

*Part Three*

**HIV/AIDS in the History of Epidemics**



# Historical Perspectives on HIV/AIDS

## Lessons from South Africa and Senegal

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### Introduction

The historical discourse surrounding the HIV/AIDS pandemic in Africa has been politically charged from its inception. Initially, some actors believed that the disease could be grasped exclusively in medical terms, and it took some time before the importance of cultural and social aspects was acknowledged. Closely associated with the politics of HIV/AIDS in South Africa have been the views of the President of South Africa Thabo Mbeki. His interventions in the scientific and political discourse on HIV/AIDS will be discussed in the conclusion to this paper. However misguided his position, Mbeki is by no means the first to grasp that epidemics are mirrors of society and its social tensions. To understand the social history of health in disease in South Africa, as in all other societies, it is impossible to separate the human body from the body politic.

While no one would leave out the politics of HIV/AIDS today, too often the scourge is viewed as a unique, unparalleled and incomprehensible catastrophe. While it is true in one sense that every disease, and every pandemic is different, historical precedents do exist both in the history of disease in South Africa, and elsewhere on the continent. Historians can contribute to the debate, and perhaps distil lessons from the exercise. In two insightful essays on this theme, Howard Phillips has illustrated both the continuities and the discontinuities represented by HIV/AIDS in South Africa.<sup>1</sup> He also indicates in what sense the AIDS epidemic is unique, even if the response is not new. In this article, I draw on his examples and add my own from the social history of health and disease in Senegal.

### South Africa

South Africa's epidemiological record demonstrates how the politics of race have always been inextricably linked to public health issues. Sexually transmitted diseases (STDs) preceding HIV/AIDS have frequently spread with the accelerated migration of young male adults.<sup>2</sup> Seamen, soldiers and migrant workers have often been inadvertent carriers in South

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<sup>1</sup>Howard Phillips, "AIDS in the Context of South Africa's Epidemic History: Preliminary Historical Thoughts", *South African Historical Journal*, 45 (2001), 11-26; and "AIDS in South Africa: An Historical Perspective", *Society*, 40 (2003), 72-76.

<sup>2</sup> <sup>2</sup>Karen Jochelson, "Sexually Transmitted Diseases and AIDS in Nineteenth- and Twentieth-Century South Africa", in Setel, Philip W., Milton Lewis, and Maryinez Lyons (eds.), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*, Westport, CT: Greenwood Press, 1999, 217-43.

Africa and in the wider world. But South Africa's early and continuous practice of labour migration, together with the single-sex compound system of the mining economy, greatly facilitated the spread of syphilis (as well as respiratory ailments like tuberculosis). The system separated young black Africans from their wives for months or years, tolerated prostitution at the work sites, and then dispersed these labourers at the end of their contracts, often with these serious illnesses, back to their rural homes, where they unwittingly infected their loved ones.

Historical responses to infectious disease have followed a general pattern characterised by denial, blaming the victim, arbitrary use of state power, and criticism of allegedly negligent official authorities. Denial of the presence of the disease, or of its seriousness has occurred on several occasions. In the early 1880s Cecil Rhodes ordered his medical staff to dissimulate when a smallpox epidemic broke out among workers in the diamond fields around Kimberley. The illness they described they called "Kaffirpox". A similar euphemism designed to protect business interests prompted some physicians during the bubonic plague outbreak in Cape Town in 1901 to label the disease as a benign fever. During the apartheid years, the government of South Africa refused to acknowledge serious cholera outbreaks in the Bantustans to avoid having to build costly water purification plants.

Stigmatisation and the blaming of victims has a long association with epidemic disease. The South African version early on developed a racial tone. In the nineteenth century, the linkage of the Enlightenment notion of "rational" control over a dangerous state of nature combined with western bio-medicine to transform Africans into living laboratory specimens.<sup>1</sup> With the coming of bubonic plague to Cape Town and Port Elizabeth at the turn of the twentieth century, whites took discrimination one step further. Black Africans were uncivilised carriers of disease and needed to be separated from whites, a form of residential segregation which now dominated white discourse, and which Maynard Swanson famously labelled the "sanitation syndrome".<sup>2</sup> Bubonic plague and the politics of race and ethnicity helped diminish liberal resistance to discriminatory legislation in Cape Colony, and had implications bearing on the Constitutional Act of 1910, which established the South African Union on terms highly unfavorable to the interests of non-whites in the new federation.

