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A Manageable Catastrophe

Perhaps the most extraordinary aspect of the African AIDS epidemic is its limited social and political effect. This is a disease which in a number of countries will be the cause of death of half the population.... It has increased the mortality levels of adults in their prime, 20–40 years, to pre-modern levels. At any one time one third of the people one meets in cities like Harare or Blantyre are infected and have at the most only a few years to live....The additional death rate because of the epidemic, up to ten per thousand annually in some countries, is of a similar magnitude to the experience of France during the First World War, an experience that traumatized the French. Yet East and Southern Africa are not traumatized. Governments are not threatened by accusations of mishandling the epidemic. Not a single protest demonstration has occurred. Life goes on in a surprisingly normal way. There has not even been any very marked change in sexual behaviour, and society is not dominated by government demands that there should be. There is no paranoia and little in the way of new religious or death cults. In some ways it is very impressive.

John Caldwell, 1997[1]

> Recently a peaceful demonstration in [Queenstown, South Africa] by AIDS patients begging for drugs to treat their otherwise fatal disease was broken up by riot police. The demonstrators, most of whom were HIV-positive women, were beaten, and 10 were shot. The next day in Moscow, people infected with HIV chained themselves to government buildings, also demanding access to life-sparing medicines. We are entering a new stage in the world's great modern plague in which long-complacent governments are awakening to discover that the HIV virus, first noticed in 1981, now threatens to foment social unrest, undermine state authority, weaken armies, challenge economies and reverse hundreds of billions of dollars' worth of development investment.
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> Laurie Garrett, 2005[2]

At present levels of infection, about one sixth of all the people in sub-Saharan Africa will contract HIV in their lifetimes. But the epidemic does not threaten the continent's rulers – democratic or otherwise. AIDS kills millions every year, more than war and famine combined. It kills adults, devastating families and leaving orphans. But governments are not being overthrown. Indeed, with a few exceptions such as Botswana, African leaders' responses lack urgency and scale. Governments find resources for many things, but AIDS programmes are rarely near the top of their list. There are straightforward reasons for this neglect. African electors are not demanding that their governments make AIDS a priority. Society is neither collapsing nor being transformed in revolutionary ways. African rulers, with a sound appreciation of how power functions, know that they won't be removed from office or even face political threats on account of AIDS. John Caldwell is right.

Laurie Garrett says that 'this is the Black Death'.[3] By invoking this spectre and predicting social meltdown in Africa, she wants to frighten powerful governments into massive and urgent action. This drumbeat of doomsaying has made an impact in

Washington DC and New York, but not in Africa, where pundits' forecasts of collapse are routinely discounted and fear of an abstract apocalypse has long since failed to spur political action.

This book argues that African governments, civil society organizations and international institutions have proved remarkably effective at managing the HIV/AIDS epidemic in a way that minimizes political threats. In doing so, they have adopted a model of response to AIDS that focuses on process rather than outcome – chiefly the smooth and coordinated functioning of their own institutions, but also adherence to certain principles, some of which are based on evidence, and some on faith. These process indicators, such as UNAIDS's 'three ones',[4] are rigorously assessed. Encouragingly for democrats, this process emphasizes human rights and the participation of civil society leaders, and it has thereby ensured that democracy in African is not threatened by the epidemic and may even be strengthened. With a few important exceptions where different intersecting stresses come together, AIDS is unlikely to cause socio-political crisis.

Providing antiretroviral treatment to people living with HIV and AIDS is the most effective means of managing AIDS. It is an easily measured service-delivery operation. It is a humanitarian activity that prolongs people's lives and reduces the social and economic impacts of the disease. Treatment has a ready constituency – people living with HIV and AIDS – and it is unsurprising that it has recently received a great deal of political energy and commitment. Amid the current enthusiasm for scaling up treatment, it is easy to overlook the fact that it will not roll back the epidemic.

The HIV/AIDS epidemic is being managed, not solved. For HIV/AIDS to be rolled back, the right political incentives for HIV prevention need to be in place. The first requirement is a good and rapid measure of success. Astonishingly, the only good indicator – *incidence* of HIV infections – simply isn't measured. Instead, HIV *prevalence* – the total number of existing infections –

Table 1.1: Life expectancy, related measures and HIV prevalence for selected countries

Country	Additional life expectancy at 20 years e20	Life expectancy at birth e0	Adult HIV rate 2002 (%)	Under 5 mortality per 1,000 5q0
Japan	61.9	81.7	<0.1	4
United States	57.9	77.4	0.6	8
Brazil	52.4	68.7	0.7	35
Bangladesh	48.6	62.4	0.2	69
Chad	41.1	48.3	4.8	200
Niger	39.6	46.4	1.2	262
South Africa	**35.5**	**45.7**	**21.5**	**66**
Sierra Leone	33.0	37.4	7.0	283
Malawi	**30.7**	**37.5**	**14.2**	**178**
Zambia	**27.3**	**36.5**	**16.5**	**182**
Botswana	**24.9**	**38.0**	**37.3**	**112**

