Moral and social complexities of AIDS in Africa

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1. HIV/AIDS in Africa and South Africa

AIDS has become the major reality of the African continent, despite the fact that this is still, incredibly, being denied by some of the continent's most prominent and influential leaders. According to the most reliable current opinion, AIDS probably is a fairly recent phenomenon, but might well have lingered relatively unobtrusively in small, undeveloped, yet stable rural communities in Africa for many decades because of their lack of contact with the wider world and their comparatively limited sexual behavior patterns (Van der Vliet 1994). Developments such as increased trade, "uhuru" (liberation from colonialism), urbanization and more sexual freedom facilitated the recent epidemic spread of the disease.

Not since the Black Death of the mid-fourteenth century[1] has a disaster of such magnitude confronted humanity. There are, however, significant differences between the AIDS pandemic and the Black Death. These are, amongst others:

1. at the start of the 21st century, we know what we are dealing with, what its cause is, and how to prevent it;
2. the speed at which the disease occurs and operates. Whereas the Black Death hit and killed within weeks or even days, AIDS is a slow-working ailment that can linger for years before it starts to destroy;
3. otherwise than in the case of the plague, which killed indiscriminately, AIDS targets certain groups (the sexually active and drug-addicts) who happen to be the young and economically active sectors of society;
4. in Africa, women turn out to be much more vulnerable than men.

In spite of massive, global investments and efforts, neither a vaccine nor a cure is currently available. In addition, even if a vaccine should eventually, after prolonged clinical trials involving almost unprecedented large groups of research subjects, be found, it is still unclear how accessible and effective it would be on a continent marred by the problems of Africa.

Sub-Saharan Africa is the area that is by far the worst struck by this disaster. The statistics of the pandemic, which are more comprehensively dealt with in chapter 1, are staggering, as illustrated by the next quotation:

> Of the 36 million adults and children in the world living with HIV/AIDS in 2000, more than 70% reside in Sub-Saharan Africa… 17 million Africans have died since the AIDS epidemic began in the late 1970s, more than 3.7 million of them children. An additional 12 million children have been orphaned by AIDS. An estimated 8.8% of adults in Africa are infected with HIV/AIDS, and in the following 7 countries, at least 1 adult in 5 is living with HIV: Botswana [with] the highest estimated adult infection rate – 36%…, Swaziland, Zimbabwe, Lesotho, Zambia, Soputh Africa and Namibia. (McGeary 2001, p. 48-49)

It is further reliably estimated that 3.8 million Africans became HIV positive in the course of 2000 (McGeary, 2001, p. 48). HIV/AIDS have superseded military conflict as the single biggest cause of death in Africa. In 1999 1.4 million people died in East and Southern Africa of AIDS – twice as much as in the Rwandan massacre. Up to

70% of hospital beds in Africa are currently engaged by AIDS patients. Of the 25 million Africans due to die of HIV/AIDS, the majority will die within the next five to eight years (Swanepoel 2001).

The figures about my own country, South Africa – the most developed economy in Africa – are particularly alarming[2]. South Africa has the largest number of people living with HIV/AIDS in the world, namely 4.7 million, that is one in nine of the total population, or about 20% of South Africa's adult population (*SA Dept. of Health*, 2001). It is reliably estimated that 420 000 children have been orphaned (cf. Cullinan 2001), and 250 000 people die each year from the disease (McGeary, 2001, p. 49). By the year 2000, 500 000 South Africans have already died of AIDS. As far back as 1997, 50 000 new infections occurred every month.

Projections are that the epidemic will reach its peak in 2010 with 6 million people infected by then. In such a situation, 52% of all deaths in South Africa will be AIDS related. More remarkable is the projection that 80% of all deaths in the 20-50 year olds range will be AIDS related. (Van der Vliet 1998). According to a recent UN report on AIDS (November 1999), less than half of South Africans will reach the age of 60, against a figure of 70% in other developing countries and 90% in developed countries. The life expectancy in South Africa has climbed from 44 in the early fifties to 59 in the early nineties. Because of AIDS, it will plummet to 45 in the next 5 years (Pretorius 1999); in fact, in a recent lecture by Alan Whiteside, he foresaw that, in the absence of meaningful interventions, there is a very real possibility that life expectancy in South Africa could drop to 35 within the next decade. It is estimated that, at the current rate, the South African population growth – once almost out of control at a whopping 3.2% - will drop to zero in 2025.

2. The complexities of understanding and curbing HIV/AIDS in (South) Africa

The purpose of this article is to identify and critically discuss some of the enormous complexities involved in trying to deal with a disaster of this kind in the context of under-development, as is manifested by most countries in Sub-Saharan Africa. We shall be dealing with these complexities, the impediments they pose for constructive action in the face of the pandemic, and suggested solutions, if any.

A ***complexity*** refers to a kind of problem that not only has no clear-cut or self-evident answer, but is also often thus constituted that an analytical approach wherein we distinguish parts and whole, often with the expectation that addressing the parts will fix the whole, is not always successful either. In complexities or complex systems, the whole is more than the constituent parts; the approach to the solution of complex problems often requires a problem consciousness and a sense of interactive influences that defy our natural intuitions or analytical prowess (Cilliers 1998).