For their part, some black Africans also saw disease in political terms, attributing the arrival in the 1890s of rinderpest, an imported cattle disease, as a deliberate white conspiracy to destroy African cattle and drive pastoralists into wage labour. A century later, some young African activists in Soweto satirically labelled AIDS "Afrikaner Invention to Deprive us of Sex", a scare tactic to control personal behaviour.

The arbitrary use of state power under the guise of medical exigency is another common feature. At various times, the state imposed the following discriminatory measures: a complete ban on Indian immigration during the cholera scares of the 1890s; the forced removal of black Africans from central Cape Town and Port Elizabeth during the bubonic plague outbreaks of 1901; the "de-verminisation" of all black African train passengers during the typhus epidemics of the 1920s and 1930s.<sup>3</sup>

Another infectious disease had an even more immediate impact on the political and social landscape of South Africa than did bubonic plague. The world influenza pandemic of

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<sup>1</sup> Jean Comaroff, "The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body," in Shirley Lindenbaum and Margaret Lock (eds), *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life* (Berkeley: University of California Press, 1993), 324.

<sup>2</sup> Maynard Swanson, "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909," *Journal of African History*, 18 (1977), 387-410.

<sup>3</sup> Shula Marks and Neil Andersson, "Typhus and social control: South Africa, 1917-50," in Roy MacLeod and Milton Lewis (eds.), *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: Routledge, 1988), 257-83.

1918 also contributed to the extension of discriminatory residential segregation laws.<sup>1</sup> It led to the 1919 Public Health Act and the later recommendations of the Stallard Commission, which in turn formed the basis of the Native Urban Areas Act of 1923. The terrible demographics of HIV/AIDS and the loss of a generation of young mothers and fathers has its echo in the influenza pandemic. It cost South Africa, like virtually every other jurisdiction in the world, roughly ten percent of its prime workforce and created a missing cohort that worked its way through society for a generation. The economic and social costs of HIV/AIDS mortality threatens to be far more severe, of course.

Racist policies both reflected and shaped the course of chronic health problems such as tuberculosis and the diseases associated with malnutrition.<sup>2</sup> Curative treatments pursued by the South African medical community did not succeed against a disease of poverty like tuberculosis because they failed to address the gross inequalities endured by black South Africans: a permanently transient labor force, overcrowded housing, inadequate sanitation, low wages, and poor health facilities. Similarly, South African nutrition scientists often inadvertently provided ideological support to white supremacists by denying, or not realising, that the political economy of mining was the real cause of South Africa's food inequalities, leading to much malnutrition among black South Africans. Instead, even those scientists who were liberals were blinkered by their assumptions that Africans were incompetent farmers, and that African women were inadequate mothers and wives. In this vast exercise in blaming the victims, many in the white research community showed disrespect for local cultures, and dismissed Africans as an ignorant people without scientific knowledge.<sup>3</sup>

## Senegal

In colonial Senegal as elsewhere in Africa, epidemics and public health policy to combat them became part of the ideological contest between conqueror and conquered. Deeply embedded in French medical assumptions was a triumphalist Enlightenment rationality which empowered Western bio-medical science while contemptuously rejecting the applied knowledge of local healing specialists.<sup>4</sup> Here again Africans were held to be a people without knowledge. Also rooted in the Enlightenment was the assumption that Western sanitary measures were humanitarian acts conferring moral legitimacy on their sometimes heavy-handed paternalist rule over "the other".<sup>5</sup> For many Senegalese, on the other hand, the bubonic plague outbreak was regarded as part of the colonial conquest, biological warfare in either symbolic or concrete form. European motives for attempting disease control were

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<sup>1</sup>Howard Phillips, *'Black October': the Impact of the Spanish Influenza Epidemic of 1918 on South Africa* (Pretoria: The Government Printer, 1990).

<sup>2</sup> Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989); and Diana Wylie, *Starving on a Full Stomach: Hunger and the Triumph of Cultural Racism in Modern South Africa* (Charlottesville: University Press of Virginia, 2001).

<sup>3</sup> Wylie shows how such disrespect persisted in the South African medical community well after 1945. Wylie, *Starving on a Full Stomach*, Part Three, entitled "People without Science: A Modern Rationale for White Supremacy." Several authors have addressed the connection between science and racism in South Africa. See among others Harriet Deacon, "Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town," *Journal of Southern African Studies*, 22 (1996), 287-308; Saul Dubow, *Scientific Racism in Modern South Africa* (New York: Cambridge University Press, 1995); and Susan Parnell, "Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation", *Journal of Southern African Studies*, 19 (1993), 471-88.

