilitation and support services are essential in order to help sufferers learn how to reprogram their approach to alcohol and to aid them in resisting temptation. In the short to medium term—from a few weeks to a year or two—this generally means rehabilitation clinics and psychological counseling. In the long term—years or, sometimes, decades—this usually means support groups like Secular Organizations for Sobriety, SMART Recovery, Women For Sobriety, and, most famously, Alcoholics Anonymous (AA). Founded in 1935 by Bill Wilson and Bob Smith (Bill W. and Bob S. to members, who use only their first names and last initials), AA offers a template for sober living, mentorship from fellow addicts, and daily support meetings. AA preaches total abstinence for members; some other groups prefer to focus on a return to moderation in drinking.

Needless to say, many of these therapies and support structures entail significant expense or logistical difficulty. Therefore, they tend to be available only in more affluent countries or at least only in urban areas. This makes combating alcohol abuse at a societal level particularly imperative in less developed countries.

***Combating Abuse in Society***

When organizations attempt to take a top-down approach to fighting alcohol use—among them the Center on Alcohol Marketing and Youth, Coalition for the Prevention of Alcohol Problems, Mothers Against Drunk Driving

(MADD), Robert Wood Johnson Foundation, and World Health Organization (WHO)—one of the first challenges they face is knowing exactly where alcohol is being consumed and in what quantities. Historically, reviewing tax records and calculating how much pure alcohol each sale represents have comprised the preferred method for answering these questions. Every bottle of wine purchased, for example, might count as 0.09 liters of alcohol, each case of beer 0.12 liters.

In the past several decades, however, the problems with this methodology have become very apparent. Homemade alcohol—which is particularly common in sub-Saharan Africa, some parts of Asia, and some parts of the Americas—is not included in the tally nor does alcohol that is produced illegally or is smuggled from other countries. Furthermore, knowing when and where alcohol was legally purchased does not necessarily make clear when and where it was consumed. In particular, traditional methodologies have no way of accounting for the practice of "stockpiling," which is common before the outbreak of wars or the implementation of tax increases. Finally, assumptions about precisely how much alcohol is in a particular product have become increasingly unreliable and problematic. In Australia, more than 10,000 different brands and varieties of alcoholic beverages are for sale. In the United States, the number exceeds 30,000. It is impractical or impossible to maintain an accurate list of how much alcohol each variety contains, and using one blanket figure for "beer" or for "wine" or for "whiskey" does not properly account for the wide variations in the level of alcoholic content in those beverages.

Because of these issues, and the need to improve what is known about alcohol use worldwide, WHO created the Global Alcohol Database (GAD) in 1997. The GAD is a vast collection of data collected by researchers, activists, and government organizations. It covers alcohol production and availability; levels of consumption; patterns of consumption; harm and consequences; economic aspects; alcohol control policies; and prevention, treatment, and drinking guidelines. It is the most comprehensive resource of its kind in existence. The WHO supplements the GAD each year with its *Global Status Report on Alcohol and Health.*

Of course, good information is only a tool for anti-alcohol activists and not a solution. It is important to publicize what has been learned from the GAD and other sources through information campaigns, which are sometimes undertaken independently by the WHO or other organizations or are conducted in partnership with government agencies. These campaigns—conducted through television or radio commercials, posters and signage, distribution of literature, and Web sites, among other media—have been launched in more than 100 countries and have focused on such subjects as the dangers of drunk driving, the negative effects of alcohol on young people, the health consequences of alcohol abuse, the dangers of alcohol in the workplace, and the risks of drinking while pregnant.

Another area of focus is young people's access to alcohol. At least 17 countries have no minimum drinking age, while 65 others place limits on underage drinking only at the point of sale (in other words, youths cannot drink in bars or stores but can purchase liquor for home use). The most effective approach to imposing greater limits on young drinkers, one advocated by WHO, is oversight of alcohol producers through a government-managed licensing system. The licenses generate income, which pays the costs of the program, and puts the onus of enforcement primarily upon the sellers of alcohol. Those who violate government edicts regarding age restrictions run the risk of losing their license and, with it, their business.

Raising taxes on alcohol also reduces consumption and abuse, a conclusion that has been confirmed in more than 100 studies. This approach has been adopted in 132 countries, 20 of which have taken the additional step of using some portion of the revenues for alcohol-related health or information programs. Thailand, in the face of the issues noted above, has been among the leaders in this area. In 2001, the Thai government established ThaiHealth, which is funded with taxes on alcohol production and sales. ThaiHealth uses its resources to treat addicts and to educate Thai citizens about the dangers of alcohol. It also serves in an advisory capacity to the Thai legislature.

WHO and other organizations—notably MADD—also lobby governments for the passage and enforcement of drunk driving laws. The 24 countries that have no legal limit are naturally a particular focus of attention. Most others set the maximum allowable blood alcohol content (BAC) for drivers between 0.05 percent and 0.1 percent

(most countries with Muslim-majority populations have a zero-tolerance policy, and many countries have much smaller legal BAC levels for underage or commercial drivers). Of course, these laws are not meaningful if they are not enforced. Therefore, lobbying efforts also emphasize enforcement, in particular “visible” enforcement—studies have shown that checkpoints, information campaigns, road signs, and other indications that make clear that sobriety laws are being enforced tend to make drunk-driving laws considerably more effective.

Another way in which government policy can be used to combat alcohol abuse is through restrictions on advertising by the producers of alcoholic beverages. At present, 21 countries regulate such advertising in some way, most commonly by banning television commercials for spirits or by disallowing sponsorship of sporting events or athletic teams by alcohol producers.

Finally, governments can also combat the effects of alcohol use and abuse by sponsoring treatment programs and providing other medical resources. At present, the governments of 126 countries have some kind of policy regarding the treatment of alcohol abusers, and 98 have implemented that policy nationwide. However, only four countries—Croatia, Israel, Moldova, and Ukraine—have a specific line item in their budgets for alcohol treatment. Nearly all countries claim that they are unable to treat all who need assistance.

## The Future

Certainly there has been progress in combating problem use of alcohol in the past several decades. Important new drugs have been developed, new tools like the GAD have been created, and effective strategies have been identified. However, the effective advertising and lobbying of the alcohol industry, the ubiquity of spirits in many cultures, and lingering prejudices that prevent people from seeking help have all counterbalanced these successes.

WHO continues to take the lead in anti-alcohol activism, and in 2010 it issued a list of 10 ongoing areas of focus:

1. Pressing governments to develop alcohol management policies
2. Increasing the capacity of health systems to handle alcohol abusers and dependents
3. Preventing the sale of alcohol to underage drinkers
4. Drunk-driving laws
5. Limiting the availability of alcohol
6. Restricting the marketing of alcoholic beverages
7. Increasing the price of alcohol
8. Reducing the negative consequences of drinking
9. Reducing the prevalence of illegally produced alcohol
10. Continued monitoring of behaviors and collection of information

In short, the organization remains committed to the same approaches that activists have been utilizing for years. In all cases, the evidence is encouraging, but the extent to which these efforts will be effective in the long term remains to be seen.

*Christopher G. Bates*

See also: Drug Abuse.