

THE AFRICAN HIV/AIDS PANDEMIC:

AN EXAMINATION OF THE IDEOLOGY OF RACE AND ITS
EFFECTS ON THE SPREAD OF THE DISEASE

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INTRODUCTION

The spread of HIV/AIDS has grown tremendously since it was first discovered as a disease. According to UNAIDS, 60 million people have been infected by the disease globally, and as of the end of 2002, there are 42 million people living with the disease.¹ Regional statistics indicate the pandemic nature of the disease in sub-Saharan Africa. As of the end of 2002, 29.4 million adults and children were living with HIV/AIDS in the region – 70% of the global HIV/AIDS population. The statistics are staggering and appear to be getting worse.

The catastrophic nature of the disease in sub-Saharan Africa has fostered intense international discussion among activists focusing primarily on what can be done to change the course of this disease. The disease is not only killing people it also endangers the viability of African governments. The disease exists alongside other issues resulting from poor development (e.g. tuberculosis, malaria, famine, poor public health infrastructure, poverty). Issues of poor development as well as the disease's death toll feed into each other creating a seemingly endless downward spiral toward the destruction of many national governments. Since about the mid-1990s, there has been a focus on the role, or rather the insignificance of the role the West has played in the epidemic. With the power it possesses both politically and economically, countries composing the West are in a position to assist African nations in slowing and eventually ending the destruction of this disease. So, why has it not stepped up into this position, during one of the worst humanitarian crises to ever hit sub-Saharan Africa?

¹ UNAIDS/WHO, Joint United Nations Program on HIV/AIDS, *AIDS Epidemic Update, December 2002*, Geneva, Switzerland, UNAIDS/02.58E, 3 and 6.

It is my argument that racist ideology propagated during the colonial era has shaped responses both within Africa and the West to the epidemic. With an ideology of racial superiority, colonizers structured their respective societies in a manner that would reinforce the notion of White superiority and Black inferiority. The pervasiveness of ideology made it so that societal structure as well as the outright racist practices of the colonizers forced Africans to buy into the idea of their inferiority. And, despite the end of colonization, this ideology still persists in Africa as well as in the West – although not as easily identifiable because of the shift of racism’s manifestations, on an institutional level, from being overt to covert.

It is the persistence of racism that I argue has prevented the Western world from engaging with this crisis on the level of which it is capable. What’s more, within the African context the persistence of racism has perpetuated an air of silence around the issue. Constructions of Black inferiority, especially the construction of Black sexuality, are still present in the minds of many. I believe it is a fear of perpetuating these constructions and in some cases, a belief that these constructions are accurate, that has produced the stigma attached to AIDS, and therefore an unwillingness to acknowledge the disease’s presence. While some may argue that factors such as weak or ineffective governments, weak economies as a legacy of the colonial past, poor social services and poor public health infrastructure are behind the lack of effective progress in the region, I feel ideology is at the root of this problem. I agree that these issues have absolutely had an impact on the lack of progress on abating the disease. I feel, however, that if all of these measures were remedied, the effects of an ideology of racism would still linger and hamper intervention efforts, due simply to the nature of ideology – our ideas necessarily

dictate our actions. It will be shown that despite the presence of significant funding, the mindset of the people has dictated the results of intervention efforts – namely that results have been limited.

To illustrate my argument, I will begin with a discussion of ideology. I will use Louis Althusser's articulation of ideology. Althusser's discussion is particularly useful in that it focuses on its role in a society which has at its foundation the exploitation of a group or groups of people by a dominant group. Following a discussion of ideology will be a discussion of the construction of Black sexuality. While I indict the notion of racial superiority in general, I focus on the construction of Black sexuality because it seems that early accounts of interactions between Europeans and Africans focused on the perception of the Black body. The view of the Black body as pathological, laid the foundation I argue for the articulation of other notions of White superiority. On a more practical level, that AIDS is a disease whose primary mode of transmission is sex necessitates a discussion of sexuality.

Following a discussion of historical constructions of Black sexuality, I will then discuss, the history of diseases, with a focus, of course, on sexually transmitted diseases (STDs) in Africa. My argument within this section will be that Africa has a history of stigmatizing diseases, due in large part to colonizers' desire to maintain a racial hierarchy. The legacy of such a history is that disease, especially STD, is still stigmatized.

The final two sections will focus on the response to the disease in the present. The section on the African response will focus on how current response has been shaped by colonial racism, the construction of sexuality, and the treatment of STDs in light of this

history. The section on the Western response will show just that and how that response has been shaped by racist attitudes maintained in the West.

Prefatory Notes/Comments

- While I speak of sub-Saharan Africa, my research has focused primarily on countries in southern/southeastern Africa (e.g. South Africa, Botswana, Tanzania, Zimbabwe) as they have been hardest hit by the disease, and have had little success in interventions, whereas countries in other regions of Africa have been able to get their prevalence down to 2% (Senegal in west Africa).
- My discussion of colonialism will focus primarily on colonies of the United Kingdom. Many European countries have their hand in shaping the African continent. Each country had its own brand of colonialism and so as to avoid confusion, for myself, as well as for readers, I have decided to focus on one particular brand. I do believe however, that there are many crosscurrents particularly in the area of racial superiority. Thus, in my section on ideology I do speak of colonialism in general.
- The use of the term ‘Western’ is very problematic, especially in a post-*Orientalism* society. It has come to mean many different things to many different people. To use it is to potentially play into the notion of the Oriental, exotic, Other, Said was contesting. My usage of the term West or Western refers to those countries, of the first world, which have not experienced the brutalities of imperialism/colonialism (with the exception of the United States, albeit, the United States experience is dramatically different from the experiences in Africa, Central and South America, or Asia). And who currently enjoy political, economic, and/or cultural prominence within the scheme of international relations. The term also refers to the values espoused by these countries. I am aware of the short list of countries this includes, an

indictment in itself of Western world dominance, in spite of its position as a statistical minority. For the purposes of this paper, the use of the term Western or West will prioritize the United Kingdom and the United States – the UK because of its former imperial dominance and the United States because of its post-World War II inheritance of the legacy of imperialism and therefore its current status as the sole superpower.

- Throughout the paper, I use the labels “Black” and “African,” often interchangeably. This usage is by no means a suggestion of a “Black” or “African” monolith. My usage of the terms is to show the crosscurrents in experience across African cultures as well as a uniformity of the Black experience across the diaspora. The notion of diaspora refers specifically to racist attitudes in colonialism as well as during slavery in the United States. Although they are two different phenomena, the constructions of Blackness used within both are essentially the same.

