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The HIV and AIDS Policy Environment in Apartheid South Africa (1982–1994)

> Officialdom can never cope with something really catastrophic.
> Albert Camus, *The Plague*

Introduction

The focus of this and the following two chapters is the NP government's response to HIV and AIDS. This chapter covers the broad public policy environment in which HIV and AIDS first appeared in South Africa; chapter 3 discusses the biomedical and workplace responses to the nascent epidemic; and chapter 4 concludes the focus on the NP years by setting out the legal and public sector responses.

The first purpose of this chapter is to examine the context of the early years of HIV prevalence in South Africa. This will highlight the societal context of the country in 1982, the year the first two cases of AIDS were reported. The response of the South African government in those days is an essential determinant for how the epidemic would be seen in the years to come. It is thus important to describe the policy environment within which the government was operating, the variables that impacted on possible policy responses, and the normative drivers or vectors of these interventions.

This implies two main areas of focus: a description of how the South African socio-political environment in the early 1980s provided a perversely ideal breeding ground for the rapid spread of HIV infection; and the initial response that set the tone for how the South African government and other key public policy actors would come to view AIDS as a problem, and then respond to such a conceptualisation. Ironically, the context of the initial response exemplified exactly the kind of problems that drove the early epidemic even deeper underground,

P. Fourie, *The Political Management of HIV and AIDS in South Africa*

supporting governmental inaction or misdirected interventions that exacerbated the spread of HIV in South Africa.

Apartheid South Africa: an environment of risk

Apartheid South Africa provided a rich societal Petri dish in which HIV and AIDS could flourish. The epidemics of the past (e.g. Spanish influenza immediately after the First World War) and the present (e.g. SARS in 2003) demonstrate that major epidemics do not crop up by chance. Instead, they tend to occur when circumstances offer a favourable breeding ground to pathogens. As is the case with individuals, a population's immunity to societal ills can be weakened by several co-factors, and South Africa in 1982 was a society most vulnerable to HIV.

This confirms Louis Pasteur's notion that '[t]he microbe is nothing; the terrain everything'.[1] The 'terrain', it is important to note, refers as much to biological factors as it does to non-biological ones, and hence the socio-political context of South Africa in the early 1980s is a significant determinant of the spread of the epidemic. Despite this, Fransen notes that little empirical evidence has been collected about the levels of societal determinants of behaviour and the effectiveness of various policies to bring about behavioural change and reduction of HIV transmission or acquisition: 'Even less is known about such policies from the economic point of view (cost-effectiveness). Among researchers, only a few have tried to start the study of factors underlying risky behaviour and HIV status at population level.'[2]

Since, in Fransen's opinion, this hinders the search for new and potentially effective prevention programmes and policies, the lack of quantitative material would clearly lead to the impotence of pundits of rational choice theory even to start an attempt at drafting a response to HIV and AIDS.[3] The unfortunate fact is that such a lack of data and other supporting information was a feature not only of the 1980s; a lack of epidemiological data and information about behavioural matters continues to be a negative factor in South Africa's policy response to HIV and AIDS to this day.

In 1982 South Africa was governed by a political party bent on racial separation and discrimination. Society was defined by an unequal distribution of resources, widespread poverty, the profligate duplication of civil services, international isolation and regional military insurgencies, the absence of democracy and effective/good governance, domestic political instability and gender inequality. At the time there was widespread ignorance about HIV and AIDS – and given the fact that it was a

newly identified pathogen with very few victims, the reality was that policy actors had very little incentive to mobilise public resources to counter its impact. Furthermore, a complex set of cultural factors was playing a catalytic role in the environment within which AIDS was introduced. The social cohesion that is needed to combat HIV and AIDS was absent – and, some would say, continues to be absent to this day.

Instead, there were traditional social practices that fostered infection, a decaying social fabric, great female vulnerability and an economic production system that relied on migratory labour (rural–urban, but regionally as well). All these factors created an environment of risk for the people of South Africa, and this risk was compounded by the fact that although AIDS was first recognised as a syndrome in 1981 and HIV as its cause in 1984, a systematic national and international response to the epidemic did not start to take shape until 1986–7. According to Dorrington and Johnson, this environment of risk was of such a magnitude that 'on any scale of high-risk situations South Africa in the 1980s ranked near the top'.[4]

Some of the key factors that compounded apartheid society's AIDS risk profile are reviewed below.

