

BUCKLING – Introduction

An AIDS epidemic as severe as the one plowing through South Africa will change society. AIDS impact literature indeed predicts catastrophic outcomes, but the scenarios tend to be roughly hewn and formulaic, and fixate on the epidemic's likely impact on productive and governance capacities. Thus they foresee a chain of effects in hard-hit settings that culminate in stunted economic growth, dysfunctional state institutions, possibly even 'derailed development' and state failure.

This approach expresses dominant ideological trends of our time, not least the overriding obsession with productive processes and growth potential, governance and security. The well-being of humans is refracted through these cognitive screens. What emerges is a fuzzy picture of a calamity that flattens everything in its path with a sort of 'democratic' disregard. Narratives about the impact of AIDS therefore tend to ignore the distribution of risk and responsibility in society, the evasive agility that privilege and power affords, and the sheer fact that adversity often is also the mother of short-sighted invention. In this fanciful world, we're somehow all bobbing in the 'same boat', if not exactly equal then all equally-at-peril. Scrubbed clean of its gnarly injustices and inequalities, society is reduced to a fiction in which a special place is reserved for a heartwarming but vapid faith in the abilities of 'the poor' to weather adversity, with a little help from their friends. In all this, AIDS is seen to feature as an exceptional and distinct

factor of destruction, its interplay with the broader dynamics that determine the distribution of power, resources and entitlements seldom earning close examination. A misshapen picture of how AIDS alters our worlds is one result. A short-sighted guide to strategies for containing the epidemic, and preventing or repairing the damage, is another outcome.

This publication's starting point is the need for a more and rigorous picture of the AIDS epidemic's impact, an analysis that takes proper account of how the epidemic meshes with the specificities of society. 'Buckling' is intended as a modest step toward such an understanding. The method chosen is transparently simple: a critical review of a large volume of AIDS impact research evidence focused around a specific socio-logical and political-economic reality – in this case, South Africa. 'Buckling' widens the perspective and tilts it in ways which, hopefully, reveal more clearly the contingency and complexity of the epidemic's impact, and which bring its interplay with other dynamics into clearer view, particularly those involved in the reproduction of deprivation and inequality.

First, the introduction positions the epidemic within a wider historical and ideological context. Chapter Two ('Gauging the epidemic') then surveys the epidemiological evidence and some of the controversies surrounding it. Chapter Three ('Ground Zero') examines and critiques the conventional

narratives of AIDS impact on households, of orphanhood and of home-based care, and shows how the epidemic is accentuating and hardening some of the most grievous features of our society. Chapter Four ('Fall-out') pans wider to critique the popularized images of societal impact, and offers an alternative analysis of what AIDS is wreaking in South Africa.

What emerges is a nuanced but horrifying picture of a society that is being ruptured and buckled into an antithesis of the humane, just and dignifying society millions struggled for and continue to strive toward. It need not be this way: history does not run on rails. But this epidemic is reiterating and intensifying already-powerful features of society with such ferocity that it will require extraordinary boldness and invention to reclaim the future. We have not yet been where we are likely headed.

Rooted

South Africa is experiencing one of the most intense, and probably the largest HIV/AIDS epidemic in the world. The epidemics in South Africa and several of its neighbours are unique in at least two respects. National adult HIV prevalence levels in southern Africa have soared to heights not seen anywhere else in the

world.¹ And, with the exception of Zimbabwe, there is no sign yet of a nationwide decline in any of those epidemics. HIV levels seem to be stabilizing – but at extraordinarily high levels of 20% or more in six southern African countries, including South Africa.ⁱ This apparent ‘stabilization’ probably reflects a terrible equilibrium – with the numbers of people newly infected with HIV roughly equalling the numbers dying of AIDS.ⁱⁱ

These epidemics are changing these societies, but in ways that are not yet fully understood. These epidemics cannot be understood or effectively confronted – nor, as we shall see, can their impact be appreciated or cushioned – without taking account of the ways in which power is amassed, exercised and distributed across and between societies. The origins and driving factors of South Africa’s AIDS epidemic are entangled in the development paths that have moulded the country – in the highly unequal social relations these generated and in the ideological systems (the patterns of behaviours, norms, beliefs and affectations) that coalesced along those paths. In South Africa a social template was established which suited ideally the propagation of a virus such as HIV. Systematic dispossession and dislocation, the fragmentation and polarization of society, and

the recasting and, in some places, dismantling of social systems helped create a social and ideological terrain that would hugely favour the spread of the virus. Already in the late 1940s, the social epidemiologist Sidney Kark’s analysis of the syphilis epidemic in South Africa became a benchmark for alternative traditions of epidemiology when he concluded that ‘the problem of syphilis in South Africa is so closely related to the development of the country that a study of the social factors responsible for its spread is likely to assist in its control’ (Kark, 1949).ⁱⁱⁱ Today, the ferocity of the AIDS epidemics in southern Africa similarly iterate particular configurations of social, cultural and economic orders.

Especially evident in South Africa is the formative role of circular migration (Walker et al., 2004),² an engineered pattern of mobility associated since the late 19th century with labour regimes designed to service capital accumulation centered largely on mining, as well as agri-business, before later also extending to urban manufacturing and service economies. Transport networks were assembled to service these economies, with major rail and road systems linking harbours, mining hubs and agricultural basins. The resultant patterns of circular

migration split (mainly male) workers from their families and communities for long periods of time.³ Even during the apartheid era these patterns were transnational (with the South African economy, for example, using migrant labour from Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe). The arrival of HIV in the sub-region coincided with dramatic changes that affected population mobility and systems of migrant labour. The gradual demise of apartheid since the mid-1980s enabled more cross-border migration, and this increased exponentially in the 1990s as formal and informal regional trading ballooned. Inside South Africa, internal migration also increased substantially as the enforcement of apartheid laws crumbled. Some 60% of KwaZulu-Natal men and one third of women between 19 and 49 years of age were migrants, according to one survey in the mid-1990s (Walker et al., 2004). Throughout the sub-region, women in particular became more mobile, their migratory quests for work often stemming from increasingly insecure livelihoods in rural areas (Crush, 2001).

This is not just a matter of history and its imprints. The economic marginality and insecurity of poor men and especially poor women in southern Africa has probably worsened in the

1 Nowhere else has national adult HIV prevalence reached or exceeded 20%, as it has in Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe. National prevalence in Uganda, according to some estimates, reached 15% in the early 1990s, after which it declined steadily – most probably due to a combination of increased AIDS mortality and changes in sexual behaviour. It is sometimes pointed out that HIV infection levels reached double figures in parts of Thailand in the early 1990s. This is partly true. In the Upper North, HIV prevalence among new army conscripts was approximately 12% in 1991-1993; among pregnant women prevalence reached almost 8% in the Upper North of Thailand in 1995. National HIV prevalence never reached such levels. See UNDP

(2004). *Thailand’s response to HIV/AIDS: Progress and challenges*. Bangkok. UNDP, p 21. Nine countries in southern Africa had adult HIV prevalence levels of 10% and more at the end of 2003 (UNAIDS, 2004a). Together, those nine countries accounted for 2% of the world’s population – but almost 30% of the global total of people living with HIV (between 10.5 and 12.6 million people, according to UNAIDS estimates).

2 In South Africa, for example, HIV prevalence has been found to be twice as high among migrant workers (26%) compared with non-migrant workers. However, the high prevalence of HIV in southern Africa currently means that it is considerably more difficult to map the prevalence and spread of disease onto spatial patterns of migration than it was in the past (Crush, 2001).

3 Mark Lurie’s (2000) often-quoted observation remains apt: ‘If one were to design a social experiment in an attempt to create the conditions conducive to the spread of HIV and other sexually transmitted diseases, you would remove several hundred thousand rural men from their families, house them in single-sex hostels, provide them with cheap alcohol and easy access to commercial sex workers and allow them to return home periodically. These conditions roughly describe the situation for more than eight hundred thousand gold miners and countless other migrant labourers working throughout South Africa today.’

past two decades amid the introduction of neoliberal economic adjustments – overlaying gender and other inequalities that provide the relational dynamics which enable a mainly heterosexual AIDS epidemic to flourish.⁴ The labour market has been radically restructured, with vast numbers of workers shifted from a ‘rationalized’ formal sector into insecure contract and casual labour roles, the ‘informal’ sector or unemployment. The past two decades have seen massive job losses in most sectors of the economy, including industries in which female workers predominated, such as textiles and clothing.⁵ Unemployment, the shift from permanent to casual employment, and stagnant pay have hit African women hardest, most of whom are trapped in poverty with sporadic access to poorly paid and insecure jobs. The overlap of gender and socio-economic inequalities is especially harsh in South Africa, where many women depend on social grants, remittances from male partners and other kin, and other, inconsistent and informal sources of income. All this has further weakened women’s

economic status, aggravating gender inequalities and exacerbating their exposure to HIV risk. Research in Mamdeni, for example, has shown a close correlation there between exceptionally high HIV infection levels, widespread transactional sex, and job losses in the female-intensive textile and garment industry (Hunter, 2002). Driven by relative poverty, many women and girls find themselves using sex as a commodity in exchange for goods, services, money, accommodation, and other basic necessities;⁶ transactional sex reflects the superior economic position and access to resources men generally enjoy.⁷