IDEOLOGY, CAPITALIST EXPLOITATION, AND COLONIAL OPPRESSION

I have posited that at the root of the problems of relative Western inaction on the AIDS epidemic and struggles within African nations to deal effectively with its rapid progress is ideology – racist ideology, products of the colonial era in Africa and its ‘kissing cousin,’ slavery and Jim Crow within the United States, surviving today and driving the thoughts and actions of those falling under it. This assertion necessitates a discussion of ideology and its functioning within a capitalist state.

Expanding upon the works of Marx, Louis Althusser identifies two necessities for reproducing the conditions of production, something essential to the maintenance of the social structure of a capitalist state. These two necessities are: “(1)[reproduction] of the productive forces; and (2) [reproduction] of the existing relations of production.”² Louis Althusser defines ideology as “the system of ideas and representations which dominate the mind of a man or social group.”³ Reproduction of the productive forces is accomplished by the reproduction of raw materials and the reproduction of labor power, i.e. the labor force, through the wage. The reproduction of the existing relations of production also requires the reproduction of the labor power. It is not, however, the reproduction of the physical bodies which compose the labor force, but “a reproduction of its [the workers’] submission to the rules of the established order, i.e. a reproduction of submission to the ruling ideology for the workers, and a reproduction of the ability to manipulate the ruling ideology correctly for the agents of exploitation and repression, so that they, too, will provide for the domination of the ruling class ‘in words’”.⁴

² Louis Althusser, “Ideology and Ideological State Apparatuses (Notes towards an Investigation),” *Lenin and Philosophy*, trans. B. Brewster, Monthly Review Press, 1971, 127-186, 128.

³ *Ibid.*, 158.

⁴ *Ibid.*, 133.

Submission to the ruling ideology is accomplished through apparatuses – the Repressive State Apparatus (RSA) and the Ideological State Apparatus (ISA). It is unnecessary to go extensively into Marx’s definition of the State except to say that the State is the RSA, i.e. all of the authoritative aspects of the State (the police, courts, prison, army, the government and the head of State, and to say that as the name suggests, the State as the RSA functions primarily by repression. What is more important is the ISA: “It is the latter [the ISAs] which largely secure the reproduction specifically of the relations of production, behind a ‘shield’ provided by the repressive State apparatus.”⁵

While the RSA is a single entity, there are multiple ISAs. Althusser identifies eight ISA’s: the religious ISA (i.e. the Churches); the educational ISA (the public and private school systems); the family ISA; the legal ISA; the political ISA (the political system, including parties); the trade union ISA; the communications ISA (i.e. the media); and the cultural ISA (e.g. Literature, Arts).⁶ These ISAs, functioning primarily by ideology, unified by their effort to promote the ruling ideology and working with the force of the RSA behind it are able to secure “the reproduction of the relations of the production, i.e. of capitalist relations of exploitation.”⁷

What I have attempted to show through this discussion of the State and its Repressive and Ideological Apparatuses is that all capitalist nations necessarily function by ideology. What is more, the nature of ideology makes it so that the ideology under which the state is functioning seems natural; that there is no alternative. This functioning is akin to how Antonio Gramsci articulates how a ruling group achieves hegemony. Stated simply, hegemony is acquired first by coercion, which usually takes the form of

⁵ Althusser, 150.

⁶ Ibid., 143.

⁷ Ibid., 154.

violence. Once this group has achieved dominance it is maintained by consent given to it by the oppressed group. This consent is acquired by the ruling class establishing an ideology which reinforces its dominance throughout all of society. All societal institutions reflect this ideology and thus the dominance of the ruling class. What's more this ideology is presented as 'common sense.' The acceptance of and adherence to this 'common sense' signals that the oppressed group has consented and that hegemony has been established.⁸

Now that a theoretical basis on ideology has been established, I can move on to how it has affected the structuring of African colonial society and continues to affect postcolonial Africa.⁹ I believe that one of the most influential ideologies influencing African colonies is that of racism: "Any program or practice of discrimination, segregation, persecution, or mistreatment based on membership in a race or ethnic group;" predicated on the belief, whether conscious or subconscious, that one race or ethnic group is superior/inferior to the other.¹⁰

In a perfect dramatization of Althusser's theory of capitalist exploitation and Gramsci's hegemony, European imperialists imposed an ideology of racism on African peoples. It was not an easy feat, as the indigenous populations did put up significant resistance. However, through the continued use of increasingly violent force, dominance was achieved. To maintain this dominance, African society was restructured to foster the

⁸ I have utilized Michael Omi and Howard Winant's stance on Gramsci as they have articulated it in: *Racial Formation in the United States : From the 1960s to the 1990s*, New York : Routledge, 1994.

⁹ This is not to say that African colonies were functioning as capitalist states. My argument is that the ethos behind imperialism, that of capitalist exploitation, was imposed upon African societies and the relations inherent within a capitalist system, necessarily came along with that imposition. Thus, the exploitative nature of the relationship between the bourgeoisie and the proletariat in a capitalist state, is seen in the relationship between the colonizer and the colonized in the colonial 'state.'

¹⁰ Richard Delgado and Jean Stefancic, *Critical Race Theory: An Introduction*, New York: New York University Press, 2001.

sense of White European superiority to Africans. Thus the religious ISA posited the Christian church as superior to any indigenous ‘religious’ practices, the political ISA placed the colonial government above African sovereignty, and the educational ISA prioritized European cultural values over those of the colonized society.¹¹ Through this imposition and restructuring of society consent and thus hegemony is established. Evidence of this hegemony can be seen in the presence in what some have called African-Europeans, Africans who have so taken on European values that they privilege them.¹² A more concrete example of this is Léopold Senghor’s championing of the French language over his native tongue: “We express ourselves in French since French has a universal vocation and since our message is also addressed to French people and others. In our languages [i.e. African languages] the halo that surrounds the words is by nature merely that of sap and blood; French words send out thousands of rays like diamonds.”¹³ Language is, as Ngũgi wa Thiong’o characterizes it, “a carrier of culture” thus for Senghor to see more value in the French language than in his native language, regardless of the circumstance, is in my belief a prioritization of French culture over his own Serer culture (the Serer are an ethnic group within present day Senegal).¹⁴

¹¹ I use the term ‘religious’ here only for lack of a better term in Anglo/Euro/Western culture to capture African spirituality. Wade Nobles points out that the European and African views of religion differ greatly. Within African cultures, ‘religion’ is so incorporated into everyday existence as to make it almost indistinguishable from other parts of African culture. This is not the case in European society where religion is set aside as a distinct cultural phenomenon. See, Wade W. Nobles, *African Philosophy: Foundations for Black Psychology*, *A Turbulent Voyage: Readings in African-American Studies*, Ed. Floyd W. Hayes, III, San Diego: Collegiate Press, 2000, 280-291. In addition, my conflation of education and cultural values is a result of my belief that what is taught in a school is a reflection of what a culture or society views as *worth* knowing.