Risk profile

Biomedical factors

In terms of shaping a response to an epidemic, it is essential to know what kind of epidemic is emerging. Epidemiologically, two strains of HIV emerged in South Africa in the 1980s: the HIV-1 clade remains the dominant strain in the country today, but it has two sub-variants which reflect the kind of society in which it spread in those early days. It thus brings to the fore two kinds of epidemic to which the medical authorities and the government should have responded. Clade B predominated among gay men (the first two AIDS deaths in 1982 were the result of this variety), while clade C has become associated with heterosexual and perinatal transmission. In Karim's view, this suggests the emergence in the 1980s of 'two independent HIV epidemics unfolding in South Africa' – an earlier variety through homosexual transmission, and a heterosexually transmitted variety a few years later.[5] Injecting drug use (IDU) has never been a significant mode of infection in South Africa.

HIV is a 'free-riding' infection, which targets individuals whose immune systems are already compromised by other diseases. In South Africa in the 1980s (as today), tuberculosis (TB) and sexually transmitted diseases (STDs) are rife, particularly among the poor in the community. Almost half of the entire black population has had TB at some stage of

their lives, which leaves these individuals immunocompromised for life.[6] Furthermore, high levels of STDs go untreated, for a number of reasons: many STDs are asymptomatic, individuals will often not seek treatment, treatment is ineffective, and sanitation and adequate nutrition are absent.[7] Couple these factors with a political-economic system which did not favour primary health care and rural medication, and the context for vulnerability is clear.

Economic factors

Income is one of the most significant factors correlated with HIV prevalence. The poor – due to an inadequate diet, the need to travel long distances to work, and so on – are most affected by the epidemic. Also, many do not have access to proper treatment for STDs or cannot afford treatment. As Dorrington and Johnson note:

> Of HIV and AIDS admissions to Somerset and Groote Schuur Hospitals between 1988 and 1993, only 48 per cent of heterosexual males had ever been employed, and of those who had been employed, 74 per cent had been employed in unskilled or semi-skilled labour.[8]

Terreblanche notes that black South Africans are particularly vulnerable to HIV because of the legacy of apartheid and the unequal distribution of health and other resources in the 1980s and earlier: this historical framework of systemic exploitation led to a system where 'comprehensive, co-ordinated and effective policies for alleviating poverty and preventing AIDS are not implemented, poor health and [hence] AIDS will remain an important – and ominous – poverty trap leading to the further pauperisation of especially the poorer half of the population'.[9] This reflects the incremental impact of bad policies in the 1980s, echoing what incremental public policy theory might say on the matter.

Ironically, the AIDS epidemic did not escalate in South Africa until the 1990s – it was one of the last countries in Africa to be affected. However, the legacy of apartheid and its ultimate contribution to the cycle of poverty, together with an industrial economic base which promoted migrant labour and exploitation did, in Evian's words, 'ensure that South Africa [would] be no exception and [would] surely face a massive and devastating AIDS epidemic'.[10]

Sexual behaviour factors

South Africa in the 1980s was an exceedingly patriarchal society, and women's disempowerment finds its most severe application in sexual

relations. Rape (including marital rape) is endemic, and cultural factors ensure that women have very little say in their sex lives. The inequality between the sexes is one of the key factors underlying the risk factors in society – and South African society is no exception to the rule. Under apartheid even white women did not have equal rights with men – female school teachers and other public sector workers, for example, received lower salaries than their male counterparts. Black women were the most legally disenfranchised sector of South Africa society. Married women were seen as the legal minors of their husbands.

These factors led to a situation where women were not only underrepresented in public life, but were for the most part also powerless in the private domain of their homes. Skewed power relations related to sexual behaviour were not questioned, allowing them to continue unabated. In addition, both homosexual relations and commercial sex work were criminalised in apartheid South Africa, so that homosexuals had no moral or legal recourse in a society that frowned on homosexual activities. Commercial sex workers had (and continue to have) no legal system to call on in the event of abuse or exploitation. These individuals were thus also excluded from an embracing health system.