However, it is not always and simply a matter of victimhood. The many computations of sexuality and desire feature, too, as Jonathan Berger (2004) has reminded us. Many young women look to older men as potential marriage partners, or as sources of assistance in obtaining access to education and jobs, and addressing other aspirations or desires. Research in several

African countries indicates that some young women ‘trade’ sex and companionship for gifts that have connotations of ostentation and luxury (clothes, jewelry, cellular phones, perfumes, etc.) and which boost their self-esteem and status among peers (Luke & Kurz, 2002; Longfield et al., 2004). In urban areas especially, these relationships are formed amid aggressively propagated cultures of consumerism, and in the midst of vivid juxtapositions of deprivation and abundance, covetousness and fulfilment. Sexuality, status and consumption become closely intertwined. Besides the obvious importance of procreation and the overlooked roles of hormones and libido, sex is entangled also in people’s need to have fun, to seek and express trust, to build status and self-esteem, to escape loneliness, even to relieve boredom. Research in South Africa, for example, indicates that in the context of deep impoverishment and high unemployment (and in the absence of affordable recreation), sexual relationships often feature in bids to boost self-esteem and peer status, or simply to relieve

4 This is not to suggest that such epidemics explode wherever there are severe inequalities. But severe inequalities appear to be a precondition for epidemics as eviscerating and apparently unremitting as those experienced in southern Africa, where intersecting forms of inequalities define social relations.

5 The lifting of tariffs in the textiles and clothing industry, along with other moves to harden its ‘competitive edge’ have depressed wages and spurred the conversion of secure jobs into ‘casual’ labour. According to the South African Clothing and Textile Workers’ Union (Sactwu), some 88 000 jobs were lost in this sector in 1989–2003, with half the factories shutting their gates for the last time between 1990 and 2001. The process continues throughout the region; in late May, 1 600 Namibian textile workers lost their jobs in one week, for example; see IRIN, ‘Textile sector stumbles as foreign owners pull out’, 19 May 2005.

6 Men in their late twenties and thirties, however, are more likely to be HIV-

infected, and the dependencies built into such relationships can severely limit women’s abilities to protect themselves against HIV infection. Most explanations of transactional sex with older men attribute it to material desperation. In many instances, this is indeed the case. But often other factors are at play, as one recent multi-country survey in sub-Saharan Africa has shown; see Luke N, Kurz KM (2002). *Cross-generational and transactional sexual relations in sub-Saharan Africa: Prevalence of behaviour and implications for negotiating safer sex practices*. September. Washington, AIDSmark. Available at www.icrv.org/docs/crossgenssex_Report_902.pdf. Prevention strategies aimed at reducing unsafe sex have to be built on recognition of the fact that, for some women, sex can be one of the few valorized forms of capital at their disposal.

7 Transactional sex appears often to involve younger women and older men. Such ‘age mixing’ (whether inside marriage or outside it), appears to be

an important factor in southern and East Africa’s epidemics, where a young woman’s chances of becoming infected tend to increase with the age gap between her and her partner (Kelly et al., 2003). This is partly because older men are more likely to have been exposed to HIV, and because girls and young women are physiologically more susceptible to infection (UNAIDS, 2004b). In rural Zimbabwe, for example, HIV prevalence was approximately 16% among teenage girls (15–19 years) whose last partner was less than five years older than themselves, but among girls with partners 10 or more years older, HIV prevalence was twice as high (Gregson et al., 2002). In Kisumu, Kenya, among women three years or less the junior of their husbands, none was found to be infected with HIV, but half the women with husbands 10 years or more their senior were HIV positive.

boredom and torpor (Jewkes et al., 2001). What makes these quests dangerous for so many is that they are played out not only in areas where HIV has firm footholds but also in circumstances marked by glaring gender and other inequalities.

Research is also confirming a strong association between sexual and other forms of abuse against women,^{iv} which increases the odds of becoming HIV-infected.^v The links between intimate partner violence and an increased likelihood of HIV infection, for example, appear solid:⁸ At antenatal clinics in Soweto, HIV infection was found to be significantly more common in women who had been physically abused by their partners than in those who had not been abused (Dunkle et al., 2004).

The HIV/AIDS epidemic is intertwined, in other words, with the circuits and terms on which power, authority, value and opportunity are distributed – highly unequally, in the case of South Africa.⁹ Many of these inequalities are still being reproduced along an economic growth path that favours high-end, skilled labour and requires the increased informalization of other tiers of workers (especially women) – all of this occurring within systems of social relations that saddle women with most of the responsibility for social reproduction (bearing, raising

and socializing children; managing the domestic realm; and providing care and other forms of support).

Points of reference

AIDS discourse tends to not shy away from hyperbole. The epidemic is typically portrayed as an exceptional, even unique, phenomenon. An unprecedented impact is anticipated, of an order comparable to or exceeding the upheavals of the 14th century or the famines and other disasters that beset parts of Asia and Africa in the 19th century. De Waal (2003b:7), for example, has claimed that ‘none of the existing models for disaster, whether they are based on plagues, famines, environmental disasters, or wars, match the specific character of the HIV/AIDS pandemic’. Whether or not that is correct, the spectre of disorder and collapse hovers about AIDS impact literature, much of it forecasting eventual disintegration in ‘vulnerable countries’ that are unable to cope with the epidemic’s effects.¹⁰

The distinctive features of AIDS are the concentrated toll it takes among young adults in the prime of their productive and reproductive lives, the fact that this toll tends to cluster

within households (with partners infecting each other and the virus also being transmitted to newborns), and the long-term momentum a serious epidemic can acquire. Famines and infectious diseases usually claim the lives of the weak and frail – the very young, the already sick, and the elderly. Natural disasters tend to be less discriminate, although they are usually geographically concentrated (the December 2004 Asian tsunami having been an exception).¹¹

Wars, too, are indiscriminate, although significant proportions of casualties are concentrated among males in their late teens to late thirties. Memorials in French villages, for example, still bear witness to the fact that in many thousands of small communities a significant proportion of their young men (mostly in their late teens and twenties) died during World War I. During the Rwandan genocide of 1994, almost one million Tutsis and Hutus (as much as one eighth of the population) were slaughtered in three months. During the four-year period that Cambodia’s Khmer Rouge regime was in power (1975–1979), an estimated 1.5 million of the country’s 7.9 million people perished amid the wholesale destruction of agricultural, transport, commercial and health infrastructure (Kiernan, 1996).¹² Along with the American bombing of Cambodia

8 HIV-positive women were more likely to have experienced a history of physical and sexual violence at the hands of male partners than were women without HIV, according to studies in Kigali, Rwanda, and in Tanzania (Van der Straten et al., 1998; Maman et al., 2002).

9 These are not the only factors that decide the pace and severity of a mainly heterosexual epidemic such as South Africa’s. Other possibly definitive factors include which HIV subtypes are dominant, the prevalence of other sexually transmitted infections which can aid HIV transmission, whether or not circumcision is commonly practised, the physiological vulnerability

of women (especially girls and young women), and more. The relative weight of these respective biological, physiological and sociological factors in specific settings remains a matter of supposition.

10 For a relatively restrained example, see Stabinski L et al. (2003) for an attempt to frame the AIDS epidemic in high-prevalence countries as a ‘disaster’, defined as a ‘serious disruption of the functioning of a society, causing widespread human, material or environmental losses which exceed the ability of a society to cope using only its own resources’ (p 1101). A more lurid example is a discussion paper ‘AIDS, economics and

terrorism in Africa’, which was issued to coincide with the 2005 gathering of the World Economic Forum in Davos, Switzerland (see below).

11 These are not entirely ‘indiscriminate’ disasters; poor communities usually bear their brunt.

12 There has been considerable controversy about the Cambodian death toll. Kiernan’s (1996) estimate of 1.5 million tallies with that extrapolated from several other surveys. Research suggests that several provinces lost 20% or more of their inhabitants.

(which is estimated to have killed at least 150 000 Cambodians, although possibly many more, in 1969-1973)^{vi}, this constituted the most systematic and concentrated obliteration of lives, institutions, infrastructure and developmental capacities perpetrated anywhere since World War II. The effects have been grievous and have seeped deep into Cambodian society, possibly eclipsing the aftermath of any pestilence anywhere in recent times.