¹² Boniface Obichere, “African History and Western Civilization,” *A Turbulent Voyage: Readings in African-American Studies*, Ed. Floyd W. Hayes, III, San Diego: Collegiate Press, 2000, 45-52.

¹³ Léopold Senghor quoted in Ngũgi wa Thiong’o, “The Language of African Literature” *Colonial Discourse and Post-Colonial Theory: A Reader*, Ed. Patrick Williams and Laura Chrisman, New York: Columbia University Press, 1994, 435-453.

¹⁴ wa Thiong’o, 439.

It is my hope that this discussion has shown how racist ideology and imperialism combined to alter African self-perception to the point that Africans no longer saw themselves through their own eyes but through the eyes of their oppressors. It is my belief that this warped sense of viewing the self still persists despite decolonization.

The problem does not lie solely within Africa, however. Racism still exists within the minds of former imperialists as well as the United States, whose history of racism is just as brutal if not more so, as Europe's. Images of the 'Dark' and primitive African continent still enter contemporary discourse. That the racism is not as overt does not mean that it no longer exists.

The inability of Africans to wring themselves free from the bonds of colonial racism as well as racism's persistence in the West I feel poses a serious problem to work on the issue of HIV/AIDS. In particular I am speaking of the notion of African sexuality, one of the ways through which European superiority was articulated, and the hold I believe it still has on the African and Western psyches. To maintain a negative image of African sexuality is to in a sense preserve an ideology that engenders exploitative relationships, it also serves to preserve the hostility that coincided with this exploitation, in its later stages, as decolonization approached. Progress on the AIDS issue will not occur in an environment of inequity, shame and hostility, but rather in one of parity, open communication and cooperation.

Following is a discussion of Black/African sexuality and how it was articulated and manipulated by Europeans, to fit a larger scheme of White racial superiority.

THE CONSTRUCTION OF BLACK SEXUALITY

Blacks have historically been denied the privilege of constructing their own sexuality. Instead, White, European perceptions of differences exhibited by Africans have shaped discussions of Black sexuality, marking it as deviant and pathological. It is my belief that the construction of Black sexuality by Whites in both Europe and America was part of a larger racial project to establish White racial superiority. I argue that the obvious malicious intent behind this construction had a significant impact on the treatment of sexually transmitted diseases (STDs) in the African context.

The association of Black people with sexual desire has a history as long as the history of European interaction with people from the African continent, pre-dating even the English interaction with the continent with which we are most familiar: “Long before first English contact with West Africa, the inhabitants of virtually the entire continent stood confirmed in European literature as lustful and venerous”.¹⁵ As both the frequency and duration of interaction with Black people increased, greater detail was given to characterize Black sexuality. It was during a sexual revolution, of sorts, during the nineteenth century, not coincidentally during the time of intensified European colonial interest, that the notion of Black sexuality moved beyond hypersexual into the realm of deviance and pathology. This revolution consisted of what Diana Jeater identifies as two shifts in European views on sexual morality:

First, the married couple was granted a much greater degree of privacy, with the family and its activities relegated to a private sphere governed by rules of personal morality. Secondly, there was an explosion of debate, discussion, and investigation around sexual activities deemed to be ‘unnatural’, which covered a

¹⁵ Winthrop D. Jordan, *White Over Black: American Attitudes Toward the Negro, 1550-1812*, Charlotte, North Carolina: University of North Carolina Press, 1968, 33.

diverse set of newly defined practices not linked to the legitimate conception of children.¹⁶

Also occurring at the time of these shifts was an increasing tendency to link “concepts of morality with concepts of civilization and justice, and the associated development of a pathology of perversity in Europe in the second half of the nineteenth century”.¹⁷ Jeater argues that these particular developments fed into a larger fear of British degeneration.

The British brought their transformed views on sexual morality and their fear of racial decay with them to the African context and were met with cultures who obviously did not share their views or fears. For one within African cultures marriages were often ‘contractual’ in nature, entered into as a matter of “lineage obligation”.¹⁸ Secondly, there was also no sense of the private within sexual matters; the sense of contract surrounding marriages coupled with the communal sense of African cultures meant that activities deemed to be in violation of the marriage agreement were open to public scrutiny. In addition, Jeater asserts, “there was no sense of sexual activity being right or wrong in itself”.¹⁹ The conflict between African and European marital/sexual mores was not viewed simply as cultural difference however. In combination with the increasing sense that morality equaled civilization, and a need to establish racial superiority as justification for European colonization, a divergent African (sexual) morality was equated with a lack of civilization or primitiveness. The ‘perversion’ of the African sexual mores also lied in their divergence from those in Europe – their difference made them unnatural. This was

¹⁶ Diana Jeater, *Marriage, Perversion, and Power: The Construction of Moral Discourse in Southern Rhodesia 1894-1930*, Oxford: Clarendon Press, 1993, 35.

¹⁷ *Ibid.*, 37.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

the environment, hostile to difference, in which African sexuality as deviant and pathological was constructed.

The confluence of these new takes on sexual morality, civilization, and perversion, and how these worked to form the notion of Black sexuality as deviant, can be seen in the example of the ‘Hottentot Venus.’ Europeans held the belief that Africans’ ‘immoral’ sexual practices was a function of some innate characteristic. To the European colonizer, the most accessible sign of African difference was their physiology. That the African *body* was ‘markedly’ different from the European’s was supposedly a sign or reflection of that innate characteristic which allowed for the difference in his/her sexual practices.

The Khoi, or Hottentot woman, known as the ‘Hottentot Venus’ and Sarah or Saartje Baartman, was brought to England in 1810 and then France to display her ‘overly’ voluptuous body.²⁰ It was through the figurative (and after her death in 1816 literal) dissection of her body that the differences between all Black and White bodies were articulated (she came to represent all of Black female sexuality, and eventually all Black sexuality) as well as how Black sexual immorality was a function of these differences: “Her physiognomy, her skin color, the form of her genitalia label her as inherently different. In the nineteenth century, the black female was widely perceived as possessing not only a ‘primitive’ sexual appetite but also the external signs of this temperament – ‘primitive’ genitalia.”²¹ The perceived ‘perversion’ of the Black woman’s sexual parts (her genitalia and her buttocks) came to signify the perversity of Black sexuality. The location of lasciviousness within the Black body combined with what

²⁰ The Khoi, or Hottentot are an ethnic group from Southern Africa.