I shall, however, not be arguing that everything about AIDS in Africa is helplessly and uncontrollably complex. Much can be done about the problem in Africa – much more than is currently being done, particularly in South Africa, which, as was shown above, has become the epicenter of the pandemic in Africa.

The first and foremost of these complexities is the phenomenon of poverty in (South) Africa.

2.1 Poverty as social context for HIV/AIDS in Africa

To talk of poverty in connection with AIDS in Africa is both necessary, but often also confusing. According to the president of South Africa, Thabo Mbeki, poverty is the main cause of AIDS. This blunt statement fails to take into account a very basic distinction often lacking in the public discourse on AIDS in Africa. This is the distinction between the *cause* of the epidemic, and the *social context* within which the epidemic thrives[3]. There can be no doubt that AIDS is caused by a retro-virus which shows an unprecedented ability to undermine the human body's immune system, and for which neither a cure or a vaccine has as yet been found. Viral diseases, as we know, do not all become epidemics. To become an epidemic, a niche or social context is required. In Africa, besides factors such as relatively recent urbanization, migrant labor, natural and man-made disasters (such as war, floods and famine) and trade (sex tourism and the movement, above all, of truckers across the continent) (cf. Van der Vliet, 1999, pp. 1-4), poverty is the main aspect of this niche or social context.

Poverty, has accompanying side-effects such as prostitution (i.e. the need to sell sex for survival), poor living conditions, education, health and health care. These are major contributing factors to the current spread of HIV/AIDS. It is, for example, estimated that 6 million South Africans live in informal settlements or shanty towns. With the advent of South Africa's new democracy in 1994, the country still had one of the worst records in terms of social indicators and income inequality. About half (44%) of South Africans were regarded as poor, and still are[4]. Unemployment in South Africa is rife; fewer than 30% of poor working age adults are working in the formal sector of the economy. Almost 80% of the poor in 1994 had no piped water to their homes, no modern toilets (90%) or electricity (85%). More than a third (35%) of children under the age of five are nutritionally stunted, compared to 6% in richer households (*South African Health Review*, 1999, p.3).

As far as the provision of health services are concerned, it must be born in mind that South Africa does not have a history of a very effective health system. In 1992/3 the country was spending 8.2% of its GDP on health care – comparatively much in global terms. In spite of that, South Africa ranked below 60th in terms of "health status indicators". This could be attributed to the fact that the private sector spent over 60% of the total spending on heath care on less than 20% of the country's total population. The remaining 80% of the population are dependent on the public health services, which were spending the remaining 40% of the resources (Ibid., p. 70). The annual per capita expenditure on health care in the public sector currently is R1000, as against R5100 in the public sector (Benatar 2005). In 1998 62% of South Africa's general practitioners, 77% of its specialists, 88% of pharmacists and 89% of dentists worked in the private sector (*South African Health Review*, p. 72).

Benatar writes as follows about the serious deterioration in the quality of South African health services:

> Fifteen years ago South Africa had the potential to develop a strong public health system offering balanced primary, secondary and tertiary services. Such

> a system would have been aided and strengthened by a small and strong private sector with many private medical practitioners also doing part-time work in public hospitals. But the pace and extent to which privatization has been allowed [in South African health care services] has largely destroyed this potential (Benatar 2005).

What is the solution? In this connection, I would like to make only two points:

First, we should be careful to resist the temptation of becoming so overwhelmed by the reality of poverty in Africa that the analysis becomes disempowering, i.e. that we start to believe that AIDS will only be brought under control if Africa miraculously is transformed into a set of economically prosperous, Western-like countries. That, to use an understatement, is not going to happen soon, and if that is the definitive condition for relief, Africa is irreversibly doomed. The "all or nothing approach" (Trengrove-Jones, 2000) should be abandoned and realistic aims must be set and pursued.

To only stress the poverty side of the problem, is to expediently avoid facing up to matters that can make a difference, such as

- addressing and criticizing conventional sexual and religious mores,
- making condoms available on a massive scale,
- co-operating with multinational pharmaceuticals and Western governments to make anti-retroviral drugs available and more affordable,
- exploring the import of generic equivalents without burning all bridges carrying patent rights,
- imaginatively introducing sex-education to school curricula, and
- drawing on the influence of important societal roll models.

Second, this catastrophe compels us to reflect critically on the massive imbalances between the wealth of Africa and the West, and thereby to rethink the requirements for human well-being on a global scale. The fact of the matter is that Sub-Saharan Africa generates no more than 1% of the total wealth produced in the world. The buying power of all the countries south of the Sahara, excepting South Africa, in total just about matches that of a country such as Norway.[5] The developed world can no longer ignore the fact that Africa is the home of 10% of the world's population, lives on 1% of the global economy, and carries 70% of the world's HIV/AIDS burden. Furthermore, "Annual per capita expenditure on health care is less than US$10 in many African countries, as compared with between US$ 2000 - $4200 in industrialized nations" (Benatar, 2001, p. 5).