Compounding these factors, in many instances African customary law entrenches women's economic insecurity. In Zambia, for instance, widows of AIDS casualties are often victim to instances of 'property-grabbing' – the law allowing or not acting against in-laws who claim the land of the diseased family member. Also, society's dependence on women and girls as caregivers within the household makes it impossible or very difficult for females to enter the public sphere and realm of political decision-making. In a sense, then, these traditional conceptions of mothering means that the 'private' is not allowed to become 'public', and the result is that women remain impotent, suppressed, and thus societally and economically excluded. As Mboi emphasises:

> [g]ender expectations/roles are crucial in determining if or how a woman may protect herself, her sexual partner(s), even her unborn child from HIV infection. Within [developing countries] widely held stereotypes about what is 'proper' and 'normal' for men and women regarding sexual feeling and expression severely limit the latitude most women have (or will exercise) for action in the micro-settings where sexual divisions are made. In general 'knowledge', 'pleasure', 'rights' and 'initiative' belong to men, while 'innocence', 'acceptance' and 'duty' are portrayed as 'normal' for women.[11]

Migration patterns

Human migration was a key feature of apartheid South Africa. The apartheid government instituted the homeland system and thus forced black South Africans to move to parts of rural South Africa where they would not be able to find work, so that blacks were obliged to migrate to and from larger urban areas in the search for work. This gave rise to the 'hostel system' which was set up to accommodate migrant workers (who also travelled in from neighbouring countries), and burgeoning networks of commercial sex work to service these hostels. Since the apartheid law prevented workers from bringing their families to their places of work, workers were separated from them for long periods at a time, and in this environment the commercial sex industry flourished. Since commercial sex was criminalised under the NP administrations (and remains so), there were no apparent avenues open to government agencies which might wish to implement HIV and AIDS programmes for commercial sex workers. Furthermore, given their criminal status, sex workers were loath to report their activities to the legal and health authorities, driving this vector for the spread of the epidemic underground.

To illustrate the context of migration, Dorrington and Johnson note that:

- In the decade between 1975 and 1985 alone, more than 3.5 million black South Africans were relocated to the twelve homelands.
- In 1990 more than 2.5 million migrant workers (drawn from rural areas and neighbouring countries) were working in mines, factories and farms.
- In 1989 roughly 40 per cent of the workforce of the Chamber of Mines consisted of migrant workers from outside South Africa.
- In 1995 90 per cent of all black employees in the gold mining industry were migrants, and 89 per cent of those workers were accommodated in single-sex hostels.[12]

As these migrant workers moved back to their homes, they provided an excellent mode of transmission for HIV from their places of work to their families, who might otherwise have remained safe from the virus.

Political turmoil

It is a well-accepted fact that military conflict and the movement of large numbers of military personnel, refugees and even peace-keepers can increase the spread of HIV. South Africa in the 1980s was embroiled in a near-civil war which led to exactly the kind of social dislocation and

turmoil that provides an environment for the spread of the disease. The apartheid government followed a strategy of destabilising the region, fuelling civil wars in Angola and Mozambique, and launched military attacks on many neighbouring countries.[13] The African National Congress (ANC) and Pan-African Congress (PAC) set up military bases and other kinds of political presences in these countries, adding to the number of military personnel in particular that were present in those countries.

Inside South Africa, the province of Natal in particular was afflicted by violence and political conflict between ANC and Inkatha Freedom Party (IFP) supporters. Even in the years immediately preceding the first democratic elections in April 1994, South Africa was in the unenviable situation of being 'the only country in the world which had to contend with an exponential rise in HIV prevalence rates in the context of major political transition'.[14] As Dorrington and Johnson note, all of this 'led to a collapse of social cohesion and a disintegration of parental authority, and is a significant factor contributing to the higher levels of HIV prevalence'.[15]

These five factors led Dorrington and Johnson to conclude:

> [t]hat South Africa has experienced such a rapid spread of the HIV and AIDS epidemic should not have come as a surprise to anyone familiar with the conditions in this country prior to 1994. Apartheid left the country with all the ingredients to ensure that it would have the most explosive and extensive epidemic in the world. This, coupled with the mismanagement of the epidemic at virtually every turn, has meant that the country is now facing a disaster which it barely comprehends.[16]