²¹ Sander Gilman, “Black Bodies, White Bodies: Toward an Iconography of Female Sexuality in Late Nineteenth Century Art, Medicine, and Literature,” *Critical Inquiry* 12, (Autumn 1985): 204-242, 213.

Sander Gilman identifies as a “commonplace” association of the primitive with “unbridled sexuality,” cemented the equation of Black and abhorrent sexuality into the European imagination.²²

²² Gilman, 229.

TREATMENT OF INFECTIOUS DISEASES IN AFRICA

The treatment of infectious diseases within the African context has seemingly always taken on a negative tone with respect to the native population, i.e. Black Africans. That is, epidemiological studies within Africa have focused on behaviors in an effort to understand how a disease is transmitted and hopefully how to eradicate it. This particular stance undoubtedly reflects the presence of the ‘perverse’ Black body within the European imagination; implicit in this focus is an assumption that there is something inherent within the characters of Black Africans, some sort of predilection or predisposition for risky behaviors. The Black body is a manifestation of this predilection. A serious side effect of this type of diagnosis is that it places blame for contracting a disease on individuals, wholly discounting any situational factors which are shown to have had a large impact on disease progression.

Randall M. Packard and Paul Epstein, focusing on Africa in the late 19th and early 20th centuries, provide a brief history of medical research on tuberculosis and syphilis as these diseases gained epidemic status. When tuberculosis entered the region, i.e. Southern Africa, European medical researchers noticed that the African population experienced “higher rates of morbidity and mortality” than Europeans.²³ This observation apparently became the primary focus of medical research on the disease thus establishing within medical discourse the Self-Other dynamic already prevalent in other areas of European discourse on Africa; African Otherness was marked by the differences between the African experience with the disease and the European experience. Attach this narrow focus to limited epidemiological data and a lack of knowledge of other

²³ Randall M. Packard and Paul Epstein, “Epidemiologists, Social Scientists, and the Structure of Medical Research on AIDS in Africa, *Social Science and Medicine* 33 (1991): 771-794, 771.

factors, e.g. contemporary social and/or economic conditions which may have contributed to said higher morbidity and mortality, and there is no wonder that “the explanations of European medical authorities came to reflect wider perceptions about Africans which were current in European colonial society.”²⁴

The dominant theme within TB discourse was that Africans were still living in a mode of pre-civilization.²⁵ Thus, African susceptibility to the disease was directly linked to the population’s inability to catch up with European ‘civilization’ as it was imposed upon them via colonization. Interestingly, there was also an emphasis on the health of those who remained in rural areas versus those who moved to urban industrial centers – rural populations tended to have better health relative to their urban counterparts. So, not only are Africans unable to become “civilized,” but a shift from an agrarian lifestyle to an industrial lifestyle, i.e. civilization, poses a health risk. They are somehow unsuited for civilization! This notion of African primitiveness placed complete responsibility of infection on the native African population:

These constructions of African sickness and health, by focusing attention on the African’s maladjustment to civilization, placed responsibility for the adverse environmental conditions under which Africans lived squarely on the shoulders of the Africans themselves. In doing so, it deflected the attention away from the low wages and inadequate housing policies of employers and government officials.²⁶

This essentialist view of Africa and African peoples so dominated the minds of physicians, researchers and public health officials that it was not until the middle of the twentieth century that any real attention was given to the conditions which facilitated noticeably higher rates of infection. At this time, however, attempts to critique precipitating social conditions such as poverty and poor housing, directly connected to

²⁴ Packard and Epstein, 771.

²⁵ Ibid.

²⁶ Ibid., 772.

the overarching colonial situation, were still however competing with negative perceptions of African behavior making efforts to reform said social conditions difficult. And as of the early 1990's, TB programs still focus on some internal "African characteristic" which allows for infection: "TB control programs in Africa continue to view tuberculosis as a behavioral problem, focusing on treatment failures due to patient default rather than on the failure or inability of governments to cope with environmental factors which continue to generate new cases of the disease."²⁷

The treatment of syphilis by the medical research community in many ways mirrors its treatment of tuberculosis. As with tuberculosis, there was limited knowledge of the epidemiology of the disease. In particular there was confusion over the differing strains of syphilis and the symptoms particular to each strain, making it difficult to distinguish between sexually transmitted versus non-sexually transmitted strains; it was often the case that patients were diagnosed with the sexually transmitted strain.²⁸ There was also limited knowledge of actual sexual practices, customs, and norms in Africa and the effect of European colonization upon them. The tendency to categorize syphilis cases as sexually transmitted combined with primarily stereotypical knowledge of African sexuality allowed for further study of the disease, as well as treatment and prevention programs to focus on behavior modification.

²⁷ Packard and Epstein, 772. In addition, as of the World Health Organization's (WHO) release of its 2003 *Global Tuberculosis Control Report*, TB is still on the level of epidemic in sub-Saharan Africa. While "growth in the global incidence rate of TB has slowed to 0.4% per year . . . WHO report found the TB epidemic is still growing unabated in sub-Saharan Africa." Unsurprisingly, in countries of sub-Saharan Africa where HIV/AIDS also has high prevalence, TB rates have increased dramatically. See – Programme on Communicable Diseases, Geneva, Switzerland. World Health Organization. 2003. Press Release. <http://www.who.int/mediacentre/releases/2003/pr25/en/>; and World Health Organization, Global Tuberculosis Control: Surveillance, Planning, Financing, *WHO Report 2003*, Geneva, Switzerland, WHO/CDS/TB/2003.316.

²⁸ Ibid., 772. There are four strains of syphilis: sexually transmitted, endemic (non-sexually transmitted), yaws, and pinta.

As with the tuberculosis case, it is obvious that underlying the diagnosis of behavior modification are assumptions about the sexual practices of Africans. Specifically, the belief that African cultures were highly or overly sexual pervaded the theories of the medical community, leading it to believe that the supposed sexual promiscuity of African peoples facilitated the spread of the disease. A 1906 study of the spread of syphilis in Uganda asserted that significant changes within the social structure of Uganda such as the introduction of Christianity and the elimination of adultery had contributed to the breakdown of African moral sanctions making it easier for Africans, particularly African women, to follow their natural inclination toward sexual promiscuity.²⁹ Later investigation of the findings of the 1906 study discovered that the strain of syphilis actually being spread was endemic, rather than the sexually transmitted variety; thus challenging the notion that a lapse in African morality was at the root of syphilis infection. By that time however the damage had already been done. A theory of infection had already been constructed by assembling medical observations to “fit pre-existing assumptions about African sexuality and disease.”³⁰ This theory would shape how public health officials formulated policy on the matter, for example the decision to regulate the behavior of prostitutes. As was the case with the public health response to tuberculosis, environmental factors such as poor living conditions or poor sanitation – factors which play a major role in the spread of endemic syphilis – were disregarded.