The 'Spanish Lady'

The 1918-19 influenza epidemic killed more than 20 million people globally in just over six months (though some estimates put the toll at least twice as high).¹³ In India, the 'flu claimed an estimated 17 million lives, in France at least 400 000, while in the USA it killed at least 500 000 and possibly as many as 675 000 people, more than the combined number of American deaths in World Wars I and II, the Korean War and the Vietnam War (Kolata, 2000). In South Africa, it is estimated to have killed 140 000 people in late 1918, roughly 2% of the entire population (Simkins, 2001). In Alaska and parts of southern Africa, entire villages are said to have been wiped out. The epidemic struck with extraordinary speed and hit three distinct age groups hardest: infants and babies under five years, the elderly (especially those older than 60 years), and people between 20 and 40 years of age (Kolata, 2000). Mortality rates were high enough to cause shortages of coffins in Cape

Town, where some of the deceased had to be buried in mass graves (Kilbourne, 1987). In hard-hit cities, illness and death cut into business operations. The demographic shock was severe, but short-lived. Life expectancy in the United States of America, for instance, recovered to pre-epidemic levels within a year; in South Africa it took longer, although the impact appears not to have extended much beyond the early 1920s.

Middle passage

The search for reference points is perhaps better directed at the Atlantic slave trade, ramifications of which probably dwarfed the damage wrought by any famine or scourge in Africa. In 400 years (from the late 15th century to the late 19th century) some 18 million African slaves were exported from tropical Africa – most from West Africa and destined for the Americas and the Caribbean, but a significant number also transported via the Sahara Desert or Red Sea and from East Africa. Of this number, at least 9 million slaves were shipped across the Atlantic Ocean; at least one million more did not survive the 'middle passage', and an unknown number died before ever reaching the coast of Africa and before being herded onto ships.^{vii} The effects of the Atlantic slave trade have proved hard to assess^{viii}, although there can be little doubt that they were massive and prolonged. In Basil Davidson's view, 'the Atlantic trade had grown to such size by 1650 that for at least

two centuries it did unquestionably bring a major influence to bear on many coastal and near-coastal peoples from the mouth of the Senegal to the southern borders of Angola' (2003:219).

Long-term depopulation and demographic skewing were two of the effects noted. By the early 20th century African populations appear to have grown at a considerably slower pace than European, American or Asian populations. Those changes, however, cannot safely be attributed solely to the slave trade, as Davidson has pointed out. Colonial population estimates tended to undercount (as shown in Nigeria and Ghana, for instance), while the upheavals and invasions of the 19th century also took a horrible toll on many populations. Joseph Miller's study of the Angolan slave trade suggests that an average of 6 people per 1 000 were captured each year, compared to an estimated 50 people per 1 000 who died from disease and other natural causes.^{ix} Still, it meant that most sizeable communities could expect to lose at least one young man in each agricultural cycle or two – and the probability of kidnapping, capturing and enslavement lasted for centuries (Reader, 1998). Numerous African societies lost their best producers, the youngest and strongest of their men and women – not once or twice, but in successive generations over several centuries. The worst damage was inflicted on communities that were relatively small and economically weak, many of which disintegrated. In heavily raided areas, settlement patterns changed. The psychosocial effects of

13 The outbreak was known in Britain, Canada, France and the United States as the 'Spanish flu' – possibly because the epidemic received more press

coverage there, since Spain was not subject to wartime censorship – though in Spain it was known as 'the French flu', another example of

the tendency to lay calamities at the doors of others.

repeated, periodic raids, the violent separation of kin, and the disruption of authority systems are not known in detail, but must have been deeply traumatizing.

But the slave trade's most lasting and profound consequences did not stem directly from its demographic impact: they were more obtuse. Slavery transformed local economies and had a profound effect on the exercise – and usurpation – of political power. Able-bodied young men and women were removed from local economies and sold abroad for goods, creating a cycle of transactions and dependency that would change Africa's history. The trade commercialized local economies, even those that were not directly involved in the slave trade, creating a demand and eventually a reliance on imported goods. Local political economies warped, as warlords and merchants acquired the leverage to compel indebted chief and elites to capture slaves as payment for loans. The long-term consequences were severe:

Essentially, the Atlantic trade was a large and long-enduring exchange of cheap industrial goods, mainly cottons and metalware and firearms, for the 'raw material' of African labour [...] By providing Africa with cheap substitutes, the Atlantic slave trade under-

mined the local production of cotton goods and metalware; against the partial benefit of cheaper imports, it discouraged expansion from the handicraft stage [...] Above all, the overseas slave trade introduced and confirmed an underlying dependency that the colonial period was going to complete (Davidson, 2003:221).

The terms of Africa's dependence on European industrial economies and the basis for its chronic 'underdevelopment' were thus laid. The slave trade had shackled Africa to the economic imperatives and political ambitions of Europe (Reader, 1998). Comparatively little is known or understood, though, about the long-term social and sociocultural imprints the slave trade left.

If the literature on the long-term effects in Africa of the Atlantic slave trade remains thin on sociological detail, a cataclysm that occurred several centuries earlier in Europe has yielded, by contrast, a treasure trove of studies that hint at the kinds of ramifications AIDS might unleash.

'King Death'

The plague (or Black Death, as it later became known)¹⁴ which swept through western Europe between 1347 and 1351 was a singular, highly compressed shock – albeit on an unmatched scale. In four years, 'King Death' claimed an estimated 25 million lives, killing at least one third of Europe's population, and possibly halving England's population (Kolkata, 2000; Kelly, 2005).¹⁵ In some cities, such as Florence, between one half and three quarters of the population was wiped out. Although often seen as an indiscriminate epidemic, the plague – like almost all epidemics – was nothing of the sort, at least not in places like Oxford, where carefully maintained records showed a much higher mortality rate among the rural poor compared with the elites.^x

The plague shifted Europe on its foundations, with consequences that would alter the course of European history (Herlihy, 1997). Average life expectancy in western Europe prior to the Black Death was believed to have been around 35-40 years; in the second half of the 14th century, it fell below 20 years. It took some 100 years before Europe's population again began to grow, and more than 200 years before it reached its pre-plague levels.¹⁶

14 The phrase 'Black Death' was not used in the Middle Ages. Coined by Scandinavian writers in the 16th century, it entered into wide use only in the early 18th century, with the publication of a book titled *The black death* and written by a German physician; see Herlihy (1997).

15 The death toll remains difficult to peg with precision, and for obvious reasons. According to Herlihy (1997), local records suggest the populations of some cities and villages in England and Italy shrank by 70-80%. According to him, 'Europe about 1420 could have counted barely more than a

third of the people it contained one hundred years before' (1997:17).

16 Just as with AIDS, a minority position does question the primacy of the plague in the demographic and other disruptions witnessed in western Europe during that period. Focusing on an area of Normandy, France, Guy Bois developed a tantalizing Marxist analysis of the crisis, attributing it largely to a wider crisis in the social order (of feudalism, specifically), with the plague a subordinate factor. See Bois G (1984). *The crisis of feudalism: Economy and society in Eastern Normandy c. 1300-1550*. Cambridge

University Press. Cambridge; for a brief discussion, see Herlihy (1997:35-38). Parts of the 'denialist' camp in South Africa seem similarly inclined, although their contributions have not yet ventured beyond the declamatory phase. Lacking a conceptual framework, analytical rigour and an informed engagement with the various types of data such an undertaking would require, the 'denialist' output – for all its pretences of excavating the social and political-economic undercurrents of the AIDS crisis – remains largely intellectually barren (see below).

Demographic ruptures of such intensity conceivably would have badly damaged institutions, particularly those reliant on highly skilled persons. Yet the picture seems mixed. At the height of the plague, universities were still being founded (in Florence, for example) or expanded (Cambridge established Trinity Hall and Corpus Christi College in 1350 and 1352 respectively). In the decades immediately after the plague, universities continued to be set up, including in Cracow (Poland), Orange (France) and Vienna (Austria) (Pennington, 2005).

More generally, as David Herlihy (1997) has shown, the routines of work and service were upended, as the high death rates left posts vacant and services unfulfilled. The volumes of land under cultivation shrank due to labour shortages which, with dramatic effect, also forced landowners to revise the terms of their relations with labour tenants and other workers. Agricultural rents collapsed and the wage demands of workers (especially those of artisans and other skilled workers) soared (Herlihy, 1997; Cantor, 2001). Not only did the labour market change, but the status and power of its various strata radically altered as greater possibilities for social and economic mobility opened up in rigidly stratified societies. Some forms of discrimination were temporarily abandoned due to the need to maintain essential services. Growing demand for the services of priests and physicians opened the way for new entrants into those ranks, some of them brazen charlatans and others (like women physicians) path-breakers. Grudgingly, the Church

acceded to women performing pastoral functions or administering sacraments, while in the courts, women were for the first time allowed to serve as witnesses.^{xi}

The ranks of craftsmen and other professionals were drastically thinned, and the professions responded by vigorously recruiting new members. That meant relaxing rules of admission, with guilds spreading the 'net broadly and bring[ing] in new apprentices with no previous family connection with the trade' (Herlihy, 1997:45). Incrementally, in such ways, the wedge of social transformation worked its way through society. In the longer term, the ructions were much more dramatic, for the Black Death 'let loose hectically intense social pressures which the old-order conservatism could not contain' (Rissik, 2005). The fuse of the English Peasants' Revolt of 1381, for instance, was lit when landowners convinced Parliament to impose controls they hoped would reinforce their control over peasants.¹⁷ More generally, the plague divided, separated and polarized. In Herlihy's summary:

The plague caused divisions between the healthy and the sick; between those in the cultural mainstream and those at its margins ... and between the mass of society and its cultural leaders, its governors, priests, and physicians. These fissures cut across society in complex and at times pernicious ways ... (1997:59)

Herlihy, rather grandly, maintains also that the labour shortages caused by the plague accelerated the quest for and the introduction of new, labour-saving technologies, especially in agriculture. This is moot. In silk and wood manufacture, the big technological advances preceded the Black Death, as did the development of new types of scythes and more complex field systems.^{xii} Nonetheless, the changes that can plausibly be traced to the plague's decimating passage were clearly momentous and echoed down the centuries.