African countries also carry extremely heavy debt burdens – often, as in the case of South Africa, incurred by an illegitimate previous regime. It is indeed a serious ethical question whether this catastrophe does not compel us to rethink the requirements for human well-being on a global scale. As Benatar argues:

> Perpetual economic growth for some cannot continue at the expense of others without sacrificing our humanity. The root causes of poverty should be openly

> acknowledged and studied more seriously, and powerful nations should be required to address these. Crucial to a new approach will be the recognition that it is not merely altruism that is called for, but rather a long-term perspective on rational self-interest in an increasingly interdependent world. (Benatar, 2001, p. 6)

2.2 Denial, lack of leadership and the politicization of HIV/AIDS

The management and possible curbing of the AIDS pandemic on the African continent is immensely exacerbated by the denial of its seriousness and the lack of political will on the part of the leadership to tackle the problem. There are a few exceptions. In Senegal and Uganda, comprehensive national programs were launched to address the problem, and they yielded considerable success (for discussion, cf. World Bank 2000, pp. 18-22). But they remain exceptions. The lack of political will on the part of the leadership in South Africa, in its turn exacerbated by President Mbeki's flirtations with the views of discredited "dissident" scientists such as Duesburg, Rasnick and Mhlongo (cf. Duesberg & Rasnick 1997) , who challenge the theory that AIDS is caused by a virus, remains a serious impediment to the creation of an imaginative, yet workable national strategy for approaching a problem which clearly is evolving into a national, if not global, disaster.

One can only speculate about the reasons for this state of denial. One theory is that the financial implications of a comprehensive AIDS strategy are so enormous that these leaders cringe from facing the challenge. Another theory is that the denial is born from a deep-seated, post-colonial scepticism about the structure of the global economy and the role of large, multinational conglomerates, in this case represented by the pharmaceutical corporations. Difficult as it might seem to believe when the statistics mentioned in the beginning are taken into account, the perception is rife within the ruling party in South Africa that information about the AIDS pandemic is either unreliable[6] or created to serve the interests of the pharmaceutical companies, who have a monopoly on effective anti-retroviral drugs. South Africa, other than countries such as India, does honor the international patent regulations protecting the pharmaceutical companies' interests. Consequently, the production and distribution of generic equivalents for these drugs are illegal in South Africa, although efforts have recently been made, particularly by an organization called the Treatment Action Campaign (TAC - a militant NGO campaigning for affordable treatment of HIV/AIDS), to do this.[7]

In 2000, a cohort of major drug companies challenged South Africa's alleged right to import or produce generic equivalents of their patented medicines in court, but dropped the action soon afterwards. Reasons were not given, but one can imagine that such an action turned out to be a serious public relations risk for these companies, given the extent of their business in the developing world and the criticisms such action might evoke amongst their (often quite vocal) critics back home.

Reacting to criticism and to the prospect of increased generic competition, Merck became one of the pharmaceutical corporations to declare that it would dramatically reduce the price of HIV drugs to the developing countries (*Time*, March 19, 2001, p. 17). Following suite, Bristol-Meyers Squibb announced that it cut the cost of the two drugs that it manufatures, Videx and Zerit, to a combined price of US$1 per day. In

2001, an American AIDS patient payed US$16 per day. But even with these huge price decreases, African countries are still not able to afford these drugs without significant aid from abroad. [8]

As suggested earlier, the hesitation and denial of the leadership is, to a certain extent, understandable, though hardly pardonable. Just at the time when an intellectually gifted leader such as Thabo Mbeki was ready to launch his idea of an "African Renaissance" (cf. Mbeki, 1998 and Makgoba, 1999) and to promote Africa as the continent of the 21st century, they ended up with the challenge to handle one of the severest health nightmares a politician can imagine. In the process, as is persuasively argued by Van der Vliet, all the existing prejudices against Africa were reinforced, if not exacerbated. One of the cruel effects of AIDS, as was realized from the outset, is that it often afflicts people who are *already* victims of prejudice and discrimination: homosexuals (initially), drug addicts, eventually the poor and the wretched. "The coincidence of a new disease, in marginalized communities, in troubled and insecure times, was a recipe for an new wave of prejudice" (Van der Vliet, 1996, p. 53).

This reinforcement of old prejudices has now shifted from individuals and communities to a whole continent. AIDS is increasingly called "the African epidemic". This inevitably fosters a politicization of the discourse about the pandemic which, in turn, complicates its effective management considerably. In a rather inflammatory article, Simon Watney articulates the kind of resentment that the identification of AIDS and "Africanness" have fostered in many intellectual and leadership circles on the continent:

> …Africa has been effectively demonized in a post-colonial discourse of perpetual catastrophe and unnatural disasters. This undifferentiated apocalyptic Africa has proved an ideal site in which to find and "see" disease. "African AIDS" thus condenses ancient fears concerning contagious disease, together with vengeful fantasies concerning "excessive" sexuality, understood in essentially pre-modern terms as both the source and the cause of AIDS…The racism and homophobia which Western culture has visited on racial and sexual minorities for millenia now threaten to turn back on heterosexuals themselves, in their seeming refusal and inability to acknowledge the realities of HIV infection and disease. It would appear that we are witnessing a fundamental reorganisation of Western racism, as the constitutive colonial analogy between race and class is dissolved, and African blackness is reconceptualised as an analogue of the sexually perverse. (Watney 1989, p. 59)