The way in which colonial governments handled outbreaks of tuberculosis and syphilis is indicative of the way in which other outbreaks, particularly HIV/AIDS would

²⁹ Packard and Epstein, 772.

³⁰ *Ibid.*, 773.

be treated as they emerged as matters of public concern.³¹ Stereotypes of African culture which marked Africans as Other by depicting them as unequipped for civilization or possessed of abnormal sexual desires, allowed for them to be viewed as essentially different from their European and/or Western counterparts; it is this difference, according to theory, which caused them to experience such high incidences of infection.

AIDS research in the African context centered on the idea of difference. A focus during early research on the disease was a believed difference in the mode of transmission in Africa when compared to cases in the west. Western transmission was seen to occur mainly homosexually, whereas in Africa transmission was thought to be almost completely heterosexually.³² Determining the reason for this difference was the main goal of AIDS researchers. Essentialist notions of the Black body and its sexuality were absolutely employed in formulating theories on this difference. One theory posited that AIDS was epidemiologically more developed in Africa than in the West, that heterosexual transmission was a later stage in the development of AIDS, assuming therefore that AIDS had been in Africa longer than in the West. Employing this theory along with data on the Simian T-lymphocyte Retrovirus III in African green monkeys, it was proposed that AIDS originated in Africa.³³ The “primitiveness” of the African as manifested by the similarity between the human and simian immunodeficiency viruses, and his/her ‘pathological’ sexuality (this author can only imagine how far researchers

³¹ Packard and Epstein, 773.

³² Packard and Epstein point out that there was no knowledge of other risk groups such as IV drug users or homosexuals, 773.

³³ Ibid. Simian T-lymphocyte Retrovirus III is closely related to Human T-lymphocytic virus type III (HTLV-III), one of the initial names for HIV.

believed this pathology extended) combined not only to bring AIDS upon him/herself but also to spread it to the larger world community!³⁴

The protest this argument faced, primarily from the African community, allowed for it to be discarded. Which is not to say that following attempts to explain differences in the mode of transmission were any less dependent on Western constructions of Africans. The theory to follow still employed the stereotype of the ‘hypersexual African’ if not the stereotype of the ‘primitive African’: “It was argued as early as 1985 that the heterosexual transmission of HIV in Africa was the result of higher levels of sexual promiscuity among Africans, or in the current language of social science research on AIDS ‘polypartner sexual activities.’”³⁵ That the image of the ‘primitive African’ was discarded, or rather set aside, made no difference in the medical discourse surrounding HIV/AIDS. The African population was still at fault for its spread.

SOUTH AFRICA – A CASE STUDY

It is my hope that by taking a brief look at actual enacted public health policies concerning infectious diseases, specifically sexually transmitted diseases (STDs), in South Africa during the 19th and early 20th centuries, will reveal in greater depth the effects of a paradigm centered on African difference and the danger the legacy of such a paradigm poses to Africans and their health. Interestingly, in the South African case, public health policies also reveal the general ideology of white racial superiority prevailing during the colonial period: “Government attempts to control the spread of STDs in South Africa from the late nineteenth century to the mid-twentieth century,

³⁴ In some of the earliest European accounts of Africans and their sexuality, it was suggested that Africans practiced bestiality, copulating with apes. See, Winthrop D. Jordan.

³⁵ Packard and Epstein, 773.

although shaped by international trends in schemes for intervention, also reflected the gradual development of a segregationist state.”³⁶

As Packard and Epstein have discussed in general of the sub-Saharan region, medical discourse on syphilis (and STDs in general) in South Africa was also plagued by stereotypes of African sexuality – placing the blame of transmission on the Black South African population and effectively discounting the possibility of cofactors.³⁷ Karen Jochelson asserts that “the history of sexually transmitted diseases in South Africa has been shaped by the broader processes of landlessness, poverty, migrancy, proletarianization, urbanization and consequent changes in family relationships and sexual mores.”³⁸ These issues, resulting from the imposition of industrialist, capitalist ideals upon an agrarian society, were not taken into account, however, in the formation of public health policy. Policy instead focused on controlling the behavior of populations identified as having particularly high prevalences of infection – meaning prostitutes as well as migrant workers (African or White)– and therefore highly promiscuous.

In 1895, pass laws were enacted which “prohibited the issue of a traveling or working pass to any applicant obviously suffering from an infectious disease.”³⁹ Had this policy been in response to a disease transmitted via mere person to person contact, it could easily be read as a benign, although misguided attempt, to control an infectious

³⁶ Karen Jochelson, “Sexually Transmitted Diseases in Nineteenth- and Twentieth-Century South Africa,” *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*, Ed. Philip W. Setel, Milton Lewis, and Maryinez Lyons, Westport, CT: Greenwood Press, 1999, 217-241, 224.

³⁷ It is important to mention the racial diversity of the South African population during its colonial period. The population consisted of the native Black population, which will henceforth in this section be referred to as Africans, British colonial administrators, and Afrikaners (South African Whites with European ancestry); unless otherwise noted the term ‘Whites’ will be used to identify Europeans and Afrikaners. The Afrikaner community consisted of a large working class also affected by syphilis. It will be revealed that the type of treatment received by Whites (Europeans and Afrikaners) was quite different from the treatment received by the African population.

³⁸ Jochelson, 217.

³⁹ *Ibid.*, 225.

disease. It targets however the sexually transmitted strain of syphilis, thus implicating supposed “carrier groups” as willful participants in the disease’s spread and reflects its creators’ malice toward these groups. It is important to point out that the general population was affected by these laws, not just the [Black] African population. Jochelson argues, however, that while at the time these laws did not single out the native African population, they did “[lay] the foundation for detecting STDs in the African and white populations in different ways and for the assumption that all Africans were potentially diseased.”⁴⁰

Subsequent laws confirm Jochelson’s argument. The Urban Areas Native Pass Act passed little more than a decade later in 1909, reflects a shift in the way disease control was viewed by public health officials. The act specifically required [Black] African workers to be tested for infectious diseases before they were allowed to work, displaying, as Jochelson argues, a presumption that Africans were more likely to be diseased than their white and Afrikaner counterparts.⁴¹

Time continued to mark a need to distinguish between African and White syphilis and STD patients. As advances in public health were made both scientifically as well as in the realm of medical ethics, policies that in a sense meted out punishment (e.g. denying work passes) to STD patients were discarded as “outdated.”⁴² This did not mean, however, that racist ideology was discarded. It was still necessary to maintain the racial distinctions that were increasingly becoming a part of the societal structure. Thus, while the Public Health Act of 1919 made the “government responsible for providing free laboratory diagnosis to ascertain if a person had an STD; free treatment, including

⁴⁰ Jochelson , 225.

