# The politics of AIDS in South Africa: beyond the controversies

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Discussion of AIDS in South Africa needs to move beyond a simplistic "for or against" stance on President Mbeki's denial of a connection between HIV and AIDS. The authors propose ways to widen the debate and hence to increase understanding of the epidemic

At the beginning of 2000 Thabo Mbeki sent a letter to world leaders expressing his doubt that HIV was the exclusive cause of AIDS and arguing for a consideration of socioeconomic causes. He subsequently invited scientists who shared his view to sit with orthodox experts on AIDS on a presidential panel to advise him on appropriate responses to the epidemic in South Africa. Until April 2002, when Mbeki formally distanced himself from the AIDS "dissidents," the international scientific community's interest in South African policies on AIDS was almost exclusively focused on the polemic raised by the president. His statements questioning the AIDS statistics, on poverty as a cause of immune deficiency, and on the dangers of antiretrovirals, together with government stalling on the roll out of nevirapine to prevent transmission of HIV from pregnant mothers to their babies, dominated the debate.[1–3]

However, the July 2002 Constitutional Court judgment ordering the government to make nevirapine universally available to pregnant women infected with HIV, followed in October by a cabinet statement supporting wider access to antiretrovirals, may have finally ushered in a new era. It should now be possible to discuss the reality of AIDS in South Africa without reducing the argument to simple dualisms (such as being for or against a viral cause of AIDS, for or against the president). We propose an approach to discussing AIDS in South Africa that is rooted in political economy and political anthropology. Such an approach will shed light not only on the objective determinants of the epidemic, especially social inequalities, but also on subjective responses, such as those of Mbeki.

## Summary points

Until recently the international medical community's view of HIV/AIDS in South Africa has been dominated by the argument over President Mbeki's stance on the epidemic

Applying the tools of political economy and anthropology to an analysis of AIDS in South Africa will bridge the gulf between positions and will help in the management of the epidemic

Suspicion of Western drugs and denial of the epidemic can be understood as deeply embedded effects of the actions of the apartheid regime

## Causes and processes: the political economy of AIDS

With an estimated five million people infected, South Africa has the highest number of people with HIV in the world. The most striking epidemiological fact is the extremely rapid growth in HIV seroprevalence, for example from 0.7% in pregnant women in 1990 to 24.5% in 2000, reaching 36.2 % in KwaZulu Natal.[4] The impact on adult mortality has been dramatic. In 2000 AIDS accounted for 25% of all deaths, and mortality was 3.5 times higher than in 1985 among 25-29 year old women and two times higher among 30-39 year old men.[5] This rapid evolution, unprecedented even on the African continent, is often seen as yet another symptom of South African "exceptionalism," a phenomenon often referred to in the social sciences.[6]

Yet one need not look far—whether historically or in other countries—to appreciate that social conditions are important in determining exposure to disease.[7 8] Had a coherent social epidemiology of HIV been more prominent in the scientific arena, rather than the dominant biomedical and behavioural approach, Mbeki might have found interesting alternatives to the explanations of the epidemic given on the dissidents' websites.

Three social factors seem to place South Africa at a higher risk of HIV. Firstly, social inequalities in income and employment status are powerful predictors of HIV infection—although, interestingly, the correlation is neither linear nor unequivocal. Several factors are involved in the association. A low income or level of employment is associated with[9]:

- A greater exposure to risky sexual experiences
- Diminished access to health information and to prevention
- Higher frequency of sexually transmitted infections generally
- Absent or delayed diagnosis and treatment, and

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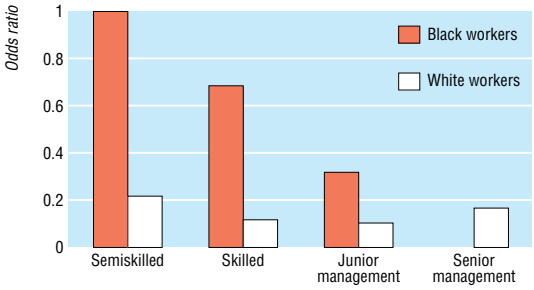


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**Fig 1** Odds ratios of HIV seroprevalence among employees in South Africa[9]

- Less concern about one's health and the future, because of the harshness of the present.