Although some of these emotional allegations may not be devoid of all truth, they are not very helpful when we are confronted with the question of how, in practical terms, to go about assisting in the relief of the suffering of real people living with HIV/AIDS. One of the main complexities facing the management of the disease in Africa, is, therefore, this kind of consistent politicization of the discourse about AIDS - a politicization which raises the level of inflammatory rhetoric and moral outrage about the injustices of the universe and the global economy, but which is not very helpful when practical programs are to be devised for the help of ordinary, not always politically conscious sufferers: the people who are the real victims of the denial and

hesitant leadership of those who have it in their power to do something about the crisis in Africa. The solution, as I see it, is, twofold:

1. acknowledge, for once, the crisis and stop obfuscating its understanding or management by undue politicized rhetoric about an alleged social outrage which, essentially, is a health problem and can significantly be curbed if primarily addressed as such;
2. seek optimal partnerships and co-operation with the pharmaceutical multinationals as well as other supportive governments who have it in their power to facilitate the provision of essential anti-retroviral drugs at more affordable prices.[9]

2.3 Behavior changes under conditions of deprivation and illiteracy

I have written above about the need for a comprehensive AIDS prevention campaign in (South) Africa, and the tragedy of its persistent delay by the national authorities. However, one of the most serious problems facing the issue of prevention in the African context, is how to effectively communicate with the people most vulnerable, viz. the masses of relatively uneducated, often illiterate people living in the rural areas.

Africa in general, and South Africa in particular, is an under-urbanized environment. One of the destructive consequences of apartheid is that that system's declared intention of discouraging urbanization (in order to keep people in their "homelands", even if it meant forcibly moving people to these arid, uninhabitable and over-populated regions) by means of Verwoerdian social engineering (cf. Johnson, 1983, pp. 523-526) succeeded in keeping, until fairly recently, the vast majority of people in the rural areas. Currently, the figure is still in excess of 40% of the total population. In addition, 75% of the poor live in the rural areas (*South African Health Review*, 1999, p. 3). A rural existence in South Africa is by and large an existence devoid of opportunity or resources. Life is, for the large majority, a continuous struggle to get hold of your next meal. Education and health care facilities are either non-existent, or in a state of perpetual collapse. Something as basic as clean, disease-free drinking water is regarded as a luxury. In the past year, KwaZulu-Natal has been hit by a cholera epidemic, simply because of the inaccessibility of clean water for tens of thousands of people living in areas that are very difficult to access with water storage tanks. People's only access to water is from the contaminated rivers flowing through the region.

Effective communication with people is, to a significant extent, a function of their ability to read, and, on the basis of that reading, to grasp concepts that are not self-evident to them. Literacy, however, is a huge problem in South Africa. If literacy is defined as the ability to read, write and numerate (normally conditional on 7 years of schooling), then 41% of the adult population of South Africa is illiterate (Bot, Wilson & Dove, 2000, p.73). Macfarlane, reporting on a recent conference on this topic, claims that the figure is 45% (Macfarlane 2000). A map in the *Education Atlas of South Africa* shows that in one third of the country's 354 magisterial districts – all located in the rural areas – the illiteracy rate is between 60% and 80%. In the majority of the magisterial districts, over a third of the adults are illiterate. Urban and developed residential areas have the lowest illiteracy rates of between 11% and 20%. KwaZulu-Natal, where the AIDS pandemic is at its worst (according to the latest

Dept. of Health figures the infection rate in this province rose from 32.5% in 1999 to 36.2% in 2000), is also the province with the highest number of illiterate adults (1 982 845), while the Northern Province is proportionally the worst off (where 52% of all adults are illiterate).

Virginia van der Vliet rightfully asks in her book: "How do you reach a poor, isolated, illiterate rural or urban woman, who is not at school, at work, or at church or a clinic attender?" (1996, p. 97). One has to go further and ask: "If you reach her, how do you start communicating the complexities of HIV to this woman? How, first of all, do you explain that she might become devastatingly ill simply from having sex with her husband, who is a migrant laborer, and that it is best to have them both tested? She might be ill already, only, she'll not yet know it, since the disease might take long to present with symptoms. There are drugs that can help her, only, they are unaffordable for a person in her position. She, if HIV positive, can infect her husband or lover(s), only, they will similarly not be ill immediately, etc. The point is: to understand and explain the phenomenon of HIV/AIDS is complex. This woman will, in all probability, either not understand what is being communicated to her, not believe it, or shrug it off as just one of the many hazards that she has to face in order to continue her struggle for survival.

To get ordinary people to change their behavior is, as we know, difficult enough. When AIDS originally struck in the gay communities of San Francisco and New York in the early eighties, a change of behavior was effected, albeit only after a spirited campaign, utilizing media of all sorts. The gay men who were at particular risk were mostly well-educated people who read newspapers, watched television and, most importantly, were sufficiently empowered to mobilize themselves and lobby for support and accelerated research about this life threatening disease.