<sup>4</sup>Nancy Gallagher has argued that a similar power struggle occurred in Tunisia at the time of French conquest, when Arab medical specialists clashed with European practitioners of Western bio-medicine. See her *Medicine and Power in Tunisia, 1780-1900* (Cambridge: Cambridge University Press, 1983).

<sup>5</sup>Comaroff, "The Diseased Heart of Africa".

questioned, and the measures often fiercely resisted, partly because they were highly intrusive yet ineffective, and partly because they were simply alien.<sup>1</sup> Moving forward a century, the same belief in a conspiracy theory prompts some young Francophone Africans to call HIV/AIDS, whose acronym in French is SIDA, “Syndrome imaginaire pour décourager les amoureux” (an imaginary syndrome to discourage lovers). The parallel with South Africa here as well is striking.

The politics of public health in colonial Senegal have manifested themselves in the histories of yellow fever, bubonic plague, influenza, and STDs. Yellow fever was endemic, and most Senegalese survived their first encounters with the disease in childhood and acquired lifelong immunity.<sup>2</sup> Not so for “unseasoned” fresh arrivals to the colony, most of whom were French. Once the vector was understood to be the *Aedes Egypti* mosquito, French health authorities embarked upon a vigorous campaign to eradicate the mosquito and its breeding sites in stagnant water. A major piece of legislation was the so-called “law of the three interdictions”, passed on 12 December 1912, prohibiting the collection of rainfall on roofs, in bottles on walls, or in ground-level containers. Yet drinking water, especially in Senegal’s northern towns, was always in short supply. Since health authorities did nothing to address the problem of an adequate supply of potable water, small wonder that the Senegalese population deeply resented legislation which addressed the health needs of the small French minority, and ignored Senegalese concerns.

In 1914, the third world pandemic of bubonic plague arrived in Senegal, not to withdraw for the next thirty years. French attitudes towards urban living in Senegal at that time were no different from those of Europeans elsewhere on the African continent. Precedents and policy for separating Senegalese from Europeans in the towns and cities of Senegal go back at least to the foundation of Dakar in 1857. Here too the “sanitation syndrome” was at work. Virtually the entire French medical community agreed that Senegalese should live separately from the French, and used the Dakar bubonic plague outbreak of 1914 as a paradigmatic case.<sup>3</sup> Private and public French voices not only blamed the Senegalese victims of this scourge, they sought to exploit the epidemic to intensify their control over African property and lives in Dakar. The most glaring example was the creation the Médina as a segregated village removed from the central plateau area dominated by French businesses and residences.

To combat the plague, health authorities authorised highly intrusive and coercive measures. Although quarantines and *cordons sanitaires* were ineffective against biting insect-borne diseases, officials insisted on these practices, which caused food shortages in outlying villages and added to the death toll. Control of cultural space was violated by the denial of Muslim and other ritual burials in favour of mass burials in lime. Health officers burned the property of Senegalese while sparing unsanitary French buildings. They made anti-plague vaccination compulsory for Senegalese, and optional for French, even though the inoculation offered only limited protection and brought with it harsh side effects. As in South Africa, the Senegalese population responded with resistance ranging from failure to report cases and clandestine burial to harassment of health agents, strikes, boycotts, and street demonstrations. Some even went so far as to interpret bubonic plague, or the vaccination campaigns, as an attempt of the French to wage biological warfare on the Senegalese majority. Most

<sup>1</sup>Myron Echenberg, *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914-1945* (Portsmouth, NH., 2002).

<sup>2</sup>Myron Echenberg, “‘For their own good’: The Pasteur Institute and the quest for an anti-yellow fever vaccine in French Colonial Africa”; in Jean-Paul Bado (ed.), *Conquêtes médicales: Histoire de la médecine moderne et des maladies en Afrique* (Paris: Karthala, 2005).

<sup>3</sup>See Raymond F. Betts, “The Establishment of the Medina in Dakar, Senegal, 1914”, *Africa*, 41 (1971), 143-52; Elikia M’Bokolo, “Peste et société urbaine à Dakar: l’épidémie de 1914,” *Cahiers d’études africaines*. 22 (1982), 13-46; and Assane Seck, *Dakar, Métropole ouest-africaine* (Dakar, IFAN, 1970).

importantly, and in contrast to South Africa, a small, politically aware Senegalese elite used legal means to resist arbitrary treatment. Blaise Diagne and the Senegalese *évolués* successfully opposed discrimination masking as health policy. Residential segregation in the Dakar Médina failed, and Senegalese, mostly assimilated but some not, continued to live in the city centre.