Clearly, apartheid was responsible for much of the structure which determined the patterns of behaviour that led to the rapid dissemination of HIV in South Africa. These patterns in turn precipitated many of the events that journalists reported on in the sensationalist first months and years of the South Africa AIDS epidemic. Summarising the three main apartheid structures that underpin South African AIDS to this day, Fassin refers to *social inequalities, gender violence* and *migrations*.[17]

Ostensibly uncomplicated, this is an important point, since it defines the three-headed monster that needed to be addressed and remains to be addressed in combating HIV and AIDS. Government policies regarding the epidemic should, in an ideal world, have focused on addressing these. In shying away (as will become clear in subsequent chapters),

the apartheid government's definition of the HIV and AIDS problem became increasingly erroneous. The country is paying the price to this day.

Apartheid – in the extent to which and the duration for which it was allowed to continue – made South African AIDS unique and exemplary.[18] It made the country *unique* in terms of its epidemiological as well as its political specificity – how the socio-political context wrought by apartheid led to the spread of the virus in this country and how the political system underscored the inequities creating the social conditions for its spread. On the other hand, apartheid made South Africa *exemplary* in terms of bringing to light the key variables that drive the disease at the global level: the importance of historical precedents and the social characteristics of ostensibly 'medical' issues. Public policymakers thus have much to learn from how the epidemic started and has been disseminated in this country, since 'South Africa is a society where history has seen the development of high levels of legally entrenched susceptibility [to HIV and AIDS]'.[19]

The normative environment

In addition to the factors describing the high AIDS risk landscape of South Africa in 1982, one also has to take into account the importance of the normative discourses of the time. Given the socio-political pressures present in the early 1980s, it is clear that there were contending ideological discourses, particularly with reference to the governmental regime type required for the future. The political culture in most countries can be classed as individualistic, moralistic or traditionalist[20] – and the normative response of the political culture in 1982 was an important co-factor in describing the AIDS risk environment.

The normative environment is as important as the five factors noted above, since it provides insight into the values permeating South African society at the time. These values are important in determining what centres of authority would be legitimised by ideological and moral constituencies. These contending constituencies become important, pluralist theorists would say, in determining the policies that governments will support, how they will define policy problems, which issues will make it onto the policy agenda, and so on. As Jochelson notes:

> [r]ather than examining disease in a political context as a set of pathogens, or victimizing individuals for 'deviant' behaviour, what is needed is an appreciation of social and historical processes which have shaped unsafe sexual behavioural patterns of today. A political

> economy approach to disease considers the relation of ecological, political and social aspects of disease to the economic transformations wrought by colonialism and capitalism in Africa.[21]

As will become clear, the (often contradictory) values in a society are also essential in determining impressions of where the structural causes of a problem lie, and in doing so, the normative 'blame game' commences. If something – an act or an individual – can be blamed (with moral backing), it becomes an easy target for the building of a mythology of exclusion, moral censure, legal targeting and victimisation. The following sections look at some indicators of the moral-normative environment which, coupled with the factors noted above, provided the socio-political normative context in which the apartheid government was set to respond to the AIDS issue in the early 1980s. This section reviews the context by focusing on the popular culture of the time, as reflected in media reports regarding AIDS in the 1980s, religious and moralistic communities, and traditional societies.

Media reporting and popular culture

As early as 1986 some commentators were noting how the media were exploiting the unfolding AIDS story in South Africa by focusing on its sensationalist value. Here, in a morally conservative society, was a story including aspects related to 'sex, promiscuity, death, blood and the possibility of an uncontrolled pandemic' that would sell newspapers, in the absence of any prominent societal insistence on factual accuracy.[22] The result, in Grundlingh's mind, was 'mythmaking … a revival and affirmation of prejudices and a new emphasis on conservative morality'.[23] And no story about disaster and victims would have been complete without the allocation of culpability: this was the time of morally-based blame dressed up as scientific reporting, providing public bodies with a good opportunity to latch on to this discourse and act (or refuse to act) accordingly. This was also the time when the AIDS issue would become problematised – in other words, society and the media would conceptualise where the real problem with HIV and AIDS lay, personalise the problem and attack those deemed responsible, instead of targeting the virus itself and the underlying causes of its transmission.