The complexity of dealing with the epidemic in Africa is that these kinds of resources are simply absent. Most rural Africans lack both the material, social and educational resources, even to understand, let alone to foster, their interests in a way even remotely comparable to what happened in the US in the eighties. In addition, even if they are able to do this, the society in which they live does not have the resources to rise to this kind of challenge in a way similar to what happened in the US and Europe.

The solution to this complexity is not self-evident. Clearly more and better education is called for. But that will mainly benefit the younger generation, not the adult population referred to above. Adult education is therefore also clearly required, but the resources for that, and the motivation of the people who stand to benefit from it, are limited. It may be that the sheer brutality and extent of suffering and death that people from these communities are about to experience in the near future, might cause an outrage that will provide the opportunity for education that will focus the mind. However, by then most of the damage will have been done for the foreseeable future. On what exactly to do about this problem, the jury is unfortunately still out.

2.4 Women's vulnerability

In the example chosen in the previous section in connection with the communication difficulties to inform and empower people about their predicament in Africa, it was not without additional reason that the case of a poor rural woman was raised. The

position of women in Africa adds another burden to the spectrum of complexities that confront us when trying to deal with HIV/AIDS.

The situation in Africa has shown definitively that AIDS flourishes most demonstrably in a society where women are particularly vulnerable. In Africa, there are currently 2 million more women than men infected by AIDS (Pretorius 1999). Not only are these women physically more prone to become infected than men during normal sexual encounters, but their status and role put them at considerably greater risk. Women, because of their devalued status in the traditional African homestead, have significantly less control over the nature and frequency of their sexual contacts than their normal Western counterparts. They are, typically in underdeveloped societies, much more likely to be illiterate. Before and after marriage, they are perceived to be, and often also perceive themselves to be, totally dependent on men. Consequently, if and when they opt out of marriage or concubinage, they have very few marketable skills. In the absence of the latter, commercial sex often is the only outcome.

Van der Vliet also points out how vulnerable monogamously married women are:

> Raised in [a] strongly patriarchal society, with a tradition of polygamy, macho ideas of masculinity, and an emphasis on her duty to bear children to ratify bridewealth contracts, [the married woman's] rights to demand fidelity or the use of condoms, or to refuse sex, are, for most women, not negotiable. Economic dependency on her partner weakens her position further. (1999, p. 3)

Add to this the grim evidence of a rapid increase in so-called "sugar daddy" relationships, in which older men seek out younger sexual partners (often mere children) – partly because of their (the men's) perception that young girls might not be infected, while they themselves, of course, often are – and a scary picture of the moral depravity of sectors of South African society emerges. This is an environment very conducive to the flourishing of the AIDS epidemic.

The position of women in the current HIV/AIDS epidemic in (South) Africa is made all the more precarious by the severe forms of stigmatization that people who acknowledge their HIV status currently have to face in that region.[10] In an issue of *Time*, Johanna McGeary tells the story of Laetitia Hambahlane (not her real name), a 51 year person with AIDS (McGeary 2001, pp. 48-50). The narrative starts with the observation that, in Africa, "to ackowledge AIDS in yourself is to be branded as monstrous" (p. 48). Once Laetitia was diagnozed after falling sick in 1996, her employers

> fired her without asking her right diagnosis. For weeks she could not muster the courage to tell anyone. Then she told her children, and they were ashamed and frightened. Then, harder still, she told her mother. Her mother raged about the loss of money if Laetitia could not work again. She was so angry she ordered Laetitia out of the house…When Laetitia ventures outside of the house, neighbours snub her, tough boys snatch her purse, children taunt her…One day local youths barged into her room, cursed her as a witch and a whore and beat her [She contracted the disease from her husband] When she

> told the police, the youths returned, threatening to burn down the house (McGeary, 2001, p. 50)

In 1998 Gugu Dlamini, a young woman in KwaZulu-Natal decided to "come out of the closet" about her HIV positive status and started to campaign on her own and others sufferers' behalf. She was stoned to death in her neigbourhood (SA Health Review 1999: 309).

Women's disempowerment in Africa is, to a significant extent, the result of, in many instances, insufficient education. UNICEF has recently made available figures that show that many African women are dangerously ignorant about HIV and its perils. More than 70% of adolescent girls in Somalia between the ages of 15 and 19 – an age, as has often been proved, when women are almost at their most vulnerable - and more than 40% in Guinea Bissau and Sierra Leone have apparently never heard of AIDS. The overwhelming majority of Africans who are HIV positive, do not know that they are carrying the virus, and are blissfully continuing to infect other people. One study has shown that 50% of Tanzanian women know where they can be tested for HIV, but that only 6% of these women have in fact been tested. In Zimbabwe only 11% of women have in fact been tested for the disease. Many of those that have been tested, prefer to not be informed of the results, mainly because of fear of stigmatisation. In the Ivory coast it has been found that of all women who discover that they are HIV positive, less than 50% return for treatment to prevent mother-to-child-transmission (*UNAIDS AIDS Epidemic Update* December 2001: 17)