Seldom considered in the context of AIDS is how the epidemic might play itself out in non-material – or ideological – realms. Shocks this extreme enflame doubt, invite 'heresy' and provoke rebelliousness. The dialogues that ensue are personal and intimate but also lewdly public – and they tend to drift in two directions: secular skepticism and rebellion in thought (if not deed), and millenarian or 'apocalyptic' faith. Common to both is a suspicion and possibly even a rejection of orthodoxy and of hegemonic ideology. Like AIDS currently, the Black Death in western Europe encouraged 'popular distrust of expert opinion, particularly of the medical profession, and ... led more forcefully to suspicions, fears and hatreds of the alien', as Samuel Cohn has observed.^{xiii} As to the actual cause of the cataclysm, exotic accounts did the rounds. Academics at the medical faculty of the University of Paris, under orders from the monarchy, contrived a meticulous astrological explanation for the plague: 'With a careful thesis, antithesis, and proofs,' Barbara

17 The immediate trigger was the levying of a third poll tax, but the revolt was long in the making, with the 1351 Statute of Labourers having caused

lasting resentment. Designed to curb workers' demands for better pay and working conditions, the Statute was used to fix wages and limit the

mobility of labour, and was viciously enforced.

Tuchman (1978) wrote, they 'ascribed it to a triple conjunction of Saturn, Jupiter, and Mars in the 40th degree of Aquarius said to have occurred on March 20, 1345.'

However, the more popular view, adamantly promoted by the Church, was that 'King Death' was nothing less than the wrath of God, unleashed to quell sinfulness. This strengthened the hand of social reaction, while filling Church coffers. In France, donations to religious institutions rose by 50%, while in England about one quarter of all willed estates went to the Church. Roaming groups of flagellants reformed, initially with the Pope's blessing, preaching virulent anti-Semitism on their treks before they were disbanded by the military arm of the Church. Other cultural and ideological shifts ensued, for by the early 14th century already, the all-encompassing authority of organized religion was not everywhere associated with beneficence and goodwill. For many, the plague further indicted the Church, its mandarins and the worldview they peddled. Some historians have drawn links between 'King Death' and the rise of anti-clericism and the emergence of puritan sects in England, for example (Kelly, 2005). Others even trace some of the early stirrings of the Enlightenment,

and specifically the tradition of skepticism that fed it, to the 'Great Mortality'.

On the eastern flanks of the Mediterranean and in Asia Minor, meanwhile, societal reactions were different. Political elites escaped the kinds of popular challenges seen in parts of western Europe. The plague did not feed off factional rivalries, nor did it foster xenophobia and waves of anti-Semitic pogroms as it did throughout western Europe.^{xiv} This highlights the importance of the underlying social and political-economic conditions in societies battered by crises such as this. The plague penetrated every cranny of society, but in doing so it also interlaced with social dynamics. Dislodging it from that tangle of interactions is difficult, perhaps not feasible: 'From the matrix of forces shaping the late medieval world, it is impossible to factor out those attributable to plague alone' (Cohn in Herlihy, 1997:19).¹⁸

Search for meaning

Humans find it difficult to think of epidemics as phenomena that 'happen', as opposed to phenomena that are 'made' or

perpetrated.¹⁹ This is understandable. Senselessness or arbitrariness on such a devastating scale unhinges us. We seek order and meaning, and insist on detecting and plotting patterns in apparent randomness. And so, plagues are often interpreted as forms of reckoning, a spiritual accounting or a balancing of scales. Or they attract suspicions of insidious intent. Throughout modern history, new diseases have been answered with a hunt for scapegoats. Once the 14th century plague, which probably originated on the Central Asian steppes, arrived on the shores of mercantile Europe, for instance, the afflicted clung confidently to the belief that it was being spread deliberately.²⁰ Intricate conspiracy theories were spun, fed with false confessions obtained under torture.²¹ The eye of suspicion fell on lepers and other social outcasts, but settled most firmly on Jews, and to tragic effect. Pogroms swept across western Europe; more than 350 massacres of Jews were recorded during the Black Death. 'As ever', as Andrew Rissik observes, 'what matters wasn't what was true, but what seemed at the time to make wider sense'. And so it is with AIDS, too. Swirling about it is an obdurate suspicion that something this ghastly and relentless cannot be mere happenstance, even that HIV was a deliberate concoction, designed to exterminate blacks.

18 Mary Lindemann has issued the same caution, pointing out that it was very difficult to disentangle 'the effects of the plague from the other factors' at work in a century marked by 'endemic warfare, famine and declining populations even before the plague hit'; see Lindemann M (1999). *Medicine and society in early modern Europe*. Cambridge University Press. Cambridge, p 43.

19 The impulse is especially prominent in philosophical traditions in which the principle of culpability is prominent. Random mishap and misery, lacking apparent purpose and the hand of agency, is both bewildering and unsatisfactory. Blame has therefore tended to accompany disease. Usually

the blame is directed at the Other, sometimes at the victims themselves, although sometimes the victims and the Other are one and the same – as with India's great cholera epidemic, which killed probably 25 million people in the mid-19th century. There, the colonial government attributed the outbreaks to the 'local sanitary imperfections' that derived in the main from the 'filthy habits' of Indians. For more, see Watts S (1997). *Epidemics and history: Disease, power and history*. Yale University Press. New Haven.

20 Among the lore of the Black Death there is one instance where the plague indeed seems to have been spread purposively. When Mongol soldiers attacking the trading hub of Caffa (or Kaffa), on the eastern rim of Crimea,

in the early 1340s succumbed to the plague, their general reportedly ordered that the corpses be hurled into the city, in the hope that this would infect the defenders.

21 The 'confession' by a Jewish surgeon, Balavigny, in Switzerland, proved particularly enthralling. His claim – that he had poisoned 'Christian' water wells with the pestilence – provided enticing texture to the conspiracy theories, which proceeded to decipher the plague as a Jewish plot for world domination, masterminded by a Spanish rabbi. See Joan Acocella, 'The end of the world', *The New Yorker*, 21 March 2005.

The circuitry of 'denial'

Infectious diseases are met instinctively with attempts to demarcate danger and safety. These are cleaving maneuvers that seek to distinguish the 'pure' from the 'contaminated', typically by ascribing to people traits, behaviours and motives that either guard against or invite affliction. It is in order to establish and police these perceived boundaries that social strictures are imposed and disciplinary forays are mounted. Victimization and polarization typically rank among the outcomes. There's nothing 'innocent' about these reactions. Invariably they also express other contests, ambitions and resentments. Look hard enough, and they betray their eminently political nature.

All this is plainly evident with AIDS, not just in the stigmatization of people living with HIV and the abandonment of those succumbing to AIDS but also in the virulent tendency to regard and treat women as vessels of contagion and 'disease-carriers'. This is in keeping with the long, squalid history of male imaginings of the female – in which the nurturer/whore, angel/witch dichotomies, and the association of

women's bodies with impurity and contamination retain their prominence. It's a disquietingly global phenomenon that is firmly lodged in South Africa too. Women are deemed to be the ones 'who bring AIDS into the home'. The fact that it is often women who are the first to discover their serostatus – usually once pregnant – grants this prejudice even more reflexive force.²²

In a persecuting society such as South Africa, awash with racialized intolerance and fearfulness, it is no surprise that popular understandings of AIDS should also be coloured with racist assumptions that draw on entrenched stereotypes and prejudices. Central in this have been the 'pathologizing discourses' in which black sexuality is constructed as rampant, unbridled and insatiable. These acquired their initial outline during the early periods of colonialism, and have featured strongly since also in medical science – with extraordinary luminosity during South Africa's syphilis panics of the 1930s and 1940s, for example. For many whites, those scares reinforced stereotypes of black African men as voracious and insatiable sexual predators, a staple of racist prejudice. Similar imagery has circulated in AIDS discourse (Walker et al., 2004). These kinds of imageries of black Africans have served as a

screen against which Western cultures have constructed their own, contrasting self-portraits which boast of restraint, purity, calculation and rationality, as Fanon famously observed.^{xv}

The linking of race, libido and death in colonialist discourses – and the apparent complicity of medical and social science in this – still resonates loudly in South Africa. It hovers as a kind of 'contemporary past', as histories that refuse to relinquish their footing in the present,^{xvi} as President Mbeki noted in late 2004:

I, for my part, will not keep quiet while others whose minds have been corrupted by the disease of racism, accuse us, the black people of South Africa, Africa and the world, as being, by virtue of our Africanness and skin colour – lazy, liars, foul-smelling, diseased, corrupt, violent, amoral, sexually depraved animalistic, slaves – and rapists.²³

Earlier, in April 2002, Mbeki had described what he saw as a fundamental tension between the realities lived by black Africans and the images circulating in the domains of Western science:

22 The fact that HIV estimates in sub-Saharan Africa have been based largely on the testing of anonymous blood samples drawn from women attending antenatal clinics probably has inadvertently reinforced this blaming association between women and the spread of HIV.

