Society Abroad

AIDS IN SOUTH AFRICA: AN HISTORICAL PERSPECTIVE

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Notoriety for all the wrong reasons sums up the dominant international image of South Africa over the last half century. Until 1994, its official policy of apartheid made it the polecat of world opinion; since then, apart from a brief phase when it seemed to epitomize "democracy triumphant," AIDS has increasingly replaced apartheid as the one word automatically conjured up by the name "South Africa."

In 2002 South Africa has the largest and fastest growing HIV/AIDS epidemic in the world: it is estimated that 22 per cent of its adult population is HIV+, and that by 2010 AIDS-related deaths will have cut life expectancy to 43 years. In 2000 *Time* magazine referred to AIDS in South Africa as being "worse than a disaster," and of the heart of the epidemic, Kwazulu-Natal, as being "the cutting edge of a continental apocalypse."

Nor have such dire descriptions been the sole preserve of outside observers. It "defies description," remarked a leading local AIDS scholar recently, while the South African chair of the AIDS 2000 conference in Durban said he "could find no parallel in history for AIDS"—it was an epidemic "the likes of which we have never seen." To the drafters of South Africa's official HIV/AIDS Strategic Plan for 2000-2005, the pandemic is "an incomprehensible calamity."

The lack of a comparative perspective which such views suggest is a reflection not only of the authors' short historical memory, but also of the relative failure of historians of South Africa to make past epidemic experiences part of the mainstream narrative of the country's history. In trying to repair this omission, this article will suggest that if AIDS in South Africa is indeed put into the comparative perspective of the country's epidemic history, our ability to comprehend it (and perhaps even to deal with it) is expanded significantly by the recognition this permits of which of its features are in fact part of well-established epidemic patterns in South Africa and which are not. Identifying these continuities and discontinuities makes it easier to get the measure of this epidemic and thus be less awed by it.

Arrival, Transmission and Dispersion

In looking comparatively at the main features of the epidemic of HIV/AIDS in South Africa, what immediately stands out is how many of these accord with the country's prior epidemic experiences. The arrival, transmission and early dispersion of the dominant heterosexual strain of HIV-1 from person to person via sexual intercourse has much in common with the history of other sexually transmitted infections in the country. Like it, they found in South Africa's longstanding and well-developed system of migrant labor a very facilitating environment, via its concentration of young black African men in cities and single-sex mine compounds, far from their wives or families for months on end, and its subsequent dispersal of these men (many now unwittingly HIV+) back to their rural homes during holidays or at the end of their contracts.

As was the case with syphilis during the diamond and gold rushes of the 19th century, it seems that the heterosexual strain of HIV-1 was also introduced to South Africa by a men-to-the-mines route. In the latter case it was probably migrant mineworkers from Malawi who brought the HIV virus to the Witwatersrand in the early 1980s. In fact, the movement of young men to and within South Africa—migrant laborers, sailors, active or demobilized soldiers—has long been a key mode of transmission of all epidemic diseases in modern South African history. Young men on the move along the country's well-developed transport network have been critical to the introduction and spread of communicable diseases since at least the

18th century. In this regard, HIV/AIDS clearly fits into a very well established pattern.

Responses

South African society's responses to the appearance of HIV/AIDS in the country also display many parallels with responses to earlier epidemics. Just as they evoked cascades of finger-pointing and stigmatization along the fissures of existing prejudices, with blame for epidemics attributed variously to "dirty Muslims," "unhygienic natives" (i.e., black Africans) and "malevolent whites wanting to exterminate blacks," so has HIV/AIDS called forth a torrent of blaming—for instance, of gay white men for what the heterosexual establishment labeled their "devious form of sexuality," of heterosexual black Africans for what racist whites called their "unbridled promiscuity" and of white Afrikaners for deliberately introducing what many young black Africans saw as a conspiracy to decimate them in a bid to uphold apartheid. Indeed, in the early 1990s the latter belief caused young activists in Soweto to lampoon the acronym AIDS as actually standing for "Afrikaner Invention to Deprive us of Sex." More traditionally, other black Africans interpreted this epidemic, like so many before it, as the product of malevolent individuals employing witchcraft.