As regards women's power over their sexuality, the identity of their sexual partners, the frequency of sexual intercourse and the use of condoms, the most that can be said is that this is an area where there is a dire and urgent need of more research. Too little is known about the culture of African sexual practices and the impediments on sexual behaviour that would be conducive to the prevention of AIDS. This is a highly sensitive area where concerns about political correctness often obfuscate reliable and relevant knowledge. One often hears about the natural resistance to condoms in many African communities, but I am not aware of solid research that has been done about this. It is claimed that improved education had a significant impact on the situation in Uganda, also as regards condom use. For example, UNAIDS report that "in the Masindi and Palissa districts…condom use with casual partners in 1997-2000 rose from 42% and 31%, respectively, to 51% and 53%. In the capital, Kampala, almost 98% of sex workers surveyed in 2000 said they had used a condom the last time they had sex" (*UNAIDS AIDS Epidemic Update* December 2001: 17). It remains a question how reliable these findings are or could be. The problem, however, is not only the frequency of condom use. The more problematic issue is the status of women, their knowledge of HIV and its dangers, particularly to themselves, and their power to determine and structure their own sexual contacts. This issue cannot be divorced from their general status and empowerment in society. Everything possible therefore has to be done to enhance that status and power.

What can we do about these problems? They are complex, because both social roles and perceptions are deeply ingrained in the psyche of members of underdeveloped communities. South Africa has made impressive efforts to legislate in favor of more gender equality; e.g. one third of all members of parliament in SA must be women. But this has small effect on the situation in the rural areas. Gender equality is an ideal

that has almost nowhere in the world been attained. We have to speed it up – everywhere. The situation surrounding AIDS in Africa is one of many examples of the way in which women's health is threatened by inadequate social status. How to address the problem of stigmatization[11] remains unclear. Education remains a paramount need. In addition, I would stress the importance of role models going public about their HIV status – a move that has been suggested for politicians in SA, but met with very little success. It has to be attempted on a wider scale; the crisis warrants even this possible intrusion of privacy, although such action must remain voluntary.

Lastly, one cannot but ask whether the almost inordinate emphasis that has been placed on the right to privacy in the management of AIDS, has not, even if inadvertently, contributed to the increased stigmatization of the disease in society. The more HIV/AIDS patients see and hear AIDS activists and advocates insisting on the patient's paramount right to privacy and to his/her sole decision-making power about disclosure of status, the more the idea grows that, because AIDS is seemingly such a "big deal", it must be a terrible shame to have the condition; hence stigmatization is reinforced in a vicious circle of rights-talk, privacy hang-ups, increased shame and persistent stigmatization. What must much rather be encouraged, is the perception that AIDS, although a very serious and potentially fatal disease, is nevertheless a disease like all others, something that is manageable and with which a person can live responsibly for an indefinite period of time, akin to the experience of so many patients who have cancer and live with it for many years. Only when this perception becomes general in society, will stigma disappear, management of the disease improve and surveillance and statistics about the disease become truly reliable.

2.5 HIV/AIDS and the disenchantment of intimacy

The last problem I wish to address, has to do with the fact that AIDS is intimately linked with sex, and that this link constitutes a perplexing complexity when trying to manage the epidemic in conditions of social and economic deprivation.

The fact is that the majority in (South) Africa lead a brutalized existence because of continuous and unrelieved poverty. In such circumstances, authority and order are often restored by appeals to the law of the jungle. In this scheme, everyone vies for him- or herself, and the physically strongest often prevails, which reinforces the vulnerability of women. Crime flourishes, and crime breeds increased dependence on kinship and patronage relations. Violence prevails, and a sense of civil responsibility disappears. Planning and perspective become extremely short-term, and a disposition is fostered in which little more is of importance than the pleasure and profit of the present moment. A sense of hope and futurity, as the outcome of rational and responsible planning in the present, tends to evaporate.[12]

In such circumstances, sex remains one of the few avenues of intimacy and an accompanying sense of self-worth or dignity. In the sexual bond, a residue of personal warmth, care and privacy is kindled. Sex, as is persuasively argued by both Robert Nozick (1989, pp. 61-67) and Igor Primoratz (1999, pp. 34-40), can be a mode of communication. "Sex also is…a way of saying or of showing something more tellingly than our words can say" writes Nozick (1989, p. 63). Moreover, sex is not

only about pleasure, as the hedonist would argue. It's also about engaging other people in the sphere of intimacy, thus communicating in a special way. If pleasure was the only purpose of sex, argues Robert Solomon, "…it would seem that our sexual paradigm ought to be masturbation, and sexual release with other people [then only becomes] an unnecessary complication" (Solomon, 1994, p. 276). Writes Primoratz:

> These crucial traits of sex among human beings – its great importance in human life, and the fact that it is something humans do or experience with others – are best explained when sex is seen as a type of body language: a language in which we communicate to others our feelings and attitudes about them, and about ourselves too (Primoratz, 1999, p. 36).

If all of this is true, the trauma of the AIDS epidemic within the culture of the poor is better understood. Sex remains an outlet, a dimension of privacy and intimacy, an opportunity of special communication (particularly for those whose powers of communication with others have been incurably depressed by sustained lack of opportunity) for the poor and the destitute – a recourse that the deprivation and brutalization of their everyday lives might seem not be able to take away from them.