23 See Thabo Mbeki, 'Dislodging stereotypes' (Letter from the President), *ANC Today*, 4(42), 22-28 October 2004. Available at <http://www.anc.org.za/ancdocs/ancoday/2004/at42.htm>. President Mbeki was reacting in Parliament to a question from an opposition Democratic Alliance politician about HIV/AIDS and the role of rape in the epidemic. The response, which runs to three pages of text, makes only cursory reference to

HIV/AIDS and to rape – the latter referred to as a 'contact crime', a clinical choice of language that contrasts with the impassioned declamations about race and racism. There's a hint here of one of the overlooked hallmarks of South African 'denialism' – the overbearing male-ness of a discourse that is typically silent about gender injustices and inequality, and their role in the epidemic. At its core, this is a discourse by men about men, with women a shadowed presence. Lisa Vetten's remarks about President Mbeki's statements on rape seem apt here: '[I]n repeatedly and exclusively confining the debate to African men, Mbeki is deflecting attention away from the sexual predatoriness [sic] of men generally, regardless

of colour ... not once in these debates have the words "gender inequality" appeared in the President's writings or utterances. In *ANC Today* he writes only in the most general terms about "contact crime" (rather than rape) and ascribes the causes of these crimes to poverty and community degradation. No onus is placed on South African men generally to examine and change their unequal relations with women.' See Lisa Vetten, 'Mbeki and Smith both got it wrong', *Mail & Guardian*, 29 October – 4 November 2004. Available at <http://www.csvr.org.za/articles/artvet15.htm>.

Because of the pursuit of particular agendas, regardless of the health challenges facing the majority of our people, who happen to be black, in our country there is a studied and sustained attempt to hide the truth about diseases of poverty.

If we allow these agendas and falsehoods to form the basis of our health policies and programmes, we will condemn ourselves to the further and criminal deterioration of the health condition of the majority of our people. We cannot and will not follow this disastrous route. We are both the victims and fully understand the legacy of centuries-old and current racism on our society and ourselves.

We will not be intimidated, terrorised, bludgeoned, manipulated, stampeded, or in any other way forced to adopt policies and programmes inimical to the health of our people. That we are poor and black does not mean that we cannot think for ourselves and determine what is good for us.^{xvii}

Around the same time, a bilious tract titled 'Castro Hlongwane, caravans, cats, geese, foot and mouth, and statistics' flamboyantly declaimed on similar themes. Distributed in senior structures of the ruling African National Congress (ANC) by Peter Mokaba (now deceased) but, according to some reports, penned with possible involvement from president Mbeki,²⁴ it dismissed the 'HIV/AIDS thesis' as:

informed by deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people [...] Driven by fear of their destruction as a people because of an allegedly unstoppable plague, Africans and black people themselves have been persuaded to join and support a campaign whose result is further to entrench their dehumanization (Anon, 2002).

Casting the government in the role of victimized heretic, the screed junked 'as baseless and self-serving the assertion that millions of our people are HIV-positive' and rejected 'the claim that AIDS is the single largest cause of death in our country' (Anon, 2002). Stirred in were calls for defiance against 'the omnipotent apparatus'²⁵ that allegedly seeks to dehumanize

Africans by recycling racist prejudices about 'African sexuality' and stoking unwarranted panic about AIDS.

Interventions of this sort confirmed that memories of encounters with colonial power and science linger strongly. One example was the rinderpest epidemic that struck the east coast of South Africa in late 1896. Following on the heels of 'natural' setbacks (including droughts),^{xviii} rinderpest scythed through black and white cattle-farming communities in what was then Natal and Zululand. Dubbed *umaqimulana*, the disease felled huge numbers of cattle, and prompted various responses. On the one hand, there were attempts to enforce customs deemed to shield against this apparently supernatural force; on the other hand, there were the panicked demands from white commercial farmers that the contagion be halted before it also decimated their herds.²⁶ If the quarantine measures applied by the authorities were resented, the subsequent vaccination of black-owned cattle by roaming teams of veterinarians, court officials and police stoked angry distrust about the true motives of the exercise. Western medical science was being experienced as an invasive and destabilizing force. The fact that vaccinated cattle showed temporary symptoms of rinderpest, and that the most

24 Electronic versions of the document reportedly bore an embedded signature which suggested that they were written on President Mbeki's computer. Some of the pamphlet's themes were elaborations of points made in a December 2000 letter attacking the head of the Medical Research Council, Dr Malegapuru Makgoba, for not siding staunchly enough with the Presidency on HIV/AIDS and antiretroviral treatment controversies. Ostensibly written by Limpopo province premier Ngoako Ramatlhodi, the letter, however, reportedly bore the same embedded electronic signature as the pamphlet. (An electronic signature, however, does not constitute conclusive proof of authorship.) See Howard Barrell (2002). 'Would the real AIDS

dissident please declare himself'. *Mail & Guardian*. 19 April. Available at <http://www.aegis.com/news/dmg/2002/MG020419.html> (accessed 7 April 2005).

25 This 'apparatus' is deemed responsible for the 'pressures that are directed at serving particular commercial and political interests at the expense of the health of our people' (Anon, 2002). As the author(s) pointed out, the 'omnipotent apparatus' phrase had been drawn from Herbert Marcuse's book *Eros and Civilisation*, in which the political philosopher wrote of 'a period in which the omnipotent apparatus punishes real non-conformity with ridicule and defeat'.

26 By some accounts the rinderpest had a hand in changing social attitudes and behaviour, especially of young women. By denuding the social and material capital that cattle represented, the disease shifted social relations. For many, 'lobola' or bridewealth became unaffordable and this released some women from the regimented strictures of the prevailing social order. Elders complained of rising promiscuity among women, which some feared would prolong the epidemic. A romanticized past of purity, discipline and obedience was ruptured. For literature details on this trend, see Carton (2003) footnote 32.

effective serum at the time protected cattle for only four months (after which the beasts were again susceptible to infection) deepened suspicion about this 'white man's disease' (Carton, 2003:4).²⁷ Measures ostensibly taken to 'protect' blacks seemed to achieve the opposite, leaving them worse off.

The distrust shaped reactions to flu vaccination efforts in the Eastern Cape during the 1918 influenza epidemic, too. Carton (ibid), for example, cites references to the vaccine as a genocidal tool, 'a device of the Europeans to finish off the Native races of South Africa, and as it had not been quite successful, they were sending out men with poison to complete the work of extermination'. The parallel with claims circulating on the fringes of AIDS skepticism are obvious.²⁸

In the decades that followed, the use of science-based knowledge by the authorities in South Africa intensified. Sometimes it took the relatively 'neutral' form of promoting new cultivation, irrigation or contouring techniques in agriculture or livestock vaccination requirements. But it was also expressed as a blend

of racism and Malthusianism that gave rise to the apartheid state's 'family planning' initiatives among black South Africans. In extreme fashion, it would manifest in the chemical and biological warfare experiments of Wouter Basson, and his search for ways to surreptitiously induce infertility in black South Africans.²⁹

Just as South African history has fed a fervent suspicion about disease, science and power – and the loathsome ways in which they can be made to converge – AIDS has come to function as a kind of prism, vividly focusing these discursive trends and inviting the 'denialism' of which President Thabo Mbeki and others in the ruling African National Congress have been accused.

President Mbeki did not invent this tendency when, in 2000, he set about questioning the casual relationship between HIV and AIDS. The doubts dated back at least a decade, and had fuelled numerous rumours, including the stalwart claim that HIV had been concocted in laboratories and was part of a plot to exterminate blacks.^{xix} But nowhere else were the

doubts issued from such lofty heights, and with such insistence. By first 'legitimizing' and then politicizing errant doubts, President Mbeki and his circle of skeptics seemed to modify them into gestures of 'dissidence' and 'rebellion'. Indeed, Schneider and Fassin (2002:549) have read South African 'denialism' as a form of 'defiance' against 'official scientific knowledge' and an 'identification with those on the margins, whether of science or society'. But there is a strong case for arguing that it is both less and more than that. While there has no doubt been a pretence of broadcasting necessary and 'courageous' truths, these poses have been struck in the highest office in the land and from within the heart of the state. More appropriate than the folksy image of the underdog squaring off against massed power would be comparisons with other occasions when the state backed quack science (such as the Lysenko debacle of the 1930s, and the dogged interventionism of the George W Bush administration).³⁰

Although part of a wider reaction against the contumely, denigration and exploitation that Africa continues to endure, South

27 Medical science generally was an important adjunct of colonial projects, especially after the rise of bacteriology, which made possible the development of relatively effective drugs and treatments for many afflictions encountered in Africa, Asia and the Americas. England's London School of Hygiene and Tropical Medicine and France's Pasteur Institute were particularly active on those fronts.