Strasheim was the first media analyst to identify how the social construction of 'news' regarding HIV and AIDS would focus on the apportioning of blame; how the conceptualisation of the problem would be personalised in specific groups of individuals.[24] Homosexuals, black people, commercial sex workers and intravenous drug users

became the perpetrators blamed for introducing the virus into society. Homosexuals bore the brunt of society's scorn, and politicians were quick to equate the problems posed by the virus with these individuals who, because of their 'deviancy', were endangering society. In 1985 a prominent member of an opposition political party stated in a newspaper that AIDS was God's punishment for homosexuals' unnatural acts, and such divine retribution was soon projected as just punishment for the immoral acts of intravenous drug users and commercial sex workers as well.[25]

The initial, facile response was thus for the government to support popular notions that the AIDS problem in South Africa was a God-given solution to these outcasts' deviant behaviour, a just punishment that would remove these moral blights from South African society. This meant that government did not have to look towards the impact that their own apartheid policies was having in preparing the ground for further HIV infections in South Africa – they had their scapegoats and government's moral position was underscored by quotes from scripture that enforced the NP government's criminalisation of homosexuality, recreational drug use and commercial sex work. In addition, since the first two South African AIDS fatalities were gay white men, the black community reacted by supporting this moral position: AIDS was seen as a 'predominantly "white" problem'.[26] AIDS thus became associated with 'the Other'; someone else was always to blame and stigmatised – 'blaming other people for a problem as a substitute for tackling the problem itself'.[27] The government was as guilty of this as any other sector of South African society.

Media reports focused on areas where the culpable homosexuals could affect 'normal' South Africa – on 24 February 1985 the *Sunday Times* ran a front-page banner warning of the insidious 'Gay blood peril' in South African blood banks. Strasheim notes how the media, church groups and government ministers acted together to reinforce the association of homosexuals and AIDS: in the same edition of the *Sunday Times* the Minister of Health called on homosexuals not to donate blood; at the same time, calls to make AIDS a notifiable disease started to appear in the popular media.[28] All of this led to a situation where so-called 'social problem groups' felt more marginal, became increasingly victimised, and hid their presence and actions from the rest of society even more. Instead of revealing the societal issues that established apartheid South Africa as a fertile breeding ground for viral transmission, government rhetoric in the media served to stigmatise and isolate those deemed morally and physically guilty of endangering broader society.

This kind of sensationalist reporting and stigmatisation of gays in particular was underwritten by a horrible double standard – the South African media were happy to print bigoted moral views, but professed squeamishness about communicating life-saving strategies to the broader public. As late as 1993 Van Niftrik noted the following about the state of South African AIDS reporting:

> [t]he [government-owned and controlled] national radio and television network is obdurate in its refusal to transmit meaningful AIDS awareness messages. It contents itself with paying lip service to the killer disease by flighting [*sic*: floating?] such watered-down messages as to be obscure to all but the most intelligent – who know all about HIV and AIDS anyway. All but one radio station will not even consider condom ads, and television will only allow material which is so veiled in euphemism that it might as well be promoting a glass of warm milk to ensure a good night's rest.[29]

Ironically, even if the state-run media were willing to report accurately and constructively on HIV and AIDS, its transmission and other factors, the legislative environment governing such publications proved to be a hurdle: the Publications Act was aimed at halting the dissemination of pornographic and politically contentious material, and in doing so it also mired the distribution of information regarding the sexually transmittable nature of HIV.[30]

This leads Strasheim to conclude that 'the AIDS threat [in the mid-1980s was] symbolic – the hysteria [was] over what it [had] been built up to be, not what it [was]. The resultant social reaction to the AIDS moral panic … made the media reporting of AIDS part of the problem, instead of part of the solution.'[31]