The world influenza pandemic struck Senegal in the fall of 1918 and affected work in fields following the rainy season.<sup>1</sup> Schools and clinics were closed, and the colonial administration virtually ceased to function in most regions of the country for six weeks. Upon its retreat, flu left roughly 47,000 dead among population slightly over 1 million, making it the worst single medical calamity in modern Senegalese history. As was the case the world over, health authorities lamely sought to control flu's spread and to cure its victims. Nevertheless, the chief of the Health Service, Dr. Thoulon, believed in alcohol as a stimulant and prescribed this, even for Muslim patients. Its compulsory administration to Senegalese soldiers caused great offense to their families and to Muslim religious authorities.

No full study of the earlier history of STDs in Senegal yet exists. An overview by Charles Becker and René Collignon suggests a pattern common to the experience of South Africans. French colonial public health officials were too quick to blame Senegalese, and to assume a high prevalence of STDs without sound evidence. Social Darwinist assumptions too often led health authorities to predict degeneration of the population. Rather than recognising stoicism in the face of scourges which could not be easily recognised or treated, French health officials castigated the Senegalese for their indifference to chronic gonorrhoea and symptoms of primary syphilis, or for their allegedly "excessive copulation".<sup>2</sup>

Yet colonial health authorities did take one step which would bear fruit later. They imposed controls on sex workers, obliging them to submit to medical inspection and licencing periodically. The arrival of antibiotic injections in the 1950s created a revolution in treatment, and by the time of independence, the capital region of Dakar had some control over STDs, an issue of some importance when the country would encounter HIV/AIDS.

Despite historical similarities with South Africa in its colonial public health history, Senegal's recent experience differs greatly in one dramatic sense, its encounter with HIV/AIDS. As John Iliffe notes in his excellent new history of the HIV/AIDS pandemic in Africa, Senegal "was arguably the only country in sub-Saharan Africa to prevent a generalised HIV/Aids epidemic, its adult prevalence never rising much above 1 per cent."<sup>3</sup> Drawing on Green, and especially N. Meda et al, Iliffe offers a series of explanations for Senegal's good fortune.<sup>4</sup>

First, the initial infection to strike Senegal was the less virulent HIV-2 form. The first HIV-1 case was not observed until 1986. HIV-2 was endemic among sex workers in Dakar and especially in southern Casamance, bordering on the epicentre of the disease in Guinea-Bissau. The first HIV-1 cases were mainly foreigners or Senegalese men who had travelled

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<sup>1</sup> Myron Echenberg, "'The dog that did not bark': memory and the 1918 influenza epidemic in Senegal"; in David Killingray and Howard Phillips (eds.), *The Spanish Flu Pandemic of 1918-19: New Perspectives* (London: Routledge, 2003), 230-38.

<sup>2</sup> Charles Becker and René Collignon, "A History of Sexually Transmitted Diseases and AIDS in Senegal: Difficulties in Accounting for Social Logics in Health Policy"; in Setel, Philip W., Milton Lewis, and Maryinez Lyons (eds.), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport, CT: Greenwood Press, 1999), 73.

<sup>3</sup> John Iliffe, *The African Aids Epidemic, A History* (Athens: Ohio University Press, 2006), 71

<sup>4</sup> In addition to Iliffe, see also Edward C. Green, *Rethinking AIDS prevention: learning from successes in developing countries* (Westport: Praeger, 2003), p. 227-37; and especially N. Meda, I. Ndoye, et al, "Low and stable HIV infection rates in Senegal: natural course of the epidemic or evidence for success in prevention?" *AIDS*, 13 (1999), 1397-1405

elsewhere in West or Equatorial Africa and who frequently had histories of homosexuality and drug use.

The second factor was cultural, having to do with conservative Muslim values. Senegal's overwhelmingly Muslim population everywhere except the Casamance experienced a late median age for sexual debut, at roughly 19 years for both sexes in the late 1990's. Non-marital sex rates were low outside the capital of Dakar, and condoms were widely used with casual partners. Muslim leaders cooperated with the country's Aids Control Program, launched as early as 1988, and discussed the disease and behaviour in their Friday sermons. Unlike many Christian churches elsewhere in Africa, Islam had a tradition of leaving moral judgments to God and of rejecting stigmatization for those who were HIV positive.