28 Noteworthy, too, was the prophet Nontetha Nkwenkwe's claim that the epidemic was divine punishment for sexual promiscuity and debauchery (Carton, 2003). There were many other examples where public health measures seemed indistinguishable from other efforts to extend the control of the colonial (and later, the apartheid) state over black South Africans, including the 'deverminisation' campaigns in Durban and the clearly discriminatory quarantining operations during an outbreak of the plague. See Youde J (2005). *South Africa, AIDS, and the development of a counter-*

epistemic community. Paper prepared for the 2005 International Studies Association Conference. 1-5 March. Honolulu.

29 The analogy was not lost on President Mbeki who, in 2000, reportedly railed against South Africans being used as 'guinea pigs' for dangerous antiretroviral drugs which he likened to 'biological warfare of the apartheid era'. He was referring to the provision of the drugs in the Western Cape, at that stage governed by the opposition. As we observe below, AIDS 'denialism' has been used routinely as a party political tool, at all ends of the spectrum. Mbeki's remarks in this case were made shortly before the municipal elections. See Drew Forrest, 'Behind the smoke-screen: The record reveals President Thabo Mbeki's true stance on AIDS', *Mail & Guardian*, 26 Oct 2000.

30 Reflecting on his experiences as Medical Research Council president, Dr Malegapuru Makgoba in 2002 suggested as much: 'The politicization of

scientific research, trying to do research according to political ideology and along party political lines, and trying to manage, recruit and appoint staff along these lines have never worked successfully anywhere where excellent science is being done. This approach has been a death knell to science [...] Innocuous as it may currently appear, the long-term effects of this are devastating and will take too long to rectify. I think it is therefore critical that we nip this pernicious problem in the bud early on. These are the challenges I faced and resisted and will resist for as long as I live. We should always remember what Lysenko did to Soviet science and the future generation of Soviet scientists.' See 'Dr Makgoba – a passion for excellence', *MRC News*, August 2002, Vol 33 No 4, p 6. Available at <http://www.mrc.ac.za/mrcnews/aug2002/makgoba.htm>. For a caustic summary of the Bush administration's conduct, see Mooney C (2005). *The Republican war on science*. Basic Books. New York.

African 'denialism' is of a 'special type'. It has adopted the idiom of Afro-nationalism, and a vestigial 'third world-ism' of the sort that achieved ascendancy in the two decades following the 1955 Bandung Declaration.^{xx} Its axial concepts therefore are race, colonialism and sovereignty. Around this has erupted a swirl of thinking that also touches on other vital questions, including the ethics and practices of transnational pharmaceutical corporations, the credibility and politics of scientific enterprise, even the very authenticity of reality. 'Denialism' draws on an array of traditions – including that of national liberation (and, with it, the paternalist relationship national liberation movements have fashioned with 'the people' and 'the masses'), analyses of the exercise of power in capitalist society developed by Marxist intellectuals associated with the Frankfurt School, critiques of Enlightenment-based knowledge marshalled within post-colonial theory, and more.³¹

Questioning and critiquing the accuracy of information and dominant understandings of HIV/AIDS have served as a prelude not for refining and acting on that knowledge but for denying the epidemic's very existence. This should not surprise us. For the rhetoric and sensibilities that have evolved into the 'denialism' associated with President Mbeki and others in the African National Congress government are only nominally about AIDS, science and poverty. To considerable extent, 'denialism' func-

tions as a grammar for other, overarching *political* engagements and pursuits. And AIDS serves such an enterprise not as a mere pretext, but because it draws into focus so many outrages and injustices.

'Denialism' functions, in the first instance, as a platform for pinpointing, denouncing and attacking racism. In this sense, AIDS has provided a necessary vent for the righteous but sublimated anger that was bottled-up during the 1990s, when it was subordinated to the imperatives of stability, conciliation and calm. The eruption of 'denialist' discourse reflects what seems like a shift from that interlude – with its bewildering silences and maddening overtures that seemed to suspend history itself – toward a more forthright confrontation with realities that cannot yet be consigned to the past. That shift should not be exaggerated, though. The chidings directed at business have been rare and delicate, for example, while the historical and contemporary crimes of capital have encountered little of the wrath unleashed around AIDS. To an extent then, 'denialism' seems to be doing service also as a substitute or a vehicle for other confrontations and condemnations. In this role, it fulfils an ideological function alongside other discursive devices that are designed to shore up affinities, loyalty and solidarity among the constituents of the ANC.^{xxi} It spotlights the ignominy that has marked so much of South

African (and African) history, condemns racism and the ongoing injustices and indignities that millions endure, and advertises a determination to vanquish those blights.

Yet all this occurs against a background of policies, many of which demonstrably prolong and fortify the reproduction of inequality and circumstances of indignity. It happens alongside inscrutable accommodations with (former) administrators and beneficiaries of institutionalized racism. And it accompanies the embrace of (Western) consumerism and acquisitive zeal. As such, 'denialism' fits into a discursive project the ANC has proved especially adept at: blending the 'old' with the 'new', the orthodox with the heterodox, and employing sometimes-radical principles and perspectives associated with national liberationism in the service of conventional, sometimes-conservative agendas.^{xxii}

South African 'denialism' also has a more literal, 'profane' political heritage. Soon after the country's democratic era began in 1994, critics of the new government settled on AIDS, crime and violence as their preferred routes of attack. A series of debacles in 1995-1997 seemed only to highlight the vulnerability of the ANC government on this front. The lights had hardly dimmed on the Sarafina controversy when the government's apparent endorsement of virodene hit the headlines.

31 In fact, the arguments draw on discrepant philosophical traditions. On one hand, the reliability and veracity of HIV/AIDS estimates are challenged from within the empirical tradition, with observed and, if possible, enumerated facts deemed to constitute truth (see below). At the same time, the critique of scientific integrity mounted by 'denialists' fits also with the post-modernist enterprise of dismantling the idea of 'truth' and

demonstrating the intimacy of 'truth' and hegemonic power. Science is deemed to pursue 'truth' in line with the logic and requirements of capital, in this view, and is thoroughly instrumentalized. Such critiques of science's instrumentalization-subordination even-to the imperatives of capital accumulation owe much to the work of Herbert Marcuse and other Frankfurt School alumni. For a bracing overview of this tradition,

written from a Marxist perspective, see John Bellamy Foster's 'Science in a skeptical age', *Monthly Review*, 50(2), a review of John Gillot and Manjit Kumar's book *Science and the retreat from reason* (Monthly Review Press, 1997).

Then came the disputes about the side-effects of zidovudine, with then-deputy president Mbeki wading into the fray (Marais, 2000).^{xxiii} Conservative political opponents and the largely unreconstructed mainstream media prodded and pierced with relish. Soon another twist was added. As the government wheeled out its prevention-focused Presidential Partnership Against AIDS in 1998, the clamour for an antiretroviral treatment programme commenced (Schneider & Fassin, 2002).

Initially focusing on mother-to-child transmission (MTCT), and spearheaded by the Treatment Action Campaign (TAC), that quest soon dovetailed with a dogged international campaign, led by AIDS, health and social justice activists and targeting pharmaceutical corporations, G8 leaders and recalcitrant governments alike. Assailed by the left for pursuing a neoliberal economic programme, and now challenged from all ends of the political spectrum for allegedly disregarding the lives of its citizens, government's reactions grew ever more livid. It is as if this indignation blurred perspective, allowing the wispy outlines of conspiracy to enter fields of vision. By 2000, what might have been a measured debate had degenerated into a brawl. The fact that AIDS had become the mobilizing issue for an avowedly progressive and, as it quickly became clear, tactically savvy formation seemed especially wounding. Here was a burgeoning social actor with the nerve to challenge the government in the name of that government's constituency. Soon after the TAC launched a court application to force the

roll-out of nevirapine to reduce MTCT, it found itself at the receiving end of contumely seldom directed at other targets:

Thus does it happen that others who consider themselves to be our leaders take to the streets carrying their placards, to demand that because we are germ carriers, and human beings of a lower order that cannot subject its passions to reason, we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease ...^{xxiv}

Beyond this, 'denialism' operates also within a wider orbit that transcends South Africa – an Afro-centric project of recuperation, usually termed an African Renaissance. By simultaneously denouncing racism and (neo)colonialism, by affirming Africans' right and duty to describe their own realities and define their own futures, by rejecting the imageries of Africa circulating in and by the West, and by contrasting this with a romantic and unsullied past, denialism in South Africa sits snugly within the ideology of an African Renaissance. All this bristles with tantalizing contradictions. The concept of self-reliance, for example, is a product of the Enlightenment. By the end of the 20th century, though, it had been morphed and appropriated within post-colonial discourse as part of an explicit and trenchant critique of Enlightenment thought and its instrumental value in colonialism. Afro-centrism, too, sits firmly within the binary framing of reality that constitutes

one of the pillars of Enlightenment thought³² – even if, subsequently, it found a new oppositional lease of life in relativist thought. Within African Renaissance ideology, 'self-reliance' acquires further contradictions. There it is incongruously – though without apparent damage – hitched to a push for deeper integration into a harshly skewed and unequal global economy, and to acceptance of 'good governance' and related conditionalities required by Western donors.^{xxv}