Sources: Col. 1: WHO Statistical Information System, *Life Tables for 191 Countries*; Cols 2, 4, 5: WHO, *World Health Report*, 2005; Col. 3: UNAIDS, *Report on the Global AIDS Epidemic*, 2004; Col. 6: Population Division of the Dept. of Economic and Social Affairs of the UN, 2004; UNAIDS, 2004; Cols 7–8: Population Division, 2004.

is monitored rather inadequately. Prevalence can go up and down for many reasons, including changes in surveillance methods, population migration and deaths of people living with AIDS, as well as new infections. Relying on prevalence figures, we have only the vaguest grasp of whether prevention measures are having any impact at all. Even if African publics and international activists wanted to call governments and agencies to account for their performance, they do not have the tools to do so. A government's political commitment to preventing HIV/AIDS consists solely in a promise to implement a package of internationally recommended prevention strategies. There is no discernible system of political rewards for success and penalties for failure, so we should not be surprised that governments and international institutions have not made much progress in preventing HIV infections.

% of total deaths under 5 years	% of total deaths attributed to AIDS	Adult deaths per 1,000 45q15 (women)	Adult deaths per 1,000 45q15 (men)
<0.1	<0.1	45	96
1.0	0.6	82	139
11	1.3	129	240
24	<0.1	258	251
48	9.9	444	513
68	1.8	477	508
10	**49.1**	**579**	**642**
56	10.0	517	597
36	**31.6**	**615**	**652**
33	**34.9**	**685**	**719**
12	**75.0**	**839**	**850**

Life Expectancy and Public Opinion

Caldwell's sketch of AIDS's demographics remains broadly correct today. Table 1.1 ranks selected countries on the basis of the additional life expectancy of a 20-year-old. Countries with HIV prevalence over 10 per cent of adults are marked in bold.

Column 1 shows that a young adult in the United States in 2006 can expect to live until nearly eighty; a Zambian teenager to less than fifty (e20 is the number of additional years a 20-year-old can expect to live, while e0 is life expectancy at birth). From a class of 100 ninth-grade American girls aged fifteen, 90 will see their sixtieth birthdays. Less than one third of their counterparts in Malawi can expect to live that long (45q15 is the probability of a fifteen-year-old dying in the next 45 years of

life). A Batswana teenager today has a lifetime chance of contracting HIV of well over 75 per cent.[5] Today's generation faces a greater inequity in global life chances than its predecessors, and this is increasingly due to adult mortality and not child deaths (column 4 shows child mortality: 5q0 is the number of children who die before they reach five). Young adults in developed countries expect to live longer and more prosperous lives than their parents. In much of sub-Saharan Africa, the opposite is true, and this reversal is very recent. Just fifteen years ago, Zambians could expect to live to almost 60, and life expectancies in poor countries were closing the gap on the wealthy AIDS-impacted countries are losing ground fast. Between 2000 and 2004, South Africans' life expectancy fell behind that of people in Chad and Niger.

There have been wobbles on the path to development before. This is different. Africa's shocking life expectancy regression is due overwhelmingly to AIDS. A famine lasts a couple of years and leaves its scars, but even the worst – such as China's 'Great Leap Forward' disaster of 1958–61, which killed perhaps 30 million people – are demographically absorbed within a decade or so. AIDS is here to stay: we must speak of an 'AIDS endemic'. We just don't know if HIV infections will 'stabilize' at a particular prevalence level, and what that level might be. We don't know if levels will fluctuate, with future 'waves' of infection – perhaps driven by new viral strains – rolling through the population. 'We are threatened with extinction,' Botswana's President Mogae told the UN General Assembly in 2001. 'People are dying in chillingly high numbers. It is a crisis of the first magnitude.'[6] Strictly speaking, Mogae is wrong: demographic modelling suggests that even very high prevalence levels – up to 40 per cent or so – can be sustained indefinitely without a fall in the absolute numbers of a population. At that prevalence, the great majority of adults will end their lives early to AIDS. Today's crash in life expectancy will not be quickly reversed. But Mogae poses a question of vast

importance: how can social order be sustained under such protracted calamity?

But across eastern and southern Africa, AIDS does not head the population's list of priorities. The Afrobarometer public opinion surveys show that AIDS is a concern to African publics but that it rarely ranks at or near the top.[7] The finding is consistent. Begun in 1999 by the University of Cape Town, the Afrobarometer is the first systematic attempt to poll public opinion in the continent. Three rounds of general surveys, including questions on a wide range of public issues, have been conducted in a growing number of countries. The first survey covered 12 countries in eastern and southern Africa. The 2004 round covered 18 countries, ranging as far as Senegal and Madagascar. The surveys include questions on attitudes to AIDS, personal experience with AIDS, and – significantly for this inquiry – how people regard government policy. It is an extraordinarily rich dataset.