Religious-moralistic responses

The moralistic and sensationalist stance of the media was for the most part supported by the white, Afrikaner churches. Dutch Reformed Church ministers stated on television and from the pulpits that AIDS was God's way of punishing sinful lives, and warned that homosexuals and commercial sex workers should abandon lifestyles that ran counter to God's commandment. In a conservative society, such a response is fairly predictable, and as more became known about the manner in which the virus could be transmitted, a religious mythology was developed to strengthen the church's position. For instance, when it became apparent that unborn children could catch the virus from their mothers,

or that individuals could be exposed to HIV via blood transfusions, these individuals and babies were referred to as 'innocent victims':

> This term implies that they deserve our sympathy and some societal acceptance. Conversely, it implies that those who contracted it sexually are guilty and that whether or not they knew of the risk of HIV infection when they were infected, they deserve some social censure. Clearly, double morality was practised here.[32]

Thus in the early days of AIDS it became morally acceptable in the Afrikaner churches to blame the victim – particularly if he/she, due to an unacceptable lifestyle, was 'responsible' for his/her own infection. The virus was not the problem; the victims were. Grundlingh notes that this led to a situation where such a logic could absolve 'the state or social institutions from responsibility for creating social conditions in which AIDS flourished'.[33] The Director-General of National Health and Population Development stated as late as 1989 that 'Transmission of HIV is mainly by promiscuous sexual contact, and it is therefore a social and behavioural problem in the community'.[34]

Instead of examining the specific societal variables that enabled the spread of HIV and some governmental introspection about policies that could entrench it, the government, its agents as well as its church perpetuated the moral mythologies of blame and stigmatisation. Even when, by the late 1980s, it became clear that AIDS was becoming a predominantly heterosexual phenomenon, the NP government and church preferred to exculpate themselves and their own (white) constituents by stigmatising promiscuity among the black population: 'The association of black people with dirt, disease, ignorance and an animal-like sexual promiscuity made it almost inevitable that black people would be associated with AIDS' origin and transmission.'[35]

However, there was a difference between the Afrikaner churches and others. In some instances non-Afrikaner South African church groups realised early on that AIDS would challenge them to re-evaluate scripture and morality regarding sex and sexuality.[36] If AIDS were to be addressed at the structural level – the level underpinning patterns of human behaviour as well as the events reported on by the media – it would be necessary for the churches to review their stance on issues such as same-sex relations, the use of contraceptives (for the Catholic Church in particular, the use of condoms remains anathema), abortion, care for the terminally ill and the criminalisation of commercial sex work.[37]

Condemnation from the pulpit served to stigmatise large sections of South African society, driving risky sexual behaviour underground rather than exposing it and discussing it in a solution-oriented rather than a problem-oriented way. But such a shift would be difficult, and it was only in the late 1980s that theology journals started to address AIDS issues more openly. Calling for Christian non-judgement of and care and compassion for people with HIV and AIDS, Louw, for instance, noted:

> [b]ecause of [the] connection between AIDS and ethics, counselling the person with AIDS is much more complicated than with any other disease. Discrimination and persecution in the light of strong ethical issues make the person with AIDS a vulnerable and most tragic figure. For the most part AIDS patients are stigmatized by society and church.[34]

Clearly, not all churches were as judgemental as the Dutch Reformed and other Afrikaner church groups. In September 1986 the Executive Committee of the World Council of Churches (WCC) sent a message to its communities around the world, for the first time singling out a specific medical condition and calling on the churches to respond to the AIDS crisis with pastoral care, education for prevention and social ministry. The message cautioned against notions of discrimination, stigmatisation, exclusion and righteous blame. In particular, it cautioned against the view that, in focusing on the ethics of prevention, churches should absolve themselves from caring for AIDS patients. In an effort to get away from the notion that treatment undermines so-called 'just punishment' from God, the WCC called for compassion, thus attempting to strike a balance between condemning sinful acts and caring for the infected.

The Anglican Church noted in a 1987 newsletter that '[q]uite obviously promiscuity is both morally and medically undesirable. But it is also very important that Christians should have a deep understanding and compassion for those suffering from AIDS who often endure a great feeling of rejection and isolation.'[35] Unfortunately, the church supporting the apartheid government of the day found it impossible to draw a similar distinction between sinful sexual behaviour on the one hand and the sinner on the other, opting instead to make the victim a perpetrator.