As is usual with finger-pointing, this action reveals more about the pointer's pet aversions within a deeply divided society than about the individual or group pointed to. Blaming others for misfortunes is integral to human behavior—and not just in South Africa—and when the misfortune is as threatening as a lethal epidemic, this response is magnified. Moreover, when the blamer is armed with power, this has usually been wielded against those perceived as the source of the threat. Just as governments in pre-AIDS South Africa sought to bar entry to all Mozambicans during the smallpox epidemic of 1883 or to place an unqualified ban on all migrants from India during the cholera scares of the 1890s or to evict all black Africans from central Cape Town in the face of the bubonic plague outbreak of 1901 or to "de-verminize" all black African train passengers during the typhus epidemics of the 1920s and 1930s, so in 1987 did the apartheid government plan to deport all HIV+ foreign migrant laborers and the Johannesburg Blood Transfusion Service decide that it would no longer accept blood from any black African donor because, it held, they were likely to be HIV+. Of a piece with such actions too was the murder in 1998 of Gugu Dlamini "because she had degraded the neighborhood" by announcing her HIV+ status on local radio. The appeal of vigorous action against stigmatized, socially or politically weak "out" groups or individuals during times of epidemic fear and panic has, for most of South African history, proved almost irresistible to those with power. To this HIV/AIDS is no exception.

It is also not without precedent in South Africa's epidemic history for those in authority or their agents to adopt a position of denial, at odds with mainstream medical opinion, for reasons more political, economic, or ideological than scientific. There are examples of the mining sector denying the presence of smallpox lest news of this disrupted the essential flow of migrant labor to the mines; of the Cape colonial government downplaying the presence of dreaded bubonic plague during the South African War so as not to interfere with military operations; and of the apartheid government refusing to acknowledge that cholera was rampant in its Bantustan homelands so that it might avoid responsibility for building expensive water purification plants.

President Mbeki's querying of the connection between HIV and AIDS or the magnitude of AIDS mortality thus probably needs to be problematized as far more than just the product of fancy or intellectual contrariness, and is anything but unprecedented. Nor should he surprised at the level of public outcry evoked by his idiosyncratic pronouncements and musings. Epidemics pose too elemental a threat to society for official comments not to attract vigorous and critical reactions or to become the object of political point-scoring, especially in a society as divided as South Africa. Epidemic outbreaks in the country over the last 120 years were consistently accompanied by lambasting of governments for their (mis)handling of the situation, all very much in keeping with popular responses to epidemics at other times and places in history. In such frightening situations, those in power have been hard put to escape sharp censure.

Equally common during past epidemics in South Africa and elsewhere is that the premium on finding an antidote rises very dramatically, for obvious life and death reasons. Thus, driven by humanitarian and economic motives and heavy pressure from government, laboratories in South Africa hurriedly produced vaccines or drugs against

all manner of diseases in the midst of epidemic outbreaks during the 20th century. The development of the anti-AIDS "wonder drug," Virodene, by two Pretoria researchers in 1997 and the enthusiastic backing this received from the government falls squarely into a well-established mould—as does the fact that in almost all cases, such precipitate procedures produced drugs with no beneficial effect save as, at best, placebos.

The same urgent demand for an antidote to an epidemic has, of course, drawn even more wide-ranging responses from outside of biomedicine all through modern South African history, and in this regard HIV/AIDS is no different either. Traditional healers, homeopaths, spiritual healers and even outright quacks intent on cashing in on popular panic have long plied their trade with zeal in such situations, offering their distinctive cures with hyperbolic promises of guaranteed success during epidemics, for, as long as there is no single sure cure, some part of the public will be attracted by such promises from practitioners of alternative medicine.

Another sector of the economy with a long professional interest in epidemic life and death has been the life insurance industry. In examining its response to epidemics in South Africa, only the "Spanish" flu epidemic of 1918 is comparable with AIDS, for only these two claimed (or threatened to claim) a significant number of lives from among the insuring classes. In both situations the industry sought to safeguard its reserves, either by vigorous advertising for new policies in 1919 to make up for its huge pay-outs in 1918 or, two generations later, by loading the premiums of new life-cover applicants who were HIV+.

Consequences

In the magnitude of their demographic and socio-economic impact on South Africa, the "Spanish" flu and HIV/AIDS also have much in common. For reasons still not adequately explained in the case of "Spanish" flu, like AIDS it was particularly lethal to young adults, claiming upwards of 300,000 such lives in its six-week rampage through South Africa in 1918. At a stroke, therefore, the country lost some 9 percent of its prime workforce, parents and potential parents.

The consequences of this were both immediate and long lasting, and continued to echo through South Africa's demographic and social history for two generations. The creation, almost overnight, of over 500,000 orphans pushed the state, parastatal bodies, and organized religion into a massive orphanage construction program—primarily for those who were white, which the government supplemented with special grants for "flu widows" with children. For the majority of black African orphans it did very little, however, leaving them to be indentured, incorporated into extended families or to fend for themselves as best they could. The social, psychological and emotional consequences of the massive disruption in the lives of over half a million South African children born between 1900 and 1918 give some hint of the enormous social and other costs that might be expected as a result of those orphaned by AIDS.