⁴¹ Ibid.

⁴² Ibid., 227.

hospitalization if necessary; and for refunding two-thirds of the costs of local authorities' STD schemes," it did not ensure that its provisions would be met equitably.⁴³ For example, prior to passage of the Act, African and White STD patients received relatively similar treatment. However, after its passage, it was seen as beneath Whites to be treated in the same hospitals as Africans. Consequently, in over seven urban centers, White-only clinics were established and the number of White patients at integrated facilities began to decline. The difference between African and White STD treatment would only continue to grow. While Jochelson does not indict the Public Health Act as overtly racist, she does link it to a larger governmental plan:

In a period in which a new South African nationalism began to emerge, uniting English and Afrikaans speakers, STDs and promiscuous sexuality were viewed as public matters, because they affected the health, virility, and future of a new South African nation. Administrators believed that free, accessible treatment and health propaganda would complement social welfare for poor whites . . . This would clearly elevate poor whites above Africans and, doctors and administrators hoped, halt the moral and physical decline of the white race and thus help protect white political supremacy."⁴⁴

The Act was part of a larger "racial project" spurred on by fears of increasing interaction between Africans and Whites, particularly in urban settings.⁴⁵ Using public health and medical discourse as its foundation, the Union government established the African Other through a binary of deserving and undeserving patients; that the African population was identified as a source of White physical and moral decay made them undeserving of the treatment dictated by the Act's provisions: "Government health

⁴³ Jochelson, 225.

⁴⁴ Ibid., 227. The South Africa Act of 1910, established the Union of South Africa consisting of Transvaal, Orange Free State, Cape Colony, and Natal.

⁴⁵ Michael Omi and Howard Winant, *Racial Formation in the United States : From the 1960s to the 1990s*, New York : Routledge, 1994. The term racial project is taken from Omi and Winant. It is defined as "simultaneously an interpretation, representation, or explanation of racial dynamics, and an effort to reorganize and redistribute resources along particular racial lines. although Omi and Winant discuss racial projects within the U.S. context, I believe the terminology can be utilised within the African context because of the reasons mentioned in the prefatory notes and comments.

services for Africans were premised on the assumption that Africans were primarily migrants whose health was only important insofar as it determined their fitness to labor and suitability for contact with the white population.”⁴⁶ The process of Other-ing the African population under the guise of protecting the public health would continue – STD examinations were compulsory for migrants seeking work; Africans with STDs were often hospitalized or sent off to rural areas. By the 1950’s, racialized STD treatment had been firmly established in South Africa with Whites being entitled to treatment and Africans essentially being indicted for their infection.⁴⁷

As previously stated, the colonial situation created several cofactors in addition to sexual behavior for the transmission of STDs in South Africa. Landlessness, poverty, migrancy, proletarianization and urbanization are all phenomena resulting from the usurpation of land, first by the Dutch and then by the British, from the native African populations. The native populations dispossessed from their homelands and thus unable to maintain the agrarian lifestyle with which they were familiar, were forced by the necessity of survival to engage in the industries introduced by their colonizers (e.g. mining). Those living far from industrial centers were forced to migrate often semi-permanently to those centers. The migrant labor system had significant consequences on sexual norms in South Africa. Women, often left behind while their spouses migrated in search of work, were essentially forced into prostitution or other illicit activities to ensure their survival.⁴⁸ Men far away from their families established relationships, ranging from casual encounters to serious, with women near their places of employment, unfortunately

⁴⁶ Jochelson, 230.

⁴⁷ Ibid., 231.

⁴⁸ Ibid., 223. Women did also migrate in search of work, however, the sexual division of labor and/or a labor market already overcrowded by men made it difficult to find employment.

increasing their potential for STD contraction.⁴⁹ Migrancy also increased the likelihood of cross-community infection, with STDs being introduced into communities previously uncontaminated because of infected workers returning to their home towns or provinces. Neither public health policies nor general government policies reflected any of these transmission possibilities.

How has South Africa's history of poor STD treatment impacted its treatment of HIV/AIDS? Jochelson asserts that "the extent of STDs in the general population is a somber warning about the future spread of HIV and AIDS."⁵⁰ That the South African population is still plagued by STD prevalence speaks to the failure of the public health sector to address issues appropriate to abating infection. Despite this evidence, paradigm shift was still difficult to impose in South Africa. HIV/AIDS emerged in a society rife with racial tension: "AIDS proved a powerful image for social disorder in the 1980s, metaphorically evoking white fears about escalating black political protest and the disintegration of apartheid. Through the 1970s and 1980s as the country slipped into recession, the currency devalued, and the union movement consolidated its strength, the country's economic vulnerability was of primary concern. AIDS heightened the country's sense of economic crisis and anxieties about dependence on a volatile African labor force."⁵¹ Amidst this socio-political climate, HIV/AIDS discourse from the medical community relied heavily on the pre-established difference-centered paradigm, rather than shifting toward one that incorporates known co-factors. AIDS became politicized as the apartheid government connected the disease's growing devastation with

⁴⁹ Jochelson, 232.

⁵⁰ Ibid., 233.

⁵¹ Ibid., 233-234.

emerging liberation movements.⁵² In addition, the government promoted different methods of disease prevention to the White and African populations, effectively stifling attempts to educate the public about the disease.

Needless to say, these conditions in combination, crippled South Africa's ability to cope with HIV/AIDS in a time where decisive government action arguably could have altered the course of the disease. It was not until 1993 that condom promotion, even on a small scale, became part of government efforts. And it was not until 1994, after the collapse of the apartheid regime, that a "National AIDS Plan" was created.

⁵² Jochelson, 234.

HIV/AIDS AMIDST THE EPIDEMIC

The South African case is but one example of how a legacy of stereotypes and racism, impacts current HIV/AIDS treatment. Despite differences in the duration of the outright propagation of racist ideology, South Africa's state of standstill during the early 1990s as a result of said racism, is similar to those of other countries in southern Africa. The early 1990s was a time characterized by increasing deaths, increasing rates of infection and decreasing life expectancy, and a time when decisive governmental action could have arguably altered the course that we see the disease has taken. Unfortunately what was prevailing during that era – misinformation about the disease, including methods of transmission and prevention, as well as negative perceptions transmitted from the Western world, in spite of its more advanced knowledge of the disease – led to an attitude that the disease was something to be pushed aside.⁵³ That, if left disregarded, HIV/AIDS could reach the proportions it has was not a consideration.