Whereas the Afrikaner churches and the NP government seemed bent on focusing on preaching preventative morality, the other Christian churches started to make a move towards examining the post-infection implications of AIDS. This was an important lesson that the government of the time failed to heed: instead of looking at the implications of HIV infections and making policies to ameliorate their impact early on, the

NP government elected to maintain its focus on moral messages aimed at preventing infections. As the infected individual was, in the opinion of the government, responsible for his/her HIV status, the government felt morally supported in its position to condemn, blame and stigmatise those already infected, and not care for them.

Traditional societies

In addition to the media and religious community response to AIDS in the 1980s, the black section of South African society for the most part reacted in a way that ran counter to what would later be identified as the optimal manner to combat a nascent epidemic. It has been noted that the black community initially saw AIDS as a white problem, affecting the gay community in particular. Since same-sex sexual relations were portrayed as counter to the traditional culture of the black community,[40] the ground was prepared for further obfuscation and mythmaking within this community – denying that AIDS would be a problem in 'traditional' societies which distrusted white remedies and a biomedical response due to the discriminatory apartheid policies of the time. In fact, early attempts by sectors of the medical and civil society communities to inform traditional communities of the dangers posed by HIV and AIDS were viewed as an '**A**frikaner **I**nvention to **D**iscourage **S**ex'[41] – the AIDS acronym itself becoming the victim of myth, denial and stigmatisation.

In addition to the socio-political reasons explaining why AIDS posed such a danger to the black South African community, there are cultural factors that especially raised black South Africans' AIDS risk profile. In the first place, biomedical response strategies have focused on individual rationality and the rights and privileges of the individual in determining his/her own sex life. However, in traditional African societies:[42]

- The emphasis is more on collective rights than on the rights of the individual.
- Women traditionally do not have the power to negotiate sex with their husbands: it is also the function of the husband to give consent for the wife to be examined by a medical doctor.
- Some analysts would say that the concept of 'fidelity' in a society that tolerates polygamy is contentious. If someone has 20 or 40 wives, the risk for HIV transmission in a community rises exponentially. In a society where there is partnering outside marriage polygamy is not the answer; in such a case it increases the risk. Viljoen notes that 'a man's wealth was measured by the amount of cattle and wives that he had'.[43]

- Condoms are viewed with distrust, since they negate the man's 'right' to pleasure and fertility (particularly in a society where the number of children is an indication of one's wealth), and an infertile wife is viewed as a social outcast.
- Women have little right to counter their husbands' insistence on high-risk 'dry sex', which increases their vulnerability to HIV infection.

These factors serve to underscore the fact that in Africa as elsewhere people are not logical (in terms of the conventional, western conception) and do not necessarily behave in the rational manner that the biomedical response model presupposes: 'You can create general awareness and knowledge about AIDS and its mortality, but that does not necessarily change people's behaviour.'[44]

In addition, it is common in many traditional cultures (as is the case in Afrikaner culture) to establish a link between cause and effect, and then to find a way of punishing a guilty party.[45] In many instances, the victim of a disease would see such an ailment as '*Isidiso*', or 'black poison'[46] – witchcraft is blamed, and the patient seeks the help of a traditional healer instead of consulting a medical doctor. (This is particularly the case in rural areas, where biomedical resources during apartheid were and to this day remain hard to come by.) Zazayokwe notes that such an environment makes it difficult to implement effective educational programmes and other strategies to combat AIDS, since it is 'the tendency of people to blame AIDS on others', and sometimes on metaphysical or supernatural forces (much in the way the Dutch Reformed Church dealt with the issue).[47] Tragically, traditional healers sometimes rely on skin-piercing practices to cleanse the body of ailments, which provide another avenue for the transmission of HIV.

Conclusion

This chapter has demonstrated how South Africa in the 1980s provided an environment of high risk for the spread of the AIDS. Due to apartheid policies the population was politically and economically vulnerable to the intrusion of a sexually transmittable pathogen. To make matters worse, the normative environment underscored the denial, stigmatisation and discrimination required to render an effective response early on almost impossible.

We now turn to describe the response of the South African biomedical community in those early days.