The loss of young mothers in 1918—and with them all their babies as yet unborn—also left a permanent nick in the country's demographic profile, which finally worked its way through the life cycle only recently. Consequently, its impact was felt at every social stage over the last 84 years—birth, school-going, entry to the labor force, marriage and retirement. For instance, school enrollments in South Africa in the second half of the 1920s were down as, in the words of the Cape Education Department, "children of school-going age have not been increasing in number at the same rate as the total population." It is likely that there will be many similar reports in South Africa in the second decade of the 21st century.

As for the sudden excision of a segment of the workforce by "Spanish" flu in 1918, it is clear that agriculture was most sharply affected, with seed left unsown and mature crops unharvested. Famine was a widespread consequence. Also, because of a loss of labor, output on the country's mines fell sharply for a few months in 1918-19, until the labor recruitment agencies could fill these gaps. Now, 84 years later, with the full economic impact of HIV/AIDS still developing, such evidence of how a serious epidemic can throttle key sectors of the country's economy and destroy families' economic bases through the death of the breadwinner are ominous.

Casting an eye over all these parallels between HIV/AIDS and earlier epidemics in South Africa's history, it is clear that in many of its central features HIV/AIDS fits squarely into deeply rooted epidemic patterns and precedents in South Africa. That it does suggests that, in some measure at least, such similarities arise from the very structure, composition and mode of operation of

South African society. What HIV/AIDS does is to highlight this fact very clearly, provided one does not allow its magnitude and our historical amnesia to mask what it has in common with prior epidemics. Viewed with the benefit of such historical perspectives, HIV/AIDS appears anything but *sui generis*.

Yet, it would be misleading and one-sided to see HIV/AIDS solely in terms of its similarities with previous epidemics. As the medical historian, Charles Rosenberg, reminds us, to comprehend a particular epidemic, "we must distinguish between the unique and the seemingly universal, between this epidemic at this time and place and the way in which communities have responded to other episodic outbreaks of fulminating infectious disease in the past." If HIV/AIDS is to be fully apprehended therefore, its distinctive sides have to be highlighted too and incorporated into any rounded assessment of it.

Distinctive Features of HIV in South Africa

Broadly, these distinctive features can be put into four categories. Foremost among these is its biology, in particular the fact that, unlike South Africa's other epidemics like smallpox, bubonic plague, influenza, typhus, cholera and polio, its onset is slow and its progress relatively leisurely. In these respects, it resembles TB and syphilis more than a fulminating epidemic disease, though, unlike TB and syphilis, its course is not (yet) reversible or even cheaply retardable.

From this fact have flowed several momentous social, political and economic consequences peculiar to HIV/AIDS in South Africa. Its long, steadily draining duration has created a swelling number of AIDS invalids requiring increasing family or institutional nursing care in their dying years, and thus calling into being numerous AIDS advice, support and care groups. Parents being in this condition have produced a generation of "orphans in the making." Secondly, its relatively gradual advance in its early phase in South Africa meant that opportunities for intervention to try and prevent its further spread by education and publicity were numerous and consequently generated initiatives unprecedented in South Africa's epidemic history, such as massive AIDS awareness campaigns; the introduction of intensive programs of sex education into schools; free, and mass distribution of condoms by the state and the official commissioning of safe sex videos and *Sarafina 2*, the high-cost stage play meant to carry an effective anti-AIDS message. In this respect, HIV/AIDS transformed the terrain of the discussion of sexual activity in South Africa out of all recognition.

Moreover, HIV's relatively slow conversion into full-blown AIDS in an individual, created a generation of people living with AIDS, fit, keen and able to organize around their condition, to lobby and to draw support from sympathetic individuals and institutions around key issues. As a result of these initiatives, derived ultimately from the biology of the disease, AIDS-related NGOs proliferated in South Africa. On top of these, a veritable AIDS monitoring and projection industry was born. To this surge in AIDS-related NGOs, no prior NGO created by public initiative in response to an epidemic like TB or polio could hold a candle.

For the same basic reason—the extended window of opportunity for action provided by the slow-paced escalation of HIV into AIDS—pharmaceutical firms have found themselves in the unusual situation amidst an epidemic of being able to have an immediate impact on the disease with their newly-developed drugs. Many have been taken by surprise by the political, moral and financial implications of a position they had seldom met with before.