But that is to quibble. Part of the appeal of 'denialism' resides in the fact that it incorporates important and heartfelt critical impulses that resonate in progressive traditions. The eclectic philosophical heritage of 'denialist' argumentation, for example, does not scupper the assertion that science, in many respects, is enlisted in and sometimes positively indentured to the quest to maximize profits.³³ Similarly, when the Presidential AIDS Advisory Panel convened by President Mbeki is tasked, among other things, with examining the 'prevention of HIV/AIDS, particularly in the light of poverty, the prevalence of co-existing diseases and infrastructural realities in developing countries' it is difficult to demur without seeming to favour a narrow-minded view that ignores the sociology of disease. The importance of impoverishment and inequality in South Africa's epidemic is not invalidated because 'denialists' try to displace the causal relationship between HIV and AIDS with those factors. Indeed, there seems little to dispute in a thesis that positions HIV/AIDS as an exceptionally devastating aspect of a larger, enfolding and

32 The very *idea* of 'Africa' can be said to be a by-product of colonialism – by way of the struggle against colonialism.

33 It is not only within capitalism that science has been instrumentalized, as the infamous Lysenko affair of the 1930s in the former Soviet Union

reminds. In that case, science was yoked to the programmes of particular political factions within the state.

ongoing outrage (much as Pierre Bois attempted to do with his revisionist history of 14th century Europe and the Black Death – see above). The epidemic and its impact are inextricably interlaced with the ways and the terms on which power, rights, resources and opportunities are distributed in society. The problem, of course, is that South Africa's 'denialist' politicians do nothing of the sort: they go the whole hog, and deny the epidemic exists. They follow through not with defiant plans for dismantling the socio-economic and sociocultural causes of this wave of mortality, but with a staid determination to stay the course of economic orthodoxy, leavened with Keynes-lite 'deviations'.

Squaring circles

A central weakness of AIDS 'denialism' is that it can't resist the pull of conspiracy theories. While the 'Castro Hlongwane' screed, circulated in the ANC in early 2002 (see below), succumbed enthusiastically, even more careful efforts have tilted toward the notion that HIV and AIDS estimates have been deliberately inflated and that even those scientists who are alert to the distortions don't 'fess up' for fear of being banished from the sumptuous brotherhood of an 'AIDS industry'.

The reasoning runs something like this: Estimates vary, sometimes widely, which betrays a lack of certainty.

If we can't achieve certainty, then surely the door must be held ajar for other possible explanations. But, one might ask, explanations of what exactly? Not, as it transpires, explanations of the technical and other reasons for differing estimates. Rather, the grasp is more ambitious: uncertainty is seen as proof of, at best, reckless guesswork and, at worst, fraud and deceit – all rooted in the residue of racism and contrived by vested interests and their lickspittles in science, duped activists, the media, and all manner of other 'convenient fools'.

A special role is reserved for the pharmaceutical industry, seen as intent on seizing the vast profit-raking opportunities that antiretroviral provision in Africa represents. Such an arrangement might well provide a healthy motive for skullduggery and deceit. Although antiretroviral drugs feature nowhere near the industry's top earners in industrialized countries, the sheer volume of need in Africa could change that, especially if treatment roll-out is financed through donor subsidies and grants – or so the argument implies. It's odd thinking for people, many of who have had at least a brush with Marxist theory. The market's remarkable capacity to absorb and capitalize on change – whether trivial, threatening or tragic – is a function of its systemic logic, its need to engulf and digest everything in its path. It doesn't require a vast conspiracy – akin to faking a moon landing on a Hollywood soundstage – that involves 'inventing' an epidemic and, almost 15 years

later, marketing 'quack', 'life-threatening' drugs as an effective form of treatment, in order to boost pharmaceutical turnover by a fraction. In reality, from the major pharmaceutical corporations' vantage, Africa merited scant interest as a market for antiretroviral drugs: Africans who needed the drugs *and* could pay for them constituted pitifully feeble demand.

Pharmaceutical corporations were not all that keen on going to Africa; instead, Africa was brought to them. In the late 1990s, global activist demands for antiretroviral provision in Africa were creating an international public relations nightmare for those corporations, which had never quite managed to scrub the muck from their reputations. By 2000, the industry found itself lumbering in the path of several developments. One was the prominent place health and disease had assumed on progressive activist agendas around the world; in fact, not since the infant formula debacles plaguing Nestlé in the 1970s and 1980s had public health kindled such blazing resolve in international activism. Health and medicines were again being recognized as an important terrain on which to contest inequality and injustice. Alongside this came the burgeoning opposition to the drive to codify global regulatory regimes in ways that would unabashedly service the accumulatory needs of transnational capital. Foremost among these was TRIPS (the Agreement on Trade-Related Aspects of Intellectual Property Rights). For pharmaceutical corporations

especially, a new patent regime was a strategic imperative, a gateway for achieving and preserving more securely key monopolies in a sector that was beginning to lift the lid on a Pandora's box of money-spinning discoveries. AIDS – and especially antiretroviral provision in Africa – marked the spot where those respective agendas clashed. To its dismay, the industry was thrust centre-stage in this drama, and cast, convincingly and justifiably, as a heartless ogre of mammoth proportions. If anything exemplified the case of the global social justice movement, it was the routine disdain with which pharmaceutical corporations put profits before people in Africa. This wasn't just a run-of-the-mill public relations hiccup; at risk was a vital strategic objective of achieving an intellectual property rights regime that could boost and safeguard major corporations' growth in the 21st century.

Those were the real stakes for the industry – not the marginal rise in turnover it could wrench from a continent where lack of affordability so firmly thwarted demand. For them antiretroviral drugs and Africa had

ended up spelling trouble.³⁴ The compromise – facilitated by the G8 powers – was to relent to activist demands that antiretroviral prices be trimmed in Africa and other 'developing' regions, loosen some shackles on generic production, and accept the conditional relaxation of some TRIPS strictures (at the 2002 Doha round of the World Trade Organization).

Limits of understanding

Our knowledge of the HIV/AIDS epidemics is sufficiently solid to provide a firm and confident basis for understanding, yet not sufficiently developed to enable untangling their many remaining mysteries.^{xxvi} This absence of seamless certainty, and the quest for it – an endless to and fro – is one of the hallmarks of science. It is also a perennial feature of epidemiology. The rapid spread of the 1918 influenza virus, which in North America (for instance) seemed to out-sprint returning service men and women, long baffled scientists (Kolota, 2000). Even the debate about what exactly caused the Black Death continues.^{xxvii} The comparative rareness of pneumonic plague still puzzles; so, too, the reasons for its often-sudden arrival

and departure. In this absence of certitude, combined with the confidence that it can be filled, that has provided modernity with its dynamism.

Presented as the linchpin of the 'denialist' argument, the disputes over the accuracy of HIV and AIDS estimates are something of a Trojan horse. In casting doubt on the estimates, the aim is not to identify or achieve a more accurate picture of the epidemic but to demonstrate its alleged fraudulence. The lack of absolute certainty is transformed into a refutation of the knowledge that *has* been assembled.³⁵ The fact that some questions remain unanswered cannot serve as grounds for dismissing those answers that have been arrived at; by such reasoning, the entire edifice of science should be dismantled.³⁶

And yet 'denialism', reckless and damaging as it has proved to be, has served a useful purpose. It has illustrated how phenomena as traumatic as AIDS inevitably serve also as arenas for contests between rival systems of knowledge and rival claims to 'truth'. It has shown that those skirmishes are always also distillations of other political and ideological struggles. And it has reminded us that scientific endeavours do not evolve aloof from society, answerable only to a remote search for 'truth', but to some or other extent are always buffeted by the roil of competing interests and forces.

34 Also tempering pharmaceutical industry's enthusiasm for antiretroviral drug provision in Africa was the concern that the anticipated emergence of new drug-resistant HIV strains would drastically trim the product-life of antiretroviral drugs the industry produced (and sold primarily in the industrialized world). Research and development of new drugs would then have to be accelerated and expanded, incurring additional costs that would eat into profit-margins in a climate where activist pressures were strong

enough to force pricing restraint.

35 This discursive tactic has become a staple of 'denialism'. The 'Castro Hlongwane' text, for example, starts with a list of 'unanswered' questions, probably a self-consciously echo of an essay in the African National Congress' *Sechaba* journal 14 years earlier, which had commenced in similar fashion with a list of questions before providing a thinly veiled conspiratorial exposition; see Mzala (1988).

36 It's the lack of certainty – that 'radiant uncertainty' – that acts as one of the main catalysts of scientific endeavour. For a fascinating examples of some of the major questions still facing science, see *Science* magazine's 125th anniversary issue, available at <http://www.sciencemag.org/sciext/125th/#online>.