To anyone familiar with the figures for HIV prevalence in southern and eastern Africa and some of the scenarios for crisis these imply, what is most striking about the Afrobarometer data is how low concern about AIDS ranks. In the 1999 survey few people named HIV/AIDS as a priority for the government's agenda.[8] Instead they ranked government action on unemployment, poverty, crime, education and general health improvements as higher priorities. In the second round (2002), the rankings were similar. South Africans put unemployment at the head of 'the most important problems facing the country that the government ought to address'. Despite growing concern, AIDS ranked lower.

Location matters: Afrobarometer data show diverging profiles of public opinion on AIDS in different countries. For example, South Africans are much more critical of their government's performance than Batswana. Unlike the monolithic pandemic portrayed in the aggregate figures, each society sees HIV/AIDS in its own way. Everywhere, there is concern over AIDS, but it is

*Table 1.2: Priorities for African publics**

Botswana		Uganda		Malawi		Mozambique		South Africa	
Unempl.	61	Poverty	45	Famine	54	Unempl.	60	Unempl.	80
Poverty	36	Health	34	Poverty	35	Health	35	Crime	33
AIDS	29	Unempl.	26	Farming	32	Education	28	Poverty	29
Education	21	Education	25	Economy	22	Poverty	25	**AIDS**	27
Farming	14	Water	17	Health	22	Famine	13	Education	14
Health	13	Farming	16	Unempl.	20	**AIDS**	13	Corruption	12
Crime	12	Economy	13	Water	16	Farming	11	Health	10
Economy	12	Crime	12	Education	16	Water	11	Famine	9
Famine	10	Corruption	11	Crime	12	Crime	10	Water	8
Water	6	Roads	9	Roads	6	Corruption	6	Economy	7
Corruption	3	**AIDS**	7	Corruption	4	Economy	6	Farming	3
Infrastruct.	3	Famine	5	**AIDS**	3	Roads	4	Roads	2

* As percentages of respondents mentioning an issue in the top three priorities.
Source: Afrobarometer, 2002 'What are the most important problems facing this country that the government should address?'

usually hidden in a thicket of other worries that shadow people's lives. This is our starting point: if African voters are not concerned with HIV/AIDS, it follows that the politicians they vote into office will not be impelled to make AIDS a priority.

Structure of This Book

The four substantive chapters of this book (chapters 2–5) address a series of issues around the politics of HIV/AIDS, relating it in turn to public concern and imagining, activism and civil society, threats to social and political functioning, and power relations.

Chapter 2 begins with the larger question posed by the Afrobarometer data, 'why a pandemic that has caused such a widespread sense of personal loss in many countries, and is imposing significant burdens on households, is not named as a priority

public issue more frequently?'[9] This is framed around the issue of denial, construed first as a simple refusal to recognize reality and then (more interestingly) as the determined effort to reconstruct a 'normal' social and moral order in the midst of the epidemic. Key to overcoming denial is the role of the media – not as a purveyor of messages about AIDS but as a news source that provokes discussion.

Chapter 3 examines the nature of civil society and activist mobilization around AIDS in Africa. Beginning with a close examination of the violence at the Treatment Action Campaign (TAC) protest in Queenstown, South Africa in July 2005, this chapter illustrates how HIV/AIDS is *not* a harbinger of revolution or political crisis. For different reasons, the key stakeholders in the public representation of HIV/AIDS – including AIDS activists themselves – have not framed the issue as a challenge to the legitimacy of governments. Since its foundation in 1998, South Africa's TAC has become the continent's most influential AIDS activist organization. Facing a government with an overtly denialist position on AIDS, the TAC has nonetheless framed its objectives as fulfilling the provisions of the South African constitution, not overthrowing it. Moreover, AIDS activism has undergone its own revolution, working within global structures of governance and assistance.

Popular mobilization is not the only way in which AIDS could challenge governments. If the disease were to destroy administrative capacity, breed a generation of delinquent youth or unleash social and economic crises such as famine, it could bring down democracies. Chapter 4 examines these possibilities, and finds them improbable. The evidence for catastrophic socio-economic repercussions is as yet slender. But we must be alert to the more subtle and far-reaching ways in which AIDS can influence the trajectory of social development.

Perhaps more importantly, African rulers have found means of minimizing the dangers posed by AIDS, and indeed turning the

epidemic to political advantage. A case study of this is elaborated in Chapter 5, which examines the Ugandan 'success story' through the lens of President Yoweri Museveni's political career. This chapter also turns to how the emerging international AIDS apparatus is changing the matrices of power in Africa, creating new forms of both accountability and dependency. As vast treatment programmes are rolled out, consuming a large proportion of aid to Africa, governance will change yet again. Today's norms and structures provide for good representation by civil society leaders, including AIDS activists.

But we should not mistake managing the political and social threats emanating from the AIDS epidemic for an effective response to the immense human tragedy of HIV/AIDS itself. The concluding chapter reminds us how little we know about the reasons for Uganda's decline in HIV prevalence during the 1990s and suggests that we still lack the kind of evidence we need if we are to be able to design effective policies and programmes to overcome HIV/AIDS. We are not seriously demanding that our leaders prevent HIV infections, and we should not be surprised that they are failing to do so.