Once AIDS appeared, disaster not only lurked in the sphere of the public, where one, in this condition, is almost predisposed to expect it, but in the only remaining sphere where one might have hoped to retain some measure of control and dignity: the private and the intimate. Lee Grove shows how sex and death now, in fact, become identified:

> "To die", "to have sex" – that coupling has always been figurative, metaphorical, sophisticated wordplay, a literary conceit, out of those outrageous paradoxes dear to the heart of a racy divine like John Donne.
>
> Outrageous no longer. The coupling isn't figurative anymore. It's literal. (Grove, quoted in Edelman, 1989, p. 301)

HIV/AIDS carries forward the brutalization of the everyday lives of the destitute in Africa into the sphere of the private. The result is the eventual brutalization of intimacy itself. Now sex becomes the topic of a depersonalized, mechanized, instrumentalist discourse. Condoms – a kind of technology hardly reconcilable with African sexual practices – become the avenue to security. Control over the management of privacy is increasingly lost; it is sometimes even experienced by the victims as the loss of the right to privacy.

Again, as in the case of most true complexities, it is almost fundamentally unclear what could be done about this problem. I'll stick to one remark. Many of us believe, and mostly for good reasons, that human sexuality represents the truly profound, some will even say sacred, dimension of human existence, and that the discourse on human sexuality therefore deserves some protection from the banalities of the public sphere. The AIDS epidemic in Africa, however, where sex often is even more of a taboo in public discourse than elsewhere in the world (Mabanga 2000), shows the limitations of such a view in a situation where a sexually transmitted disease attains pandemic proportions. Too much of a taboo mentality towards sex for the sake of, e.g., protecting children from premature exposure to the risks and perils of adulthood, and

resulting in an accompanying taboo on the public dispensing of fixtures such as condoms, can and does backfire when a sexually transmitted epidemic strikes. We ought to rethink, very carefully, the purpose and wisdom of all the taboos of public discourse. However useful in some contexts, they can become an obstacle that attains life-threatening proportions.

3. Concluding remarks

The purpose of this chapter was to identify and critically discuss significant complexities facing any effort to manage and curb the rampant AIDS pandemic in Africa. To stimulate a sense of the complexities involved, as the chpater tries to do, is hopefully not to reinforce a sense of hopelessness. Many things can be done – as has been argued - and have indeed been done to successfully curb, or even halt the epidemic's current apparent unbridled spread.

A recent publication by the World Bank lists, to my mind prudently, initiatives which experience has proved work, and those that do not work. According to the mentioned publication, the following programs have proved significant positive effects:

- Changing behaviour to reduce risks through communication, including mass media, peer education, theatre, and counselling, especially among youth.
- Making STI diagnosis and treatment readily available and affordable.
- Treating opportunistic infections, including tuberculosis.
- Making condoms affordable and widely accessible.
- Ensuring a safe blood supply.
- Making voluntary counselling and testing (VCT) available and affordable.
- Preventing transmission from mother to child. (*Intensifying Action against HIV/AIDS in Africa*, 2000, pp. 20-21)

What does not work? According to the same publication, many years of experience have shown that the following strategies do not work and that some can actually be damaging to program efforts:

- Expecting health-oriented national AIDS committees to lead an intensified response to the epidemic in the absence of adequate, sustained, and high-level government support.
- Inadequately targeting interventions to small sections of populations at increased risk of both HIV infection and transmission.
- Withholding knowledge from young people that would protect them from infection, under the guise of "cultural and social norms."
- Targeting the vulnerable, especially women and young girls, without addressing the root causes of their vulnerability.
- Stigmatizing and marginalizing those infected and affected by this epidemic.
- Investing in expensive pilot studies that have no chance of being sustained, replicated, or expanded.
- Building plans and programs that are externally driven, based on available funding or donor interest rather than well-coordinated programs based on need and proven strategies.

- Designing programs without community involvement. . (*Intensifying Action against HIV/AIDS in Africa*, 2000, p. 21)

Whatever might be said or found to be the best available strategies ought, however, to carefully consider the complexities discussed in this article. Otherwise the effort of reaching the heart of Africa in its current predicament is bound to fail.

In conclusion: The phenomenon of HIV/AIDS has, probably more than anything else, proved our vulnerability to disaster, in spite of the unprecedented advances in medical science at the beginning of the 21st century. Joseph Wayne Smith even writes of a "crisis of civilization" in this regard – an expression that, to my mind, is too alarmist. But we might well, by Smith, be reminded of a

> fundamental truth that has been lost to the mind of modern Western techno-industrial society, but was well known and accepted by ancient civilizations – human beings, despite intelligence and culture are still biological organisms in an environment which by no means requires human beings to exist, and does not guarantee the eternal existence of the human race (Smith, 1991, p.5).