Secondly, mobility is a well known determinant of epidemics, but in South Africa the situation is particularly complex. Mass resettlements of populations under apartheid, seasonal labour migrations, movements along major trade routes, refugees fleeing war in other parts of Africa, and, since 1990, return of political exiles and liberation armies have all contributed to the spread of infections.[10] Thirdly, sexual violence—whether by known or unknown perpetrators, in commercial or conjugal sex—facilitates viral transmission. Sexual violence is linked with common forms of social and political violence that have long been part of the everyday life of townships and inner city areas.[11] The combination of the three factors can be seen in the practice of "survival sex," whereby young women in the townships, often migrants from impoverished rural areas, use their bodies as an ordinary economic resource outside the context of prostitution but within the culture of male violence.[12]

Inequality, mobility, and violence are partly the legacy of centuries of colonial exploitation and racial segregation, culminating in the institution of apartheid in the second half of the 20th century. Epidemiologically this segregation translates as differential HIV seroprevalence between black and white groups and between social classes (figure 1). The case of the mining industry illustrates this legacy. The extraction of a black male labour force from the villages to work the mines has been the motor of the South African economy since the end of the 19th century. These men are accommodated in barracks or hostels, far from their spouses, and commercial sex and access to alcohol are more or less institutionalised social activities in hostel compounds. This social situation explains why educational programmes have had little success in fostering preventive practices, such as condom use.[13] Furthermore, environments where men far outnumber women seem to create explosive conditions for the spread of HIV. In the mining town of Carletonville, even adults with a single lifetime sexual partner face an extraordinarily high prevalence of HIV (figure 2).[14] In this instance, social context has a far greater bearing on risk of infection than individual sexual behaviour.[15]

## Suspicion and denial: towards a political anthropology of AIDS

A political economy of HIV/AIDS falls short, however, of explaining the suspicion in South Africa of science and orthodoxy—a suspicion that is widespread and not confined to the president and his advisers. Examining objective social causes does not preclude an understanding of the politics of AIDS as a subjective phenomenon.[16] A political anthropology may make some sense of what is often presented as merely irrational.

The global controversy created by the president was preceded by several local controversies involving the government. In 1996 the government was accused of wasting public money on a musical show that was supposed to spread the message of prevention. In 1997 it was criticised for officially supporting a treatment, Virodene, that was later identified as an industrial solvent with no benefit. And from 1998 it was denounced for blocking the use of antiretroviral drugs, which the government justified by citing the drugs' side effects.[17] In all these arguments, as well as in the virus versus poverty controversy from 2000, two closely linked features appear. The first is the racialisation of the issues, with the government accusing its opponents, whether activists or politicians, of racism. The second is the theme of conspiracy against Africans, either from the country's white conservatives or from the pharmaceutical industry. Both features combine in the somewhat contradictory notion that the AIDS epidemic and its treatments are part of a plot to eradicate the black population.

In South Africa racialisation and conspiracy are rooted in history, and the realm of public health is not exempt from their effects. Epidemics have often been used to enforce racial segregation. The bubonic plague of 1900 in Capetown was used to justify the mass removal of Africans from their homes to the first "native locations" under the first segregationist law, passed in 1883 and called, significantly, the Public Health Act.[18] When AIDS appeared in South Africa it was immediately interpreted in racist terms: some white leaders evoked a supposed African "promiscuity;" they denounced the danger that infected black people posed to the nation; and they even publicly rejoiced over the possible elimination of black people by the disease, as one member of parliament did in 1992.[19] As has recently been shown, in the last years of apartheid government laboratories were developing chemical and biological weapons (including anthrax, intended to eliminate black leaders), were researching contraceptive methods to induce sterility in the African population, and were allegedly attempting to spread HIV through a network of infected prostitutes.[20]

So, what could be seen elsewhere as unfounded suspicion was in South Africa plain reality, historically