Pressures of a similar unprecedented kind on government saw, even before the introduction of a new political dispensation in 1994, equally novel administrative initiatives in the history of epidemics in South Africa: the creation of a dedicated AIDS Unit within the Department of National Health; the establishment of specialized AIDS Training and Information Centres throughout the country; a request to the official Law Commission to investigate all aspects of the law with regard to AIDS; a bid to set up a single body, the National AIDS Convention of South Africa, involving trade unions, business, the churches, the government, and even the ANC government-in-waiting to develop a joint national policy on AIDS. What the latter points to is the second distinctive feature of the HIV/AIDS epidemic in South Africa—its political context.

The election of 1994 produced in South Africa a government with a wholly unprecedented commitment to the human rights of all citizens, which introduced a sea change in state policy towards HIV/AIDS. Aware of the rapid inroads by the disease into the country's black African majority in particular, once in power, the new ANC govern-

ment gave the fight against the disease greater priority than any of its predecessors had done when faced by an epidemic particularly prevalent among that largest segment of the population. Within months of assuming office, the ANC identified AIDS Awareness as a special Presidential Lead project and doubled the budget for combating this epidemic, with sex education programs in schools, public information campaigns via the mass media, condom distribution, and the expansion of STI clinics being the chief beneficiaries. Alongside this enormous increase in funding for prevention and care, the ANC's promise of a compassionate approach to those with the disease, informed by a respect for human rights, began to permeate wider state interventions too. For instance, the new government overturned the policy of the Police, Correctional Services and Defense Force to carry out across-the-board HIV testing on all applicants for jobs in their services as this "affronted the spirit" of the bill of rights and contravened new labor laws. Similarly, it rejected the idea of HIV/AIDS tests for all new hospital patients, which had been mooted in the early 1990s, as it deemed this to be an infringement of human rights, while in the country's prisons it ended the segregation of HIV+ inmates and distributed condoms to all prisoners.

HIV/AIDS is thus the first epidemic in South African history to occur within the context of a burgeoning human rights culture in which the state has at least acknowledged the rights of all infected citizens, if not always zealously pursued them in practice. In this regard it is in a category of its own in the country's history.

The third dimension of the HIV/AIDS epidemic, which distinguishes it from its predecessors, stems, like the second, from a changed South African context. By the time that the disease emerged in the 1980s, the extent to which biomedicine had penetrated into South African society was far greater than could have been the case during earlier epidemics. While it is true that biomedicine was not the only system of treatment to which a majority of the population turned in the face HIV and its symptoms, it is likely that in an increasing number of cases it was the first.

No longer did biomedicine elicit the same level of popular circumspection and even hostility which vaccination or de-verminization had during past epidemics. The fact that AZT and Nevirapine are names probably as familiar in remote rural areas as in the country's cities is a product of this process of the biomedicalization of South African society. In terms of the degree of acceptance of biomedicine, the HIV/AIDS epidemic has taken place against a background markedly different from that of earlier epidemics in South Africa.

Fourthly, the international setting in which HIV/AIDS has occurred in South Africa is so different from that of earlier epidemics that it constitutes a wholly new environment. Certainly prior epidemics in the 20th century saw governments in South Africa try to draw on overseas medical expertise to help them combat both epidemics and epizootics. Yet, despite this history of a growing input from outside experts, nothing they did remotely compares with the scale of the huge international resources against HIV/AIDS offered to South Africa, particularly since 1994. With the WHO and UNAIDS in the lead, an extensive international anti-AIDS framework has been put into place to combat the disease around the world, with "best practice" laid down by global health and philanthropic bodies, both official and unofficial. To a degree unparalleled in South Africa's epidemic history, this has shaped both governmental and non-governmental policies and practices in the country. This globalized and Africanized dimension of South Africa's campaign against HIV/AIDS was epitomized by the holding of the XII International AIDS conference in Durban in July 2000. "[W]e count on you as a critical component part of the global forces mobilized to engage in struggle against the AIDS epidemic confronting our Continent," President Mbeki told the delegates.

HIV/AIDS is both with and without precedent in South Africa's epidemic history. Many of its features fall firmly within the pattern of previous epidemics and the responses they evoked, the main differences being of degree not of kind. Simultaneously, however, it is equally clear that in important respects, HIV/AIDS is novel in the country's epidemic experience too. This marrying of continuities from past epidemics with wholly new features is ultimately what is most distinctive about it. It does not stand wholly outside of South Africa's epidemic past; it has grown out of it.

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