Third, the Government took an enlightened approach to the disease from the outset. President Abdou Diouf was proactive, and quick to allow the Senegalese medical community to intervene, whether to control the blood supply, to use public education, or to accept assistance from international non-governmental organizations.

Lastly, Senegal's historical public health experience contributed to success. Under French rule, the licensing and inspection of sex workers had constituted a mechanism of control of STDs which was not found in former British territories in Africa. In post-colonial Senegal, health authorities not only expanded the number of health clinics treating STDs from Dakar to other towns, they established a medical culture in which people were encouraged to seek biomedical treatment for STD infections.

## Conclusion

No discussion of HIV/AIDS in South Africa past or present can avoid the controversy pitting President Thabo Mbeki against the international scientific community and the pharmaceutical companies. Several writers have addressed Mbeki's position on AIDS.<sup>1</sup> Mbeki has been stung by the assumptions about African inferiority and sexual promiscuity buried within conventional AIDS wisdom.<sup>2</sup> His experience as a black South African has taught him that labels of inferiority ultimately translate into arguments and policies reinforcing subordination.<sup>3</sup> Arguing that the pace of AIDS infection has been different in Africa than in West, he believes it requires an African response to the problem. In Africa, the disease has attacked heterosexuals, has attained a much higher death rate, and the figures continue to rise in epidemic proportions.

Yet Mbeki has also gone further. Although he has claimed not to endorse dissident theory, and purports to keep an open mind, he has defended these dissidents against what he feels have been vicious attacks reminiscent of the apartheid days. He has also resented the neo-colonial tone of many scientists who have often spoken as if the only freedom of Africans "was to consent to truths they decreed in their scientific establishments."<sup>4</sup> Finally, Mbeki

<sup>1</sup> See Philippe Denis, "La croisade du président Mbeki contre l'orthodoxie du sida", *Esprit*, 271 (2001), 81-97; Helen Schneider, "On the fault line: the politics of AIDS policy in contemporary South Africa", *African Studies*, 61 (2002), 145-68; Deborah Posel, "Politiques de la vie et politisation de la sexualité", in Didier Fassin (ed.), *Afflictions. L'Afrique du Sud de l'apartheid au sida* (Paris: Karthala, 2004), 47-73.

<sup>2</sup>Randall M. Packard and Paul Epstein, "Medical Research on AIDS in Africa: A Historical Perspective"; in Fee, Elizabeth and Daniel Fox (eds.), *AIDS: The Making of a Chronic Disease* (Berkeley: University of California Press, 1992) 350; Rosalind J. Harrison-Chirimuuta, "AIDS from Africa: Western Science or Racist Mythology?"; in Andrew Cunningham and Bridie Andrews (eds.), *Western Medicine as Contested Knowledge*, Manchester: Manchester University Press, 1997, 46-68.

<sup>3</sup>Howard C. Stevenson, Jr., "The Psychology of Sexual Racism and AIDS: An Ongoing Saga of Distrust and the "Sexual Other", *Journal of Black Studies*, 25 (1994), 77.

<sup>4</sup>See Mbeki's open letter to President Clinton and to Secretary-General Annan, in the *Sunday Times* (South Africa), 23 April 2000. Full text at [www.virusmyth.com](http://www.virusmyth.com).

continues, the HIV/AIDS issue has perpetuated the negative image of Africa as a sick continent, and has led to “Afro-pessimism”, the belief that there is no hope for the future. Well before the AIDS controversy sprang up, Mbeki had been a proud articulator of the “African Renaissance”, as a means of having Africans rediscover and affirm their cultural identity.<sup>1</sup>

Although sincerely felt, Mbeki’s rigid and reductionist opinions have done considerable damage to the struggle against HIV/AIDS in South Africa.<sup>2</sup> He has failed to realise that while medical epidemics are constructed, they also kill people. Two remarkable figures with a political history similar to Mbeki’s, Nelson Mandela and Zackie Achmat, have understood this well. As Mandela has often said, “HIV/AIDS is a war on humanity”. Mandela’s moral intervention and Achmat’s activism have done much to bring about a change in the South African government’s position.