The fact is that we as humans, despite our ability to transplant hearts and kidneys, to cure many forms of cancer, and even to map the human genome, are currently confronted by a disease that can only be controlled at massive cost, and that has turned out to be a mass-killer for those without the resources required to keep its effects at bay. One question, amongst others, is: if AIDS can appear and destroy at a rate similar to what is currently occurring in sub-Saharan Africa, what other dangers are lurking in the future? The achievements of medicine and medical technologies over the past century are unprecedented and rightly infuse a sense of security and optimism for the future. However, we are well advised not to over-estimate ourselves and our achievements in this regard.

HIV/AIDS is a disconcerting fact of our time, place and situation in the world. This chapter hopefully also suggested something of the way in which disease is a function of our total human condition – biomedical, yet also social, political and behavioral. Above all, HIV/AIDS has demonstrated, not only our vulnerability, but also the limits to our powers. Even though the disease may, for all that we know, one day be conquered entirely, its message, in an age of unprecedented medical power and technological prowess, remains, for all times singularly appropriate: we are human, and our humanity is a function of the dialectic between limited insight and as yet inconceivable opportunity and creativity. Let us seek to overcome, bolstered by the confidence of the numerous successes of the past. And yet, let us not forget or forsake humility, for we are not gods and our power to master and to heal can easily become a self-destructive force. Only in this ambiguity between our might and our limits can we pursue the adventure of human living.[13]

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ENDNOTES

[1] Tuchman (1979, pp. 92-125) remains one of the most interesting and comprehensive narratives of this event. See also Jay 2000.

[2] Figures on HIV/AIDS in South Africa are largely based on surveys made at antenatal clinics. These findings are annually reported in die Dept. of Health's *National HIV and Syphilis Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa* (references in this article indicated as *SA Dept. of Health*). The latest of these reports was released on March 20, 2001. According to this report 80% of pregnant women, of whom 85.2% are African, attended antenatal clinics provided by the Public Health Sector in South Africa. About sixteen and a half thousand women who visited these clinics in the previous year were tested for the first time at the 400 clinics that operate in all nine provinces of South Africa. The report further shows that about 24.5% of the women were found to be HIV positive by the end of 2000. These figures were 22,4% at the end of 1999, and 22.8% at the end of 1998. The rate of increase of these infections has therefore been curbed in comparison with the situation over 8 years preceding 1998. For example, in 1992, the percentage of infected women at these clinics was 2.2%. In 1996 it was 14.2%, in 1997 17% and in 1998, as indicated, 22.8%. (This last jump represented a 33.8% rate of increase in the prevalence of HIV infection since the previous year) Of particular concern was also the increase in the rate amongst 15-19 year old girls from 12.7% in 1997 to 21.0% in 1998. According to a report in *The Cape Times* of March 21, 2001, South Africa's Minister of Health, dr. Manto Tshabalala Msimang, was quite pleased with the lower escalation rate of infection over the past three years, in comparison to what happened before. She is even quoted as saying: "We're on top of issues. We're getting there"! When one takes account of the magnitude of the problem in South Africa and the rest of Southern Africa, as is argued in the rest of this article and in all other reliable literature, such a statement gives ample proof of the extent to which the current South African government has lost track of reality.

[3] In this connection, Virginia van der Vliet writes of the "ecology" of a disease (Van der Vliet 1996: 77-116 and Van der Vliet, undated). She quotes Guenter Risse's definition of this concept: "the dynamic relationship between the biosocial environment and humans" (1996: 78). Epidemics need to find the correct niche in which to flourish. The ecology of AIDS refers to the "interaction between social, biomedical, environmental and behavioral conditions which allow for the rapid transmission of HIV" (Van der Vliet, 1999, p. 1).

[4] "Poor" in this context refers to an *annual* income of below ZAR10 000 (US$ 1282) per household of 4.5 people.

[5] This was disclosed to me by a colleague in the Dept. of Economics at Stellenbsoch University, South Africa.

[6] About the problem of the alleged unreliability of data on the AIDS pandemic, see chapter 2 of this volume.

[7] For a comprehensive discussion of the way the TAC has handled their protest against the South Government's hesitance to address the AIDS problem, see Friedman& Mottiar 2005.

[8] For a comprehensive discussion of the recent cuts in the prices of antiretroviral drugs in South Africa, see Natrass's discussion and figures in chapter 3 of this volume.

[9] For a persuasive argument in this regard, cf. Resnik 2001.

[10] For an extended discussion of this issue, cf. Van der Vliet, 1996, pp. 52-76.

[11] In a recent Masters dissertation for the M.Phil (Bioethics) degree at the University of Cape Town, Paul Roux argues persuasively for the thesis "that the process of informed consent, although appropriate in Africa as an exercise in the recognition of autonomy, when applied in the case of African women may have the unexpected and deleterious effect of isolating her from a traditional support base and enhance the likelihood of non-disclosure of HIV status, and should therefore be adapted to meet the needs of this special situation" (Roux, 2001, p. 10). This "adaptation", according to the author, mainly entails involving the family much more in the process of obtaining consent. Roux argues that his research has shown that this approach greatly contributes to a lesser risk of stigmatization.

[12] For a compelling, though disconcerting account of the excesses that violent crime have attained in South Africa, see Venter 2001: 31-116

[13] I wish to thank Loretta Kopelman for her valuable comments on earlier drafts of this article.