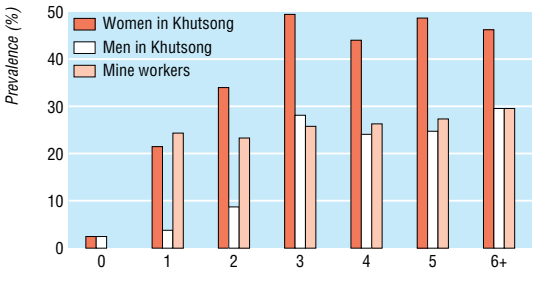


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**Fig 2** HIV prevalence among men and women in Khutsong township and among mine workers in nearby Carletonville[14]

attested. Remarkably overlooked for purposes of national reconciliation, this history still remains deeply present to many South Africans and explains much of the mistrust towards Western science, medicine, and public health.

An understandable defiance is thus an important element of what is usually termed denial.[21] In fact, denial—a common response among people facing an intolerable situation—has two facets.[22] One is a denial of reality: a reaction that something can't be true, that it is not possible. The other is a denial of the unacceptable: a reaction that something is not normal, that although it exists it should not. Both facets are involved in the denial of the reality of HIV/AIDS. It is difficult for anybody—even a state leader—to fully comprehend the magnitude of the epidemic and its demographic consequences, such as the loss of 20 years of life expectancy within two decades. Also, it is seen as morally unacceptable that a plague can affect the population so massively and so unequally precisely at the point when democracy has at last been achieved—in what seems a remorseless prolongation of the suffering of the weakest people in society.

## Conclusions

Change occurs rapidly in South Africa, but history continues to show through the surface of present events. The marks of apartheid are still deeply inscribed in the bodies and minds of the people who had to suffer under it, a decade after its end, and the country's AIDS crisis manifests the legacy of the politics of the past.[23] To limit the explanation of HIV infection to poverty is certainly an oversimplification: public health policies need to take into consideration the interdependence of inequality, mobility, and violence. Conversely, to focus attention solely on behaviour change or on treatment is to overlook the powerful social determinants of HIV in South Africa.

Clarifying the objective and subjective dimensions of the reality of the epidemic can help people understand otherwise incomprehensible issues and thus ease the dialogue between apparently irreconcilable positions. For instance, understanding people's suspicion and denial is vital in the management of the HIV epidemic. An effective politics of AIDS entails a "politics of recognition": contrary points of view should be understood rather than discredited.[24]

But a better understanding rooted in history does not mean indulgence of errors or acceptance of conservatism. On the contrary, recent events have shown that the HIV/AIDS debate has increased people's awareness of health inequalities and has advanced the battle for social rights. In South Africa, AIDS is not just a tragic and dramatic phenomenon: through the mobilisation of activists as well as lay people and through the fight for social justice it has also come to be a resource for democracy.

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### Correction

*Distinguishing between salt poisoning and hypernatraemic dehydration in children*

Errors occurred in this article by Malcolm G Coulthard and George B Haycock (18 January, p 157). The conclusion of case 2 says that the court found the mother not guilty of manslaughter. In fact the case referred to was not the subject of a criminal trial, but a family court hearing concerning the continuation of care orders. This error was partly caused by miscommunication in the *BMJ* editorial office, for which we apologise. Also, in the description of case 2, the statement that "the odds of a second innocent death were suggested (incorrectly) to be 73 million to 1" could be misread as indicating that this opinion was stated during that court hearing, which was not the case. Two of case 2's siblings had died in infancy and his parents made a complaint about the care that they had received from their general practitioner. As a result of this the medical records of all the children were reviewed by expert witnesses. A paediatrician argued that two infant deaths within the family made infanticide statistically almost certain, and that the episodes of hypernatraemia indicated salt poisoning. As a result of these concerns care orders were obtained on the three surviving children; case 2 was fostered. The subsequent family court hearing determined that the children had not been salt poisoned. The care orders were revoked on two children and sustained in case 2. All the children were returned to the family home, where they remain. In addition the authors wish to declare that they were expert witnesses in the cases referred to in their article and in other cases.