Mandela’s tremendous prestige and his impressive skills at mediation became evident during the Eleventh World Congress on HIV/AIDS, which met in Durban in July, 2000. For the first time, extensive discussion took place around the hitherto neglected social, economic, cultural and political dimensions of the pandemic. While Mbeki remained intransigent, and continued his attack on what he called the “grossly unethical” behaviour of the giant pharmaceutical companies, Mandela put his mediator’s skills to work at Durban:

I do not know enough about science or the politics of science to even start to contribute to the debate raging around the periphery of this conference. But in all disputes, a point is arrived at where no party – no matter how right or wrong – will any longer be totally right or totally wrong.<sup>3</sup>

Mandela had grown troubled by the misunderstandings Mbeki’s objections might produce. By denying the seriousness of HIV/AIDS or by reading it as a western conspiracy, Mbeki allowed young South Africans to believe that they did not have to modify their sexual behaviour. Especially worried about mother-to-child transmission, Mandela was anxious to see the South African government endorse the use of the anti-retroviral (ARV) drug, Nevirapine. Mandela’s speech at Durban called on South Africa to join with Uganda, Senegal, and Thailand in mounting concerted action to combat mother-to-child transmission, pursue vaccines, and end stigmatisation and discrimination of victims.

Meanwhile, an HIV-positive South African named Zackie Achmat was making a name for himself and the movement he founded, the Treatment Action Campaign (TAC).<sup>4</sup> Ironically, Achmat shared with Mbeki a history of activism and militant resistance to apartheid, but their diverging personal experiences had carried them down very different paths. While Mbeki, a senior figure in the African National Congress, was hand-picked by Nelson Mandela to succeed as head of the African National Congress and president of South Africa, Achmat was organising fellow HIV-positive South Africans to oppose the negative position of Mbeki and his government towards ARVs.

Achmat shared some of Mbeki’s assumptions but reached very different conclusions. He recognised that the AIDS discourse presenting a sick and promiscuous African had deep colonial roots, and he also resented Afro-pessimism as the latest discourse of African inferiority. He also expressed anger at the greed of the pharmaceutical companies. But unlike Mbeki, Achmat recognised the value of the ARVs, and pushed hard to alter pricing policies

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<sup>1</sup>See Thabo Mbeki “I am an African”, statement made on the occasion of the adoption of the Constitutional Bill by the Constitutional Assembly, Cape Town, 8 May 1996, reprinted in Thabo Mbeki, *Africa. The Time has Come. Selected Speeches by Thabo Mbeki* (Cape Town: Tafelberg, 1998).

<sup>2</sup>Denis, “La croisade”; Hein Marais, *To the edge: AIDS Review 2000* (Pretoria: University of Pretoria, 2000).

<sup>3</sup>The full text of his address can be found in “Nelson Mandela on Treatment Access”, October, 2003; <<http://www.thebody.com/atn/393/mandela.html>>.

<sup>4</sup>Zackie Achmat, “Treatment Access as a Human Right”, October, 2003. <http://www.thebody.com/atn/393>.

while also urging Mbeki to change his position. Using tactics of the anti-apartheid years such as street demonstrations and civil disobedience, the TAC kept up pressure for a change in public health policy. Achmat and the TAC mobilised 5,000 people wearing HIV-positive tee shirts into the streets at the Durban Conference in 2000.

Achmat and the TAC put forward a wise suggestion that researchers needed to focus on co-factors in HIV/AIDS, rather than on blaming victims for their risky behaviour. Attention needed also to be paid to structural inequalities which caused patients to die from a treatable disease because they were poor. Achmat had grasped the lesson of history which had escaped Mbeki; that criticism of the old politics of health and disease should not lead to the rejection of such demonstrably useful products of western bio-medicine as ARVs which had transformed HIV/AIDS into a chronic rather than a life-taking disease.

After Mandela and Achmat had taken the stage at Durban in 2000, in the fall of that year Mbeki reluctantly gave ground. Since 2001, he has remained relatively silent on the AIDS issue, probably as a result of pressure from the trade unions and the business sector. His government has also allowed Nevirapine to be administered to pregnant HIV-positive women in KwaZulu-Natal. The victory not only promised to save thousands of lives in South Africa. It also demonstrated the power of civil society in a democracy to create positive change.

The history of how societies have responded in the past to pandemic disease offers a simple but important lesson in public health policy. The experiences of colonial Senegal and of South Africa would suggest that health policies and programs imposed from above which do not respect subaltern voices are doomed to face strenuous resistance and likely failure. Senegal's post-colonial history, however, offers a more positive lesson. It shows that health policies attuned to the local medical, cultural and social environment are much more likely to succeed.