There has thankfully been an attitudinal shift on the part of national governments. There is recognition of the need for aggressive action in order to effectively abate the havoc that the disease has wreaked. 'National Plans' have been formulated and seemingly there is agreement all around that the primary focus should be on prevention. Unfortunately, prevention programs in many southern African countries have been hampered because the attitudinal shift that has taken place within the government has not taken place among the general population. Vestiges of the links between the Black body and disease transmission are in the minds of the general population.

⁵³ Botswana Minister of Health Dr. Joy Phumaphi, "Botswana AIDS Crisis," *The Diane Rehm Show*, radio program, WAMU, American University Radio, Washington, DC, January 29, 2002.

THE STIGMA

One obvious indicator that negative perceptions of Africans and disease remain is the stigma attached to AIDS. Botswana Minister of Health, Dr. Joy Phumaphi states, “The biggest impediment to all [HIV/AIDS] intervention programs in Africa . . . is the stigma attached to being infected . . . because AIDS is associated with immorality.”⁵⁴ The stigma of STD infection, particularly HIV/AIDS infection, has promoted an atmosphere of silence surrounding issues of sex and sexuality. In Zimbabwe for example, within the Ndebele culture “the subject of sex is surrounded by secrecy and shame. As a result sexual partners do not discuss sexual matters easily, while African parents delegate sexual instruction of their children to other relatives, such as grandparents or aunts.”⁵⁵ An atmosphere of open communication on all prevention-related matters including sex and sexuality is necessary if intervention programs are to be successful. A case in point is Uganda, the first African nation to successfully slow down the epidemic. Much of this is due to President Museveni’s aggressive grassroots approach, in which he often personally addressed local communities, stressing the importance of HIV/AIDS and sex education, condom distribution and the importance of HIV testing.⁵⁶

A result of this stigma is an unwillingness to acknowledge AIDS’ presence. For example within communities AIDS-related deaths are not identified as such, regardless of

⁵⁴ Phumaphi.

⁵⁵ Dr. T. Vos, “Attitudes to sex and sexual behavior in rural Matabeleland, Zimbabwe,” *AIDS Care* 6(2) (1994): 193–203, 194.

⁵⁶ UNAIDS/WHO, Joint United Nations Program on HIV/AIDS, *AIDS Epidemic Update, December 2001*, Geneva, Switzerland, WHO/CDS/CSR/NCS/2001.2. In Uganda, HIV prevalence has seen consistent decrease over an eight year span. Among pregnant women prevalence, has fallen from 29.5% in 1992 to 11.25% in 2000.

how obvious the cause is: “At funerals in Botswana, there is always a ritual announcement of the cause of death, and it is almost never announced as AIDS. It is attributed to tuberculosis, or a mysterious ‘slimming disease,’ or the anger of ancestors.”⁵⁷ On an official level, in some communities, death certificates will list a co-infection as the cause of death without acknowledgement that the infection was AIDS-related. This stigma also manifests itself through what seems like a region-wide unwillingness to receive HIV testing. In Botswana less than five percent of the population has been tested despite the high prevalence – one-third of Botswana’s adults are HIV-positive as of December 2002.

SAFE SEX PRACTICES AND CONDOM USAGE

Safe sex practices, particularly condom usage, have been identified as another integral aspect of prevention programs. Alongside attempts to provide better access to condoms are efforts to educate the public about the importance of condom use during sexual activity. There is a legitimate fear that this message is not getting across however. Because of the air of silence around sex and sexuality, negotiating condom use is difficult. This is especially so for women, who have emerged as a risk group – they are in more danger of acquiring the disease than men. In many cultural groups traditional gender roles are still enforced: “In Zimbabwe, the superiority of men over women remains undisputed. Though at Zimbabwe’s Independence women’s social position was boosted by improvements in the law . . . men have remained firmly in charge.”⁵⁸ These cultural norms dictate that women, if they are to be viewed as respectable, maintain an air

⁵⁷ Michael Grunwald, “All-Out Effort Fails to Halt AIDS Spread; Botswana’s Program Makes Progress, but Old Attitudes Persist,” *Washington Post*, 2 December 2002, sec. A:1.

⁵⁸ Karla Meursing and Flora Sibindi, “Condoms, Family Planning and Living with HIV in Zimbabwe,” *Reproductive Health Matters* 5 (May 1995): 56-67, 58.

of shyness or shame about them, particularly with respect to sex. Thus a woman who expresses her desire to use a condom can potentially be seen as interested in sex and some may assume her to be a prostitute.⁵⁹

Another issue surrounding condom usage is the fear that they will break or malfunction in some other manner. Some have argued that these notions may actually be a response in protest of Western racism or other hints of Western superiority directed toward Africa: “[T]hese constructions appear to be protests of African nations against Western countries pushing their ideals of family planning, or that they are reactions to conspiracy theories that AIDS is a way for Western countries to get rid of Africans.”⁶⁰

Although attitudinal shifts in the government along with a significant step up in the intensity of the implementation of AIDS plans have made way for tremendous progress – Botswana’s antiretroviral treatment program sponsored by Merck is evidence of this⁶¹ – a change on the side of the government is not enough. Botswana again serves as an example to this – despite the institution of the antiretroviral treatment program, a “vast majority” of Botswanans have not been persuaded to submit to an HIV test. Oscar Motsumi, an officer in Botswana’s treatment program, is quoted as saying, “This country has been bombarded with HIV messages, but there hasn’t been any change in behavior . . . We need a new mindset.”⁶² The HIV/AIDS epidemic in Africa has reached such levels that everyone is a potential victim. A new mindset must absolutely take hold if

⁵⁹ Vos, 199.

⁶⁰ Karen Elizabeth Schifferdecker, *Poison in the Honey: Gender Ideologies, Sexual Relations, and the Risk of HIV Among Youth in Dar es Salaam, Tanzania*, Ph.D dissertation, University of Connecticut, 2000; Ann Arbor, Michigan, UMI Dissertation Services, University of Michigan, 2000, Microfilm.

⁶¹ Grunwald. The program offers free antiretroviral treatment to HIV/AIDS sufferers. Of the over 3000 patients that have enrolled so far, only five percent have died. It is estimated that had those patients not had the treatment the death rate among them would have been from 30% to 40%.

⁶² Ibid.

prevention efforts are to maintain the effectiveness, they have demonstrated in their early stages.