Gaps, cracks and blindspots

No epidemic in history has been studied and scrutinized to the extent that AIDS has in the past twenty-odd years. The information gathered and the knowledge gleaned from it continues to grow. Advances in the biomedical knowledge of HIV, AIDS and, increasingly, the functioning of various forms of treatment have been especially striking. In comparison, efforts to incorporate social research and analysis into the study of AIDS lag. Hitching 'development' to 'AIDS', for example, has become a reflex, although too often an empty, rhetorical one. AIDS research and analysis has assimilated very little of the *critical knowledge* that has accumulated in development theory and practice over the past quarter century, not to mention the other pertinent fields of sociology, social anthropology, political geography and economics. Precious little genuine, multidisciplinary rigour is evident in AIDS literature. The attempts to document, interpret and analyze the impact of AIDS in places with severe epidemics exemplify these shortcomings.

In trying to discern the likely impact of AIDS in South Africa, and the various ways and paths along which that impact would circulate through society, we have to acknowledge the limits both of current research output and the framing of that research, little of which is capturing the impact on systems and processes, or exhibiting understandings of the social dynamics with which AIDS intersects. The literature by and large has acquired a familiar and standard look, with common and recurrent features. Typically, AIDS and its impact are regarded as discrete phenomena that leave a trail of clearly discernible con-

sequences in their wake. Impact is then gauged in distinct units and sectors of society, where it is quantified and enumerated, but with little sense of the jumbled interplay between them.^{xxviii}

Much AIDS impact research and writing glosses over the intricate ways in which societies (re)arrange and (re)organize themselves, as we show in more detail below (see Ground Zero). Sometimes the conceptual baseline, the default point of reference is inappropriate, even alien to the reality being studied. The phrase 'extended family', for example, betrays an assumption that a compact, 'nuclear' family unit constitutes normalcy everywhere (when, in fact, the reverse holds). Likewise, the shifting arrangements of child-care beyond the father-mother axis in most of Africa earns cursory attention in orphans research (Stein, 2003). Numerous studies have quantified the impact of an AIDS illness and/or death within households, but little is known of the impact AIDS in one household might have on other, apparently unaffected ones. Households (and communities) tend to be pictured as homogenous entities. Few AIDS-related studies have examined relations of power inside households, and how these affect the allocation of resources, duties and entitlements – or how they might alter in the face of adversity. Tied to this is a tendency to exaggerate households' adaptability, since the internal dynamics for the most part are left opaque and fuzzy. The reality can be disconcertingly inflexible – if roles and duties are rigidly assigned by gender, for example – and policy and programme design has to take account of this.

The concept of 'vulnerability' features prominently in AIDS literature. It is meant to refer to an exceptional state of affairs, to circumstances that *should not* be the norm. It marks frailty, disempowerment and insecurity – which, in the context of HIV/AIDS is translated into a likely inability to fend off possible infection or to cope with its effects. But what does such a concept reveal about a society in which perhaps half the population can be considered vulnerable – not just to HIV and the aftermath of infection, but to a barrage of routine adversity? Most damningly, the literature is almost bereft of attempts to locate the epidemic's impact and people's experiences of it within the context that determines how power, resources and opportunities are reproduced and distributed across society. These are limiting perspectives that stunt our understandings of the epidemic and of people's encounters with it, and that distort the kinds of policy and programme responses which eventually find acceptance.

Chapter endnotes

- i Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe at the end of 2003 – according to UNAIDS (2004). *2004 Report on the global AIDS epidemic*. UNAIDS. Geneva. p 191.
- ii UNAIDS (2004). *AIDS Epidemic Update December 2004*. UNAIDS. Geneva. p 19.
- iii Kark SL (1949). The social pathology of syphilis in Africans. *South African Medical Journal*, 23:77-84. Reprinted in *International Journal of Epidemiology* (2003), 32(2):181-186, and Myer L, Morroni C, Susser ES (2003). Commentary: The social pathology of the HIV/AIDS pandemics. *International Journal of Epidemiology*, 32(2):189-192. See also Walker L, Reid G, Cornell M (2004) *Waiting to happen: HIV/AIDS in South Africa*. Double Storey books. Cape Town, pp 60-85.
- iv For example, one in ten young South African women (who have had sex) have reported being forced to have sex, according to one national survey (Reproductive Health Research Unit & Medical Research Council, 2003).
- v See, for example, Maman S et al. (2000). The intersections of HIV and violence: directions for future research and interventions. *Social Science and Medicine*, 50:459-78; Garcia-Moreno C & Watts C (2000). Violence against women: its importance for HIV/AIDS. *AIDS*, 14 (supplement 3): S253-65; Jewkes RK, Levin JB, Penn-Kekana LA (2003). Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Social Science and Medicine*, 56:125-34.
- vi John Pilger, for example, has noted that ‘in one six-month period in 1973, more tonnes of American bombs were dropped on Cambodia than were dropped on Japan during the Second World War’; John Pilger. *The Guardian*. 30 January 2004.
- vii For a bracing summary, see Reader (1998:368-425).
- viii For a summary of two, more or less diametrically opposed views, see Reader (1998:397-399).
- ix See Miller JC (1998). *Way of death: Merchant capitalism and the Angolan slave trade 1730-1830*. University of Wisconsin Press. Madison; cited in Reader (1998).
- x The mortality rate at Oxford University matched that in the upper levels of English society (25-27%), while among the rural poor and those clergy that served them it was 40%. See Catto JI, Aston TH, Evans R (eds.) (1992). *The history of the University of Oxford: Late medieval Oxford (History of the University of Oxford)*. Oxford University Press, quoted by Hugh Pennington in ‘Two spots and a bubo’, *London Review of Books*, 21 April 2005.
- xi Herlihy (1997:41-42). These concessions were called ‘privileges’.
- xii See Samuel Cohn’s Introduction to Herlihy (1997:9-13).
- xiii In his Introduction to Herlihy (1997:5).
- xiv See Cohn (in Herlihy, 1997:14).
- xv In *Black skin, white masks* (1986), among other writings.
- xvi For an incisive review, see the essays collected in *South African Historical Journal*, 45(2001) 1-190.
- xvii See *ANC Today*, 2(14). 5 - 11 April 2002, available at <http://www.anc.org.za/ancdocs/anctoday/2002/at14.htm>. In his ‘letter to world leaders’ two years earlier, President Mbeki had struck a similar note: ‘It is obvious that whatever lessons we have to and may draw from the West about the grave issue of HIV/AIDS, a simple superimposition of Western experience on African reality would be absurd and illogical.’ For excerpts from the letter, see ‘Reciting comfortable catechisms on AIDS is not good enough’. *Sunday Times*. 23 Apr 2000.
- xviii See Carton B (2003). The forgotten compass of death: apocalypse then and now in the social history of South Africa. *Journal of World History*, 37:199-218.
- xix Some South African periodicals even ran articles to this effect – as *Drum* magazine, for example, did in 1991; see Walker et al. (2004).
- xx The Declaration was adopted at the Bandung Conference, a gathering of mostly newly-independent Asian and African states. It included trenchant defiance of colonialism and neocolonialism, and emphasised the need for self-determination within the context of economic and cultural co-operation between ‘third world’ countries. The meeting was held in Bandung, Indonesia.
- xxi For a more thorough discussion, see chapter 8 in Marais (2001).
- xxii For more on this, see Marais (2001: 260-261).
- xxiii For a thorough discussion of this period, see Marais H (2000). *To the edge: AIDS Review 2000*. Centre for the Study of AIDS. Pretoria.
- xxiv Thabo Mbeki, presenting the ZK Matthews memorial lecture, ‘He wakened to his responsibilities’, at Fort Hare University, 12 October 2001. For the full speech, see <http://www.anc.org.za/ancdocs/history/mbeki/2001/tm1012.html>. During 2001-2002, the ‘denialist’ or ‘dissident’ camp proved especially industrious. President Mbeki publicly dismissed AIDS mortality estimates (see below), and the Cabinet ordered Statistics SA to conduct a review of cause of death statistics. When the president announced a bigger AIDS budget and an expanded MTCT programme in February 2002, the debacle seemed set to wind down; alas, the infamous ‘Castro Hlongwane’ pamphlet appeared the following month.
- xxv For a thumb-sketch of the lineage of ‘good governance’ strictures in Africa, see Thandika Mkandawire’s ‘The itinerary of an idea’, *Development and Cooperation*, 31(10). October 2004.
- xxvi To paraphrase Stephen Jay Gould’s remark about evolutionary theory; see Gould SJ (1980). *The panda’s thumb*. Penguin Books. London, p 12.
- xxvii See, for example, Scott S & Duncan C (2004). *Return of the Black Death: The world’s greatest serial killer*. Wiley. London, where the authors question the widely-held understanding that the plague was caused by *Yersinia pestis* bacteria.
- xxviii As we shall see, the writings of Alex de Waal especially have served as welcome antidotes to this tendency.

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