THE WESTERN RESPONSE

It is my belief that the Western response to the pandemic has been more than insufficient. I attribute this insufficiency largely to an ideology of racism toward Africa. The West's history with Africa has been one in which racism was a guiding principle and despite the end of overt, institutionalized racism in the Western world, racism still exists. It has merely shifted from the overt form to a covert and insidious form. The association of Blackness with pathology is still present within the West, dictating the treatment of Black people and the status they hold within its respective society, and therefore coloring its view of Black people in Africa and its response to HIV/AIDS within the continent.

FOREIGN AID

The West cannot be indicted for a lack of monetary aid to Africa in response to the crisis. In the United States alone, Africa has always dominated the humanitarian assistance budget – between 1988 to 1999, aid to Africa has been a considerable part of humanitarian assistance, with the lowest being in 1991 with 43% of all U.S. humanitarian assistance being given to African countries and at 84% in 1988. As the seriousness of the epidemic has become more apparent money geared toward AIDS has risen consistently, the most recent pledges being \$15 billion from the United States targeting AIDS specifically and approximately 320 million (in Euros) from the European Union targeting AIDS, tuberculosis, and malaria.⁶³

⁶³ European Union at the United Nations, "EU strengthens Programme for Action on HIV/AIDS," European Union at the United Nations: European Union, February 26, 2003, < <http://europa-eu-un.org/article.asp?id=2077>>;

United States Agency of International Development, The United States State Department, "Acting on our Compassion," < <http://www.usaid.gov/about/hivaids/>>

It has been argued that HIV/AIDS occupies a relatively small portion of national (or Union-wide) spending, in comparison to areas such as defense. I do agree with this argument, and find that there is a racist ideology at play in the de-prioritization of issues regarding Africa. What is harmful about this de-prioritization of Africa, with regard to progress on the disease is that a tremendous majority of the world's wealth is concentrated in the Western world, making its composing national governments, especially the United States, the best equipped to manage the issue. While there are other global entities, e.g. the WHO, and UNAIDS, who are bearing large responsibility as far as monetary assistance, the task of bringing HIV/AIDS under control on the continent is undeniably a long one, needing efforts which I feel extend beyond their capabilities. It is my belief that a long-term commitment to assistance, particularly monetarily, by those nations possessing the greatest amount of the world's wealth is necessary to complete this task.

ANTIRETROVIRAL TREATMENT

The aspect of the Western response that most reveals the presence of racist ideology at play, is the issue of providing antiretroviral treatment. The costs of antiretroviral treatment can approach US\$15,000 a year. This cost is obviously beyond the reach of some of the world's most impoverished people. Despite knowledge of this fact, the Western world participated in efforts to block making drug treatments more affordable.

In 1997 the South African government passed the Medicines and Related Substances Control Act which "allows South Africa to import cheap copies of patented

drugs.”⁶⁴ This act was highly contested by drug companies within the west, e.g. GlaxoSmithKline, Merck, Bristol-Myers Squibb, arguing that patent rights were being violated and that the act would hamper business. Drug companies went as far as to launch a court case asking for the act to not be implemented. The U.S. has also played a role in the denial of generic drugs. It was not until nearly three years ago that US trade policies connected to intellectual property were loosened to allow for African countries to import generic drugs.

The denial of access to treatment is essentially a death sentence. It demonstrates Western devaluation of human life, and within the African context, is arguably a case of the White West assuming racial superiority over Black Africa. This devaluation by the West I feel reinforces the negative mindset which allows for the stigmatization of AIDS and fosters the silence surrounding issues of sex and sexuality.

The case in the South African court was dropped in 2001, and as has been stated, Merck is sponsoring a five-year program of free antiretroviral drug treatment in Botswana. This points to a recognition of the true danger of this epidemic and signals a firmer commitment to abate its havoc. What must be kept in mind is that a mindset, resulting from years of colonization which had racism as one of its bases, is still plaguing Africa. The articulation of any racist ideology by the West (e.g. beliefs that Africans will not be diligent in maintaining the strict regimen demanded by antiretroviral drug treatment, a sentiment which has been expressed) reinforces the mindset. As has been discussed, this mindset threatens the long-term success of national HIV/AIDS

⁶⁴ Cable News Network (CNN), CNN.com, “AIDS drug court battle dropped,” April 19, 2001, <<http://www.cnn.com/2001/WORLD/africa/04/19/safrica.drugs/index.html>>.

intervention programs. The Western world has a significant role to play in changing this mindset.

CONCLUSION

Despite the great deal of attention given to the issue of HIV/AIDS in Africa, the situation does not seem to be getting better but worse – both infection rates for adults and children and death tolls are on the rise. In addition, a horrible relationship exists between the HIV/AIDS crisis and the poor infrastructure within many African countries, i.e. the HIV/AIDS crisis exacerbates structural problems and structural problems stifle intervention efforts.

What I hope has been demonstrated is that a shift in thinking needs to occur if long-term progress is to be made. This shift needs to occur within the West as well as in African countries. The short-term effects of this would be a more pro-active stance within the general African population. In the long-term I believe what will occur is Western recognition of just how much the cofactors (such as poverty and migrancy) effect disease transmission. Current thinking focuses response on the behaviors of African people, a dangerous focus. This is not to make light of the significant role sexual attitudes and activities plays in the current status of the disease, but to look at only behaviors is to make light of the other problems devastating the continent, keeping it in a Third World state. There is already recognition within Africa of the significance of structural cofactors: “Drug treatments, however, will not solve the crisis. That’s particularly true in Africa, where the health-care infrastructure is so feeble. Africans say they need more substantial help – particularly relief from crippling debt that drains health and education budgets.”⁶⁵ Perhaps this recognition by the West will be the impetus for more extensive effort into assisting African nations.

⁶⁵ Jeffrey Bartholet, “The Years,” *Newsweek* 17 January 2000, 33-37, 36.

The future of many African nations has been threatened by HIV/AIDS. It is clear that a dramatic change must occur to avoid the future that many have foretold. An ideological shift is such a change. How this will occur is up for debate. The grips of racism are tight, especially when it cannot be easily located. I do believe that just as our thinking dictates our actions, our actions can have the same impact on our thinking. So, perhaps that is the key. Action. Concerted efforts on both sides to not only recognize the ideologies behind their actions but to engage in acts that counter those ideologies, i.e. for the West to be more engaged, for many within the African population as well as their national governments, to acknowledge the disease, alter behaviors, and become more proactive. The effort will surely not be easy and surely some actions will be more effective than others. It is my belief, however, that with so much at stake, the effort no matter how difficult will be well worth it.

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